Anatomy of a Reservation of Rights Letter

In insurance, as in any business, the name of the game is to attract more buyers so as to increase revenues and improve profit margins. In a competitive market, the game becomes even more challenging, and companies look for ways to distinguish themselves from their competitors by offering new products or by enhancing their existing products and services to make them more client-friendly.

In the insurance industry, we talk about claims service as being the ultimate product that an insurance company sells. If that’s true, and if the name of the game is to please the customer by offering improved, client-friendly products, why then do insurance companies so often respond to the notice of a claim submitted by an insured or by their broker on their behalf with a letter referred to in the industry as a Reservation of Rights (R of R) letter? At best, these letters raise concerns in the mind of the insured and at worst, they not only frighten the insured, but often infuriate them, and confirm the already deeply held suspicion that the insurance company is looking for ways not to pay the claim.

Anyone who has worked in the insurance industry for even a modest period of time knows that it is a complex, multi-dimensional industry. The challenge for brokers is to understand the client’s needs, and then locate a product or cluster of products that will meet those needs for the lowest or most reasonable price possible relative to the value represented by that product.

Insurers price their products based on their best guess of what it will cost to sell the product and pay the estimated number of claims that are expected for a particular risk. In order for the product to be profitable, those predictions must hold true. If the insurer were to pay claims that were not intended to fit within the scope of the coverage provided, that would negatively impact on the predictions, and the product would not produce the expected profits. The insurer may then have to discontinue the product or charge a higher premium for it.

The trouble is that claims don’t often come in nice, neat packages with allegations that fall perfectly within the scope of coverage. There are some claims that include only a single allegation that fits squarely within the scope of coverage under the policy. For example, an allegation of defamation will fall within the scope of coverage under most CGL policies. However, most often there will be a collection of allegations within the claim, some of which fit within the scope of coverage while others do not. In those situations, even though the insurer may be sympathetic to the plight of the insured, if the insurer were to cover such uncovered allegations, it would likely pay out more in claims than predicted, and the pricing model would fail, resulting in the insurer having to either increase the price or discontinue the product offering — neither of which is beneficial to the insured. But the law in Canada is clear that the insurer cannot just be silent about those allegations that do not fit within the scope of coverage. The Supreme Court of Canada has given insurers clear instructions on how to assess coverage. In Nichols v. American Home Assurance Co., [1990] 1 S.C.R. 801, the Supreme Court of Canada held that the insurer must assess coverage based on the allegations set out in the claim. The
Supreme Court also made it clear that if there is a possibility that the duty to indemnify will be triggered based on the allegations in the claim, the insurer’s duty to defend will be triggered. Canadian Courts have also made it clear that if an insurer does not point out areas of non-coverage that it is aware of when the claim is reported, and if the insured is prejudiced as a result of the insurer’s silence on the subject, the insurer will be prevented or, in legal parlance, estopped, from denying coverage at a later date.

Enter the R of R letter, the purpose of which is to ensure that the relationship between the insurer and the insured remains transparent, and that the insured fully understands the scope of the coverage that they will receive from the insurer and, what is perhaps more important, any limitations on the scope of that coverage.

The R of R letter is a necessary evil within the insurance industry. Necessary for the reasons stated above. Evil because insurers don’t like sending them, insureds don’t like receiving them, and they create tension between the two. The question becomes what, if anything, can be done to ease the pain of having to send and receive the dreaded R of R letter?

**Step one** is for brokers and insureds to understand that insurers are required by law to be clear and upfront about what their intentions are with respect to coverage when notice of a claim is received. Sometimes the facts of the claim are such that it can take some time to finalize this process. Sometimes the allegations are such that coverage will not be determined absolutely until the case is resolved. For example, many directors and officers policies carry a fraud exclusion that is only triggered in the event that fraud is determined by final adjudication of the matter. In that scenario, the reservation of rights must remain in place until the matter has been concluded, given the very nature of the exclusion. Moreover, Statements of Claim are often amended in order to add or remove parties and/or allegations. An R of R letter is required in each of these scenarios so as to alert the insured to potential areas of non-coverage. The intent of the letter is not to frighten or intimidate the insured, or to wiggle out of covering the claim; the intent is to maintain a transparent relationship between the insurer and the insured.

**Step two** is for insurers to remember that they are only required to reserve their rights with respect to areas of coverage that are uncertain at the time that the notice of claim is received. If it is necessary to investigate the facts of the loss to determine or clarify certain areas of coverage, the reservation of rights should be updated and/or removed once the investigation is complete and the coverage issue resolved. In some cases, the reservation of rights must necessarily remain in place throughout the life of the claim due to the nature of the coverage, as mentioned above in the context of the fraud allegation. However, if fraud is not alleged, there should be no reservation of rights on that issue. The insurer can simply reserve its rights to further assess coverage in the event of any amendment to the claim. This meets the requirement of transparency while avoiding a situation where the insurer reserves on every exclusion under the policy in the absence of any allegation that relates to the exclusion.

**Step three** is for brokers and insurers to work together to educate the insured with respect to the purpose of the R of R letters so as to reduce the intimidation factor associated with these letters. It’s human nature to fear the unknown. If we can remove some of the mystery surrounding these
letters, perhaps we can succeed in removing or, at a minimum, reducing the intimidation factor, thereby making the necessary R of R letter seem a little less evil.

ENCON’s practice is to copy the broker on R of R letters so he or she is aware of the issues and is, therefore, in a position to discuss the reservation of rights with the client and bring forward any questions that the client or the broker may have with respect to the information set out in the letter. On complex reservations of rights, we go one step further and contact the broker in advance of issuing the letter to ensure that the broker is aware of the reservation of rights and can raise any questions that he or she may have and be in a position to discuss the letter with the client.