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McCarter & English LLP on Insurance Coverage for Greenwashing Claims

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McCarter & English LLP on Insurance Coverage for Greenwashing Claims: It Depends on the Packaging

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SUMMARY: This commentary discusses how the Personal and Advertising Injury Liability part of the standard commercial general liability form may provide coverage for "greenwashing" claims, and possible barriers to coverage under the Failure to Conform exclusion. ("Greenwashing" refers to claims that a product or service advertised as ecologically sound does not live up to its representations.)

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ARTICLE: In an age of increased environmental consciousness, many companies believe that "green" marketing yields more greenbacks. And for good reason - in a recent survey, over 60% of consumers surveyed across eight developing and developed countries "want to buy from environmentally responsible companies." n1

Some "green" products, however, may fail to live up to their eco-friendly claims (or at least someone will say they do). "Greenwashing" is the term coined to describe the practice of companies' deceptively representing their products as environmentally friendly. n2 Besides being dishonest, engaging in greenwashing can have serious consequences for companies in the form of enforcement actions by the Federal Trade Commission ("FTC") n3 and lawsuits by both consumers and competitors.

The FTC has guidelines for environmental marketing claims, commonly known as the "Green Guides." n4 While the Green Guides themselves do not have the force of law, actions inconsistent with the guidelines may result in the FTC taking "corrective action," if, after investigation, it has reason to believe that the behavior falls within the scope of conduct declared unlawful by Section 5 of the FTC Act. n5 The Green Guides list several examples of environmental marketing that may give rise to "greenwashing" claims. These include unqualified claims of "recyclability;" deceptive claims of recycled content, "degradability," "compostability," or ozone "friendliness;" overstatement of a product's environmental friendliness; and selective description of a product's environmental safety. n6 In conjunction with FTC actions against "greenwashers," civil litigation has been filed asserting the Green Guides as the standard against which alleged greenwashing is measured. n7

Greenwashing Claims on the Rise?

The FTC has published proposed revisions to its Green Guides. It began the review process in 2008 - a year earlier than scheduled - because of an increase in claims asserting improper green advertising. n8 If adopted, the proposed revisions will make the Green Guides both stricter and broader in scope. n9 For example, while the current Green Guides permit unqualified claims that a product has a "general environmental benefit" (e.g., "green" or "eco-friendly") if the marketer of that product can substantiate all express and implied claims, the proposed revisions categorically forbid these type of claims as being "difficult, if not impossible, to substantiate." n10 The proposed revisions further state that marketers should use clear and prominent language limiting unqualified certifications or seals of approval to a particular benefit that can be substantiated. n11 Additionally, the proposed revisions provide guidance for claims regarding renewable materials, renewable energy and carbon offsets, which are not contained within the current Green Guides. n12

Consumers' perceptions of claims of environmental benefit were among the concerns driving the FTC's revision of the Green Guides. n13 The FTC conducted a study of consumers' reactions to advertisers' "green" claims. n14 The study found that 52 percent of respondents viewing an unqualified claim that a product was "green" believed that the product had a specific attribute (e.g., that the product was made from recyclable materials, or that the product was compostable). n15 Similarly, 49 percent of respondents viewing an unqualified claim that a product was "eco-friendly" believed that the product had a specific environmental benefit. n16 On the other hand, when the general environmental claims were qualified, 31 percent of the individuals surveyed believed that the claim implied specific environmental benefits in addition to the stated attributes. n17

Even without stricter regulatory guidelines, consumer claims of deceptive environmental marketing have been on the rise. For example, since 2007, at least four consumer lawsuits have alleged that companies have falsely advertised their products' environmental impact. n18 One can also expect a rise in the number of lawsuits alleging unfair competition due to false claims of environmental benefits, under both the federal Lanham Act (which permits a company to recover for damages caused by false statements made by its competitor about its product or the competitor's own product) and state enactments of the Uniform Deceptive Trade Practices Act. n19

The anticipated rise in a new type of claim naturally begets the question, "Will my liability insurance cover it?" Because greenwashing claims are of recent vintage, courts have not had the opportunity to address coverage for them under traditional commercial general liability ("CGL") policies. Whether the defense of a greenwashing claim is covered, however, will ultimately depend on how it is pled in the underlying lawsuit when compared to the relevant policy. Assuming a plaintiff is successful, whether the insurer will indemnify for any judgment or settlement will depend on how the facts themselves correlate to the policy language. In this commentary, we attempt to read the tea leaves on this emerging issue by examining cases pertaining to insurance coverage for advertising injury claims.

Personal and Advertising Injury Liability Coverage

Generally, CGL policies provide coverage for certain misstatements under the "personal and advertising injury" coverage. Those provisions provide the policyholder with coverage for damages arising out of third-party claims for injury allegedly caused by statements made by the policyholder in certain circumstances, including marketing and advertising. Greenwashing claims would fall within advertising injury liability coverage because they typically arise from a company's promotional statements.

Many liability carriers model their CGL policies on the standard CGL form published by Insurance Services Office, Inc., universally known as ISO. The most recent edition of Coverage B Personal and Advertising Injury Liability of this form as of this writing in November 2010 states: "We will pay those sums that the insured becomes legally obligated to pay as damages because of 'personal and advertising injury' to which this insurance applies." n20 The form goes on to define "personal and advertising injury" as

injury, including consequential "bodily injury", arising out of one or more of the following offenses:

* * *

d. Oral or written publication, in any manner, of material that slanders or libels a person or organization or disparages a person's or organization's goods, products or services;

* * *

f. The use of another's advertising idea in your "advertisement," n21 . . .

If one is subject to a claim for "greenwashing," one can generally see the outlines of coverage under provisions d. and f., provided that the allegation can be construed as asserting a disparagement of another's product or the use of another's advertising idea.

Showing that a claim falls within a policy's grant of coverage is only half the battle. To ultimately obtain coverage the policyholder must also avoid the application of any asserted exclusions. One potentially applicable exclusion is the 2007 ISO form's Quality or Performance of Goods - Failure to Conform to Statements ("Failure to Conform") exclusion. This exclusion bars coverage for:

"Personal and advertising injury" arising out of the failure of goods, products or services to conform with any statement of quality or performance made in your "advertisement." n22

Unfortunately, the 2007 ISO Form has not been extensively litigated so insight into the operation of its provisions must also be gleaned from decisions concerning earlier forms. Several published cases pertaining to advertising injury liability deal with language similar to that of the 1986 ISO form, which provides coverage for "personal injury" and separately for "advertising injury." The 1986 form defines "advertising injury" as

injury arising out of one or more of the following offenses:

a. Oral or written publication of material that slanders or libels a person or organization or disparages a person's or organization's goods, products or services;

* * *

c. Misappropriation of advertising ideas or style of doing business; n23

The "misappropriation of advertising ideas" coverage in the 1986 form strongly parallels the 2007 form's "use of another's advertising idea."

The earlier forms also include another form of the Failure to Conform exclusion, which excludes coverage for:

"Advertising injury" arising out of:

* * *

(2) The failure of goods, products or services to conform with advertised quality or performance. n24

Advertising Injury Cases Involving Disparagement

"Disparage" is not a defined term in either the 2007 or 1986 ISO form. Accordingly, courts have looked to dictionaries to inform their understanding. In *Virtual Business Enterprises, LLC v. Maryland Casualty Co.*, n25 for example, the Delaware Superior Court relied on an on-line dictionary to establish that a reasonable meaning for "disparage" was "to lower in rank or reputation; ... to depreciate by indirect means." n26 Further, it is not required that a specific party be named for disparagement to occur. Federal courts in California and Illinois have recognized claims

for coverage for implied disparagement, where the insured touted the superiority of its product, necessarily implying the inferiority of its competition. n27

Knoll Pharmaceutical Co. v. Automobile Insurance Co. of Hartford demonstrates the application of implied disparagement. The underlying lawsuits involved actions (mostly class actions) by consumers and third-party payors against Knoll Pharmaceutical Co. ("Knoll") and other defendants regarding the sale and marketing of Synthroid, a synthetic form of a thyroid hormone, used to treat thyroid disease. n28 The underlying complaints alleged, among other things, that Knoll "concealed or suppressed information about cheaper bioequivalent drugs, falsely represented that there were no equivalents, and charged individual consumers and their insurers more than they would have been able to [charge] if the correct information had been known, in violation of federal antitrust and racketeering laws and state fraud statutes." n29 Among other things, the underlying complaints pointed to Knoll's corporate predecessor's advertisement for Synthroid stating that "there is no substitute for Synthroid," that there was "no proven bioequivalent product," and that "no adequate and well-controlled studies have demonstrated bioequivalence among levothyroxine sodium [Synthroid's active ingredient] products." n30

Knoll's CGL policies provided coverage for "advertising injury...arising out of," among other things, "oral or written publication of material that slanders or libels a person or organization or disparages a person's or organization's goods, products or services." n31 Knoll's insurers refused to defend it in the underlying lawsuits, causing Knoll to file a declaratory judgment action, which sought various types of relief, including a declaration that the insurers had the duty to defend it in the underlying lawsuit. n32

The insurers argued that they did not have a duty to defend Knoll because the underlying claims did not fall within their policies' advertising injury coverage. n33 The insurers asserted that the underlying allegations did not constitute "oral or written publication of material that slanders or libels a person or organization or disparages a person's or organization's goods, products or services." n34 The insurers further argued that the terms "slander," "libel," and "disparagement" entail an element of reputational injury to the plaintiff or its goods, and thus, the underlying complaint must allege direct injury from these offenses in order to trigger the duty to defend. n35

The court disagreed with Knoll's insurers, holding that they owed a duty to defend Knoll in the underlying lawsuits. n36 The court reasoned that the while the underlying complaints did not allege direct injury from the offenses enumerated in the policies, the allegations nonetheless fit within the policies' definition of advertising injury:

Defamation, which includes slander and libel, has been defined as words that reflect critically upon one's integrity in her business or profession, [citation omitted] and as a statement tending to cause harm to the reputation of another in that it lowers that person in the community's eyes or deters third persons from associating with that person, [citation omitted]. Consequently, allegations claiming that . . . [Knoll] advertised that Synthroid is superior to all other drugs that treat thyroid problems [citation omitted] are disparaging in that they criticize the quality of other companies' . . . products as being inferior to Synthroid. n37

One can imagine a covered claim for implied disparagement arising in the context of greenwashing. For example, Green & Co. affixes to its products a label with a picture of a globe surrounded by the text Smart for the Earth[™]. The label does not contain any further statements that would clarify the meaning of the logo. n38 A group of consumers brings a class action lawsuit against Green & Co., alleging that the logo on Green & Co.'s products was deceptive because it led them to believe the products were environmentally superior to other, less expensive products. Putting aside the question whether Green & Co. can substantiate its claimed environmental superiority, as in *Knoll*, Green & Co. could argue that the allegations in the consumer class action are covered under a theory of implied disparagement because the class action plaintiffs are claiming injury arising out of Green & Co.'s statements that its products are better than those of its competitors. n39

Advertising Injury Cases Involving "Misappropriation of Advertising Ideas or Style of Doing Business"

Neither the 1986 ISO form nor the current ISO form defines the term "advertising idea[s]." Generally, an advertising idea concerns the solicitation of business or manner in which one advertises. n40 Cases involving misappropriation of another's advertising idea provide some guidance on how courts may find coverage for some types of greenwashing claims. In those cases, policyholders sought coverage for third-party claims alleging that they somehow falsely presented their products to the marketplace, and that the false presentation caused injury to the third-party claimant in the form of lost sales or devaluation of its product. These types of cases provide a useful framework for considering coverage for greenwashing claims because greenwashing claims typically deal with a company's overstating or misstating its product's environmentally friendly attributes.

One such case is *Atlapac Trading Co., Inc. v. American Motorists Insurance Co.* n41 There, the plaintiff in the underlying lawsuit, Tama Trading, Inc. ("Tama") alleged that Atlapac Trading Company, Inc. ("Atlapac") falsely labeled its olive oil products as "pure olive oil" when instead they consisted of blends of other oils. n42 Tama further alleged that Atlapac's false labeling and marketing included pricing its blended oils well below the prices that Tama offered for its olive oil. n43 Tama claimed damages in the form of lost sales due to Atlapac's ability to charge lower prices for its less-than pure olive oil. n44 Atlapac tendered a claim for defense in the underlying action to American Motorists Insurance Company ("American Motorists"), which denied coverage. n45

Among other things, Atlapac argued that Tama's allegations of false designation of origin, false description and common law unfair competition potentially triggered coverage under the policy provision granting coverage for advertising injury damages arising out of "misappropriation of advertising ideas or style of doing business." n46 Further, Atlapac argued that "misappropriation of advertising ideas and style of doing business" is ambiguous and should be construed to provide coverage for the underlying allegations. n47

The court agreed with Atlapac, finding that it was "objectively reasonable for [Atlapac] to have expected coverage" because Atlapac "was buying coverage against lawsuits brought for various offenses committed in the course of its advertising activities." n48 Thus, it was reasonable for Atlapac to have expected that claims for false designation of origin under the Lanham Act and common law unfair competition would be covered under the policy. n49 The court further found that Atlapac's use of "the term 'pure olive oil' could reasonably be construed as an advertising idea or style of doing business." n50 Atlapac's expectation of coverage under the policy was therefore reasonable. n51

In *American Simmental Association v. Coregis Insurance Co.*, n52 the court applied reasoning similar to that in *Atlapac* in finding that the insurance company had a duty to defend a cattle breeding association in an underlying lawsuit alleging that the association's advertising certain cattle as "fullblood" lowered the value of the underlying plaintiffs' cattle. In the underlying lawsuit, owners of "fullblood" Simmental cattle sued the American Simmental Association ("ASA") alleging that the ASA falsely advertised non-fullblood cattle as fullblooded Simmental cattle, which in turn caused the underlying plaintiffs to lose customers and sales and damaged their reputations as Simmental breeders. n53

The ASA is a not-for-profit association that registers and promotes the designation of the Simmental breed of cattle. n54 In 1988, the association's members adopted a rule to include a classification for cattle with "foreign ancestry" (i.e., originating from either Germany, Switzerland, France or Austria), which did not consider the genetic purity of cattle receiving this designation. n55 In 1991, Tom Risinger, an ASA board member, allegedly began importing German bulls and attempted to register them as "fullblood" Simmentals with the Canadian Simmental Association, which informed him that the German cattle were ineligible for "fullblood" designation because they had Angus genetics. n56 Risinger then successfully registered the German cattle with the ASA as "fullblood." n57 In 1991, the ASA amended its by-laws to replace the title "foreign ancestry" with "fullblood," which had the effect of designating cattle as "fullblood" based solely on whether the animals originated from Germany, Switzerland, France, or Austria. n58 In 1994, the ASA, through a series of rule changes, formally adopted the revised fullblood designation for cattle with the requisite proven foreign ancestry. n59 Thus, there was no longer a requirement that the "fullblood" cattle have only Simmental genetics. n60

Shortly after the ASA formally adopted the revised full-blood designation, the underlying plaintiffs, who were members of the ASA and Simmental breeders, filed a two-count complaint against the ASA and Tom Risinger. n61 Among other things, the complaint alleged that in August 1992, Risinger and the ASA published an advertisement in the official publication of the ASA, indicating that the German cattle imported by Risinger had 100 percent Fleckvieh Simmental genetics. n62 The underlying plaintiffs alleged that the defendants' representation of the Risinger cattle as "fullbloods" was false, and caused the value of their animals to diminish by at least 50 percent. n63

St. Paul Fire & Marine Insurance Company ("St. Paul") issued a CGL policy to the ASA, which provided, among other things, coverage for "advertising injury." n64 Shortly after the underlying complaint was filed, the ASA tendered its defense to St. Paul, which refused to defend. n65

After the ASA tendered its defense, the underlying plaintiffs filed two amended complaints adding counts alleging violation of the Lanham Act and negligence. n66 The Second Amended Complaint alleged that the defendants falsely designated the animals with the title of "fullbloods," in their "advertisement," "promotion," and "representation" of the Risinger cattle as "fullbloods." n67 The complaint further alleged that the ASA's false advertising and promotion was disseminated to purchasers of Simmental cattle and Simmental breeders, who were deceived by the false advertising and promotion. n68 The underlying plaintiffs further alleged that the ASA's misrepresentation was likely to influence the purchasing decisions of those to whom the false advertising and promotion were disseminated, and injured the underlying plaintiffs by causing them to lose customers and sales resulting in business losses and impairment of the underlying plaintiffs' ability to compete. n69 The underlying plaintiffs also alleged that the defendants' misrepresentations, advertisements, and promotions would likely cause the underlying plaintiffs irreparable harm by damaging their reputations as Simmental breeders, as well as the reputation of their Simmental genetics. n70 The ASA tendered the Second Amended Complaint to St. Paul, and St. Paul denied coverage, because, among other things, the complaint did not allege damages for injuries caused by any of the "advertising injury" offenses found in the St. Paul policy. n71

The district court entered a directed verdict in favor of the ASA on all causes of action in the underlying litigation, and the Eighth Circuit Court of Appeals subsequently affirmed. n72

The central issue in *American Simmental* was whether St. Paul breached its duty to defend the ASA. The relevant insurance policy provided coverage for

injury caused by any of the following offenses that result from the advertising of your products or work:

* * *

- Unauthorized taking of advertising ideas or style of doing business. n73

The court held that St. Paul had a duty to defend pursuant to the advertising injury coverage provided by the policy it sold to the ASA. Looking to the pleadings in the underlying lawsuit, the court reasoned that the "fullblood" designation "carried with it unique economic value in the hands of the rightful users." n74 The court further reasoned that the ASA designated as "fullblood" cattle that were not entitled to the designation, and that by advertising these animals as "fullblood" in its magazine and elsewhere, the ASA diminished the value of the designation in the hands of the underlying plaintiffs - the rightful users of the designation. n75 The court, therefore, concluded that "the 'fullblood' designation was a unique 'advertising idea' [or] 'style of doing business.'" n76 Thus, there was coverage under the St. Paul policy.

Atlapac and *American Simmental* are useful in showing how courts may find advertising injury coverage for greenwashing claims. n77 Both cases involve underlying claims that the insureds improperly used a designation (in *Atlapac*, "pure olive oil" and in *American Simmental*, "fullblood") to advertise a product and that the improper designation caused damage to the underlying plaintiffs in the form of lost profit or value. One can imagine analogous claims in the greenwashing context. For example, Company A advertises its aerosol air freshener as "ozone friendly."

This claim, however, is deceptive because some of the product's ingredients are ozone depleting substances. n78 Company B markets a citrus oil-based non-aerosol air freshener that contains no ozone-depleting substances, which it advertises - accurately - as "ozone friendly." Company B files a lawsuit, alleging that Company A falsely claimed in its advertisement, promotion, and representation of its air freshener that the product was "ozone friendly." Company B further alleges that Company A's false labeling and marketing included pricing its air freshener well below the prices at which Company B sold its air freshener, and claimed damages in the form of lost sales due to Company A's ability to charge lower prices.

Applying the reasoning of the courts in *Atlapac* and *American Simmental*, there may be advertising injury coverage for Company B's claims against Company A. The claims against Company A may constitute "misappropriation of advertising ideas," as set forth in the 1986 ISO form, or "use of another's advertising idea in your 'advertisement'" as set forth in the 2007 ISO form. Like the "fullblood" designation in *American Simmental*, the term "ozone friendly" conceivably "carri[es] with it unique economic value in the hands of the rightful users." n79 Like Atlapac's use of the term "pure olive oil," Company A's use of the term "ozone friendly" could reasonably be construed as an advertising idea. n80 Thus, it would be reasonable for Company A to expect advertising injury coverage for claims brought by Company B as either "misappropriation of advertising ideas" or "use of another's advertising idea in your 'advertisement.'" n81

The Failure to Conform Exclusion

Would Company B's claims against Company A fall within the 2007 Failure to Conform exclusion or the 1986 predecessor exclusion? "[F]or the failure to conform exclusion to apply, courts have held that the underlying complaint must contain specific allegations that the policyholder's goods fail to conform to the quality or performance advertised." n82 One commentator characterizes this exclusion as "the flip-side to disparagement" (i.e., making negative comments about another's product). n83 In other words, if an insured contends that its competitor's product is terrible, and faces a lawsuit, the claims against the insured would likely be covered advertising injury. n84 On the other hand, if that same insured makes promises about its own product and then fails to deliver, the exclusion may apply. n85

A recent case, *Harleysville Mutual Insurance Co. v. Buzz Off Insect Shield, L.L.C.*, n86 sheds some light on how the Failure to Conform exclusion may apply with respect to claims of greenwashing. In *Buzz Off*, the Supreme Court of North Carolina held that the Failure to Conform exclusion barred coverage for claims brought by S.C. Johnson, Inc. ("SCJ"), which markets - among other things - OFF! brand insect repellent, against Buzz Off Insect Shield, LLC ("BOIS") and International Garment Technologies (referred to individually and collectively with BOIS as "IGT"), who together manufactured and marketed insect-repellent clothing. n87 Specifically, in the underlying action, SCJ alleged that IGT promoted its product by stating that it (1) "reduce[s] or eliminate[s] the need to apply an insect-repellant product on the skin," (2) "protects uncovered skin from mosquito bites," (3) prevents wearers from "receiv[ing] any mosquito bites," (4) "is equivalent or superior in performance to topical insect repellants, such as those containing DEET [marketed by SCJ]," (5) provides protection from mosquito bites without "the 'hassle' of applying 'messy' insect-repellant products directly to the skin," (6) "is highly effective through 25 washings," and (7) "contains a version of natural insecticide that is derived from chrysanthemum flowers." n88 These claims appeared on BOIS' website and on websites and in print advertisements of entities that manufactured clothing to be treated with the process that BOIS used to make its insect-repellant clothing and the advertising material of various retailers selling BOIS' apparel. n89 Among other things, SCJ alleged damage resulting from defendants' advertisements allegedly containing false statements concerning the efficacy of BOIS apparel. n90

IGT had purchased CGL policies covering different time periods from Erie Insurance Exchange and Erie Insurance Company (collectively "Erie") and Harleysville Mutual Insurance Company ("Harleysville"). n91 After denying IGT's requests for assistance in defending SCJ's lawsuit, Harleysville filed a declaratory judgment action against IGT and Erie, claiming, among other things, that its policy excluded coverage for the injuries claimed in the underlying lawsuit. n92 Erie counterclaimed and cross-claimed that its policies did not cover the underlying allegations. n93

The Erie and Harleysville policies provided coverage for "personal and advertising injury" arising out of "[o]ral or written publication, in any manner, of material that slanders or libels a person or organization or disparages a person's or organization's goods, products, or services." n94 The policies contained a Failure to Conform exclusion, which barred from coverage "'[p]ersonal and advertising injury' arising out of the failure of goods, products or services to conform with any statement of quality or performance made in your 'advertisement'." n95

The court agreed with Harleysville and Erie that the Failure to Conform exclusion barred coverage for SCJ's claims. The court reasoned that IGT's allegedly false statements about its products were not false because IGT made representations that SCJ's products were ineffective, but because it made allegedly false claims that its products' performance was just as good as, if not superior to, that of SCJ's products. n96 The court further reasoned, "the alleged falsity of the advertisements arises from the failure of defendants' products to actually perform as well as defendants claim they perform." n97 Thus, the underlying lawsuit "alleged facts indicating that the only falsity found in the defendants' advertisements resulted from the failure of the defendants' own products to be of their advertised quality and nature, placing the falsity of those advertisements squarely within the insurance policies' Failure to Conform Exclusion," which relieved Erie and Harleysville of any duty to defend. n98

Notwithstanding the Failure to Conform exclusion's potential application to claims like those in *Buzz Off*, it should be recognized that the exclusion has no application to many claims for greenwashing that might be asserted. The Green Guides provide a variety of examples of deceptive advertising, which would not fall within the Failure to Conform exclusion:

- "A packaged is labeled, '50% more recycled content than before.' The manufacturer increased the recycled content of its package from 2 percent recycled material to 3 percent recycled material. Although the claim is technically true, it is likely to convey the false impression that the advertiser has increased significantly the use of recycled material." n99 In this example, the statement in question is technically true. Any injury allegedly caused by this statement could not arise out of the "failure of goods, products or services to conform with any statement of quality or performance," and would not therefore fall within the Failure to Conform exclusion.

- "A package of paper coffee filters is labeled 'These filters were made with a chlorine-free bleaching process.' The filters are bleached with a process that releases into the environment a reduced, but still significant, amount of the same harmful byproducts associated with chlorine bleaching." n100 The statement may be misleading but it is 100% accurate. The Failure to Conform exclusion should not apply.

- "An advertiser notes that its shampoo bottle contains 20% more recycled content." The claim in its context is ambiguous. Depending on contextual factors, it could be a comparison either to the advertiser's immediately preceding product or to a competitor's product." n101 Here, if the allegation is that the claim misleads by suggesting that the bottle contains more recycled content than the competitor, but in fact the advertiser is making a truthful comparison with the company's prior bottles (and the claimant does not suggest otherwise), then the Failure to Conform exclusion should not apply because the product does "conform" to the "statement of quality". n102 This is particularly true in light of the fact that the usual policy interpretation rules construe ambiguities in favor of the insured and exclusions narrowly. n103

Conclusion

Courts have yet to decide questions of insurance coverage for greenwashing claims. Policyholders faced with such claims should carefully review their policies and the allegations against them. Coverage can be found where the allegations disparage a competitor (even, in some jurisdictions, without mentioning the competitor) or can be said to misappropriate an advertising idea. The Failure to Conform exclusion may bar coverage for greenwashing claims if the statements allegedly giving rise to the claim bear upon quality or performance.

Prudent policyholders examine their policies when undertaking new activities to ensure potential liabilities and losses will be addressed. If coverage is limited or unavailable, then many businesses will mold their activities to bring them within coverage, or forgo the activities altogether. Familiar examples are the abandonment of asbestos, the implementation of anti-discrimination policies, and requirements for the operation of company vehicles. Marketing

decisions should be treated no differently. Before an advertiser touts its product's or service's green attributes, it may wish to consider whether it would have coverage for the same if someone sees things differently.

Return to Text

n1 Globe-net, Consumers Rank Greenest Brands (June 11, 2010), <http://www.globe-net.com/articles/2010/june/11/consumers-rank-greenest-brands-.aspx?sub=14>.

n2 Wikipedia, Greenwashing, <http://en.wikipedia.org/wiki/Greenwash>.

n3 15 U.S.C. §§ 41-58.

n4 See 16 C.F.R. §§ 260.1-260.7; <http://www.ftc.gov/opa/2007/11/enviro.shtm>.

n5 16 C.F.R. § 260.1.

n6 See 16 C.F.R. §§ 260.6, 260.7.

n7 See, e.g., *Koh v. S.C. Johnson & Son, Inc.*, No. C-09-00927, *slip op.* at 4 (N.D. Cal. Jan. 5, 2010).

n8 Press Release, Federal Trade Commission, FTC Reviews Environmental Marketing Guides, Announces Public Meetings (Nov. 24, 2007), <http://www.ftc.gov/opa/2007/11/enviro.shtm>.

n9 See Federal Trade Commission, Green Guides: Summary of Proposal, <http://www.ftc.gov/os/2010/10/101006greenguidesproposal.pdf>.

n10 *Id.*

n11 *Id.*

n12 *Id.*

n13 *See generally* Federal Trade Commission, Proposed Revisions to the Green Guides at 41-44, <http://www.ftc.gov/os/fedreg/2010/october/101006greenguidesfrn.pdf>.

n14 *Id.* at 42.

n15 *Id.*

n16 *Id.*

n17 *Id.* at 42-43.

n18 Vanessa O'Connell, *"Green" Goods, Red Flag: Rash of Earth-Friendly Claims Spurs Rising Number of Lawsuits and FTC Actions*, Wall Street Journal, Apr. 24, 2010.

n19 15 U.S.C. §§ 1114-1127 (2010) (Lanham Act); *see* National Conference of Commissioners on Uniform State Laws, Revised Deceptive Trade Practices Act (1966).

n20 Insurance Services Office, Inc., Commercial General Liability Coverage Form, CG 00 01 12 07 at 6 (2007).

n21 *Id.* at 14. The 2007 form defines "advertisement" as: "a notice that is broadcast or published to the general public or specific market segments about your goods, products or services for the purpose of attracting customers or supporters. For the purpose of this definition: a. Notices that are published include material placed on the Internet or on similar electronic means of communication; and b. Regarding web-sites, only that part of a web-site that is about your goods, products or services for the purposes of attracting customers or supporters is considered an advertisement. *Id.* at 12.

n22 ISO, Commercial General Liability Form, CG 00 01 12 07 at 6; *see also id.* CG 00 01 10 01 (identically worded exclusion in 2001 ISO Form); CG 00 01 07 98 at 5 (similarly worded exclusion in 1998 ISO Form).

n23 ISO, Commercial General Liability Form, CG 00 01 11 85, § V(1). Note that the 1988, 1993 and 1996 ISO CGL forms contain the same definition of "advertising injury." ISO, Commercial General Liability Form, CG 00 01 11 88 (1988); CG 00 01 10 93 (1993); CG 00 01 01 96 (1996).

n24 *See, e.g.,* ISO, Commercial General Liability Form, CG 00 01 11 85, Coverage B § 2(b)(2).

n25 C.A. No. 07C-12-070 MMJ (Del. Super. Ct. Apr. 9, 2010).

n26 *Id.* at 16 (citing Merriam-Webster.com).

n27 *See E.piphany, Inc. v. St. Paul Fire & Marine Ins. Co.*, 590 F. Supp. 2d 1244 (N.D. Cal. 2008); *Knoll Pharm. Co. v. Auto. Ins. Co. of Hartford*, 152 F. Supp. 2d 1026, 1037-1038 (N.D. Ill. 2001) (applying Illinois law). . . . *But see Heritage Mut. Ins. Co. v. Advanced Polymer Tech.*, 97 F. Supp. 2d 913, 933 (S.D. Ind. 2000) (rejecting application of implied disparagement theory and citing cases).

n28 152 F. Supp. 2d at 1029-1230.

n29 *Id.* at 1030 (internal quotation marks and citations omitted).

n30 *Id.*

n31 *Id. at 1031* (internal quotation marks omitted).

n32 *Id. at 1030-1031.*

n33 *Id. at 1034.*

n34 *Id.*

n35 *Id.*

n36 *Id. at 1039.*

n37 *Id. at 1038.*

n38 *See* 16 C.F.R. § 260.7, example 5; *see also* Federal Trade Commission, Proposed Revisions to the Green Guides at 204 (proposed 16 C.F.R. § 260.6, example 5), <http://www.ftc.gov/os/fedreg/2010/october/101006greenguidesfrn.pdf>.

n39 For further discussion of advertising injury cases involving disparagement, *see* New Appleman on Insurance Law Library Edition § 19.06[5].

n40 See Beth D. Bradley, *Recent Developments in Personal and Advertising Injury Coverage* (2001) (citing cases), <http://library.findlaw.com/2001/Mar/8/126546.html>.

n41 No. CV 97-0781, 1997 U.S. Dist. LEXIS 21943 (C.D. Cal. Sept. 23, 1997).

n42 *Id.* at *2.

n43 *Id.*

n44 *Id.*

n45 *Id.* at *3.

n46 *Id.* at *16.

n47 *Id.* at *16-17.

n48 *Id.* at *19.

n49 *Id.*

n50 *Id.* at *19-20.

n51 *Id.*

n52 75 *F. Supp. 2d* 1023 (*D. Neb.* 1999), *rev'd on other grounds*, 282 *F.3d* 582 (8th *Cir.* 2002).

n53 *Id.* at 1025.

n54 *Id.*

n55 *Id.* at 1026.

n56 *Id.*

n57 *Id.*

n58 *Id.*

n59 *Id.*

n60 *Id.*

n61 *Id.*

n62 *Id.*

n63 *Id.*

n64 *Id. at 1024.*

n65 *Id. at 1026-1027.*

n66 *Id. at 1027.*

n67 *Id.*

n68 *Id.*

n69 *Id.*

n70 *Id.*

n71 *Id.*

n72 *Id.*

n73 *Id. at 1029.*

n74 *Id.* at 1030.

n75 *Id.*

n76 *Id.* at 1031.

n77 Of course these two cases are not the last word on the subject. *See, e.g.* Mylan Lab., Inc. v. Am. Motor. Ins. Co., Dkt. No. 34402 (W. Va. June 18, 2010) (construing misappropriation to mean wrongful taking of property of another).

n78 *See* 16 C.F.R. § 260.7(h), example 1.

n79 *American Simmental Ass'n v. Coregis Ins. Co.*, 75 F. Supp. 2d 1023, 1030 (D. Neb. 1999), *rev'd on other grounds*, 282 F.3d 582 (8th Cir. 2002).

n80 *See Atlapac Trading Co., Inc. v. Am. Motorists Ins. Co.*, No. CV 97-0781, 1997 U.S. Dist. LEXIS 21943 at *19-20 (C.D. Cal. Sept. 23, 1997).

n81 For further discussion of advertising injury cases involving misappropriation of advertising ideas, see New Appleman on Insurance Law Library Edition § 19.06[2] and in terms of trademark infringement, see New Appleman on Insurance Law Library Edition § 30.06[2][d].

n82 New Appleman Insurance Law Practice Guide § 43.24.

n83 *Id.*

n84 *See id.*

n85 *See id.*

n86 364 N.C. 1, 692 S.E.2d 605 (2010).

n87 364 N.C. at 28, 692 S.E.2d at 623.

n88 364 N.C. at 3, 692 S.E.2d at 609 (internal quotation marks omitted).

n89 *Id.*

n90 *Id.*

n91 *Id.*

n92 *Id.*

n93 *Id.* at 610.

n94 *Id.* at 612.

n95 *Id.* at 611.

n96 *Id.* at 622.

n97 *Id.*

n98 *Id.* at 623.

n99 16 C.F.R. § 260.6(c), example 1.

n100 16 C.F.R. § 260.6(c), example 4.

n101 16 C.F.R. § 260.6(d), example 1.

n102 ISO, Comprehensive General Liability Form, CG 00 01 12 07 (2007).

n103 Peter J. Kalis, et al., Policyholders' Guide to the Law of Insurance Coverage § 1.02 at 1-3 (2004); New Appleman on Insurance Law Library Edition § 5.02.

RELATED LINKS: For further discussion of advertising injury cases involving disparagement or misappropriation of advertising ideas, see

■ New Appleman on Insurance Law Library Edition § 19.06

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Reed Smith LLP on Replacement Cost Property Insurance Policies

2010 Emerging Issues 5397

Reed Smith LLP on Replacement Cost Policies and the Dangers When an Insurance Company Refuses to Pay Actual Cash Value

By Jay M. Levin and Jennifer D. Katz

November 8, 2010

SUMMARY: Courts are adopting different positions concerning whether the pre-condition to payment of Replacement Cost Value, i.e., repair or replacement of the damaged property, in a property insurance policy may be enforced by the insurance company if it denies coverage or otherwise refused to pay Actual Cost Value of a loss, frequently calculated as the cost to repair or replace, less depreciation.

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ARTICLE: Property insurance originally called for the insurer to pay only the "actual cash value" ("ACV") of a loss, frequently calculated as the cost to repair or replace, less depreciation. The insured would receive the value of the pre-loss property, but would usually be out of pocket for the amount of depreciation. Replacement cost coverage was developed to insure this gap. Replacement cost coverage "reimburses the insured for the full cost of repairs, if the insured repairs or rebuilds the building, even if that results in putting the insured in a better position than he was before the loss." *Rockford Mut. Ins. Co. v. Pirtle*, 911 N.E.2d 60, 65 (Ind. Ct. App. 2009) (citations and emphasis omitted). Replacement cost coverage is optional. It is "more expensive because the rate of premiums is higher and the amount of insurance to which that rate applies is usually higher Any purported windfall to an insured who purchases replacement cost insurance is precisely what the insured contracted to receive in the event of a loss." *Id.*

Most replacement cost policies require the insurance company to pay ACV once it is determined. As indicated above, these policies also require the policyholder to actually repair or replace the damaged property before the difference between ACV and the full cost to repair or replace ("RCV") is paid by the insurance company. Most policyholders, however, do not have the resources to complete repairs without the proceeds of their property insurance policies. As a result, most policyholders are unable and unwilling to begin any substantial repair project without: (1) receipt of the ACV payment from their insurance company; and (2) an agreement from the insurance company regarding both the amount of RCV and that the insurer will actually pay the RCV. These requirements are even more important now as courts are adopting different positions concerning whether the pre-condition to payment, i.e., repair or replacement of the damaged property, may be enforced by the insurance company if it denies coverage or otherwise refused to pay ACV. This article will discuss different approaches taken by courts that have addressed this issue.

In *Buckley Towers Condominium, Inc. v. QBE Insurance Corporation*, No. 09-13247, 2010 U.S. App. LEXIS 19144 (11th Cir. Sept. 14, 2010), Buckley Towers owned a pair of condominium buildings in Miami, Florida. QBE provided Buckley Towers with hurricane insurance. After Hurricane Wilma hit South Florida in October of 2005, Buckley Towers made a property damage claim. QBE refused to pay the claim. Buckley Towers' original ACV claim (noted as "Actual Cash Value Loss" on its Proof of Loss) was just over \$4.2 million. QBE neither paid nor rejected the ACV claim. Instead, QBE interpreted the claim as a demand for RCV and, therefore, responded that no money was due until repairs were completed. n1

Buckley Towers sued QBE in federal court seeking the entire RCV loss, claiming that QBE's failure to pay the ACV prevented it from completing repairs, thereby entitling it to payment of the full RCV. The jury awarded over \$11 million in ACV and, based on the argument that QBE's failure to pay ACV prevented Buckley Towers from rebuilding, awarded an additional \$8 million for RCV. The jury also awarded \$800,000 in law and ordinance damages. The District Court entered final judgment for just under \$19.4 million. n2

QBE appealed to the Eleventh Circuit, arguing that the trial court improperly applied the doctrine of prevention of performance to allow Buckley Towers to seek the full RCV loss despite its failure to repair or replace the damaged property (in contravention of the insurance policy). Despite noting that "[u]nder Florida law, the doctrine of prevention of performance may be applied when one party to a contract prevents another from performing its obligations under the contract; it bars the preventing party from availing himself of the other party's non-performance," (*id.* at *5-6 (citation omitted)), the Eleventh Circuit agreed with QBE and concluded that the District Court erred in applying the doctrine of prevention of performance. "[A]s we read Florida law, the doctrine of prevention of performance may not be wielded as a sword in a case like this one where the insured is required first to meet its obligations to repair under the policy provision." *Id.* at *11.

The Eleventh Circuit acknowledged that Buckley Towers would be unable to receive the "full range of benefits" under the policy without an advance payment, but held that this was merely "cost and inconvenience" which did not relieve Buckley Towers of the obligation to repair the building before being entitled to the full RCV. *Id.* at *7-8. The policy "unambiguously" required repair before obtaining RCV damages and Buckley Towers did not make the repairs. *Id.* at *6. The court held that:

Applying the doctrine of prevention of performance in this case would impermissibly rewrite the insurance contract on the equitable theory that it would be too costly for Buckley Towers to comply with the terms of the agreement Allowing Buckley Towers to claim RCV damages without repairing or replacing entirely removes the plaintiff's obligations under the Replacement Cost Value section of the contract. The parties freely negotiated for that contractual provision and it is not the place of a court to redline that obligation from the contract.

Nor is it a defense to say that it would be costly for Buckley Towers to comply with the insurance contract as written. Inconvenience or the cost of compliance [with contractual terms], though they might make compliance a hardship, cannot excuse a party from the performance of an absolute and unqualified undertaking to do a thing that is possible and lawful.

Id. at *7-8 (internal quotations and citations omitted). The Eleventh Circuit did not, however, address the fact that the doctrine of prevention of performance is, by its very nature, an equitable remedy. The court did not address the evidence that Buckley Towers was not able to proceed with repairs without the ACV payment, to which it was entitled. The court did not address the fact that QBE's undisputed breach of its contractual obligations to pay ACV allowed it to profit by relieving it of its liability for \$8 million in covered losses. The court also concluded that there was sufficient evidence to support the jury's finding as to ACV damages. In short, the Eleventh Circuit allowed QBE to profit from its breach of its contractual obligation to pay the \$11 million ACV loss by effectively relieving it of its obligation to pay the balance of the RCV loss.

In *Rockford Mutual Insurance Co. v. Pirtle*, 911 N.E.2d 60 (Ind. Ct. App. 2009), however, the Court of Appeals of

Indiana excused the policyholder's failure to repair under similar circumstances. Terry Pirtle bought an historic building which he insured with Rockford Mutual Insurance Company. Pirtle rented the property while he restored it. The property was damaged in a November 2000 fire. Pirtle made a claim under his policy. Rockford initially offered \$80,000 to settle the whole claim, but that was less than the amount of the mortgage and the cost to repair the building (which Pirtle's contractor estimated at over \$230,000). Rockford then offered less than \$70,000 as ACV. Pirtle rejected the offer and filed suit for breach of contract and bad faith. Rockford paid, and Pirtle accepted, \$86,146.66 in ACV, but Rockford denied liability for RCV. *Id.* at 63. The jury found Rockford breached the contract, and awarded Pirtle \$524,286.13 in damages.

The relevant issue before the *Rockford* court was "[w]hether Pirtle's recovery under the policy is limited to the actual cash value of the building *because of* Pirtle's failure to comply with the repair and replacement cost policy provision of his policy." *Id.* at 62 (emphasis added). Rockford argued that Pirtle could only recover ACV because he had not satisfied a "condition precedent" to obtaining payment from the insurance company, *i.e.*, repair or replacement of the damaged building. *Id.* at 64. The court disagreed and excused Pirtle's failure.

The *Rockford* court cited *Couch on Insurance* for the proposition that, even under replacement cost policies where actual repair or replacement must be completed before the insurers owes the RCV, the policyholder's duty to repair may be excused based on the insurance company's actions:

Even where actual replacement is mandated, compliance may be excused by the insurer's actions. The insurer's failure to advance the necessary funds to rebuild may have this effect. Replacement cost coverage was devised to remedy the shortfall in coverage which results under a property insurance policy compensating the insured for actual case value alone. That is, while a standard policy compensating an insured for the actual cash value of damaged or destroyed property makes the insured responsible for bearing the cash difference necessary to replace old property with new property, replacement cost insurance allows recovery for the actual value of property at the time of loss, without deduction for deterioration, obsolescence, and similar depreciation of the property's value.

Id. at 65. The first time Rockford made an ACV offer to Pirtle was six months after the fire, at which point the property was "in jeopardy" - "the mortgage foreclosure process had started[] and the property had been condemned by the city" - and Pirtle could not begin repairs.

The *Rockford* court held that the trial court's jury instruction on prevention of performance was correct and applicable to this situation. The court rejected holdings from other courts that a policy must be strictly construed to require completion of repair or replacement before RCV is owed. The court stated:

[w]e are convinced that equitable principles win the day in this situation; otherwise the repair or replacement endorsement paid for by Pirtle would be rendered illusory. Rockford had the ability to advance sums of money under that endorsement to assist in commencement of the rebuilding, and could have joined Pirtle in agreements entered into for repairs.

Id. at 66-67. As a result of Rockford's claims handling, specifically its actions concerning ACV payment, the jury "excused" the policy requirement of repair or replacement. *Id.* at 66. Because Rockford's failure to fulfill its obligations under the policy prevented Pirtle from repairing the property, the doctrine of prevention of performance excused Pirtle's obligation to repair or replace before full RCV was due. *See also Zaitchick v. American Motorists Ins. Co.*, 554 F. Supp. 209, 217 (S.D.N.Y. 1982), *aff'd*, 742 F.2d 1441 (2d Cir. 1983), *cert. denied*, 464 U.S. 851 (1983) (noting that policyholders "were refused any monies under the insurance contract. Not surprisingly, they were unable to replace their home. This conduct by [the insurance company] made it impossible for [the policyholders] to fulfill the condition precedent, and therefore, excuses [the policyholders] from performance of the replacement condition.")

The *Rockford* court noted, but declined to follow, *Bourazak v. North River Insurance Company*, 379 F.2d 530 (7th Cir. 1967). In *Bourazak*, North River Insurance Company ("North River") issued two policies of insurance to Edward

Shemas. One policy insured his home; the other, personal property. A fire destroyed the home and personal property. North River paid for the loss to the personal property. North River also paid the home's ACV of \$37,500. Shemas assigned any remaining interest in the policy to Mitchell Bourazak ("Bourazak"). Bourazak filed an action for additional monies under the policy.

The policy insuring the home contained an "Extension of Coverage" provision which provided that:

if the building were completely rebuilt the insurer would be liable for the repair and replacement cost, not exceeding \$22,500 [the difference between the \$60,000 and the amount paid of \$37,500]; that the insurer would not be liable for loss unless and until actual repair or replacement is completed, and that any claim for such additional liability must be made within 120 days after loss.

Id. at 531 (internal quotes omitted). The court dismissed the complaint because Bourazak did not satisfy the condition precedent of repairing or replacing the damaged property. In fact, Bourazak's complaint did not even allege that such repair or replacement was performed.

We think the conclusion thus reached is inescapable. According to the allegations of the complaint, plaintiff had 180 days from July 1, 1962 (or until about January 1, 1963) to commence rebuilding the house. Certainly the insured's expressed intention to rebuild and the removing of debris or doing excavation work preparatory to rebuilding cannot be held to be in compliance with the alleged condition.

Id. at 532 (internal quotes omitted). In addition, North River's denial of liability, though made with respect to the Extension of Coverage provision, was made two months after the conclusion of Bourazak's time to repair or replace the property and, thus, was of no import. *Bourazak* is not inconsistent with *Rockford* because, in *Bourazak*, the insurer paid ACV and there was, therefore, no claim of prevention of performance.

Pennsylvania law is even stricter, finding that the requirement to repair or replace the damaged property before receiving full RCV can be unconscionable. In *Ferguson v. Lakeland Mutual Insurance Company*, 408 Pa. Super. 332, 596 A.2d 883 (1991), lightning struck an organ inside the mobile home of Glenn and Mary Ann Ferguson. The Fergusons made a claim under their Lakeland Mutual Insurance Company homeowner's policy. Lakeland Mutual disputed coverage, resulting in the Fergusons suing. The jury awarded full RCV. The court held that the requirement of repair or replacement prior to receiving RCV was unconscionable. The court applied a "two-fold" test for unconscionability: "First, one of the parties to the contract must have lacked a meaningful choice about whether to accept the provision in question. Second, the challenged provision must unreasonably favor the other party to the contract." *Id. at 336, 596 A.2d at 885*. Relying on that test, the court reasoned that insurance policies are contracts of adhesion and the replacement provision unreasonably favors the insurance company. So, despite "clear and unambiguous" policy language, the repair or replacement requirement was deemed unconscionable.

Because Lakeland Mutual denied liability, the policyholder was faced "with the unsavory choice of either accepting the lower actual cash value of the organ or expending a large sum of money in replacement costs without a guarantee of reimbursement." *Id. at 336-37, 596 A.2d at 885*. The court noted that the policyholder could only have received the full RCV after paying everything and then bringing a coverage suit:

In fact, under the terms of the contract, [the Fergusons] could have only received replacement value in this instance after expending the replacement or repair funds and obtaining a judicial determination concerning liability.

Id. at 337, 596 A.2d at 885.

The *Ferguson* case has been distinguished by other courts. See, e.g., *Nicolaou v. Vermont Mut. Ins. Co.*, 155 N.H. 724, 931 A.2d 1265 (2007) (noting that "[w]hat was unconscionable in [the *Ferguson* case] was requiring the policyholders to repair or replace their property before they knew whether their insurer would provide any coverage at all"). Thirteen years after *Ferguson*, the Superior Court of Pennsylvania decided *Burton v. Republic Insurance Company*

, 845 A.2d 889 (Pa. Super. Ct. 2004), and relied on the insurer's payment of ACV to distinguish *Ferguson*. In *Burton*, Jeffrey and Terri Burton had a homeowners' insurance policy with Republic Insurance Company. The Burtons' home and personal property were damaged in a fire. Republic paid \$100,219 in ACV. The Burtons made some, but not all, of the required repairs, resulting in an additional payment by Republic for "withheld depreciation." *Id.* at 892. The Burtons, however, did some additional construction (which was not included in the repair estimate). The Burtons did not receive full RCV. The issue before the court was "whether the terms of Republic's insurance policy concerning replacement costs are ambiguous or unconscionable, and whether Republic's practice of requiring claimants to replace the lost property with property of like kind constitutes a breach of contract." *Id.* at 892-93. The court concluded that: (a) the policy was not ambiguous or unconscionable; and (b) the like construction requirement was not a breach of contract.

The *Burton* court held that the insurance policy "clearly, explicitly, and unambiguously conditions full replacement benefits upon the actual repair or replacement of the damaged property." *Id.* at 894. Notably, Republic had not refused to pay either ACV or replacement cost; it simply conditioned the RCV payment on actual repair or replacement. This was a basis for distinguishing *Ferguson* and finding the replacement provision of the policy was not unconscionable:

[W]e decline to extend *Ferguson* beyond the facts of that case. Instantly, [Republic] admitted liability and paid [the Burtons] the actual cash value of the damage claim at the time of the loss. It did not condition replacement cost upon receiving a judicial determination of liability; rather, it conditioned benefits upon [the Burtons'] compliance with the stated settlement procedures. Thus, unlike the claimants in *Ferguson*, [the Burtons'] replacement benefits were guaranteed to the extent [the Burtons] demonstrated that they had replaced or repaired the damaged property. Since [the Burtons] were not obligated to pursue a claim to determine liability before receiving benefits, this case is distinguishable from *Ferguson*.

Id. at 899. n4

The *Burton* court further explained that the policy requires like construction, which means that the "policyholder has to return the damaged structure as closely as possible to the condition it was in immediately prior to the loss." *Id.* at 896. n5 The requirement was deemed "reasonable" and not in breach of contract. *Id.* See also *Saleh v. Farmers Ins. Exchange*, 133 P.3d 428 (Utah 2006) (holding that policy requires payment only after repair or replacement is completed in full).

Property insurance provides a policyholder the money necessary to repair or replace damaged property. Often policyholders cannot complete repairs without the proceeds of that insurance policy. As a result, the doctrine of prevention of performance has been applied to overcome the inequitable result of an insurance company breaching its obligation to pay ACV and thereby preventing the policyholder from replacing or repairing the damaged property (which is a pre-condition to obtaining RCV). That some courts are willing to encourage insurers to withhold ACV in breach of their contractual obligations, and then profit from that breach by being relieved of their obligation to ultimately pay the difference between ACV and RCV, is surprising. The doctrine of prevention of performance was designed to prevent such an inequitable result and should be enforced when applicable.

Return to Text

n1 Buckley Towers agreed that the policy required repair before RCV damages could be sought and that it had not completed repairs.

n2 Prejudgment interest of approximately \$5.6 million was subsequently added to this award.

n3 The bad faith claim was dismissed with prejudice when the \$86,146.66 payment was made. Pirtle accepted the payment "while continuing to contest the actual cash value used." *Pirtle*, 911 N.E.2d at 63.

n4 The *Burton* court also explained that the requirement to replace damaged property with "like construction" or "items of like kind" did not create "uncertainty" about whether the Burtons would be reimbursed by Republic:

As the onus is upon the claimant to abide by the settlement procedure, no uncertainty should exist. Even where a claimant fails to comply with the terms of the settlement process and purchases property that is arguably dissimilar, the resulting uncertainty is not equivalent to *Ferguson*, where the claimants were forced to replace the damaged items *before* liability had been established.

Burton, 845 A.2d at 899 (emphasis in original).

n5 The *Burton* court also explained the rationale: "Since insurance policies are based on principles of indemnity rather than enrichment, claimants should not be permitted to exploit their losses and use them as an opportunity to remodel their homes at the insurer's expense." *Burton*, 845 A.2d at 896 (citation omitted).

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McCarter & English on American and Foreign Ins. Co. v. Jerry's Sport Ctr, Inc.

2010 Emerging Issues 5340

McCarter & English on Pennsylvania Supreme Court Joins Growing Ranks Of Courts In American and Foreign Insurance Company v. Jerry's Sport Center, Inc. By Holding Insurer Is Not Entitled To Reimbursement Of Defense Costs Where Policy Does Not Include An Express Reimbursement Provision

By Joann M. Lytle, Nicholas M. Insua and Anne E. Matthews

October 1, 2010

SUMMARY: In *American and Foreign Insurance Co. v. Jerry's Sport Center, Inc.*, the Supreme Court of Pennsylvania refuted the reasoning under which some courts have allowed insurers to seek reimbursement of defense costs pursuant to a reservation of rights and instead joined the growing number of courts to hold that an insurer is not entitled to reimbursement of defense costs where the policy does not include an express reimbursement provision.

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ARTICLE: In *American and Foreign Insurance Co. v. Jerry's Sport Center, Inc.*, No. 88 MAP 2008, 2010 Pa. LEXIS 1803, at *1-*2 (Pa. Aug. 17, 2010), Jerry's Sport Center, Inc. and its subsidiaries, Jerry's Sport Center Northeast, Inc., Bonitz Brothers, Inc. Outdoor Sports Headquarters, Inc., and Simmons Gun Specialties, Inc. (collectively "Insured"), had purchased primary and umbrella liability coverage. The policy, which insured against bodily injury, did not contain a reimbursement provision. *Id.* at *2.

The Insured was one of several firearms wholesalers-distributors sued by the National Association for the Advancement of Colored People and the National Spinal Cord Injury Association, who sought to hold the firearms industry liable for injury, death, and other damages to their members on the theory that the industry's failure to distribute firearms reasonably and safely constituted the negligent creation of a public nuisance. *Id.* at *3. The associations' complaint alleged bodily injury to their members but did not seek compensation for those individuals' injuries. *Id.* at *4. Instead, the associations sought damages to establish a fund for the education, supervision, and regulation of gun dealers. *Id.*

The Insured notified its insurer of the claim. *Id.* The insurer retained counsel for the Insured and issued a reservation of rights letter, which included a purported reservation of the right to seek reimbursement of defense costs "ultimately determined not to be covered." *Id.* at *5. The insurer also filed a declaratory judgment action seeking a determination that it had no duty to defend or indemnify the Insured and was granted summary judgment. *Id.* at *7. The insurer then sought reimbursement of defense costs, which the trial court awarded. *Id.* at *9. On appeal, the Superior

Court reversed and the Pennsylvania Supreme Court granted allocatur. *Id.* at *10-*11.

The Pennsylvania Supreme Court began its analysis by examining the competing views on the issue, with *Buss v. Superior Court*, 939 P.2d 766 (Cal. 1997) representing the majority view and *Terra Nova Ins. Co. Ltd. v. 900 Bar, Inc.*, 887 F.2d 1213 (3d Cir. 1989) representing the minority view.

In *Buss*, the insured faced 27 claims, only one of which was potentially covered. *Jerry's Sport Center, 2010 Pa. LEXIS 1803*, at *26. The California Supreme Court held that because the insurer's duty to defend extended to any claims at least potentially covered, the insurer was not entitled to seek reimbursement of defense costs for the potentially covered claim; however, the insurer could seek reimbursement of defense costs for the 26 uncovered claims because, under the policy, the insurer had no duty to defend for those claims. *Id.* at *27. The *Buss* court explained that "the insurer 'has a right of reimbursement that is implied in law as quasi-contractual, whether or not it has one that is implied in fact in the policy as contractual' ... [and] that the right [runs] against the person who was unjustly enriched and in favor of the person who suffered loss thereby." *Id.* at *28 (quoting *Buss*, 939 P.2d at 776-77).

In contrast, the *Terra Nova* court expressly prohibited an insurer's claimed right to reimbursement of defense costs where a claim was deemed potentially covered and the insurer had provided coverage until obtaining a declaration that there was no coverage. *Id.* at *36. The court explained:

Faced with uncertainty as to its duty to indemnify, an insurer offers a defense under reservation of rights to avoid the risks that an inept or lackadaisical defense of the underlying action may expose it to [sic] if it turns out there is a duty to indemnify. At the same time, the insurer wishes to preserve its right to contest the duty to indemnify if the defense is unsuccessful. Thus, such an offer is made at least as much for the insurer's own benefit as for the insured's. If the insurer could recover defense costs, the insured would be required to pay for the insurer's action in protecting itself against the estoppel to deny coverage that would be implied if it undertook the defense without reservation.

Id. (quoting *Terra Nova*, 887 F.2d at 1219-20). n1

The Pennsylvania Supreme Court found *Terra Nova* most consistent with Pennsylvania's broad duty to defend and held that the insurer was not entitled to reimbursement of defense costs absent a reimbursement provision in the policy. *Id.* at *37. The Court explained that "it is the potential, rather than the certainty, of a claim falling within the insurance policy that triggers the insurer's duty to defend," *id.* at *39, and while a determination of no coverage in a declaratory judgment action "relieve[s] [the insurer] of the continuing obligation to defend[,]. . . [it does not] retroactively eliminate the insurer's duty to defend the insured during the period of uncertainty," *id.* at *43. In rejecting the insurer's attempt to define its duty to defend based on the outcome of the declaratory judgment action, the Court found that allowing the insurer to recoup defense costs absent a reimbursement provision in the policy "would amount to a retroactive erosion of the broad duty to defend in Pennsylvania by making the right and duty to defend contingent upon a court's determination that a complaint alleged covered claims, and would therefore narrow Pennsylvania's long-standing view that the duty to defend is broader than the duty to indemnify." *Id.* at *47-*48. n2

The Court also analyzed basic rules of contract interpretation, noting that because the policy contained no reimbursement provision, the insurer had no right to reimbursement under the policy. *Id.* at *49. The Court explained that no new contract was created by the reservation of rights letter, which merely "assert[ed] defenses and exclusions ... already set forth in the policy." *Id.* To allow reimbursement based on a reservation of rights absent a policy provision providing that right, the Court said, would be "tantamount to allowing the insurer to extract a unilateral amendment to the insurance contract." *Id.*

The Court, refuting the reasoning of *Buss*, likewise rejected any equitable bases for reimbursement. The trial court originally found that the insurer was entitled to reimbursement under the theory of unjust enrichment. *Id.* at *9. As the Supreme Court explained, that theory "contemplates a person who has been unjustly enriched at the expense of another [and] must [therefore,] make restitution to the other." *Id.* at *51 (citation and internal quotation marks omitted).

However, the Court found no such unjust enrichment in this case. As the Court explained, the insurer had both a right and duty to defend, the exercise of which benefited both parties, not merely the Insured. *Id.* at *51-*52. Specifically, the insurer benefited by retaining control over the defense, which provided protection to the insurer in the event that a court determined the claim was covered, and also avoided potential liability to the Insured for bad faith. *Id.* at *53.

The Court agreed with the Insured's *amicus*, Air Products and Chemicals, Inc., that recognizing a right to reimbursement outside of the policy would empower each insurer to design its own right to reimbursement as it sees fit. *Id.* at *25, *54. As the Court explained:

This is, in fact, what occurred here. [The insurer] initially claimed a right of reimbursement of all defense costs ultimately determined not to be covered, then modified this claimed right to reimbursement by stating that it would not seek reimbursement of costs incurred before it made its final coverage determination or a court concludes it was under no duty to defend, whichever occurred first, and, finally, informing Insured that it may seek reimbursement for defense costs incurred after the filing of the declaratory judgment action. A right of reimbursement outside of the four corners of the insurance contract would open the door to this kind of maneuvering by insurance companies at their policyholders' expense.

Id. at *54-*55.

Not only does the Pennsylvania Supreme Court's ruling prohibit an insurer who elects to control an insured's defense, including how and when the defense dollars will be spent, from handing its insured the bill, but it also prevents that insurer from simply walking away from a defense that it has assumed. The court stressed:

If [an insurer] believes there is no possibility of coverage, then it should deny its insured a defense because the insurer will never be liable for any settlement or judgment. ... If, on the other hand, the insurer is uncertain about coverage, then it should provide a defense and seek declaratory judgment about coverage. ... If the insurer is successful in the declaratory judgment action, it is relieved of the continuing obligation to defend. *The court's resolution of the question of coverage does not, however, retroactively eliminate the insurer's duty to defend the insured during the period of uncertainty.*

Id. at *42-*43 (emphasis added; citations omitted). The court's conclusion extends beyond the question of whether an insurer can seek reimbursement for defense costs that it has assumed and hopefully has put an end to the practice whereby an insurer who has agreed to defend takes it upon itself to later decide that there is no coverage and walks away from its policyholder.

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n1 The Pennsylvania Supreme Court also found particularly persuasive *General Agents, Insurance Co of America, Inc. v. Midwest Sporting Goods Co.*, 828 N.E.2d 1092 (Ill. 2005), which followed *Terra Nova, Jerry's Sport Center*, 2010 LEXIS 1803, at *35-*36, and cited favorably and confirmed the holding of the Philadelphia Court of Common Pleas in *LA Weight Loss Centers, Inc. v. Lexington Insurance Co.*, No. 1560, 2006 Phila. Ct. Com. Pl. LEXIS 127 (C.C.P. Phila. Mar. 1, 2006), which also followed *Terra Nova, Jerry's Sport Center*, 2010 LEXIS 1803, at *37.

n2 The Court noted that even if it had chosen to follow *Buss*, the insurer would not be entitled to

reimbursement because the potentially covered claim in this case was like the one potentially covered claim in *Buss* for which that insurer was not allowed to seek reimbursement. *Id.* at *48.

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SNR Denton on Cedell v. Farmers Insurance

2010 Emerging Issues 5341

SNR Denton on Cedell v. Farmers Insurance: Bad Faith Is Not Enough to Destroy Attorney-Client Privilege on a First-Party Claim in Washington

By William Barker and Ronald Kent

October 1, 2010

SUMMARY: Cedell v. Farmers has clarified WA law on discoverability of an insurer's attorney-client privileged material in insurance bad faith litigation. Under Cedell, the "insurer has a right to the attorney-client privilege in a first-party-insurer claim for bad faith absent showing an established exception to the privilege applies, such as fraud." The commentary discusses the significance of the case.

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ARTICLE: *Cedell v. Farmers Insurance Co.* n1 has clarified Washington law on discoverability of an insurer's attorney-client privileged material in insurance bad faith litigation. Under *Cedell*, the "insurer has a right to the attorney-client privilege in a first-party-insurer claim for bad faith absent showing an established exception to the privilege applies, such as fraud." n2 This commentary discusses the significance of the case in the context of Washington law and the law nationally.

I. The Case

The Cedells suffered an accidental fire at their home; a year later, Farmers still had not paid their claim. They sued for bad faith. Farmers had retained Ryan Hall, an attorney, to assist it in making a coverage determination. Cedell demanded production of the claim file, and Farmers produced it with heavy redactions for privilege and work product. Farmers moved for a protective order. The trial court found adequate nonprivileged evidence to support a good faith belief that Farmers had acted in bad faith, and deemed that sufficient to invoke the fraud exception to the privilege. It then ordered an in-camera review, and concluded that, on a bad faith claim arising from residential fire, the insured is entitled to discover the entire claim file, including privileged and work product material. The court of appeals granted discretionary review, and reversed. n3

In *Escalante v. Sentry Insurance Co.*, n4 the court had reversed a denial of discovery of privileged documents, ordering further proceedings. "In general, [the attorney-client] privilege protects confidential attorney client communications from discovery or public disclosure so that clients will not hesitate to speak freely and fully inform

their attorneys of all relevant facts." But the court noted that the privilege is subject to exceptions, including where the communications pertain to future or ongoing fraud. But that exception could be invoked "only upon a prima facie showing of bad faith tantamount to civil fraud." n5 That requires a "showing of a foundation in fact for the charge of civil fraud," possibly after an *in camera* inspection of the disputed documents. n6 But an *in camera* inspection would be discretionary with the court, "requiring a a factual showing 'adequate to support a good faith belief by a reasonable person that wrongful conduct sufficient to invoke the . . . fraud exception . . . has occurred.'" n7 The *Escalante* court remanded for consideration of whether plaintiffs could make the showing necessary to pierce the privilege.

On work product, the *Escalante* court noted that there is no work product immunity for documents prepared in the ordinary course of business, rather than in anticipation of litigation. This inquiry depended on the facts of the particular case. Moreover, the nature of the issues in a bad faith case normally establishes the "substantial need" for discovery necessary to obtain access to ordinary work product. n8

As to the mental impressions of an attorney or party representative (sometimes called "opinion work product"), there is heightened but, the court concluded, not absolute protection. It held that "mental impressions, etc., are discoverable in a bad faith action if they are directly in issue, and if the discovering party makes a stronger showing of necessity and hardship than is normally required under [Wash. R. Civ. P.] 26." n9

In *Cedell*, the court rejected dicta in *Barry v. United Services Automobile Ass'n* n10 which had suggested that the privilege would not apply in a bad faith action arising from a fire insurance claim. Moreover,

An insurance company does not lose attorney-client privilege protection simply because its litigation opponent raises an issue where advice of counsel may be relevant. While an attorney's impressions may be relevant to a bad faith claim, an automatic removal of attorney-client privilege would frustrate the purpose of the attorney-client privilege without cause. The fraud exception discussed below provides a litigant with sufficient means to discover relevant attorney-client communications. We note, however, that an insurance company may not hire an attorney as a claims adjuster just to fall within the attorney client privilege. A claims adjuster's conduct is not privileged simply because the claims adjuster happens to be a lawyer. Accordingly, only information, investigation, and advice Hall gave Farmers in his capacity as an attorney is subject to the privilege. n11

Turning to application of the fraud exception to the privilege, the court applied the usual definition of "fraud":

"(1) a representation of an existing fact, (2) its materiality, (3) its falsity, (4) the speaker's knowledge of its falsity or ignorance of its truth, (5) [the speaker's] intent that [the fact] should be acted upon by the person to whom it is made, (6) ignorance of [the fact's] falsity on the part of the person to whom it is made, (7) the latter's reliance on the truth of the representation, (8) [the right of the person] to rely on it, and (9) [the person's] consequent damage." n12

This required a different showing than bad faith, and "[t]o qualify for the fraud exception to attorney-client privilege, the plaintiff must show fraud, as opposed to just bad faith." n13 On the record here, that had not been done, and the order to produce was vacated. n14

II. Analysis

Attorney-client privilege and work product protection are often cited as obstacles to discovery in bad faith cases, and plaintiffs often contest their efficacy as such. n15 A minority of courts, exemplified by *Hearn v. Rhay*, n16 hold that the privilege is deemed waived if

(1) the assertion of the privilege was the result of some affirmative act, such as filing suit, by the asserting party; (2) through this affirmative act, the asserting party put the protected information at issue by making it relevant to the case; and (3) application of the privilege would have denied the opposing party access to information vital to his defense. n17

A fairly heavy majority is to the contrary, finding waiver only where the insurer relies in some way on the content of the privileged communications. n18 *Cedell* appears to place Washington in the majority camp, by holding that "[a]n insurance company does not lose attorney-client privilege protection simply because its litigation opponent raises an issue where advice of counsel may be relevant." n19 The minority cases often seem to treat an insurer's denial of accusations of bad faith as sufficient to waive the privilege, a view *Cedell* clearly rejects.

Of course, the privilege is subject, in any context, to an exception where the client has attempted to use the attorney's services in furtherance of a crime or fraud. n20 Nothing in the usual bad faith case involves anything remotely similar to a crime or fraud. A small minority of jurisdictions have extended this exception to "crime or tort," expanding it to nonfraudulent torts. n21 Alaska has treated some types of bad faith as a form of fraud for purposes of the exception: "'bad faith legal defense to a legitimate claim by one's insured' is a form of civil fraud for purposes of the privilege." n22 In noting the availability of the exception in bad faith cases, *Escalante* had cited the Alaska case. n23 It was previously unclear whether *Escalante* intended to adopt the Alaska court's broadening of the crime-fraud exception to include some types of bad faith. *Cedell* makes clear that Washington adheres a requirement of fraud in its traditional sense.

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n1 *Cedell v. Farmers Ins. Co.*, 2010 Wash. App. LEXIS 1670.

n2 *Id.* 1.

n3 *Id.* 1-7.

n4 *Escalante v. Sentry Ins. Co.*, 49 Wn. App. 375 (1987).

n5 *Id.* at 394, citing *United Servs. Auto. Ass'n v. Werley*, 526 P.2d 28 (Alaska 1974).

n6 *Id.*

n7 *Id.*

n8 *Id.* at 395-96.

n9 *Id.* at 397.

n10 *Barry v. United Servs, Auto. Ass'n*, 98 Wn. App. 199 (1999).

n11 *Cedell*, 2010 Wash. App. LEXIS 1670, 19.

n12 *Id.* 24, quoting *Lambert v. State Farm Mut. Auto. Ins. Co.*, 2 Wn. App. 136, 141, rev denied, 78 Wn. 2d 993 (1970).

n13 *Id.*

n14 *Id.* 25-26.

n15 These issues are examined in William T. Barker & Ronald D. Kent, *New Appleman Insurance Bad Faith Litigation*, Second Edition, § 16.04.

n16 *Hearn v. Rhay*, 68 F.R.D. 574 (E.D. Wash 1974).

n17 *Id.* at 581.

n18 William T. Barker & Ronald D. Kent, *supra* note 15, § 16.04[4][a][i].

n19 *Cedell*, 2010 Wash. App. LEXIS 1670, 19.

n20 *Id.* § 16.04[4][b].

n21 Edward J. Imwinkelreid, *The New Wigmore: A Treatise on Evidence*, § 6.13.2, at 970 (2002).

n22 *United Servs. Auto. Ass'n v. Werley*, 526 P.2d 28, 33 (Alaska 1974).

n23 *Escalante v. Sentry Ins. Co.*, 49 Wn. App. 375, 394 (1987).

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SNR Denton on Cargill, Inc. v. Ace American Insurance Co.

2010 Emerging Issues 5343

SNR Denton on Cargill, Inc. v. Ace American Insurance Co.: Contribution Among Insurers on Defense Costs

By William T. Barker, Robert C. Johnson and M. Keith Moskowitz

October 1, 2010

SUMMARY: Minnesota formerly adhered to a minority rule that an insurer that has performed its own duty to defend an insured has no right to contribution from other insurers who were equally obligated to defend that insured. In *Cargill*, the Minnesota Supreme Court overruled that rule. This commentary explains that this decision accords with modern unjust enrichment law and discusses its implications.

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ARTICLE: Minnesota formerly adhered to a minority rule that an insurer that has performed its own duty to defend an insured has no right to contribution from other insurers who were equally obligated to defend that insured. In *Cargill, Inc. v. Ace American Insurance Co.*,ⁿ¹ the Minnesota Supreme Court overruled that rule. This commentary explains that this decision accords with modern unjust enrichment law and discusses its implications for larger issues regarding allocation of insurance coverage.

I. The Case

A. Background

The rule against contribution had been adopted in *Iowa National Mutual Insurance Co. v. Universal Underwriters Insurance Co.*ⁿ² Kneeland had been driving an auto owned by Michael Boyer, Inc. Iowa National insured Kneeland's car and Universal insured the Michael Boyer car. Universal refused to defend Kneeland, but it was later held that Michael Boyer was Kneeland's employer, making Universal the primary insurer. Iowa National sought reimbursement of its costs in defending Kneeland. There being no contract between Iowa National and Universal, it relied on principles of unjust enrichment.

The Minnesota court rejected that claim. It reasoned that the obligation to defend was separate from any obligation to indemnify, and that each insurer has a personal obligation to defend, which it is not entitled to divide with any other insurer that has a separate, similar duty. In the absence of any common obligation, it found no basis for a contribution obligation. Because the insured had suffered no injury by being defended by one insurer instead of another, it held that

the insured had no claim against the nondefending insurer to which the defending insurer could be subrogated. The amounts expended by Iowa National were expended to discharge its own duties and to protect its own interests, and were not recoverable from Universal. n3

The court later recognized an exception to the rule if the insured executed a loan receipt, authorizing the defending insurer to sue the nondefending insurer. n4 And if both insurers breached the duty to defend, they would be held equally liable. n5

B. The Facts

Cargill was sued for environmental contamination and requested 50 of its insurers over many years to defend. Several of the insurers, including Liberty Mutual, offered to pay Cargill's reasonable defense costs if it would execute a loan receipt agreement authorizing them to sue the others. Cargill refused to do so, because some of its policies were "fronting" policies which supported excess and umbrella policies but themselves provided no risk transfer. Cargill offered a loan receipt that would protect it from any claims on the fronting policies and Liberty Mutual refused. n6

The district court declared that it could impose a constructive loan receipt, requiring the other insurers to contribute. It certified to the court of appeals the question whether it could do so, and that court, over a dissent, agreed that it could. The Minnesota Supreme Court granted review. n7

C. The Decision

The court concluded that *Iowa National* could not readily be reconciled with the decision below, nor could the existing exceptions support that result. n8 But it reconsidered and overruled *Iowa National*.

One of the purposes of that rule was "to encourage insurers to 'resolve promptly the duty to defend issue.'" n9 But the rule did not serve that purpose, instead "encourag[ing] any insurer whose policy is arguably triggered to deny its insured a defense and, essentially, play the odds that, among all the insurers on the risk, it will not be selected by the insured to defend." n10

The *Iowa National* rule was a minority view: "[m]ost courts have held that an insurer has an equitable right, whether by contribution or subrogation, to recover defense costs, at least partially, when primary insurers also have a duty to defend a common insured; this has been described as 'the better-reasoned view.'" n11 The court quoted a definition of "equitable contribution" as

"the right to recover, not from a party primarily liable for the loss, but from a co-obligor or co-insurer who shares common liability with the party seeking contribution. . . . The right of contribution is not derivative of the rights of the insured, but belongs to each insurer independently to seek reimbursement from a co-insurer those sums which were paid in excess of an insurer's proportionate share of the common obligation." n12

The court concluded that allowing such a right to co-primary insurers was "supported by public policy and is the better reasoned position." n13 So *Iowa National* was overruled. The court reaffirmed Minnesota's rule that, while liability for injuries continuing across policy periods is apportioned by time on the risk, defense costs are apportioned equally among insurers whose policies are triggered. n14

Finally, the court held that "breach of the duty to defend precludes application of an equitable right of contribution." n15 Accordingly, it remanded for determination whether Liberty Mutual had breached that duty.

II. Analysis

A. Cargill's Ruling on Contribution Accords with Modern Unjust Enrichment Law

Iowa National was, of course, right that a defending insurer typically has no contractual relationship with a

nondefending insurer, so it has no contractual right to reimbursement. But that left the question of whether a reimbursement right could be found in the law of unjust enrichment. Unfortunately, there was at the time no unified theory of the law of unjust enrichment to which a court might look for guidance in resolving that question. Even the most scholarly treatments tended to describe only a variety of specific rules for particular situations, without clear connection from one body of rules to another. n16 Moreover, even these treatments were relatively little known to most practitioners and courts. Accordingly, most courts groped their way, as the *Iowa National* court did, based on whatever precedent they could find and their own intuitions about unjust enrichment. Sometimes, as in *Cargill*, those might be reconsidered in light of precedent elsewhere.

But lawyers and courts now have a new and carefully analyzed source of guidance. For the last several years, the American Law Institute has been preparing a Restatement (Third) of Restitution and Unjust Enrichment, a project which has just been completed (though the final version is not yet on line). For the first time, this offers a systematic theory of the law of unjust enrichment, which provides a basis for critical review of existing precedent and guidance for the development of the law in the future.

The *Cargill* rule accords with that endorsed by the new Restatement:

If the claimant renders to a third person a performance for which the defendant would have been liable had the third person asserted a claim against the defendant directly, the claimant is entitled to restitution from the defendant as necessary to prevent unjust enrichment if

(a) the claimant acts in the performance of an obligation owed independently by the claimant to the third person, or otherwise in the reasonable protection of the claimant's own interests; and

(b) as between the claimant and the defendant, the performance or the part thereof with respect to which the claimant seeks restitution is primarily the obligation of the defendant. n17

Applying this to the *Cargill* facts, the defending insurer (Liberty Mutual), would be the unjust enrichment "claimant" and a nondefending insurer would be the unjust enrichment "defendant." The insured would be the "third person" to whom a performance was rendered by the defending insurer but to whom the nondefending insurer would have been liable had the insured asserted a claim against it. Because the defending insurer had a duty to defend, it was acting in accordance with an obligation owed independently to the insured. If the defending insurer were an excess carrier, defending in lieu of a breaching primary insurer, it would be the case that the duty to defend was primarily the obligation of the nondefending insurer, and the claim would commonly be described as one for "equitable subrogation." But the Restatement makes it clear that the rule applies also to co-primary insurers:

A claim to "contribution" by one insurer against another insurer of the same risk is within the rule of this Section. Such a claim is one in which the performing party (the insurer seeking contribution) asserts that *a part* of its performance to the third-party obligee (the common insured) is primarily the responsibility of the defendant. In the language of insurance law, claims on this pattern are referred to by the label "equitable contribution." n18

Insurer advocates wishing to urge other courts to adopt the *Cargill* (and strong majority) rule on contribution rights for defending insurers should make use of the Restatement as strong supporting authority for their arguments. And both courts and advocates should consult the Restatement on other issues of unjust enrichment law.

B. Cargill Silently Approved Allocation of Defense Costs to Fronting Policies

The reason why *Cargill* refused to agree to a loan receipt was to protect fronting policies in some years, because *Cargill* itself would be required to pay any losses under those policies. In disputes over allocation of losses among insurers and with policyholders, the latter commonly take the position that (1) no losses (and, especially, no defense costs) can be allocated to the policyholder and (2) allocation to a fronting policy should be treated as allocation directly to the policyholder. The district court had rejected the latter argument, and the supreme court's ruling appears to have

silently affirmed that ruling. The district court had reasoned that:

"Cargill, a sophisticated business entity, has created this insurance structure, and it seems inequitable that they should now be permitted to avoid cooperating with Liberty Mutual (the insurer who[m] they have self-chosen to defend their liability claims) because of their concern that the insurance structure that they have created may have some adverse consequences to go along with the benefits they have received." n19

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n1 *Cargill, Inc. v. Ace Am. Ins. Co.*, 784 N.W.2d 341 (Minn. 2010).

n2 *Iowa Nat'l Mut. Ins. Co. v. Univ. Underwrs. Ins. Co.*, 150 N.W.2d 233 (Minn. 1967).

n3 *Id.* at 365-70.

n4 *Home Ins. Co. v. Nat'l Union Fire Ins. Co.*, 658 N.W.2d 522, 527 (Minn. 2003).

n5 *Jostens, Inc. v. Mission Ins. Co.*, 387 N.W.2d 161, 167 (Minn. 1986).

n6 *Cargill*, 784 N.W.2d at 343-46.

n7 *Id.* at 346-47.

n8 *Id.* at 348-50.

n9 *Id.* at 352.

n10 *Id.*

n11 *Id.* at 352-53, *quoting* Allan D. Windt, Insurance Claims & Disputes: Representation of Insurance Companies & Insureds, § 10:3, at 199-201 (4th ed. 2001), *and citing* Douglas R. Richmond, *Issues & Problems in "Other Insurance," Multiple Insurance, and Self-Insurance*, 22 *Pepp. L. Rev.* 1373, 1426 (1995) ("The majority position sounds in equity, and indeed is supported by fairness and logic." (footnote omitted)).

n12 *Id.* at 353 n.11, *quoting* *U.S. Fid. & Guar. Co. v. Federated Rural Elec. Ins. Corp.*, 37 P.3d 828, 832 (Okla. 2001).

n13 *Id.* at 353.

n14 *Id.* at 354.

n15 *Id.*

n16 *E.g.*, George E. Palmer, *The Law of Restitution* (1978); Restatement of Restitution § 112 (1937).

n17 Restatement (Third) of Restitution and Unjust Enrichment, § 26 (Tent. Dr. No. 2 April 1, 2002).

n18 *Id.* cmt. *d* (emphasis added).

n19 *Cargill*, 784 N.W.2d at 346.

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SNR Denton on McReynolds v. American Commerce Insurance Co.

2010 Emerging Issues 5342

SNR Denton on McReynolds v. American Commerce Insurance Co.: Interpleader as a Safe Harbor for Multiple Demands

By Ronald Kent

October 1, 2010

SUMMARY: *McReynolds v. American Commerce Insurance Co.* presented an issue at a doctrinal intersection: multiple claims with inadequate limits and claims subject to liens. The court held that an insurer could meet its obligation to consider the multiple offers in good faith by interpleading its policy limits and continuing to defend the insured. This commentary considers the case in light of the law elsewhere on both doctrinal points.

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ARTICLE: *McReynolds v. American Commerce Insurance Co.* n1 presented an issue at a doctrinal intersection: multiple claims with inadequate limits and claims subject to liens. The court held that an insurer could meet its obligation to consider the multiple offers in good faith by interpleading its policy limits and continuing to defend the insured. This commentary considers the case in light of the law elsewhere on both doctrinal points.

I. The Case

Michael McReynolds was seriously injured in an accident with Tania Ranieri, who was insured with American Commerce Insurance Co. ("ACIC"). McReynolds was treated at Flagstaff Medical Center ("FMC"), which filed a statutory lien in the amount of \$43,603.85. McReynolds demanded policy limits. ACIC tendered a two-party check (to McReynolds and ACIC) for its \$25,000 policy limit. McReynolds rejected the check, and sued Ranieri. He then made an offer of judgment for policy limits. Counsel advised ACIC that payment to McReynolds, without a release from FMC could expose FMC to liability on the lien. Within the time for acceptance of the offer of judgment, ACIC filed an interpleader and paid its policy limit into court. Eventually, FMC released its liens and the interpleader was dismissed. ACIC continued to defend Ranieri, but McReynolds obtained a judgment against her in the amount of \$469,110.67. Ranieri assigned any bad faith claim she might have to McReynolds, who sued ACIC. The trial court granted summary judgment to ACIC and the court of appeals affirmed. n2

The court saw the issue as "whether the insurer had a duty to properly manage the policy limits and, if so, whether the good faith filing of a prompt interpleader satisfies that duty." n3 McReynolds argued that, faced with multiple

claims (the personal injury claim and the lien claim), ACIC should have used the policy limits to minimize the insured's exposure by paying his claim and leaving the lien claim outstanding. The premise was that ACIC had refused to accept his policy limits demand. But the court disagreed with the premise, finding that ACIC "chose to pay everything by promptly interpleading the entire policy limits into the court and continuing to provide a defense." n4

Arizona law had not recognized any duty for the insurer to manage the policy limits, but to the extent that there was such a duty, the court concluded that it was "best considered as being part of the established duty to fairly consider settlement offers, giving equal consideration to the insured's interest." n5 In applying that duty, the court looked to out-of-state authority suggesting the utility of interpleader in multiple claimant situations. n6 In contrast, courts that had applied other rules "either create substantial uncertainty or risk unfair treatment of claimants." n7 Unfair treatment could result if payment to one or more claimants exhausted the policy limit, leaving nothing for others. Uncertainty would result if an insurer would risk bad faith liability by refusing to make a settlement with only some claimants and trying to effect a global settlement that would fully protect its insured. n8 Cases which had found jury questions on bad faith in such situations left the insurer with no safe course of action: it could be sued for settling too quickly with some claimants or for failing to do exactly that. n9

The better approach should offer greater certainty, so the court held that

(1) the prompt, good faith filing of an interpleader as to all known claimants with (2) payment of the policy limits into the court and (3) the continued provision of a defense for the insured as to each pending claim, acts as a safe harbor for an insurer against a bad faith claim for failure to properly manage the policy limits (or give equal consideration to settlement offers) when multiple claimants are involved and the expected claims are in excess of the applicable policy limits. n10

On the undisputed facts, this rule supported summary judgment for ACIC.

II. Analysis

A. Other Jurisdictions Have Not Found Interpleader So Complete a Solution as the *McReynolds* Court.

When insurers are unable to negotiate a global settlement among multiple claimants, they frequently resort to interpleader actions to allocate the available funds. n11 Indeed, some courts (like the *McReynolds* court) suggest that an insurer should attempt a global settlement and, if unsuccessful, seek judicial assistance by proceedings in the nature of interpleader. n12 There certainly are situations where interpleader could be useful in achieving a global settlement. n13 But, ultimately, interpleader cannot force a settlement where the claimants are unwilling. An interpleader can only enjoin other actions with respect to the fund interpleaded; it cannot enjoin pursuit of other sources of payment, such as the insured. n14

Thus, an interpleader leaves the insured subject to continued suit by any claimants whose full claims are not satisfied (which might well be all of them). As a practical matter, that may not be as troublesome as it sounds. If the insured is judgment proof (or nearly so), it will not be worth anyone's while to continue suit and, if necessary, the insured could usually discharge the claims in bankruptcy. And if the insured has assets reachable by creditors, the insured should be brought into the settlement negotiations. If the insurer follows the insured's direction on deployment of the policy limits, it should ordinarily be protected from any bad faith claim. n15

But one could get to much the same result, more neatly, by holding that an insurer faced with multiple claimants and inadequate limits is always entitled to hold out for a global policy limits settlement. That would force the multiple claimants to bargain among themselves or themselves ask the court to divide the offered, instead of devoting their energies to trying to set up a bad faith claim. I have argued for the latter rule elsewhere. n16

Because the rule articulated by the *McReynolds* court will likely have the same practical effect as the one I advocate, it would appear to be a reasonable alternative.

B. The Result Can Also Be Supported by the Fact That the Second Claim Here Was Not an Independent Claim, but a Lien on McReynolds' Claim.

McReynolds' theory was that ACIC should have paid him and left the lien claim outstanding, because that would have eliminated most of the tort exposure (over 90% of it, based on the ultimate verdict). One flaw in that logic is that Ranieri might have been no better off with reduced tort exposure. If she wanted to eliminate that exposure (e.g., to protect any future earnings), she would need to declare bankruptcy, and bankruptcy will eliminate a large judgment or exposure as easily as a small one. Ranieri's desire would be not to have to file bankruptcy at all, and that could only be achieved by holding out for a global settlement (or interpleading the policy limit).

But putting that aside, what McReynolds was requesting was something neither McReynolds nor Ranieri could have been entitled to. The liability limit is the most an insurer is obliged to pay to discharge the insured's liability. Had ACIC paid that to McReynolds, it would have remained exposed to the statutory lien claim by FMC, so that it would (or at least might) be required to pay more than its liability limit. By filing the interpleader, ACIC offered its limits and was entitled not to offer more. If, as FMC apparently concluded was the case, the lien would have been subordinated due to the inadequacy of the policy limits, then the interpleader would eventually have resulted in payment of the limits to McReynolds. If FMC really were entitled to a priority claim, there would have been nothing left for McReynolds. In neither event should he have been entitled to force ACIC to predict the law on this point, at the risk of either bad faith liability or double payment.

For these reasons, other jurisdictions hold that if the claim against the insured is subject to a statutory lien and the lienholder does not join in a settlement demand, the demand may be invalid and bad faith liability precluded, because the tort claimant alone is unable to provide a valid release. ⁿ¹⁷ The lienholder is viewed as a necessary party to any settlement. This is appropriate, because the insurer might otherwise be obliged to make a double payment of the lien amount, if the claimant failed to satisfy the lien claim out of the settlement proceeds. ⁿ¹⁸

Thus, the *McReynolds* result is clearly correct on its own facts, even if Arizona did not recognize the safe harbor articulated by the court.

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ⁿ¹ *McReynolds v. Am. Comm. Ins. Co.*, 235 P.3d 278 (Ariz. Ct. App. 2010).

ⁿ² *Id.* 1-6.

ⁿ³ *Id.* 9.

ⁿ⁴ *Id.*

n5 *Id.* 18.

n6 *Id.* 19-20.

n7 *Id.* 21.

n8 *Id.*

n9 *Id.* 24-25.

n10 *Id.* 26.

n11 *E.g., Farmers Ins. Exch. v. Schropp*, 222 Kan. 612, 615-16 (1977).

n12 *E.g., Kinder v. Western Pioneer Ins. Co.*, 231 Cal. App. 2d 894, 901 (1965).

n13 *E.g., State Farm Mut. Auto. Ins. Co. v. Marcum*, 420 S.W.2d 113, 119-20 (Ky. 1967) (evidence showed that, given the insured's lack of assets, interpleader would have resulted in settlement had it been attempted) (overruled in part by *Manchester Ins. & Indem. Co. v. Grundy*, 531 S.W.2d 493 (1975) and superseded in part by statute, as noted in *Knotts v. Zurich Ins. Co.*, 2004 Ky. App. LEXIS 22 (Ky. Ct. App. Feb. 6, 2004)).

n14 *State Farm Fire & Cas. Co. v. Tashire*, 386 U.S. 523, 533 (1967) (federal procedural law);
Oak Cas. Ins. Co. v. Lechlitter, 206 W. Va. 349, 353-57 (1999) (collecting cases).

n15 See William T. Barker & Ronald D. Kent, New Appleman Insurance Bad Faith Litigation, Second

Edition § 2.04[2].

n16 *Id.* § 2.03[9][a][i][B].

n17 *Coe v. State Farm Mut. Auto. Ins. Co.*, 66 Cal. App. 3d 981, 992 (1977);

Trinity Univ. Ins. Co. v. Bleeker, 966 S.W.2d 489, 491 (Tex. 1998);

but see Kivi v. Nationwide Mut. Ins. Co., 695 F.2d 1285, 1287-88 (11th Cir. 1983) (insurer should have addressed lien claims as a condition of settlement).

n18 *E.g., Sec. Ins. Co. v. Deshotels*, 458 So. 2d 186, 190 (La. App. Ct. 1984).

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SNR Denton on Roehl Transport, Inc. v. Liberty Mutual Insurance Co.

2010 Emerging Issues 5344

SNR Denton on Roehl Transport, Inc. v. Liberty Mutual Insurance Co.: Wisconsin Recognizes New Form of Bad Faith

By William T. Barker

October 1, 2010

SUMMARY: In *Roehl Transport, Inc. v. Liberty Mutual Insurance Co.*, the Wisconsin Supreme Court has recognized a new form of bad faith failure to settle: failing to minimize use of the insured's deductible. This commentary critically examines that decision in light of other cases addressing an insurer's duties regarding deductibles and retrospective premiums.

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I. The Case

One of Roehl Transport's trucks rear-ended a car driven by Arthur Groth, who sued. Roehl's policy had a \$2 million limit, but a \$500,000 deductible. Liberty Mutual was entitled to control settlement, though Roehl was entitled to be consulted. A jury awarded Groth \$830,400 in damages, fully consuming Roehl's deductible. Roehl claimed that Liberty Mutual could and should have settled for \$100,000, and sued for bad faith.ⁿ³ The bad faith jury found "(1) that Liberty Mutual breached duties owed to Roehl Transport in the handling of the Groth claim; [and] (2) that Liberty Mutual's failure to perform its duties to Roehl Transport 'demonstrated a significant disregard of Roehl Transport's interests such that Liberty Mutual's failure to settle Groth's claim was done in bad faith.'"ⁿ⁴ It awarded \$127,000 in damages. Liberty Mutual appealed.ⁿ⁵

The Wisconsin Supreme Court affirmed judgment on the verdict, holding:

(1) Roehl Transport, an insured with a deductible for its liability coverage, has a cognizable bad faith claim against its insurance company when the company has control over settlement of a third-party claim and engages in bad faith conduct toward the insured, even though the judgment does not exceed the policy limits.

(2) Sufficient credible evidence supports the jury's finding of bad faith and the jury's determination of damages in this case.

(3) Judicial public policy considerations do not preclude Roehl Transport's bad faith claim. n6

Roehl argued that

in investigating and handling a claim of liability against it, Liberty Mutual may not ignore the interests of Roehl Transport. Roehl Transport contends that Liberty Mutual cannot conduct a slipshod investigation, ignore settlement opportunities, mishandle the legal defense, and engage in all manner of misconduct, thus wasting Roehl Transport's \$ 500,000 deductible, but then avoid legal responsibility for its alleged bad faith actions only because the judgment entered was within policy limits. n7

Liberty Mutual responded that Roehl had bargained for lower premiums by accepting a high deductible and ought not be permitted to complain about having to pay an amount up to the deductible. n8

The court began by examining the basis for the existing duty to act in good faith regarding settlement. That "duty is implied by the terms of the insurance policy that give the insurance company exclusive power to settle claims." n9

[T]hird-party bad faith claims arose to protect holders of insurance policies against abusive, "bad faith" practices of insurance companies in adjusting or settling liability claims against the insured when the interests of the insured are in the hands of the insurance company and may come into conflict with the insurance company's own interests. n10

In the traditional duty to settle claim, there is a conflict regarding excess exposure. If the insurer settles within policy limits, it protects its insured from excess exposure, but sacrifices its own interest in seeking a defense verdict or a lesser judgment or settlement. If the settlement opportunity is at or near policy limits, the insurer may have little or nothing to gain from settling. In light of this conflict of interests, an insurer is obliged to exercise good faith in making settlement decisions. In Wisconsin, this duty includes initiating settlement negotiations when that is the reasonable course of action. n11

In the court's view, this case was analogous to those recognizing a duty to settle, because Roehl had bargained away control of settlement and was dependent on Liberty Mutual to protect its interests. At least potentially, there could be conflicts between their interests:

The insurance company might offer an unnecessarily high settlement within the deductible to avoid the expense of diligent investigation and adjustment. Or it might expend insufficient effort to investigate a claim unless or until the insurance company's own money is at risk when the value of the claim approaches or exceeds the deductible.

The insurance company's apparent interest in settling claims below the deductible is to minimize its own costs, not necessarily to minimize the total payment to the claimant. Just as in traditional third-party excess judgment cases, the insured with a high deductible needs the protection of a bad faith cause of action to guard against the risk that an insurance company's exercise of control over a claim might favor its own financial interests over those of the insured. This possibility gives rise to a cause of action for bad faith. n12

While Liberty Mutual argued that recognizing a cause of action in this context would "'open the floodgates' to a great volume of wasteful or frivolous claims," the court concluded that insurers were adequately protected by existing liability standards: "[i]nsurers in Wisconsin need not be mulcted by extortionate or questionable claims if they adhere to the standards of care which we have set forth" n13 The court also found support in cases from other jurisdictions involving deductibles or retrospective premiums, a subject that will be deferred to the analysis of the result in *Roehl Transport*. n14

Because liability here was based on expert testimony about what Liberty Mutual "could have settled for," Liberty

Mutual argued that causation was so remote and speculative that judicial public policy considerations barred the claim.
n15 The court disagreed. n16

Liberty Mutual also challenged the sufficiency of the evidence to support a finding of bad faith. Such a challenge could not succeed "unless the court is satisfied that, considering all credible evidence and reasonable inferences therefrom in the light most favorable to the party against whom the motion is made, there is no credible evidence to sustain a finding in favor of such party." n17 The jury instruction, which Liberty Mutual did challenge and that the court said was "in keeping with case law," specified that "[t]he term 'bad faith' carries with it the suggestion of dishonest or deceitful conduct." n18

The court provided a further description of the case law which supported the instruction:

Our cases have defined bad faith by reference to "deceit; duplicity; insincerity." The cases characterize bad faith as "a species of fraud." We have said that "the knowing failure to exercise an honest and informed judgment constitutes the tort of bad faith," and that "[t]he insurance company, . . . to be liable, need not be found to have committed fraud or to have acted dishonestly" A jury may properly conclude that an insurance company's "massive failure" to carry out its identified duties constitutes a "suggestion of dishonesty" or 'a species of fraud,' within the meaning of 'bad faith.'" n19

But the jury was also instructed that:

"'[B]ad faith' is a term of broad application, and it is sometimes difficult to exactly define within the framework of every case"; that the jury must "consider whether the company, in failing to perform the duties it owed to Roehl Transport[,] demonstrated a significant disregard of Roehl Transport's rights and economic interests"; that the company's "decision not to settle should be an honest one, taking into consideration both the interests of the company and the interests of the insured;" that the company's "[negligence] alone is not enough to show the company acted in bad faith"; that the jury is to "consider the totality of the insurance company's decisions in the handling of the injured party's claim to determine whether those decisions were intellectually honest and reasonable"; that if the jurors determine that the company's decisions "were not honest and reasonable decisions, then the company may be said to have acted in bad faith"; and that if the jurors "conclude that important facts were recklessly ignored and disregarded during Liberty Mutual's adjustment of the claim, then the company may be said to have acted in bad faith." n20

Contrary to Liberty Mutual's arguments, this instruction did not require a "specific finding of deceit or dishonesty."
n21

The jury was instructed that Roehl Transport bore the burden of proving bad faith by "clear, satisfactory, and convincing evidence." n22 The court found that the evidence would have allowed the jury to conclude that

Liberty Mutual's decisions demonstrated a significant disregard of Roehl Transport's rights and economic interests and were not honest. The evidence showed that Liberty Mutual employed claims personnel on the Groth claim who had little training or experience with trucking claims; that there was high turnover in staffing the Groth claim; that Liberty Mutual failed to adequately supervise the staff's handling of the claim; that the investigation of the accident and Groth's injuries and medical condition was inadequate; that the insurance company mishandled the independent medical examination so that the extent of injury and disability liability attributed to Roehl Transport was exaggerated; that Liberty Mutual made no attempt to settle Groth's claims when it had the opportunity to do so; and that Liberty Mutual failed to retain experts, including an accident reconstructionist, who could have provided evidence limiting Roehl Transport's liability to Groth. n23

That sufficed to support the verdict. n24

II. Analysis

A. Insurer Duties of Good Faith Regarding Settlement Involve Different Considerations Under Loss-Sensitive Policies than Under Fixed-Cost Policies.

Standard liability insurance policy language both gives the insurer a right to settle when it deems that expedient and restricts the insured's ability to settle by requiring that it be done only with the insured's own funds, so that a settlement by the insured would effectively forfeit coverage. n25 These provisions vest the insurer with control of settlement.

Under fixed-cost policies, where the insured's only exposure is to liability exceeding the policy limit, and in the absence of contractual language to the contrary, the insurer's right to settle with its own funds is virtually absolute, n26 though it may not sacrifice the insured's affirmative claims or commit the insured's assets to settlement. n27 Because the insured is at risk for liability in excess of the policy limit, and because (as the *Roehl Transport* court points out) this creates a conflict of interest regarding the insurer's decisions on settlement, the law in all American jurisdictions has imposed a duty on insurers to take account of the insured's interests as well as its own. n28

But some policies, like that in *Roehl Transport*, have features providing for sharing of the risk within policy limits by the insured. That may take the form of a deductible, which the insured must reimburse, or a retrospective premium, adjusted from time to time based on the loss experience under the policy. n29 As *Roehl Transport* illustrates, such loss-sharing features generate different types of tension between insurer and insured than those found in traditional duty-to-settle cases. Prior to *Roehl Transport*, courts have considered these issues in connection with challenges by insureds to insurer decisions to settle, when the insurer sought reimbursement of amounts within the deductible or to collect a retrospective premium based on the settlement.

B. If an Insurance Policy Provides for a Deductible or Retrospective Premium, the Insurer's Ability To Collect May Depend on any Settlement Being in Good Faith

1. If the Policy Language Gives the Insurer Settlement Authority, the Insured's Consent Is Not Required

If a policy is loss-sensitive, that means that a decision to settle within limits will impose costs on the insured. Courts have not agreed on the extent to which an insurer's settlement decisions under such a policy are reviewable and, if so, under what standards.

Where the policy confers authority to settle on the insurer, almost all of the decided cases authorize it to utilize the insured's funds to do so without the insured's consent. n30 Most of these cases involve only conventional policy language on authority to settle, not specific language addressing commitment of insured's funds. Obviously, use of more specific language would be advisable. An insured who does have a right to veto settlement cannot "permit" that settlement while denying the obligation to commit its self-insured retention. n31

A few cases hold that the insured must consent to a settlement for the insurer to be able to recover the deductible. n32 They are contrary to the great weight of authority and give inadequate effect to policy language conferring on the insurer the right to settle, language agreed to by even sophisticated commercial insureds.

2. Courts Apply Varying Standards To Insurer Claims for Reimbursement or Retrospective Premiums

Most of the reported cases seem to contemplate the theoretical possibility of an attack on actual settlements when the insurer seeks payment of a deductible or retrospective premium. n33 However, most of them also hold that an insurer's decision to settle will be given considerable deference, so attacks should rarely succeed.

A few cases appear to suggest that an insured's decision to bargain for the reduced premiums which accompany both a loss-sensitive provision and the omission of any right to veto settlement preclude any challenge. n34 But the facts generally indicated reasonable conduct in each case. One case hypothesized that the insured *might* be able to attack a settlement if *no* reasonable insurer would have made it, but found no facts to support such a claim there. n35 Thus,

most of these suggestions of an absolute right to settle are arguably dicta, not fully reliable even in the courts making them. n36 One case found the actual settlement "prudent and well reasoned" (perhaps because it came in the wake of a larger jury verdict) and did not address what standard would apply beyond placing the burden of showing bad faith on the insured. n37

The most articulate case as to the applicable standard is *American Home Assurance Co. v. Hermann's Warehouse Corporation*. n38 The New Jersey Supreme Court made it clear that a settlement utilizing the insured's funds is reviewable for bad faith, but it set a high threshold, not met on the facts there. It began by noting that a conflict of interest was "built-in" to the policy structure, because the insurer could always try to save defense costs (and risks to its own funds) by too readily committing the insured's funds to settlement. But insureds purchasing such policies are generally sophisticated and able to obtain policies without deductibles and/or with settlement vetoes if they wish. An insurer's duty of good faith as regards its settlement power required no more than "ordinary diligence in performing that power when in the exercise of it." n39 The allegations raised by the insured there at most raised "a question of the carrier's judgment. Bad judgment does not equate with bad faith. Given the broad discretion that must be accorded the insurer ..., courts should not second guess a legitimate, albeit questionable, judgment call." n40

Retrospective premium arrangements commonly provide for payment by the insured of *more* than the amount actually paid out, the excess being an allowance for claim handling expenses. This means that the insurer might be able to profit by skimping on claim adjustment and inflating claim payments. As a result, some courts dealing with such arrangements have been less deferential, requiring the insurer to establish that the payments made were reasonable. n41

A leading case reasoned:

Because of the conflict of interest which is inherent in this arrangement, we believe ... that the right of the insurer to collect from the insured in the form of a retrospective premium amounts paid out by it as losses should be contingent upon proof by the insurer that the settlements so made were in good faith and reasonable. The insurer, having been charged with the responsibility for investigating and adjusting the loss, is in possession of the relevant information upon which a determination of reasonableness and good faith must be based. The insured, having delegated the right and duty of investigation and settlement to the insurer, and having agreed to pay the expense incurred in carrying out this assignment, has, by the terms of its insurance contract, put the information critical to the issue of reasonableness and good faith in the exclusive possession of the insurer. If the insured is to pay out as a retrospective premium the amounts paid by the insurer in settlement of liability claims under circumstances where, theoretically at least, the settlement of the claim has been beneficial to both (to the insured to the extent of its exposure up to the \$5,000 maximum and to the insurer to the extent of its exposure for any amount in excess of that), the insured should be entitled ... to have the insurer produce the information pertinent to the reasonableness and good faith of the settlement and assume the burden of proof on the issue. n42

Other courts have supplemented this rule by requiring the insured to bear the burden of producing evidence that a particular settlement was questionable, absent which all settlements would be presumed reasonable. n43 If a settlement is problematic, ordinary discovery should enable an insured to show that. This is more efficient than requiring the insurer to present evidence justifying the handling of every claim.

An insurer's duty to minimize retrospective premiums due to itself was distinguished from any possible obligation to take action to minimize the insured's future premiums. In finding no duty of the latter sort, the court in *New Plumbing Contractors Inc. v. Nationwide Mutual Insurance Co.* n44 reasoned that the insured "is not complaining about the receipt of benefits under the [subject] policy, rather it is complaining about what it had to pay in the marketplace for insurance in future years. This does not implicate ... any implied obligation of good faith." n45 Another case suggested that *New Plumbing's* ruling on this point may be applicable only where future premiums are determined in a competitive market, rather than pursuant to a state-imposed rating structure applicable to all insurers. n46 However, because *New Plumbing* itself involved a state-imposed rating structure, the purported distinction does not apply.

By analogy to cases regarding excess judgments, it would seem that the insurer need do no more than show that it was being as careful with the insured's money as it would be with its own. One class of cases where that would seem true as a matter of law would be those where the insurer spent at least as much of its own money as of the insured's money.

One commentator disputes that point. ⁿ⁴⁷ He asserts that the insured should have the chance to gamble on trial (which might produce a defense verdict) whenever the settlement demand exceeds the fair value of the case. On this basis, he argues that the insurer can deprive the insured of this right by spending too much of its own money. He claims that this is the logical implication of the "disregard the limits" rule.

But if that were true, the insurer would have the right to refuse to offer its limits if an above-limits demand were excessive, even if the insured were prepared to make the necessary contribution to satisfy the demand. Clearly, that is not so. Each party's funds should be committed to the full extent of the objective fair settlement value, with the other party free to supplement if it prefers to eliminate the risk of greater liability.

Where the insured has an SIR and retains the functions normally performed by a primary insurer, it would seem that the insurer ordinarily could not commit the insured's funds to settlement without its consent. The major issue would seem to be what standards, if any, govern the insured's decision whether to settle. ⁿ⁴⁸

3. Roehl Transport Is Consistent with Cases Where the Insurer Did Settle

The supposed conflict in *Roehl Transport* does not apply to the actual settlement decision (in that case, the decision not to settle, or at least not to initiate settlement negotiations). Liberty Mutual had no reason to refuse a reasonable settlement that would be fully reimbursed by Roehl. After all, failure to settle might expose Liberty Mutual to liability above the deductible (as it actually did). To the extent that there is a conflict, it concerns handling of the defense: Liberty Mutual's claim handlers might have thought that they could skimp on defense efforts, so long as they believed--mistakenly--that the claim would ultimately be resolved within the deductible. From the court's description of the facts, it appears that the jury could have found such skimping--or at least reckless failure to provide an adequate defense.

But even there, Liberty Mutual had an incentive to avoid any risk of liability beyond the deductible, so its interests were largely (though not completely) aligned with those of Roehl. Thus, as in the cases where the insurer settled and sought reimbursement or a retrospective premium, considerable deference should be accorded the insurer's decisions. That implies a high threshold for any bad faith claim by the insured. *Roehl Transport* applies such a threshold and reaches what appears to be a sound result.

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ⁿ¹ *Roehl Transport, Inc. v. Liberty Mutual Insurance Co.*, 2010 WI 49 (Sup. Ct.).

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n3 2010 WI 49, 2-3.

n4 2010 WI 49, 22.

n5 The case also involved issues regarding attorneys' fees and punitive damages, but this commentary does not address them.

n6 2010 WI 49, 7.

n7 2010 WI 49, 26.

n8 2010 WI 49, 27.

n9 2010 WI 49, 41 (footnote omitted).

n10 2010 WI 49, 44.

n11 2010 WI 49, 45-50. See William T. Barker & Ronald D. Kent, *New Appleman Insurance Bad Faith Litigation*, Second Edition, §§ 2.03[1] (bases of duty to consider insured's interests), 2.03[6][d][iii] (division of authority on whether insurer must initiate negotiations).

n12 2010 WI 49, 53-54.

n13 2010 WI 49, 95, quoting *Anderson v. Cont'l Ins. Co.*, 85 Wis. 2d 675, 694 (1978).

n14 2010 WI 49, 114-115. See discussion at notes 17-31, *infra*.

n15 2010 WI 49, 140.

n16 2010 WI 49, 141-158.

n17 2010 WI 49, 118 n.28, quoting Wis. Stat. § 805.14(1).

n18 2010 WI 49, 122.

n19 2010 WI 49, 122 n.61.

n20 2010 WI 49, 124.

n21 2010 WI 49, 125.

n22 2010 WI 49, 126.

n23 2010 WI 49, 127.

n24 2010 WI 49, 128-129.

n25 William T. Barker & Ronald D. Kent, New Appleman Insurance Bad Faith Litigation, Second Edition,

§§ 2.02[3] (restrictions on settlement by the insured), 2.05[1] (insurer's right to settle).

n26 William T. Barker & Ronald D. Kent, § 2.05[1].

n27 William T. Barker & Ronald D. Kent, § 2.05[2].

n28 William T. Barker & Ronald D. Kent, § 2.03.

n29 William T. Barker & Ronald D. Kent, § 2.02[5]; William T. Barker, *Combining Insurance and Self-Insurance: Issues in Handling Liability Claims*, 61 Def. Coun. J. 352 (1994).

n30 *New Hampshire Ins. Co. v. Ridout Roofing Co.*, 68 Cal. App. 4th 495, 502 (1998) (A policy with a deductible typically allows the insurer to defend and settle claims against the insured without the insured's consent (unless the policy expressly provides otherwise). This is true even if, because of the deductible, the insured is obligated to pay (or reimburse the insurer for) the entire settlement."); *Corrado Bros. Inc. v. Twin City Fire Ins. Co.*, 562 A.2d 1188, 1191 (Del. 1989); *Cas. Ins. Co. v. Town & Country Pre-School Nursery, Inc.*, 147 Ill. App. 3d 567, 570 (1986) (alleged bad faith not relevant); *Hendrix v. City of New Orleans*, 562 So. 2d 1164 (La. App. 1990) (insurer's authority to settle absolute, especially in light of provision entitling it to reimbursement for payment of the deductible); *but see Employers Surplus Line Ins. Co. v. Baton Rouge*, 362 So. 2d 561 (La. 1978) (insurer had absolute right to settle but not to reimbursement of deductible if city did not consent; may depend on fact that insured was a public body or on lack of sufficiently explicit policy language); *Ins. Co. of N. Am. v. L.C. Young Painting & Decorating Co.*, 11 Mich. App. 304, 308-09 (1968); *American Home Assur. Co. v. Hermann's Warehouse Corp.*, 117 N.J. 1, 9 (1989).

n31 *Harbor Ins. Co. v. City of Ontario*, 231 Cal. App. 3d 927, 934-35 (1991).

n32 *Nat'l Serv. Indus., Inc. v. Hartford Accident & Indem. Co.*, 661 F.2d 458, 462 (5th Cir. 1981) (GA law); *St. Paul Fire & Marine Ins. Co. v. Edge Mem'l. Hosp.*, 584 So. 2d 1316, 1327 (Ala. 1991); *Employers Surplus Line Ins. Co. v. Baton Rouge*, 362 So. 2d 561 (La. 1978).

n33 *Contra New Hampshire Ins. Co. v. Ridout Roofing Co.*, 68 Cal. App. 4th 495, 504-05 (1998) (duty of

good faith could not limit express contractual right to settle).

n34 *Transcont'l Ins. Co. v. Century Steel Erectors*, 318 F. Supp. 2d 276, 278 (W.D. Pa. 2004); *Cas. Ins. Co. v. Town & Country Pre-School Nursery*, 147 Ill. App. 3d 567 (1986); *Orion Ins. Co. v. Gen. Elec. Co.*, 129 Misc. 2d 466, 471-72 (Sup. Ct. 1985), *aff'd on opinion below sub nom. United States Aviation Underwriters, Inc. v. Gen. Elec. Co.*, 125 A.D.2d 567 (1986).

n35 *Orion Ins. Co.*, 129 Misc. 2d 466, 471-72.

n36 *But see Transcont'l Ins. Co.*, 318 F. Supp. 2d 277-78 (seemingly applying an absolute rule).

n37 *Austin Co. v. Royal Ins. Co.*, 842 S.W.2d 608, 1992 Tenn. App. Lexis 1051, *5 (Tenn. Ct. App. 1992). *See also Nationwide Mut. Ins. Co. v. Pub. Serv. Co.*, 112 N.C. App. 345, 351 (1993) (settlement conceded to be reasonable but alleged to be in bad faith because settlement amount only \$1500 in excess of \$100,000 deductible).

n38 *Am. Home Assur. Co. v. Hermann's Warehouse Corp.*, 117 N.J. 1 (1989).

n39 117 N.J. at 9.

n40 117 N.J. at 10; *Nationwide Mut. Ins. Co.*, 112 N.C. App. at 351 (following *Hermann's Warehouse*).

n41 *Corrado Bros. Inc. v. Twin City Fire Ins. Co.*, 562 A.2d 1188, 1199 (Del. 1989); *Nat'l. Sur. Corp. v. Fast Motor Serv.*, 213 Ill. App. 3d 500 (1991); *Transit Cas. Co. v. Topeka Transp. Co.*, 8 Kan. App. 2d 597 (1983); *Ins. Co. of N. Am. v. Binnings Constr. Co.*, 288 So. 2d 359 (La. App. 1974); *Port East Transfer, Inc. v. Liberty Mut. Ins. Co.*, 330 Md. 376, 386 (1993); *Deerfield Plastics Co. v. Hartford Ins. Co.*, 404 Mass. 484, 487 (1989); *Transport Indem. Co. v. Dahlen Transp., Inc.*, 281 Minn. 253, 257-58 (Minn. 1968). *See Sec. Officers Serv., Inc. v. State Comp. Ins. Fund*, 17 Cal. App. 4th 887 (1993) (recognizing insured's right to complain of improper claim handling, settlement, and reserving practices which allegedly diminished availability of dividends and inflated experience rating for premiums, but not delineating standards of proof).

n42 *Dahlen Transp., Inc.*, 281 Minn. at 257-58. *Contra Commerce & Indus. Ins. Co. v. North Shore Towers Mgmt. Co.*, 162 Misc. 2d 778, 780-82 (Civ. Ct. 1994) (analyzing cases; to escape payment of deductible insured must meet demanding burden of proving bad faith).

n43 *Binnings*, 288 So. 2d at 362. *Port East Transfer*, 330 Md. 376, 386; see *Deerfield Plastics*, 404 Mass. at 487 n.6 (commenting favorably on this approach, but not deciding whether to adopt it). *Contra Topeka Transp. Co.*, 8 Kan. App. 2d at 600 (1983).

n44 *New Plumbing Contractors Inc. v. Nationwide Mut. Ins. Co.*, 7 Cal. App. 4th 1088 (1992).

n45 7 Cal. App. 4th at 1097.

n46 *Sec. Officers Serv., Inc. v. State Comp. Ins. Fund*, 17 Cal. App. 4th 887, 898 (1993).

n47 Stephen S. Ashley, *Reply to Letter*, 6 *Bad Faith L. Rep.* 17 (1990).

n48 That issue is discussed in William T. Barker & Ronald D. Kent, *New Appleman Insurance Bad Faith Litigation*, Second Edition, § 2.08[5].

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SNR Denton on Insurer Recoupment of Noncovered Defense Costs and Settlements

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SNR Denton on Insurer Recoupment of Noncovered Defense Costs and Settlements

By William T. Barker

September 30, 2010

SUMMARY: A recurring issue is whether an insurer that has provided a defense under a reservation of rights (including a reservation of the right to recoup the cost of that defense if a court finds there was no duty to defend) can in fact recover its defense costs. This commentary critically reviews two August 2010 court decisions and other recent decisions on this issue and argues that recoupment should be permitted under the law of unjust enrichment.

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ARTICLE: A recurring issue in the law of liability insurance is whether an insurer that has provided a defense under a reservation of rights (including a reservation of the right to recoup the cost of that defense if a court finds there was no duty to defend) can in fact recover its defense costs. On two consecutive days in August, the Tenth Circuit predicted that Colorado law would allow such a recovery, ⁿ¹ and the Pennsylvania Supreme Court refused to allow such a recovery. ⁿ² This commentary critically reviews those decisions and other recent decisions on this issue and argues that recoupment should be permitted under the law of unjust enrichment.

I. Background of the Recoupment Issue

Liability insurers are frequently called upon to defend suits against their insureds when it is questionable whether there is actually a duty to defend. The consequences of an unjustified refusal to defend can be quite unpleasant, so insurers often defend when they believe there is no duty to do so, but fear that a court might disagree. In such circumstances, they would like to be able to obtain reimbursement (sometimes called recoupment) of the amounts they expend on defense if they later establish that no defense was owed.

Similarly, an insurer defending a case with potential for a judgment in excess of policy limits is often faced with a demand that it settle for or within policy limits, even though it questions whether the claims that would be settled are actually covered by the insurance policy. But, in many jurisdictions, failure to settle might expose the insurer to liability for the full judgment, if that judgment turns out to be covered. The insurer would like to have the option of settling the claim against the insured and then, if it can establish lack of coverage, recouping the payment from the insured.

Courts are divided on these issues. n3 The state of the law, while evolving, has been reviewed elsewhere, n4 and the Pennsylvania Supreme Court collected cases. n5 This commentary will not reexamine that topic. Instead, it will argue that, as a matter of the law of unjust enrichment, recoupment should be allowed if the insurer takes the proper steps. It will then examine the arguments presented by leading anti-recoupment cases and explain why those arguments should not defeat the right to recoup.

The recoupment issue is frequently argued and analyzed as a question whether the insured has, at least impliedly, agreed to reimburse the insurer. n6 That analysis has some utility where the insurer has reserved the right to recoup and the insured has acquiesced in that reservation. It tends to break down if the insured protests the reservation and the insurer insists on it. Does the insured have to reject the conditional payment to avoid the condition, or does rejection of the condition force the insurer to choose between an unconditional payment and making no payment at all? n7 For this reason, and because unjust enrichment analysis provides an answer that is implied in law and does not depend on agreement, that analysis seems more useful. n8 But American courts and lawyers typically do not understand unjust enrichment law very well, so they tend to overlook or undervalue arguments based on that law. n9 For insurer counsel arguing for recoupment, it would be a great mistake not to make full use of the unjust enrichment argument.

Before commencing the unjust enrichment analysis, let us put aside one issue: defense of so-called "mixed" suits, containing some claims subject to a duty to defend and some not subject to such a duty. In *Buss v. Superior Court* the California Supreme Court held that, in such cases, an insurer that properly reserves its rights may recoup any defense costs attributable solely to the noncovered claims. n10 But a dissent argued that the duty to defend is a duty to defend the entire lawsuit, so that the insured could not be unjustly enriched by the insurer's discharge of such a duty. n11 Ultimately, that question is one of interpreting the contract, which is beyond the scope of this commentary. This commentary will assume the *Buss* dissent was correct on that point, so that recoupment of defense costs is even potentially available only when the insurer has no duty to defend at all.

II. Example Cases: *Health Care Management Partners*, *Jerry's Sports Center*, *Midwest Sporting Goods* and *Frank's Casing*

The two new cases are *Valley Forge Insurance Co. v. Health Care Management Partners, Ltd.* n12] and *American & Foreign Insurance Co. v. Jerry's Sports Center, Inc.* n13 Prior to them, the two most recent and prominent cases were *General Agents Insurance Co. v. Midwest Sporting Goods Co.* n14 and *Excess Underwriters at Lloyds v. Frank's Casing Crew & Rental Tools, Inc.*, n15 both of which denied recoupment. The fact patterns of these cases will be used as examples. Most of the analysis in these decisions directly addressing unjust enrichment was offered by the Texas Supreme Court in *Frank's Casing*, but *Jerry's Sports Center* and *Midwest Sporting Goods* addressed that issue indirectly.

In *Health Care Management Partners*, the United States sued the insureds for Medicare and Medicaid fraud, and they sought a defense from Valley Forge and other insurers. The insurers disputed coverage but offered a defense under reservation of rights, including a reservation of the right to recoup their defense costs. The insureds never objected to the reservation. In this coverage action, the district court declared that there was no duty to defend or indemnify, a judgment affirmed on appeal. It awarded recoupment to the insurers but denied prejudgment interest. n16 Both sides appealed, and the Tenth Circuit again affirmed. Colorado Supreme Court opinions had stated that an "appropriate course of action for an insurer who believes it is under no obligation to defend is to provide a defense to the insured under a reservation of its rights to seek reimbursement" should it later be determined that there was no coverage. n17 Even if these statements were only dicta, they were a sufficient basis to predict the Colorado court's likely decision. n18 But there was no clear authority requiring payment of prejudgment interest on the amount recouped and requiring the insured to do so might upset the balance that the Colorado court had struck in approving recoupment. So, the Tenth Circuit declined to innovate in predicting state law on interest. n19

In *Jerry's Sports Center*, the insurers (collectively, Royal) had provided liability insurance with respect to "damages because of 'bodily injury'" caused by an "occurrence" during the policy period. Jerry's was sued (along with

other firearms wholesalers) for creating a public nuisance by failing to distribute firearms reasonably and safely. Royal provided the services of a law firm experienced in defending such actions, but also reserved the right to recoup its defense costs if there were no duty to defend. However, Royal agreed not to seek recoupment of any costs incurred before it determined that a defense was not owed. Jerry's did not object to the reservation. Royal sought and obtained a declaration that there was no duty to defend, and sought recoupment of defense costs incurred after filing of the coverage action. n20 The trial court awarded recoupment, based on the law of unjust enrichment, but the Supreme Court reversed that award.

In *Midwest Sporting Goods*, Midwest was sued for creating a public nuisance by selling guns to inappropriate purchasers. General Agents Insurance Co. ("Gainsco") asserted that there was no coverage but offered a defense under reservation of rights, specifically including the right to recoup its defense costs if it were later determined that it had had no duty to defend. Midwest accepted the proffered defense without protest. Gainsco obtained a summary judgment that it had no duty to defend, affirmed on appeal. Gainsco then pursued its claim for recoupment (stayed during the appeal) and obtained a judgment for \$40,517.34 against Midwest. The Illinois Appellate Court affirmed, but the Illinois Supreme Court reversed. n21

In *Frank's Casing*, ARCO/Vastar sued Frank's Casing for collapse of a drilling platform in the Gulf of Mexico. Frank's Casing had primary insurance with limits of \$1 million and \$10 million in excess insurance with Excess Underwriters. Excess Underwriters had no duty to defend. Coverage under Excess Underwriters' policy for ARCO's claims was then in dispute. Frank's Casing faced possible liability substantially beyond its insurance limits.

During trial, Frank's Casing received a demand that it contribute \$7.5 million to settle ARCO's claims. It was undisputed that, in relation to the liability and damages exposure in ARCO's suit, this was a reasonable amount. The primary insurance had tendered its remaining limits, and Frank's Casing demanded that Excess Underwriters contribute over \$7 million to fund the remainder of the demand. Given the coverage dispute, Excess Underwriters offered to pay \$5 million if Frank's Casing would pay the remainder. When Frank's Casing refused this offer, Excess Underwriters offered to pay the entire amount, subject to the right to recover it from Frank's Casing if a court later found no coverage. Frank's Casing refused to agree to any reimbursement obligation, but continued to demand that Excess Underwriters pay the amount necessary to settle. If Excess Underwriters refused to settle, Frank's Casing threatened to hold it responsible for any excess judgment that might result from failure to settle.

Excess Underwriters agreed to fund the settlement, but reserved the right to seek reimbursement if a court later found no coverage. Frank's Casing consented to the settlement, but denied any reimbursement obligation. It later obtained a judgment that there was no coverage, and sought recoupment. The Texas courts nonetheless denied recoupment.

III. The Law of Unjust Enrichment Supports Recoupment.

A. The Absence of Coverage Establishes a Prima Facie Claim for Unjust Enrichment.

Because there was no coverage for either defense or indemnity in any of these cases, none of the insureds had actually been entitled to any assistance from its insurer regarding the claims asserted against it. n22 Each received a substantial benefit that was never due under the insurance contract. As the Restatement (Third) of Restitution and Unjust Enrichment explains, these facts make out a prima facie claim for restitution of unjust enrichment:

Where a valid contract defines the scope of the parties' respective performance obligations, a performance in excess of contractual requirements - neither gratuitous nor pursuant to a compromise - results in unjustified enrichment of the recipient and a prima facie claim in restitution.... "Restitution in such a case does not require that the contract be set aside; instead it is a means of enforcing adherence to the contract, through ordering repayment a sum to which the recipient was not entitled under the contract." n23

On this basis, the Restatement provides that

[i]f one party to a contract demands from the other a performance that is not in fact due by the terms of their agreement, the party on whom the demand is made may render such performance under protest or with reservation of rights, preserving a claim in restitution to recover the value of the benefit conferred in excess of the recipient's contractual entitlement. n24

In *Frank's Casing*, the Texas Supreme Court, in rejecting recoupment, relied on the generally accepted rule that "[w]hen a valid agreement already addresses the matter, recovery under an equitable theory is generally inconsistent with the express agreement." n25 The premise of this rule is that "[t]o recognize an equitable right to reimbursement would require us to 'rewrite the parties' contract [or] add to its language.'" n26 If recognizing a recoupment claim would alter the allocation of benefits and burdens made by the contract, this point would have force. But, for precisely the reasons the Restatement points out, recognizing a claim for recoupment of benefits not due under the contract actually enforces the contract, rather than rewriting the contract. Indeed, the very case the Texas Supreme Court relied on for the quoted rule recognizes a widely followed exception: "*overpayments* under a contract can be recovered under a theory of restitution of unjust enrichment." n27 So, the *Frank's Casing* logic on this point is unsound and ought not to be followed.

The same point disposes of the Illinois Supreme Court's concern that it is unjust to put the insured to a "Hobson's choice between accepting the insurer's additional conditions or losing its right to a defense from the insurer." n28 The insured can preserve all of its rights by accepting a defense subject to a right of recoupment. If recoupment is ever found due, it will be because the insured never had any right to a defense. Being forced to reimburse benefits it was never entitled to is hardly unjust, so neither is being asked for an agreement to do so in return for the insurer advancing amounts it may not be obliged to pay.

B. Mere Uncertainty About Existence of Coverage Does Not Create a Duty to Defend.

The foregoing analysis presumes that the later determination that there is no duty to defend means that there was never a duty to defend. Some of the anti-recoupment cases suggest that this is untrue, that there was a duty to defend until such time as the court determined that there was not. That suggestion is unsound, for reasons that will now be discussed.

This suggestion is particularly prominent in *Jerry's Sports Center*. The court summarized the law on an insurer's duty to defend as follows:

An insurer's duty to defend is broader than its duty to indemnify. It is a distinct obligation, separate and apart from the insurer's duty to provide coverage. An insurer is obligated to defend its insured if the factual allegations of the complaint on its face encompass an injury that is actually or potentially within the scope of the policy. As long as the complaint "might or might not" fall within the policy's coverage, the insurance company is obliged to defend. Accordingly, it is the potential, rather than the certainty, of a claim falling within the insurance policy that triggers the insurer's duty to defend.

The question of whether a claim against an insured is potentially covered is answered by comparing the four corners of the insurance contract to the four corners of the complaint. An insurer may not justifiably refuse to defend a claim against its insured unless it is clear from an examination of the allegations in the complaint and the language of the policy that the claim does not potentially come within the coverage of the policy. In making this determination, the "factual allegations of the underlying complaint against the insured are to be taken as true and liberally construed in favor of the insured." Indeed, the duty to defend is not limited to meritorious actions; it even extends to actions that are "groundless, false, or fraudulent" as long as there exists the possibility that the allegations implicate coverage. n29

Based on this exposition, the court agreed with the insured

that whether a complaint raises a claim against an insured that is potentially covered is a question to be answered by the insurer in the first instance, upon receiving notice of the complaint by the insured. Although the question of

whether the claim is covered (and therefore triggers the insurer's duty to defend) may be difficult, it is the insurer's duty to make that decision. Insurers are in the business of making this decision. The insurer's duty to defend exists until the claim is confined to a recovery that the policy does not cover. Where a claim potentially may become one which is within the scope of the policy, the insurance company's refusal to defend at the outset of the controversy is a decision it makes at its own peril. n30

In the court's view,

If [the insurer] believes there is no possibility of coverage, then it should deny its insured a defense because the insurer will never be liable for any settlement or judgment. This would allow the insured to control its own defense without breaching its contractual obligation to be defended by the insurer. If, on the other hand, the insurer is uncertain about coverage, then it should provide a defense and seek declaratory judgment about coverage.

In a declaratory judgment action to determine whether a claim is covered, the court resolves the question of coverage. The court's role in the declaratory judgment action is to resolve the question of coverage to eliminate uncertainty. If the insurer is successful in the declaratory judgment action, it is relieved of the continuing obligation to defend. The court's resolution of the question of coverage does not, however, retroactively eliminate the insurer's duty to defend the insured during the period of uncertainty. n31

This discussion seems to make the existence of a duty to defend depend on the insurer's state of mind. If the insurer is confident that there is no possibility of coverage, and if the court agrees, then there never would have been any potential for coverage and there would have been no duty to defend. But if, on the same facts, another insurer believed that there was no duty to defend but was uncertain whether a court would agree, that uncertainty would give rise to a duty to defend. Apart from anti-recoupment cases, there appears to be no support for the suggestion that the duty to defend is subjective in this way. And that suggestion is inconsistent with the contractual roots of the duty to defend, roots the Pennsylvania court has lost sight of, even as it purports to rely on the contractual language.

The duty to defend is a contractual duty, so its scope depends on interpretation of the contract. The language and logic of the contract dictate that existence of the duty must ordinarily be determined from the allegations of the complaint. But courts often lose sight of both the logic and the contract itself. This can lead them into error, as it did in *Jerry's Sports Center*, where the court failed to understand the meaning of the "potential for coverage" rule and the way it derives from the contractual language.

This sort of error is not uncommon when courts deal with fact situations near the edges of the duty to defend. Understandably, they are accustomed to looking to prior cases construing the same standardized contractual provisions rather than analyzing those provisions anew in every case. This process leads to error when courts apply the general rules stated in prior cases without understanding the contractual logic that generated those rules. When the wording of the interpretive gloss is substituted for the contractual language, the meaning is inevitably distorted, especially where the court providing the gloss was concerned with a problem different from that before the court seeking to rely on that gloss. In extreme cases, courts may even forget that they are construing a contract rather than making common law that best suits judicial views of public policy.

Such courts apply the rule that an insurer must defend whenever there is the "potential for coverage" without regard for the roots of that rule in the insurance contract. They forget that "[t]he insurer's duty to defend its insured arises from the undertaking . . . stated in the contract of insurance." n32 When the duty is broad, that is because the contract makes it broad. But courts must not extend the duty beyond what the contract promises. n33

The "potential for coverage" rule is rooted in the contract, but in a way imposing limits that courts often fail to grasp. Indeed, courts often show no appreciation for the relevance of the contractual language on the duty to defend, failing even to mention that the policy contained such language.

A liability insurance policy ordinarily devotes most of its coverage-defining terms to specifying who is insured and

what liabilities an insured will be indemnified against, and on what conditions. The duty to defend is created by language promising to defend any suit against an insured alleging liabilities of the sort insured.

The "potential for coverage" rule derives from this language through a contractual construction explained by Judge Learned Hand in the seminal case of *Lee v. Aetna Casualty & Surety Co.* n34 Indeed, the Pennsylvania court acknowledged in *Jerry's Sports Center* that it was relying on that construction. n35

In *Lee*, Judge Hand reasoned that the insurer, having promised to defend, "has promised to relieve the insured of the burden of satisfying the tribunal where the suit is tried, that the claim as pleaded is 'groundless.'" n36 Consequently, "if the injured party states a claim, which, qua claim, is for an injury 'covered' by the policy . . . it is irrelevant that the insurer may get information from the insured, or from anyone else, which indicates, or even demonstrates" that the allegations of a covered basis of liability are false. n37 The duty to defend has not been discharged until the court entertaining those allegations has been convinced that no liability of a type covered by the policy exists. n38

This is the first aspect of the "potential for coverage" rule. "Potential for coverage" refers to the potential for indemnity coverage, and such a potential exists if the complaint asserts any claim that, if proven, the insurer would be obliged to indemnify against. It matters not if the claim is "groundless, false or fraudulent." The insurer must protect the insured against the covered claim by successfully defending it or by paying or settling it.

Judge Hand found uncertainty about application of the duty to a suit involving allegations of both covered and noncovered grounds for the same purported liability, but he concluded that the uncertainty should be resolved in favor of the insured. This conclusion established another of the now entrenched doctrines governing the duty to defend with respect to such mixed claims: "if the plaintiff's complaint against the insured alleged facts which would have supported a recovery covered by the policy, it was the duty of the defendant to undertake the defence, until it could confine the claim to a recovery that the policy did not cover." n39

This is a second aspect of the "potential for coverage" rule: there is a potential for coverage (and a duty to defend) if any of the claims asserted would (if established) be covered, even if other claims are asserted for which there is no coverage.

The rule requiring defense of suits asserting mixed claims is supported by strong practical considerations where, as is the norm, the covered and noncovered claims arose out of the same incident. Defense of claims intertwined in that way usually must be conducted by a single chief counsel. So if the insurer is to defend the covered claims, no one else can be in a position to defend the others.

The *Lee* reasoning is universally applied, not only to mixed claims, but also to those where, due to the relatively unspecific nature of modern pleading, one cannot be sure whether the complaint asserts a covered claim. n40 If there is doubt about what claims are asserted against the insured, and if at least one of the claims that might be asserted is one that is covered, it will be assumed that the complaint actually asserts that claim, which requires the insurer to defend.

Both where the scope of the complaint is uncertain and where the complaint asserts both covered and noncovered claims, "it [is] the duty of the [insurer] to undertake the defence, until it [can] confine the claim to a recovery that the policy did not cover." n41 But the insurer "confines the claim" by defense activity, either by establishing that the covered claim is not asserted or by successfully disposing of that claim. Nothing in the traditional construction of the duty to defend depends on whether the insurer believes there is or might be coverage nor on whether a court has resolved any uncertainty about whether there is a duty to defend.

The Pennsylvania court in *Jerry's Sports Center*, and other anti-recoupment courts that rely on similar analysis have confused the "potential for coverage," as defined in *Lee* and its progeny, with the *risk* that coverage will be found. Certainly, that perceived *risk* will sometimes induce an insurer to offer a defense under reservation when, in fact, there is no potential for coverage and no duty to defend. But there is no basis in the contract language to find a duty to defend based on the *risk* that coverage might be found if there is no actual potential for coverage that would create a duty to

defend regardless of the perceived risk. So, this basis for anti-recoupment decisions is unsound and ought not to be followed.

C. The Voluntary Payment Rule Does Not Defeat Recovery.

Establishment of a prima facie claim for unjust enrichment is only the beginning of the unjust enrichment analysis. As the Texas Supreme Court and the Restatement had previously recognized, "[t]he restitution claim to recover a payment in excess of an underlying liability ... meets an important limitation in the voluntary payment rule." n42 Under that rule, "[m]oney voluntarily paid on a claim of right, with full knowledge of all the facts, in the absence of fraud, deception, duress or compulsion, cannot be recovered back merely because the party at the time of payment was ignorant or mistook the law as to his liability." n43 The insurers' uncertainty about whether there was coverage for the liabilities asserted against the insureds in *Midwest Sporting Goods* and *Frank's Casing* was an uncertainty about how the law would be applied to the known facts of those claims. So, the voluntary payment rule could apply, if its conditions were met.

The Texas court had recently explained the reason for the voluntary payment rule: "[a] party who pays a claim is deemed to have made his own decision that it is justly due. If he thinks otherwise, he should resist. He should not pay out his money, leading the other party to act as though the matter were closed, and then be in a position to change his mind and invoke the aid of the courts to get it back." n44 Other Texas courts had held that "the rule against recovery of voluntary payments is not applied rigidly where the reasons for the rule do not exist. In some cases the payor is allowed to recover the money if he clearly never intended to surrender his position." n45

1. Payment Under Duress of Circumstances Does Not Preclude Recovery.

Regardless of how rigidly the rule is enforced, the obligation to resist the claim before paying presupposes the ability to obtain a timely adjudication, before the payor is forced to risk irrecoverable harm if payment is refused. Thus, in rejecting a claim of duress in making payments not actually due under a contract, the Texas court had previously emphasized that "[a]ppellant certainly had ample time and opportunity to have had his day in court, before the business between him and appellee was closed by the last voluntary payment made by him. Not having complained until the late date at which this suit was brought, he cannot now be heard to complain." n46

Where there has been a need to act before the payor could have his day in court and a risk of forfeiture if he failed to pay, courts have been willing to find sufficient circumstantial duress or compulsion to permit an action for restitution of contractual overpayments. It should be emphasized that circumstantial duress sufficient to permit recovery of contractual overpayments is generally *not* sufficient to support an unjust enrichment recovery when there is no preexisting obligation to provide the measure of what is just. n47 So the rule urged here would have only narrow application.

In the context of contractual overpayments, a common example of circumstantial duress is a policyholder who has a life or disability insurance policy that grants a waiver of premium if the policyholder is totally disabled. If the policyholder claims to be disabled and the insurer disagrees, the policyholder faces a risk if he discontinues payment of premiums. Should a court find that the insurer was correct in denying the waiver, the policy will be forfeited for non-payment of premiums. But if payment of the premium would be deemed "voluntary" and non-recoverable, payment would forfeit the benefit of the waiver, through preventing forfeiture of the entire policy.

A few cases deny any right to recover premiums paid while disability was in dispute, taking a narrow view of what constitutes duress for purposes of the voluntary payment rule, and refusing to recognize the coercive effect of the risk of forfeiture. n48 But the better reasoned cases permit recovery. n49

As the court explained in *Still v. Equitable*, a key consideration is the lack of any means of resolving the dispute before the policyholder must decide whether to pay; duress for purposes of restitution "'is a relative . . . term' and . . . 'where there is a necessity of acting at once, less may be considered to amount to such compulsion than in other cases.'"

n50 Applying this principle to the facts before it, the court concluded that,

a person of ordinary business sense and prudence would have weighed the consequences with the same result as did the complainant. The compulsion under which the payments were made is apparent to anyone who appreciates the value of a life insurance contract. The complainant was so situated that, if he failed to establish the permanency of his disability, he could not hope to obtain other insurance. Decision could not be postponed and time was of the essence of the matter. The payments were necessary to preserve valuable rights, and ... we hold they were not voluntary. n51

This approach is not unique to insurance cases. One of the principal authorities cited by *Still* was *Young v. Hoaglund*. n52 This involved a disputed change in the composition of a corporate board. The old members of the board, disputing the legality of a meeting at which they had allegedly been ousted, levied an assessment on the stock of the company, and threatened to essentially "foreclose" the interests of those not paying by selling their shares. Plaintiff shareholders, being uncertain of whether the old directors retained the power to do this, paid (apparently without protest) and sought recovery. The new directors established, in another action, that they had properly displaced the old directors, so that the latter had had no power to levy the assessment. The California Supreme Court held that the shareholders were entitled to restitution of the payments.

The court held that "'where, by reason of the peculiar facts a reasonably prudent man finds that in order to preserve his property or protect his business interests it is necessary to make a payment of money which he does not owe and which in equity and good conscience the receiver should not retain, he may recover it.'" n53 Application of that principle was appropriate in *Young*. If plaintiffs had refused to pay, they would have lost their stock if the assessment were found to be legal. Assuming that the old directors were honest and sincere in their belief that they retained the power to assess, "it is hardly consistent for [them] to now claim that the stockholders knew that the assessment was illegal or even had reasonable grounds of believing it to be so, and therefore that the payment was voluntary on their part." n54

A final notable case supporting restitution based on action necessary to prevent a risk of forfeiture is *Sunset Copper Co. v. Black*. n55 There, a contract purchaser of real estate had gone into possession and made substantial improvements to the property. The seller then claimed to be entitled to interest on deferred payments of the purchase price, and threatened to forfeit the contract if the interest was not paid. The purchaser paid and sued to recover the payments. The court held that the threat of forfeiture was sufficient duress to allow recovery.

In his treatise on restitution, Professor Palmer agrees:

in *Sunset Copper* the purchaser ran the risk of forfeiture only if he was wrong in his contention that the contract did not provide for interest. The legal uncertainty was an element in the coercion, as the court recognized. There was a good faith dispute in that case as to the proper interpretation of the contract, and the suggestion that he had an adequate judicial remedy is true only if he was correct in his contention. If he was not, the only safe means to protect himself from forfeiture was to pay the amount demanded. On the other hand, if the terms of the contract are clear, so that the vendor's demand for an excess payment is made in bad faith, it ill becomes him to insist or for the court to hold that the purchaser should have used another remedy in resisting the unjust demand. n56

The Restatement also recognizes such circumstances as sufficient to permit a claim for restitution of contractual overpayments:

Faced with the impossibility in many circumstances, of obtaining a determination of the parties rights and obligations before the claimed performance is due, and failing a compromise, a contracting party may be compelled by circumstances to render a performance to which the other is not entitled. Compulsion lies in the fact that the alternative courses of action - rejecting the other party's demand before the requirements of the contract can be judicially determined - would expose the [payor] to a risk of loss or liability whose expected value exceeds the amount in controversy. In such circumstances, acceding to the recipient's unjustified demand is an action "in the reasonable

protection of the [payor's] own interests." n57

The right to recovery might be lost if the recipient were lulled into the belief that the payor was surrendering its position. That is the reason why a payor that intends to seek recovery must protest the payment or reserve its rights to seek recovery. n58 So, while the anti-recoupment cases are right that a reservation of rights cannot create a right that did not exist to begin with, n59 the right to be preserved need not be a contractual right. Such a reservation can preserve a right implied in law, such as the right to recover unjust enrichment.

The cases just discussed demonstrate that it is no bar to an unjust enrichment claim that the party conferring the benefit acted in part for that party's own protection. Indeed, it is the need to act for the unjust enrichment plaintiff's own protection before the parties' rights can be adjudicated that avoids application of the voluntary payment defense.

It has been argued that:

Faced with uncertainty as to its duty to indemnify, an insurer offers a defense under reservation of rights to avoid the risks that an inept or lackadaisical defense of the underlying action may expose it to if it turns out there is a duty to indemnify. At the same time, the insurer wishes to preserve its right to contest the duty to indemnify if the defense is unsuccessful. Thus, such an offer is made at least as much for the insurer's own benefit as for the insured's. If the insurer could recover defense costs, the insured would be required to pay for the insurer's action in protecting itself against the estoppel to deny coverage that would be implied if it undertook the defense without reservation. n60

In fact, the insurer defends for the benefit of whichever party is entitled to the benefits of the defense under the terms of the insurance policy. If there was no duty to defend, there was also no duty to indemnify, and the insurer will neither have discharged any obligation by defending nor benefited from the defense. Rather, all the benefits will have accrued to the insured, who would not have been entitled to receive them at the insurer's expense. Accordingly, the insured will have been unjustly enriched and should reimburse the insurer for the cost it incurred in defending.

2. The Circumstances in All of the Cases Under Discussion Created Strong Pressure to Act Before the Parties' Rights Could Have Been Adjudicated.

The foregoing analysis depends on the payor (here, the insurer) facing a requirement to act before the dispute about the obligation to pay can be resolved. In all of the cases under discussion, such a requirement was present.

a. In All of the Duty to Defend Cases, the Insurer Was Obligated to Defend or Face a Risk of Magnified Liability.

In all of the duty to defend cases, the insured had asked the insurer to defend. If the insurer were obligated to do so, refusal would be a breach. An insurer's breach of the duty to defend subjects it to the risk that the insured will defend inadequately (or even default), despite which the insurer will be required to pay any resulting judgment within limits, if it were to be determined that the judgment were covered. n61 Moreover, a breach of the duty to defend would free the insured from policy conditions that forbid the insured to settle except at the insured's own expense; a breaching insurer may be required to pay an inflated settlement, as long as it is not fraudulent. n62 In Illinois, breach of the duty to defend could have exposed the insurer to an estoppel to deny indemnification. n63 So, a refusal to defend would have exposed any of the insurers in these cases to possibly inflated liability, if it turned out that it had a duty to defend.

b. In Texas, Excess Underwriters Risked Far Greater Liability From Refusing to Settle and Had No Clear Ability to Obtain Adjudication Before Deciding

In *Frank's Casing*, if Excess Underwriters had refused to settle, and if there had been coverage, they faced the risk of much larger liability for the likely excess judgment under Texas law governing an insurer's duty to settle. n64 So refusal to pay apparently would have exposed Excess Underwriters "to a risk of loss or liability whose expected value exceeds the amount in controversy." They claimed that they had no opportunity to obtain adjudication of their coverage

obligations before they had to make a decision on the settlement. If they were right on those two points, that should have been sufficient to preclude a voluntary payment bar to their claim for contractual overpayments.

i. It Was Reasonable for Excess Underwriters to Believe They Had No Opportunity for Early Adjudication of Coverage.

As it happens, both points were in some doubt under Texas law. As to the ability to have obtained adjudication before paying to settle the claim, Excess Underwriters received the demand in the middle of the trial of ARCO's claims, when there was surely no time to have coverage adjudicated. But Frank's Casing complained that Excess Underwriters failed to make a good faith effort to resolve the coverage issue expeditiously, once Excess Underwriters were notified of the action and reserved their rights to deny coverage. If there had been a real opportunity for Excess Underwriters to have done so, that might argue for denying relief from the voluntary payment rule.

But neither Frank's Casing nor any of its amici made any attempt to show that Excess Underwriters could realistically have hoped to obtain a coverage ruling before ARCO's claim against Frank's Casing was resolved. The coverage issue usually litigated before the underlying liability is determined is the duty to defend, which depends only on the allegations of the complaint. n65 But Excess Underwriters had no duty to defend, and the duty to indemnify depends on the actual facts, not the allegations of the complaint. n66 As the Texas Supreme Court has pointed out, a ruling on coverage must be deferred if "coverage [will] turn on facts actually proven in the underlying lawsuit." n67 If this were such a case, and Frank's Casing made no attempt to shown otherwise, Excess Underwriters would not have been able to obtain a coverage adjudication before ARCO's lawsuit was resolved.

But even if coverage did not depend on facts at issue in the underlying lawsuit, that alone would not have entitled Excess Underwriters to an early ruling on coverage. Until recently, Texas law was that the duty to indemnify could not be determined until the underlying liability was resolved. n68 The Texas court made an exception for cases in which "the insurer has no duty to defend *and the same reasons that negate the duty to defend likewise negate any possibility the insurer will ever have a duty to indemnify.*" n69 This is a narrow exception, and it appears to be the only circumstance in which the duty to indemnify can be adjudicated before the underlying action is resolved. n70 It could not apply in *Frank's Casing*, because Excess Underwriters had no duty to defend.

So it appears that Excess Underwriters had no way to obtain an early adjudication of the coverage issue. Certainly it would have been reasonable for them to think so, and that should have excused the failure to file such a suit there, even if the Texas Supreme Court were to have now held that an early adjudication would have been permissible. Nor did the court take the opportunity to minimize the future occasions when insurers might be forced to the sort of choice in *Frank's Casing*, by establishing for the future the ability to obtain an early coverage adjudication on issues other than the duty to defend.

ii. Excess Underwriters Faced a Significant Risk of Liability for a Judgment Far in Excess of Policy Limits.

Even if there were no opportunity to obtain prompt adjudication, Excess Underwriters would not have needed to act immediately if the existence of reasonable doubts as to coverage would have excused it from any duty to settle. A minority of jurisdictions so hold. n71 But Texas has not addressed the issue, and the majority rule is that:

the only permissible consideration in evaluating the reasonableness of the settlement offer becomes whether, in light of the victim's injuries and the probable liability of the insured, and ultimate judgment is likely to exceed the amount of the settlement offer. ... [A] belief that the policy does not provide coverage[] should not affect a decision as to whether the settlement offer in question is a reasonable one. n72

Under that rule, if the settlement offer is reasonable with respect to the insured's probable liability and the prospective damages, the insurer turns down the offer at its peril. If coverage is found, the insurer will be liable for the excess judgment, no matter how reasonable its belief in noncoverage.

Unless and until a state adopts the minority rule on this, any insurer faced with a demand to settle a case with doubtful coverage is under real pressure to pay the amount demanded, lest it risk far greater liability.

D. Courts Should Follow Restatement § 35, Which Is Contrary to Both *Midwest Sporting Goods*, *Jerry's Sports Center*, and *Frank's Casing*.

The foregoing analysis shows that the facts in *all* of the cases under discussion fell within the rule of Restatement § 35(1):

If one party to a contract demands from the other a performance that is not in fact due by the terms of their agreement, the party on whom the demand is made may render such performance under protest or with reservation of rights, preserving a claim in restitution to recover the value of the benefit conferred in excess of the recipient's contractual entitlement.

In fact, the Restatement expressly rejects *Texas Association of Counties County Government Risk Management Pool v. Matagorda County*, n73 which the Texas court followed in *Frank's Casing*. n74 Other courts should follow the Restatement.

IV. There Is No Good Policy Reason to Deny Recoupment.

A. Recoupment Rights Will Not Affect Impecunious Insureds.

Whether recoupment rights are good or bad for others, they will have no effect on impecunious insureds. Such insureds have no ability to reimburse the insurer, even if legally obligated to do so. No plaintiff would expend resources in suing an impecunious defendant who lacked insurance, and neither would an insurer. If either did, bankruptcy could discharge the unpayable debt.

B. Allowing Recoupment of Noncovered Defense Costs or Settlements Creates No Special Problems for Adequately Funded Insureds.

An adequately funded defendant, faced with an uninsured lawsuit, would have to defend with its own resources. It is no worse off if an insurer advances the defense costs and recovers them later. If it fears that the insurer will be extravagant in defending, it has two protections. First, the insurer should be obliged to prove that any defense expenditures not specifically approved by the insured were reasonable. Second, if the insured wishes to do so, the insured could take part in the defense decisionmaking.

An insurer that defends under reservation, including a reservation of the right to recoup is responsible for providing an adequate defense (unless the insured asks that certain expenditures be foregone). If it improperly skimps on the defense, it should be held liable for any resulting increase in the judgment.

C. Insureds Who Are Neither Wealthy Nor Impecunious Should Be Able to Protect Themselves by Settlements.

If an insured that is arguably not entitled to a defense is capable of paying some, but not all, of its defense costs, it should be able to reach a settlement with the insurer for each party to bear a share of the defense costs that is reasonable in light of the uncertainty. Both insurer and insured will need to take account of the insured's limited ability to pay as well as the risk of an adjudication.

Similar considerations apply to recoupment of settlement costs. It is not clear whether *Frank's Casing* had assets adequate to pay whatever judgment ARCO might obtain. But, if it did not, that could have been addressed by three-way bargaining. Excess Underwriters were prepared to pay two-thirds of the \$7.5 million demand and drop the coverage issue, and the primary insurer would have contributed somewhat less than \$500,000. In light of the eventual holding

that there was no coverage, it seems likely that the \$5 million offer was at least a fair estimate of the prospects in coverage litigation, and may have been generous. ARCO would likely have been willing to take a discount on its demand for an additional \$2 million+, based on the value the claim would have had against an uninsured Frank's Casing that could not have paid the full amount at issue. The fact that there was no such bargaining here suggests that the residual settlement value against an uninsured Frank's Casing was no smaller than the \$2 million+ that Frank's Casing refused to pay. If Frank's Casing did have that much ability to pay and still refused to bargain in hopes of forcing Excess Underwriters to bear the whole loss, then it would have no one but itself to blame for losing a favorable settlement opportunity. Either Excess Underwriters should have been allowed to recoup or it should have been decided that a reasonable dispute as to coverage would provide a defense against a failure to settle claim.

Insureds who have some ability to pay a judgment but not the ability to pay a full judgment will be able to protect themselves from unaffordable recoupment obligations by agreeing to participate in settlements that fairly reflect whatever coverage uncertainties may exist and also reflect their abilities to pay uninsured liabilities. That will relieve them of making Hobson's choices between consenting to unaffordable settlements or exposing themselves to excess liability without the protection of *Stowers* rights. Insurers and plaintiffs have every incentive to participate on a basis that fairly reflect the prospects if both liability and coverage are litigated.

D. Conclusion

For the reasons stated above, courts should follow the Restatement and allow recoupment of noncovered defense costs and settlements if the insurer lacked an adequate opportunity to obtain adjudication of the coverage issue before having to pay and if it properly reserved its right to seek recoupment.

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n1 *Valley Forge Ins. Co. v. Health Care Mgmt. Part., Ltd.*, 2010 U.S. App. LEXIS 17098 (10th Cir. Aug. 16, 2010).

n2 *Am. & Foreign Ins. Co. v. Jerry's Sports Ctr., Inc.*, 2010 Pa. LEXIS 1803 (Pa. Aug. 17, 2010).

n3 *Compare Buss v. Superior Court*, 65 Cal. Rptr. 2d 366, 373, 378, 939 P.2d 766, 773-78 (Cal. 1997) (allowing recoupment of noncovered defense costs), and *Blue Ridge Insurance Co. v. Jacobsen*, 106 Cal. Rptr. 2d 535, 22 P.3d 313 (Cal. 2001) (permitting recoupment of noncovered settlement costs), with *General Agents Ins. Co. v. Midwest Sporting Goods Co.*, 828 N.E.2d 1092, 1101-04 (Ill. 2005) (denying recoupment of noncovered defense costs), and *Excess Underwriters at Lloyds v. Frank's Casing Crew & Rental Tools, Inc.*, 246 S.W.3d 42, 48-52 (Tex. 2008) (denying recoupment of noncovered settlement costs).

n4 See Michael M. Marick, *An Insurer's Right to Recoup Non-Covered Defense Costs and Indemnity Payments*, New Appleman on Insurance: Current Critical Issues in Insurance Law (July 2007); Lee H. Shidlofsky, *Shidlofsky on Excess Underwriters v. Franks Casing*, LexisNexis [TM] Emerging Issues Analysis,

2008 *Emerging Issues* 1999 (March 2008). See also William T. Barker & Ronald D. Kent, New Appleman Insurance Bad Faith Litigation, Second Edition, § 2.10 (from which some of the analysis here is drawn).

n5 2010 Pa. LEXIS 1803, at *16 n.9 & *24.

n6 An analysis taking that approach is Robert H. Jerry, II, *The Insurer's Right to Reimbursement of Defense Costs*, 42 *Ariz. L. Rev.* 13 (2000).

n7 The Texas Supreme Court has pointed out the ambiguity of such a situation: "Given the parties' explicit efforts to preserve their respective positions on the coverage/reimbursement question, it makes no more sense to conclude that Frank's Casing impliedly agreed to reimburse the excess carriers than it would to say that the excess carriers impliedly agreed to waive their coverage position." *Frank's Casing*, 246 S.W.3d at 48.

n8 Of course, an implied-in-fact agreement may be found in some circumstances, without regard to unjust enrichment law.

n9 Unlike the law of contracts and torts, the law of unjust enrichment had not, until very recently, been systematized, so courts and lawyers could only look to relatively ad hoc decisions, without any clear rules on how the law of unjust enrichment interacted with tort and contract law. The American Law Institute has recently completed a systematic analysis. Restatement (Third) of Restitution and Unjust Enrichment (2010).

n10 *Buss v. Superior Court*, 65 Cal. Rptr. 2d 366, 373, 378, 939 P.2d 766, 773-78 (Cal. 1997).

n11 *Id.* at 384-87, 939 P.2d at 784-87 (dissenting op). Accord *Shoshone First Bank v. Pacific Employers Ins. Co.*, 2 P. 3d 510, 516 (Wyo. 2000). Because *Shoshone First Bank* concerns allocation of defense costs between covered and noncovered claims, it is inapposite in addressing cases where there were no covered claims at all.

n12 *Valley Forge Ins. Co. v. Health Care Mgmt. Part., Ltd.*, 2010 U.S. App. LEXIS 17098 (10th Cir. Aug. 16, 2010).

n13 *Am. & Foreign Ins. Co. v. Jerry's Sports Ctr., Inc.*, 2010 Pa. LEXIS 1803 (Pa. Aug. 17, 2010).

n14 *General Agents Ins. Co. v. Midwest Sporting Goods Co.*, 828 N.E.2d 1092, 1101-04 (Ill. 2005) (denying recoupment of noncovered defense costs)

n15 *Excess Underwriters at Lloyds v. Frank's Casing Crew & Rental Tools, Inc.*, 246 S.W.3d 42, 48-52 (Tex. 2008) (denying recoupment of noncovered settlement costs).

n16 2010 U.S. App. LEXIS 17098, at *1-6.

n17 *Hecla Mining Co. v. New Hampshire Ins. Co.*, 811 P.2d 1083, 1089 (Colo. 1991); *Cotter Corp. v. Am. Empire Surp. Lines Ins. Co.*, 90 P.3d 814, 828 (Colo. 2004) ("We attempted to balance the interests of both the insurers and the insureds by ensuring that the broad rule basing the duty to defend on the complaint will not require insurers to pay defense costs if coverage ultimately does not exist under the policies. Additionally, we created an incentive for insurers to defend by allowing them to subsequently seek reimbursement.").

n18 2010 U.S. App. LEXIS 17098, at *13-14.

n19 2010 U.S. App. LEXIS 17098, at *30.

n20 *Jerry's Sports Ctr., Inc.*, 2010 Pa. LEXIS 1803, at *1-10.

n21 *General Agents Ins. Co. v. Midwest Sporting Goods Co.*, 828 N.E.2d 1092, 1094-97, 1104 (Ill. 2005).

n22 There is a suggestion in *Jerry's Sports Center* that mere uncertainty about whether a court would find coverage is sufficient to create a "potential for coverage" and a duty to defend. 2010 Pa. LEXIS 1803, at *45.

That is unsound, for reasons discussed at Section III.B. below. While *Frank's Casing* focused solely on indemnity coverage, the insurers provided only excess coverage, with no duty to defend.

n23 Restatement (Third) of Restitution and Unjust Enrichment, § 35, cmt. *a* (Tent. Dr. No. 3 Mar. 22, 2004). While the final draft of this Restatement is now in press, only the tentative drafts are currently on line.

n24 Restatement, § 35(1).

n25 *Excess Underwriters at Lloyds v. Frank's Casing Crew & Rental Tools, Inc.*, 246 S.W.3d 42, 50 (Tex. 2008), quoting *Fortune Prod. Co. v. Conoco, Inc.*, 52 S.W.3d 671, 684 (Tex. 2000). While the quoted passage addresses equitable rules (which, strictly speaking, do not include the law of unjust enrichment), the point also applies to unjust enrichment claims: "[g]enerally speaking, when a valid, express contract covers the subject matter of the parties dispute, there can be no recovery under a quasi-contract theory." *Fortune Prod. Co.*, 52 S.W.3d at 684.

n26 *Frank's Casing*, 246 S.W.3d at 50, quoting *Am. Mfrs. Mut. Ins. Co. v. Schaefer*, 124 S.W.3d 154, 162 (Tex. 2003).

n27 *Id.* (emphasis added). As the Restatement indicates, the rule allowing recovery of contractual overpayments is generally accepted.

n28 *General Agents Ins. Co. v. Midwest Sporting Goods Co.*, 828 N.E.2d 1092, 1094-97, 1102 (Ill. 2005), quoted in *Am. & Foreign Ins. Co. v. Jerry's Sports Ctr., Inc.*, 2010 Pa. LEXIS 1803, at *35. The same objection is made in *Terra Nova Ins. Co. v. 900 Bar, Inc.*, 887 F.2d 1213, 1219-20 (3d Cir. 1989) (predicting Pennsylvania law).

n29 2010 Pa. LEXIS 1803, at *38-41 (citations omitted).

n30 *Id.* at *41-42 (citations omitted).

n31 *Id.* at *43 (citation omitted).

n32 *Zurich Ins. Co.v. Raymark Indus., Inc.*, 514 N.E.2d 150, 161 (Ill. 1987).

n33 *Id.* at 161-64.

n34 *Lee v. Aetna Casualty & Surety Co.*, 178 F.2d 750 (2d Cir. 1949).

n35 2010 Pa. LEXIS 1803, at *39 ("As long as the complaint "might or might not" fall within the policy's coverage, the insurance company is obliged to defend. *Casper*, 408 Pa. 426, 184 A.2d 247 (quoting Judge Learned Hand's assertion in *Lee v. Aetna Casualty & Surety Company*, 178 F.2d 750, 752 (2d Cir. 1950)).").

n36 *Lee*, 178 F.2d at 752.

n37 *Id.* at 751. An alternate statement of this point is that "an insurer cannot avoid the duty to defend merely by concluding, based on its own investigation, that the insured has done no wrong. The duty to defend does not evaporate simply because the insurer has decided that the insured will ultimately be exonerated...." *A-H Plating, Inc. v. American Nat'l Fire Ins. Co.*, 67 Cal. Rptr. 2d 113, 121 (Cal. Ct. App. 1997).

n38 As the Texas Supreme Court put this point, "if GuideOne knows [the liability] allegations to be untrue, its duty is to establish such facts *in defense of its insured*." *GuideOne Elite Insurance Co. v. Fielder Road Baptist Church*, 197 S.W.3d 305 (Tex. 2006) (emphasis added).

n39 *Lee*, 178 F.2d at 753.

n40 *Herbert A. Sullivan, Inc. v. Utica Mut. Ins. Co.*, 788 N.E.2d 522, 530 (Mass. 2003) ("[I]f the allegations of the complaint are 'reasonably susceptible' of an interpretation that they state or adumbrate a claim covered by the policy terms, the insurer must undertake the defense");

See New Appleman Insurance Law Practice Guide, § 30.14[4][a] (2008);

22 Eric Mills Holmes, Appleman on Insurance 2d, §§ 136.2[C], 136.4[A] (2003).

n41 *Lee v. Aetna Casualty & Surety Company*, 178 F.2d 750, 753 (2d Cir. 1950).

n42 *BMG Direct Marketing, Inc. v. Peake*, 178 S.W.3d 763, 768 (Tex. 2005) (quoting Restatement, § 6, cmts. e (Tent. Dr. No. 1 2001)).

n43 *Id.*, quoting *Pennell v. United Ins. Co.*, 243 S.W.2d 572, 576 (Tex. 1951). The Restatement rejects any distinction between mistakes of fact and mistakes of law. Restatement, § 5, cmt. f. But that point is not critical here. The very existence of a reservation of rights shows that an insurer did not mistakenly believe in the existence of coverage, but rather recognized the existence of uncertainty on that point.

n44 178 S.W.3d at 768-69. Accord Restatement, § 6, cmts.d & e.

n45 *R.C. McClung Cotton Co. v. Cotton Concentration Co.*, 479 S.W.2d 733, 743 (Tex. Ct. Civ. App.-Texarkana 1972, writ ref'd n.r.e.); *Spring Bank v. Mengden*, 628 S.W.2d 130, 137 (Tex. Ct. App.-Houston [14th Dist.] 1981, writ ref'd n.r.e.) (quoting passage in text and following it to find issue of fact whether threat of foreclosure if payment not made rendered payment involuntary); *West Texas State Bank v. Tri-Serv. Drilling Co.*, 339 S.W.2d 249 (Tex. Ct. Civ. App.-Eastland 1960, writ ref'd n.r.e.) (borrower permitted to recover amounts paid to bank despite knowledge that bank had wrongfully diverted large portion of original loan proceeds to unauthorized purpose).

n46 *Ladd v. Southern Cotton Press and Manufacturing Co.*, 53 Tex. 172, 173-74 (1880).

n47 Compare Restatement, § 14 (Tent. Dr. No. 1 April 6, 2001) (defining "duress" permitting recovery in other circumstances as "coercive pressure that is wrongful as a matter of law").

n48 E.g. *Featherstone v. Stonewall Life Ins. Co.*, 147 So. 305 (Miss. 1933); *Sebastianelli v. Prudential Ins. Co.*, 12 A.2d 113, 115 (Pa. 1940) (collecting cases alleged to hold similarly). See also *Rosenfeld v. Boston Mut.*

Life Ins. Co., 110 N.E. 304, 307 (Mass. 1915) (relying on hindsight determination that plaintiff need not have paid disputed premium because he was correct in believing it not due).

n49 See, e.g., *Still v. Equitable Life Assur. Soc'y. of the United States*, 54 S.W.2d 947, 949-50 (Tenn. 1932); *New York Life Ins. Co. v. Talley*, 72 F.2d 715, 719-20 (8th Cir. 1934) (pre-Erie federal common law); *Pacific Mut. Life Ins. Co. v. McKaskill*, 170 So. 579, 582-85 (Fla. 1936); *Wenstrom v. Aetna Life Ins. Co.*, 215 N.W. 93, 96 (N.D. 1927).

n50 54 S.W.2d at 949.

n51 *Id.* at 950.

n52 *Young v. Hoaglund*, 298 P. 996 (Cal. 1931)

n53 *Id.* at 998.

n54 *Id.* *Young* has not been extensively cited in the decades since its decision, but remains good law. E.g., *Chrysler Credit Corp. v. Ostly*, 117 Cal. Rptr. 167, 174-76 (Cal. App. Ct. 1974) (dictum, collecting and analyzing cases).

n55 *Sunset Copper Co. v. Black*, 196 P. 640 (Wash. 1921).

n56 George Palmer, *Law of Restitution*, at 318 (1978) (footnote omitted).

n57 Restatement, § 35, cmt. *a*.

n58 Restatement, § 35, cmt *d* ("When restitution is authorized under this Section, the basis of the claim is not the claimant's statement to the defendant that he is performing 'under protest.' The reason for the restitution is that the claimant has performed under compulsion, conferring a benefit to which the defendant was not entitled under the contract. [] The significance of such a claim of "protest" or "reservation of rights" is to repel any inference that the disputed performance is being rendered pursuant to compromise; and to give adequate notice to the recipient that the parties dispute remains to be adjusted, by litigation of otherwise.").

n59 *Midwest Sporting Goods Co.*, 828 N.E.2d at 1102.

n60 *Terra Nova Ins. Co. v. 900 Bar, Inc.*, 887 F.2d 1213, 1219-20 (3d Cir. 1989), quoted in *General Agents Ins. Co. v. Midwest Sporting Goods Co.*, 828 N.E.2d 1092, 1102-03 (Ill. 2005), and cited in *Am. & Foreign Ins. Co. v. Jerry's Sports Ctr., Inc.*, 2010 Pa. LEXIS 1803, at *23.

n61 William T. Barker & Ronald D. Kent, *New Appleman Insurance Bad Faith Litigation*, Second Edition § 1.04.

n62 William T. Barker & Ronald D. Kent, *New Appleman Insurance Bad Faith Litigation*, Second Edition § 4.04[1]--[2].

n63 William T. Barker & Ronald D. Kent, *New Appleman Insurance Bad Faith Litigation*, Second Edition § 3.08[2].

n64 *G.A. Stowers Furn. Co. v. Amer. Indem. Co.*, 15 S.W.2d 544 (Tex. Comm. App. 1929, holding approved).

n65 *Guideone Elite Ins. Co. v. Fielder Road Baptist Church*, 197 S.W.3d 305, 308 (Tex. 2006).

n66 *Tesoro Pet. Corp. v. Nabors Drilling USA, Inc.*, 106 S.W.3d 118, 125 (Tex. Ct. App.-Houston [1st Dist.] 2002, *pet. denied*).

n67 *Farmers Tex. Co. Mut. Ins. Co. v. Griffin*, 955 S.W.2d 81, 84 (Tex. 1997).

n68 *Firemen's Ins. Co. v. Burch*, 442 S.W.2d 331 (Tex. 1968).

n69 *Griffin*, 955 S.W.2d at 84 (emphasis original).

n70 *Northfield Ins. Co. v. Loving Home Care, Inc.*, 363 F.3d 523, 529 (5th Cir. 2004) (treating *Griffin* exception as exclusive).

n71 *E.g., Mowry v. Badger State Mut. Cas. Co.*, 385 N.W.2d 171, 180 (Wis. 1986).

n72 *Johansen v. Calif. State Auto. Ass'n Inter-Ins. Bur.*, 123 Cal. Rptr. 288, 292-93, 538 P.2d 744, 748-49 (Cal. 1975).

n73 *Tex. Asso'n of Counties County Government Risk Mgmt. Pool v. Matagorda County*, 52 S.W.3d 128 (Tex. 2000).

n74 Restatement, § 35, Reporter's Note c.

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Howard on Pennsylvania Supreme Court's Missing the "Buss"

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Howard on Missing The "Buss": Pennsylvania Supreme Court Refuses to Recognize Insurers' Right to Recover Defense Costs Expended With Respect to Non-Covered Claims

By Theodore A. Howard

September 29, 2010

SUMMARY: This commentary addresses the reasoning employed and the result reached in *American & Foreign Ins. Co. v. Jerry's Sport Center, Inc.*, No. 88 MAP 2008, *2010 Pa. LEXIS 1803* (Aug. 17, 2010), where the court refused to recognize an insurer's right to recover defense costs for non-covered claims. The commentary explains why, in the view of the author, the decision (and, by extension, others like it) is seriously flawed.

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ARTICLE: With increasing frequency in recent years, courts addressing and resolving coverage disputes between policyholders and their liability insurers - especially primary carriers - have been called upon to decide claims by insurers seeking reimbursement of amounts expended to defend their insureds, subject to reservations of rights, in regard to underlying claims for which it is ultimately determined that no coverage exists. While a clear majority of the courts confronted with insurers' defense cost reimbursement claims have granted relief or, at a minimum, have recognized as a matter of principle that such claims are viable, a number of other tribunals have rejected the proposition that an insurer may compel repayment by an insured of costs expended to defend the insured against a potentially covered underlying claim based upon a *post-hoc* judicial determination that the claim is not subject to coverage. The most recent illustration of this minority view was provided by the Supreme Court of Pennsylvania, in *American & Foreign Ins. Co. v. Jerry's Sport Center, Inc.* ("*Jerry's Sport*"). n1 This commentary addresses the reasoning employed and the result reached in *Jerry's Sport* and explains why, in the view of the author, the decision (and, by extension, others like it) is seriously flawed.

Although not a completely new phenomenon, n2 the dramatic surge in the number of coverage disputes involving attempts by insurers to recoup defense costs expended on behalf of policyholders with respect to non-covered claims is commonly perceived to derive from the Supreme Court of California's decision in *Buss v. Superior Court* ("*Buss*"). n3 In *Buss*, the insurer, subject to a timely and specific reservation of rights, assumed its policyholder's defense in connection with an underlying action in which 26 of the 27 causes of action and claims for relief pled in the complaint against the insured were acknowledged by the parties to be outside the scope of the coverage provided by the insurer's general liability policies, while the remaining count of the complaint set forth a potentially covered claim. Although,

consistent with settled principles of California law, the insurer agreed to defend this "mixed" underlying action in its entirety, after the case was settled, the insurer commenced a declaratory judgment action seeking reimbursement of the costs it expended to defend the case. The trial court, intermediate appellate court and the California Supreme Court all agreed that the insurer was not entitled to seek reimbursement in regard to the one underlying cause of action, among the 27 pled against the insured, that was potentially covered under the policies at issue; however, as to the remaining 26 claims with respect to which it was undisputed that no coverage was owed, the courts were uniformly of the view that the insurer was entitled to seek reimbursement of the costs of defending those claims.

Specifically, the Supreme Court held that because the insurer's contractual duty to defend was applicable with respect to any claim potentially covered by the policies, the insurer had no right to seek recovery of costs expended to defend the insured against the single underlying potentially covered claim. n4 However, as to the remaining 26 underlying claims that were concededly outside the scope of the policies' coverage, the Court held that the insurer did not, at any time, have a contractual duty to defend for which the insured had bargained and/or paid premiums. As respects the portion of the insurer's expenditures, to the extent they could be segregated, that were attributable to the defense of the insured against the non-covered claims, the Court recognized that the insurer had a right to reimbursement "that is implied in law as quasi-contractual, whether or not it has [a right] that is implied in fact in the [policies] as contractual." n5 The Court concluded that this quasi-contractual right was enforceable in order to prevent "unjust enrichment" on the part of the insured, which had neither bargained nor paid for the benefit of a defense against non-covered claims. n6

Embracing a broad construction of *Buss*, insurers have taken the position that their potential right to obtain reimbursement of defense costs extends not only to concededly non-covered claims defended in the context of a "mixed" action, but to any *potentially covered* claim as well, as long as: (i) the defense is undertaken pursuant to a timely reservation of rights that clearly stakes out the insurer's claim of right to seek reimbursement in the event of a determination that the subject claim is not covered; and (ii) the insured accepts the defense subject to the insurer's express reservations. As noted above, the majority of courts to address the matter have endorsed the insurers' position in this regard, largely adopting and, in some instances, expanding upon the quasi-contract theory and equitable "unjust enrichment"/restitution principles invoked by the Supreme Court of California in *Buss*. n7

A lesser - but by no means insignificant - number of courts have reached a contrary conclusion and rejected the proposition that an insurer which has assumed the obligation to defend its insured in regard to an underlying claim implicating *bona fide* questions as to coverage has any right to seek or obtain reimbursement of defense costs based on an after-the-fact determination of non-coverage, even if the insurer fully reserved its right to seek such recovery and the insured accepted the defense without question or protest. n8 In *Jerry's Sport*, the Supreme Court of Pennsylvania joined that company.

The underlying claim giving rise to the dispute over defense costs in *Jerry's Sport* commenced with the filing of an action by the NAACP and the National Spinal Cord Injury Association against a host of firearms wholesalers-distributors in federal district court in Brooklyn, New York in June 2000 ("the NAACP/NSCIA action"), seeking injunctive relief and damages based on allegations that as a result of negligent marketing and distribution practices on the part of the defendant handgun dealers, members of both plaintiff organizations suffered bodily injury, death and other harms. By amended complaint filed in May 2001, *Jerry's Sport*, a major gun distributor, was named as an additional defendant. n9

Jerry's notified its general liability insurer, Royal Indemnity Co., regarding the NAACP/NSCIA action and tendered the claim for defense and indemnification under a commercial general liability policy providing primary and umbrella coverage commencing in October 2000. n10 Royal acknowledged the tender and notified *Jerry's* on June 15, 2001 that it had retained the New York firm of Leahey & Johnson to defend *Jerry's* in the NAACP/NSCIA lawsuit, based on the firm's prior experience in representing gun industry defendants in a similar prior action filed by the NAACP. In the same correspondence, Royal informed *Jerry's* that it was examining the availability of coverage under the provisions of the policy, and that it was providing *Jerry's* with a defense subject to a full reservation of rights,

including the right "to seek reimbursement for any and all defense costs ultimately determined not to be covered." n11

In light of Royal's reservations, Jerry's expressed a concern as to whether it might be better off participating in a joint defense with some of the other defendants, thereby reducing its defense cost exposure in the event it was determined that there was no coverage for the claim and Royal sought reimbursement of the amounts it advanced on Jerry's behalf. In light of information indicating that Jerry's was a "target defendant" of the plaintiffs "because of its position as one of the largest handgun distributors in the United States," and concerns that conflicts of interest might arise between Jerry's and other, less prominent defendants with respect to litigation and settlement strategy, Royal recommended that Jerry's maintain its separate representation by Leahey & Johnson. However, Royal also informed Jerry's that it could retain its own counsel to consult with Leahey & Johnson, and indicated that if Jerry's wished to shift its defense to a firm other than Leahey & Johnson, "Royal would afford [Jerry's] ample opportunity to arrange for the change in counsel." n12 Jerry's did not choose to obtain independent counsel. n13

In the meantime, Royal's assessment regarding coverage under its policy continued, and Royal reiterated that the defense it was providing Jerry's was subject to a full reservation of rights in correspondence directed to Jerry's throughout the summer of 2001. In early August, Royal indicated to Jerry's that notwithstanding its perception that no coverage existed under the policy, it would continue to fund Jerry's' defense until a final determination regarding coverage was reached, and qualified its reservation of its right to seek recovery of defense costs, stating that any defense costs incurred and paid prior to the date of its final coverage determination would not be included in any subsequent demand for reimbursement. n14

Finally, by letter of September 7, 2001, Royal communicated to Jerry's its final determination that the NAACP/NSCIA action was not covered and that Royal intended to initiate a declaratory judgment action seeking a court ruling to that effect. The action was commenced five days later. In July of 2002, Royal moved for summary judgment, requesting declarations, as a matter of law, that it had no duty to defend or indemnify Jerry's with respect to the NAACP/NSCIA claims and that it was entitled to reimbursement of all defense costs paid on behalf of Jerry's in the underlying litigation, as measured from and after the date that the coverage action was brought. n15 The trial court granted Royal's dispositive motion, in part, on February 25, 2003, "finding that Royal had no duty to defend or indemnify Jerry's Sport because the policy covered damages resulting from bodily injury, and the NAACP's suit did not seek compensation for bodily injury but, rather, sought injunctive relief and the creation of a monetary fund to educate, supervise and regulate gun dealers." The court's order did not, however, address Royal's claimed right to reimbursement of previously expended defense costs. n16

Jerry's appealed the ruling in Royal's favor, but Pennsylvania's intermediate appellate court affirmed by unpublished opinion. n17 In further trial court proceedings thereafter, Royal moved for an order requiring Jerry's to reimburse the defense costs incurred and paid in regard to the underlying action, as measured from the date of initiation of the coverage action (September 12, 2001), in the amount of \$317,540.29. n18 In August 2004, the trial court issued a preliminary ruling that Royal was entitled to recovery, based on an implied contract theory premised upon unjust enrichment and equitable restitution principles. Then, following hearings addressing quantum, the court entered a final order on June 13, 2006, holding that Royal was to be reimbursed by Jerry's in the amount of \$309,215.86, plus pre-judgment interest running from August 2004. n19

Jerry's again appealed, and this time prevailed. The Superior Court rejected the lower court's "implied contract" analysis and held that, absent the existence of an express provision in the policy establishing Royal's right to reimbursement of defense costs advanced subject to a reservation of rights in regard to a potentially covered claim for which it is later determined that no coverage was owed, an insurer in Royal's position has no entitlement to seek or obtain recovery. n20 Upon discretionary review, the Supreme Court affirmed.

After describing, in some detail, the parties' competing arguments and respective supporting authorities, the Supreme Court - relying principally upon two cases n21 - explained the bases for its decision in Jerry's' favor, citing as the key elements of its ruling the following points:

- the force of Pennsylvania's "longstanding common law rule that the duty to defend is broader than the duty to indemnify"; n22
- the absence from Royal's policy of any provision establishing a right on the part of the insurer to reimbursement of defense costs under any circumstances; n23 and
- the lack of any factual basis for a finding that Jerry's was "unjustly enriched" as a result of the defense provided to it by Royal in regard to non-covered claims, as Royal's assumption of the defense protected its own interests as well as Jerry's' interests. n24

As demonstrated below, none of these considerations constitutes a persuasive, much less compelling, rationale for rejecting Royal's defense cost reimbursement claim.

As a preface for the initial point in its three-pronged analysis, the Court observed that

[a]n insurer's duty to defend is broader than its duty to indemnify. It is a distinct obligation, separate and apart from the insurer's duty to provide coverage. . . . An insurer may not justifiably refuse to defend a claim unless it is clear from an examination of the allegations in the [underlying] complaint [against the insured] and the language of the policy that the claim does not potentially come within the coverage of the policy. n25

It is, of course, far too late in the day to question the correctness or applicability of these long-established bedrock principles of Pennsylvania insurance law, and there is nothing in the record of *Jerry's Sport* suggesting that Royal sought to do so in this instance. On the contrary, the fact that Royal readily assumed Jerry's' defense, subject to a reservation of rights, notwithstanding the fact that it harbored immediate doubts as to whether coverage existed under its policy for the NAACP/ NSCIA claims, clearly reflects Royal's awareness of and adherence to its obligation to defend its insured against a claim in regard to which coverage was doubtful.

Subject to the insured's full knowledge and consent, Royal retained experienced and competent counsel to defend Jerry's and that counsel, Leahey & Johnson, vigorously and successfully protected Jerry's' interests, securing a complete dismissal with prejudice of the underlying plaintiffs' claims against Jerry's prior to a lengthy trial in which all of the other handgun deal defendants were participants. Even after definitively determining that the NAACP/NSCIA claims against Jerry's were not covered by its policy and initiating a declaratory judgment action seeking an adjudication to that effect, Royal continued to defend Jerry's rather than abruptly terminating and withdrawing from the defense and thereby risking possible prejudice to the insured's interests in the underlying litigation. Moreover, seeking an appropriate balance between its own interests and those of its insured, Royal did not demand reimbursement of the entirety of the defense costs it advanced on Jerry's behalf upon receiving judicial confirmation as to the correctness of its no-coverage determination, but rather sought only that portion of the defense costs that were incurred and paid during the pendency of the declaratory judgment action (*i.e.*, the time period after Jerry's was fully informed of Royal's no-coverage position). Thus, even allowing Royal the partial defense cost reimbursement it sought, Jerry's would still have had the significant benefit of a substantial and effective defense against underlying claims threatening to impose serious liabilities, for which it had to bear only a portion of the expense, notwithstanding the fact that the claims in question were not covered by its liability policy in the first place - a result fully consistent with a broad conception of the duty to defend. The Supreme Court's conclusory assertion, under these circumstances, that allowing Royal to prevail on its reimbursement claim "would amount to a retroactive erosion of the broad duty to defend . . . and would therefore narrow Pennsylvania's long-standing view that the duty to defend is broader than the duty to indemnify," n26 simply ignores the realities of the situation.

In particular, the Court's perfunctory duty-to-define analysis disregards the critical distinction, in this context, between underlying claims against an insured for which there is no coverage due to the manner in which the factual allegations supporting the claim are resolved, on one hand, and underlying claims against an insured for which there is no coverage as a matter of law, on the other. As illustrated by *Scottsdale Ins. Co. v. MV Transp.*, n27 a compelling argument can be made that only the former category of cases implicates circumstances in which insurers may legitimately be precluded from obtaining reimbursement of defense costs. As lucidly explained by the Court in *MV*

Transp., where the determination as to whether a potentially covered claim is actually subject to coverage hinges on the manner in which the facts alleged against the insured are adjudicated, the insurer's duty to defend continues until the case is resolved or the insurer, at some point prior to final resolution, definitively establishes that the facts are irreconcilable with a finding of coverage. The defense obligation terminates at that point, but not before. "If it is so extinguished . . . it is extinguished only prospectively and not retroactively: before, the insurer *had a duty to defend*; after, it does not have a duty to defend *further*." n28 No right to reimbursement of defense costs advanced while the duty to defend continued in effect exists in this scenario, and nothing argued by Royal in *Jerry's Sport* suggests otherwise.

However, where the nature or essence of the underlying claim itself, as considered against the terms of the policy, reveals the absence of coverage as a matter of law, an insurer which chose to defend its insured out of an abundance of caution and in deference to the insured's interests, subject to a reservation of rights, should be permitted to seek and obtain reimbursement of the defense costs advanced once a court confirms the correctness of the insured's no-coverage position. In that situation, "[b]y law applied in hindsight, courts can determine that no potential for coverage, and thus no duty to defend, ever existed. If that conclusion is reached, the insurer, having reserved its right, may recover from its insured the costs it expended to provide a defense which, under its contract of insurance, it was never obligated to furnish." n29 Talismanic invocation of the unassailable principle that "the duty to defend is broader than the duty to indemnify" simply does little, or nothing, to advance the analysis where, due to the character of the claim against the insured, no coverage exists and a contractual defense obligation never arose.

The second major point in the Supreme Court's reasoning involves its finding "that the policy did not contain a provision providing for reimbursement of defense costs under any circumstances. Thus, the right Royal attempts to assert in this case, the right to reimbursement, is not a right to which it is entitled under the policy." n30 This finding, in turn, led the Court to hold that Royal's reservation-of-rights letters issued to Jerry's were likewise inadequate to serve as the foundation for Royal's defense cost reimbursement claim, because "Royal cannot employ a reservation of rights letter to reserve a right it does not have pursuant to the [policy]." n31

The Court's analysis in this regard seems disturbingly superficial, at best. As its decision notes, the Insuring Agreement incorporated in the Royal policy at issue expressly provided as follows:

We will pay those sums the insured becomes legally obligated to pay as damages because of "bodily injury" or "property damages" to which this insurance applies. We will have the right and the duty to defend the insured against any "suit" seeking those damages. *However, we will have no duty to defend the insured against any "suit" seeking damages for "bodily injury" or "property damage" to which this insurance does not apply.* . . . n32

Thus, the policy explicitly stated that Royal would have no obligation to defend, and Jerry's would have no basis to expect a defense, in regard to underlying actions seeking relief outside the scope of the coverage provided by the policy - *i.e.*, an action such as was brought against Jerry's by the NAACP/NSCIA, as determined by Royal and as confirmed as a matter of law by the Pennsylvania courts. Certainly it is at least implicit in the relevant policy language that defense costs advanced by Royal on a provisional basis, subject to a reservation of rights, in regard to an action asserting non-covered claims against Jerry's - and thus as to which Royal had no duty to defend and Jerry's had no right to or expectation of a defense - could be subject to recoupment by Royal.

Although neither of the appellate courts' respective decisions quote from the Royal reservation-of-rights letters with any specificity, it stands to reason that the insurer would have invoked in those letters the express admonition in the Insuring Agreement of the policy establishing that the insurer had no duty to defend non-covered claims. Thus, even if there were no provision in the policy at issue directly addressing a right to reimbursement in those precise terms, it is unclear why such an additional provision would be needed in light of the policy language explicitly disclaiming a duty to defend with respect to claims for which the policy provides no coverage. The Supreme Court's decision is silent on this point. n33

The third and last consideration accorded weight by the Supreme Court in its analysis was its endorsement of the proposition that Jerry's could not have been "unjustly enriched" by Royal's funding of its defense in regard to the non-covered NAACP/NSCIA action, thereby justifying "restitution" of any defense costs, because Royal itself derived an equal benefit from assuming the defense of the claims against Jerry's. In this regard, the Court stated, in relevant part, as follows:

As the Third Circuit explained in *Terra Nova*, an insurer faced with uncertainty about its duty to indemnify offers a defense under a reservation of rights "to avoid the risks than an inept or lackadaisical defense to the underlying action" may expose it to if it ultimately turns out that there was a duty to indemnify. 887 F.2d at 1219. Royal's ability to choose counsel allowed it to mitigate any potential future indemnification obligations. See *General Agents*, 215 Ill.2d 146, 828 N.E.2d 1092, 293 Ill. Dec. 594 (Ill. 2005) (rejecting unjust enrichment argument and holding when the insurance company tenders a defense for its policyholder it is "protecting itself at least as much as it is protecting its insured.") We further observe that by defending [Jerry's], Royal was protecting itself from the potential for a bad faith claim. In order to ensure that insurance companies assume the defense whenever there is the potential for coverage, bad faith damages are imposed where the insurer, with no good cause, refuses to provide a defense. Royal may have been subject to a bad faith action if it did not defend and a court ultimately found coverage. Accordingly, if the insurer could recover defense costs from its insured, then the insured would be paying for the insurer to protect itself. *Terra Nova*, 887 F.2d at 1219. n34

Whatever the merits - if any - of this line of reasoning in the abstract, it bears no relationship to the pragmatic reality of the circumstances in which liability insurers exercise claim-handling judgment on a day-to-day basis. In that context, the truth is that insurers, in those circumstances in which they do not simply deny coverage outright, routinely undertake the defense of their insureds subject to a reservation of rights identifying one or more grounds for possibly contesting coverage, but actually commence a declaratory judgment action seeking an adjudication that no coverage is owed in only a small percentage of those instances. Any number of variables - including, but not limited to, the fundamentally doubtful merits of the claim against the insured; the comparatively minor magnitude of the "worst case" liability confronting the insured in the event of an adverse judgment or unfavorable settlement; the insurer's disinclination to bear the additional layer of costs associated with retaining and paying its own outside coverage litigation counsel; the relative closeness of the coverage question(s); or the nature of the on-going business relationship with the insured - may cause the insurer to simply defend, notwithstanding its reservation of rights, even though an arguable basis to dispute coverage is present. As a result, the significant likelihood is that in the relatively few instances in which an insurer will conclude that pursuit of a declaratory judgment action with respect to coverage issues is warranted, the following characteristics are likely to be present: (i) defense costs are substantial; (ii) the liability claim against the insured is at least colorable if not clearly meritorious; and (iii) the insurer has a reasonably high degree of confidence in the correctness of its position that no coverage is owed as a matter of law.

However, if these premises are correct, then it is likewise apparent that in such instances, the insurer is not defending the insured for the primary purpose of protecting the insurer's own interests, because it perceives its coverage exposure to be low. By the same token, the insurer, in these circumstances, is not defending the insured in order to avoid the prospect of bad faith exposure, because if it is sufficiently confident in its no-coverage position to bring a declaratory judgment action, then the coverage issues themselves are, almost by definition, "fairly debatable" and thus not the basis for a viable bad faith claim under the substantive law of virtually all jurisdictions. n35 Thus, contrary to the Court's assumptions, the far greater likelihood in these situations is that the insurer's motivation for defending the insured, subject to a reservation of its right to seek reimbursement of defense costs, rather than simply categorically denying coverage, is almost entirely its desire to protect the insured's interests in accordance with the broad duty-to-defend principles contemplated by most states' insurance laws. Where it is then determined that no coverage is owed (and there was, accordingly, no right on the part of the insured to the defense it was provided), foreclosing reimbursement of the insurer in order to prevent "unjust enrichment" on the grounds that the insurer defended the case for its own benefit rather than the benefit of the insured gives dispositive effect to a fiction.

Ultimately, although in any situation in which an underlying claim against an insured is perceived by the insurer to

involve only a very limited possibility of implicating coverage, the insurer may exercise its prerogative to simply refuse to defend, n36 neither general principles of insurance law nor considerations of public policy favor that approach. On the contrary, insurers are not merely encouraged, but are expected, to resolve all doubts regarding coverage, however substantial they might be, in favor of the insured, and to defend under a reservation of rights rather than denying coverage outright. n37 Thus, as the Court noted, "[t]he broad duty to defend that exists in Pennsylvania encourages insurance companies to construe their insurance contract broadly and to defend all actions where there is any potential coverage." n38 By categorically foreclosing any right to defense cost reimbursement, however, the Court effectively encourages insurers to adopt the *opposite* approach, especially in any circumstances in which defense expenses are likely to be high.

Here, Royal conducted itself in as reasonable and responsible manner as was practicable under the circumstances. Notwithstanding serious (and justified) threshold doubts about whether the claims asserted against Jerry's by NAACP/NCSIA were covered, Royal:

- immediately acknowledged Jerry's notice regarding the NAACP/NCSIA action;
- arranged for Jerry's representation by experienced, competent counsel at cost-effective rates, n39 which counsel aggressively defended Jerry's and secured a complete dismissal of the claims against it, with prejudice, prior to trial;
- apprised Jerry's of its entitlement to retain substitute counsel or additional counsel to collaborate with the attorneys retained by Royal to act on Jerry's behalf (Jerry's chose neither option);
- fully and repeatedly informed Jerry's of Royal's doubts about coverage serving as the foundation for its reservation of rights and expressly reserved its right to pursue reimbursement of defense costs in the event of a non-coverage determination, without objection from Jerry's;
- completed its claim analysis and informed Jerry's of its definitive no-coverage position in a prompt manner;
- immediately initiated a declaratory judgment action seeking an adjudication of the merits of its coverage position, during the pendency of which it continued to defend; and
- after prevailing on the coverage issues, sought reimbursement of only that portion of the defense costs as were incurred and paid after Jerry's was informed of Royal's no-coverage determination.

For all of that, Royal gets nothing while Jerry's reaps the benefit of a vigorous and completely successful defense, worth hundreds of thousands of dollars, with respect to claims that were never covered in the first place, ostensibly on the grounds that allowing even partial reimbursement to Royal would be "unfair" to Jerry's.

Surely, faced with the prospect of an outcome such as this, under circumstances in which the legitimacy of its position on the coverage question *ab initio* likely insulates the insurer from the specter of bad faith exposure, a rational insurer will be more inclined to deny coverage outright and take its chances in any ensuing coverage litigation than to defend its insured pursuant to a reservation of rights that carries no weight with the courts, even if fully accepted by the insured. As a result, this ostensibly "pro-policyholder" decision may end up causing more insurers to refuse to defend their insureds in cases in which the duty to indemnify appears doubtful than would be true if some form of right to reimbursement were recognized.

In *Knapp v. Commonwealth Land Title Ins. Co.*, a pre-Buss decision of the federal district court in Minnesota involving facts and circumstances closely analogous to those presented in *Jerry's Sport*, the court sustained the insurer's right to seek and obtain reimbursement of defense costs advanced in regard to a non-covered claim, concluding that:

[t]he courts should be consistent in encouraging insurance companies to properly meet their duty to defend [their] insured[s] against third party claims and minimize unnecessary claims to enforce policy coverage. However, where an insurer has properly met its duty and subsequently successfully challenges policy coverage, it should be entitled to the full benefit of such a challenge and be reimbursed for the benefits it bestowed, in good faith, to its insured. n40

Given the overarching policy objective of insurance law, in Pennsylvania and generally, of maximizing the extent to which liability insurers honor their contractual duty to defend, even in those instances in which the existence of a coverage obligation is seriously in doubt, the approach advocated in *Knapp* and similar cases clearly reflects a more

appropriate balance between the legitimate interests of insureds and insurers, respectively, than does the result reached in *Jerry's Sport*. At least in those instances in which the insurer has, in a timely and appropriate manner, made known to the insured its intention to pursue reimbursement of defense costs advanced in regard to non-covered claims and the insured, with full awareness of the reservation of rights, accepts the benefits of the defense, *Buss* and analogous cases vindicating the right to reimbursement embody the better rule for insurers and insureds.

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n1 Case No. 88 MAP 2008, 2010 Pa. LEXIS 1803 (Aug. 17, 2010).

n2 See, e.g., *Knapp v. Commonwealth Land Title Ins. Co.*, 932 F. Supp. 1169 (D. Minn. 1996).

n3 16 Cal. 4th 35, 65 Cal. Rptr. 2d 366, 939 P.2d 766 (1997).

n4 See *Buss*, 939 P.2d at 774-75.

n5 *Buss*, 939 P.2d at 776.

n6 *Buss*, 939 P.2d at 776-77.

n7 See, e.g., *Valley Forge Ins. Co. v. Health Care Mgmt. Partners, Ltd.*, Nos. 09-1251 et seq., 2010 U.S. App. LEXIS 17098 (10th Cir. Aug. 16, 2010) (applying Colorado law); *United Nat. Ins. Co. v. SST Fitness Corp.*, 309 F.3d 914 (6th Cir. 2002) (applying Ohio law); *Cincinnati Ins. Co. v. Grand Pointe, LLC*, 501 F. Supp. 2d 1145 (E.D. Tenn. 2007) (applying Tennessee law); *St. Paul Fire & Marine Ins. Co. v. Compaq Computer Corp.*, 377 F. Supp. 2d 719 (D. Minn. 2005), *aff'd*, 457 F.3d 766 (8th Cir. 2006) (applying Texas law); *Scottsdale Ins. Co. v. MV Transp.*, 36 Cal. 4th 643, 31 Cal. Rptr. 3d 147, 115 P.3d 360 (2005); *Travelers Cas. & Sur. Co. v. RIBI Immunochem Research*, 326 Mont. 174, 108 P.3d 469 (2005); *Jim Black & Assocs., Inc. v. Transcontinental Ins. Co.*, 932 So. 2d 516 (Fla. Dist. Ct. App. 2006); *Colony Ins. Co. v. G&E Tire & Serv., Inc.*, 777 So. 2d 1034 (Fla. Dist. Ct. App. 2000). See generally *Jerry's Sport*, 2010 Pa. 1803, at *29 & n.12 (collecting additional authorities).

n8 See, e.g., *Perdue Farms, Inc. v. Travelers Cas. & Sur. Co.*, 448 F.3d 252 (4th Cir. 2006) (applying Maryland law); *Liberty Mut. Ins. Co. v. FAG Bearings Co.*, 153 F.3d 919 (8th Cir. 1998) (applying Missouri law); *General Agents Ins. Co. v. Midwest Sporting Goods Co.*, 216 Ill. 2d 146, 828 N.E.2d 1092 (2005); *Shoshone First Bank v. Pacific Employers Ins. Co.*, 2 P.3d 510 (Wyo. 2000); see generally *Jerry's Sport*, 2010 Pa. LEXIS 1803, at *31-*32 & n.13 (collecting additional authorities).

n9 See generally *Jerry's Sport*, 2010 Pa. LEXIS 1803, at *3-*4. See also *American & Foreign Ins. Co. v. Jerry's Sport Center, Inc.*, 948 A.2d 834, 837 (Pa. Super. Ct. 2008). Although injuries to the plaintiff associations' respective members allegedly attributable to illicit use of hand guns distributed or sold by the defendants were specifically referenced in the Complaint, the monetary relief sought was not in the form of compensation for the injured persons, but rather funds for the prospective creation of programs for public education and the supervision and oversight of gun dealers. See 2010 Pa. LEXIS 1803 at *4.

n10 *Jerry's Sport*, 948 A.2d at 837.

n11 *Jerry's Sport*, 2010 Pa. LEXIS 1803 at *4-*5. See also 948 A.2d at 837.

n12 *Jerry's Sport*, 948 A.2d at 837-39. See also 2010 Pa. LEXIS 1803 at *5.

n13 After extensive consultation with experts retained on Jerry's' behalf and comprehensive document and deposition discovery, Leahey & Johnson prepared and filed "an exhaustive summary judgment motion which resulted in the dismissal of [Jerry's] from the litigation before the case went to trial. Leahey & Johnson secured a stipulation of dismissal with prejudice with no conditions imposed" upon Jerry's. See 948 A.2d at 839-40.

n14 *Jerry's Sport*, 2010 Pa. LEXIS 1803, at *5-*6.

n15 *Jerry's Sport*, 2010 Pa. LEXIS 1803, at *6-*7. See also 948 A.2d at 841.

n16 *Jerry's Sport*, 2010 Pa. LEXIS 1803, at *7-*8. See also 948 A.2d at 841.

n17 See *American & Foreign Ins. Co. v. Jerry's Sport Center, Inc.*, 852 A.2d 1241 (Pa. Super. Ct. 2004) (table).

n18 *Jerry's Sport*, 948 A.2d at 842. See also 2010 Pa. LEXIS 1803 at *8-*9.

n19 *Jerry's Sport*, 948 A.2d at 842. See also 2010 Pa. LEXIS 1803 at *9.

n20 See *Jerry's Sport*, 948 A.2d at 844-45.

n21 See *Jerry's Sport*, 2010 Pa. LEXIS 1803 at *37, citing *General Agents Ins. Co. v. Midwest Sporting Goods, Inc.*, 215 Ill. 2d 146, 828 N.E.2d 1092 (2005) and *Terra Nova Ins. Co., Ltd. v. 900 Bar, Inc.*, 887 F.2d 1213 (3d Cir. 1989).

n22 See *Jerry's Sport*, 2010 Pa. LEXIS 1803 at *38-*47.

n23 See *Jerry's Sport*, 2010 Pa. LEXIS 1803 at *48-*51.

n24 See *Jerry's Sport*, 2010 Pa. LEXIS 1803 at *51-*54.

n25 *Jerry's Sport*, 2010 Pa. LEXIS 1803, at *38-*39 (citations omitted).

n26 *Jerry's Sport*, 2010 Pa. LEXIS 1803, at *47-*48.

n27 35 Cal. 4th 643, 31 Cal. Rptr. 3d 147, 115 P.3d 460 (2005).

n28 *MV Transp.*, 115 P.3d at 468 (emphasis in original; citations omitted).

n29 *MV Transp.*, 115 P.3d at 468.

n30 *Jerry's Sport*, 2010 Pa. LEXIS 1803, at *49.

n31 *Jerry's Sport*, 2010 Pa. LEXIS 1803, at *49. The Court's premise that an insurer's reservation of rights can be based only upon coverage defenses that are expressly embodied in the terms and conditions of the policy is, at best, highly dubious if not flatly incorrect. For example, under circumstances in which the insurer forms the view that notification received from the insured regarding a potentially covered "occurrence" or resulting claim was unduly delayed and thus untimely, the insurer may properly reserve its rights based not only upon the notice provisions set forth in the policy but also upon the statute of limitations governing contract actions under applicable state law. The latter defense is not based on a policy provision. Likewise, if the information initially provided by the insured to the insurer concerning a potentially covered "occurrence" or claim suggests to the insurer that the insured may have misrepresented, or failed to disclose, material facts in seeking and procuring the issuance of the policy, the insurer may, and should, preserve its right to seek rescission of the policy in its reservation of rights. As with statute of limitations, such a rescission defense is not premised upon a policy provision, but the reservation of rights is no less valid on that basis.

n32 *Jerry's Sport*, 2010 Pa. LEXIS 1803, at *2-*3 (emphasis added; record citation omitted).

n33 The Court's observation that Royal's obligation under the terms of its policy "to pay, with respect to 'any suit against an Insured we defend . . . [a]ll expenses we incur'" is "arguably" *dispositive* of the defense cost reimbursement issue - see 2010 Pa. LEXIS 1803 at *43 & n.14 - is puzzling, to say the least. This standard language says nothing more than that as to claims or actions against the insured that the insurer defends under the policy, the defense provided will be complete in regard to the expenses incurred. However, if the claim or action against the insured is not subject to coverage and the defense provided was subject to a timely and appropriate reservation of rights, the policy language invoked by the Court does not, in and of itself, establish any separate and free-standing impediment to a claim for reimbursement.

n34 *Jerry's Sport*, 2010 Pa. LEXIS 1803, at *53-*54 (citations omitted).

n35 See, e.g., *Simon Wrecking Co. v. AIU Ins. Co.*, 530 F. Supp. 2d 706, 717 (E.D. Pa. 2008) ("A successful bad faith claim requires that 'the insurer did not have a reasonable basis for denying benefits under the policy and that the insurer knew of or recklessly disregarded its lack of reasonable basis in denying the claim.' *MGA Ins. Co. v. Bakos*, 699 A.2d 751, 754 (Pa. Super. 1997). . . . '[A]n insurer is not "bound to submerge its own interest in order that the insured's interests may be made paramount" and an insurer does not act in bad faith by . . . litigating legitimate issues of coverage.' *Hyde Athletic Industries, Inc. v. Continental Cas. Co.*, 969 F. Supp. 289, 307 (E.D. Pa. 1997) (quoting *Cowden v. Aetna Cas. & Sur. Co.*, 389 Pa. 459, 134 A.2d 223, 228 (1957)).").

n36 *Jerry's Sport*, 2010 Pa. LEXIS 1803, at *42 ("In some circumstances, an insurance company may face a difficult decision as to whether a claim falls, or potentially falls, within the scope of the insurance policy. However, it is a decision the insurer must make. If it believes there is no possibility of coverage, then it should deny its insured a defense because the insurer will never be liable for any settlement or judgment." (Citation omitted.)).

n37 See *Jerry's Sport*, 2010 Pa. LEXIS 1803, at *40 ("In making this determination, the 'factual allegations of the underlying complaint against the insured are to be taken as true and liberally construed in favor of the insured.'" (quoting *Frog, Switch & Mfg. Co. v. Travelers Ins. Co.*, 193 F.3d 742 (3d Cir. 1999), citing *Biborosch v. Transamerica Ins. Co.*, 412 Pa. Super. 505, 603 A.2d 1050, 1052 (1992))).

n38 *Jerry's Sport*, 2010 Pa. LEXIS 1803, at *47 (citations omitted).

n39 As noted by the intermediate appellate court, the hourly rates charged by the Leahey & Johnson partners, associates and paralegals engaged in the representation of Jerry's in the NAACP/NCSIA matter "were on the low end of rates being charged at the time by firms representing clients in complex litigation in the New York City area during the 2001-2003 time frame." See *Jerry's Sport*, 948 A.2d at 840.

n40 *Knapp*, 932 F. Supp. at 1172. See also *Hecla Mining Co. v. New Hampshire Ins. Co.*, 811 P.2d 1083, 1089 (Colo. 1991) (*en banc*) ("[T]he appropriate course of action for an insurer who believes that it is under no obligation to defend is to provide a defense to the insured subject to a reservation of its rights to seek reimbursement should the facts . . . prove that the incident resulting in liability was not covered by the policy[.]"), followed, *Valley Forge Ins. Co. v. Health Care Mgmt. Partners, Ltd.*, 2010 U.S. App. LEXIS 17098, at *10-*11.

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Sonnenschein Nath & Rosenthal LLP on Nieto

2010 Emerging Issues 5298

Sonnenschein Nath & Rosenthal LLP on Nieto v. Blue Shield of California Life & Health Insurance Company: California Court Of Appeal Rejects Allegations Of "Post-Claim Underwriting" And Upholds Insurer's Right To Rely Upon Insured's Policy Application

By Daniel Feinberg

September 15, 2010

SUMMARY: The California Court of Appeals held that a health insurer did not engage in unlawful "post-claim underwriting" when it issued a policy in reliance on the insured's policy application, without investigating the accuracy of the insured's representations. The insurer was entitled to rescind its policy due to the insured's failure to disclose material information in the application.

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ARTICLE: In *Nieto v. Blue Shield of California Life & Health Insurance Co.*, n1 the California Court of Appeal held that a health insurer did not engage in unlawful "post-claim underwriting" when it issued a policy in reliance on the insured's policy application, without investigating the accuracy of the insured's representations. Accordingly, the insurer was entitled to rescind its policy due to the insured's failure to disclose material information in the application. This commentary examines that case in light of contrary case law regarding health service plans.

The Case

Nieto applied to Blue Shield for a health insurance policy, failing to disclose certain information regarding her medical condition and treatment. Blue Shield followed up with Nieto several times to obtain information that was missing from the application and to request additional medical-related information. Blue Shield issued Nieto a health insurance policy, and she later submitted a claim. Blue Shield then learned that Nieto had received extensive treatment and been prescribed multiple medications immediately prior to the submission of her application, none of which had been disclosed in her application. Blue Shield sought to rescind the policy, arguing that, had the information been disclosed, it either would have declined to issue the policy or, at a minimum, requested additional information. Nieto sued Blue Shield for breach of contract, bad faith, and violation of California's Unfair Competition Act. Blue Shield moved for summary judgment on its right to rescind the policy.

In response, Nieto argued that Blue Shield had engaged in "post-claim underwriting" in violation of § 10384 of

California's Insurance Code, which provides that "[n]o insurer issuing or providing any policy of disability insurance covering hospital, medical or surgical expenses shall engage in the process of postclaims underwriting." n2 Under that statute, "postclaims underwriting" "means the rescinding, canceling or limiting of a policy or certificate due to an insurer's failure to complete medical underwriting and resolve all reasonable questions arising from written information submitted on or with an application before issuing the policy or certificate." n3

The trial court granted Blue Shield's motion for summary judgment, and the court of appeal affirmed, ruling that Blue Shield could rescind the policy on the basis of Nieto's failure to disclose material information, and, in particular, that Blue Shield was not obligated to have conducted a pre-policy issuance investigation into the information contained in the application. That ruling is significant, because the court of appeal distinguished *Nieto* (which involved a health insurer governed by California's Insurance Code) from a prior case, *Hailey v. California Physicians' Service* n4 (which involved a health care service plan governed by California's Health and Safety Code). The court thus found that *Hailey's* strict limitations on an insurer's ability to rescind an insurance contract did **not** apply in the health insurance policy context.

Hailey

In *Hailey*, Hailey sought to purchase coverage under a health care service plan for herself, her husband and their son. n5 Hailey mistakenly believed that the application requested information related only to her own health, so she did not disclose any information regarding her husband or son. Based upon the information provided, Blue Shield extended coverage. A few months later, Mr. Hailey was admitted to the hospital, so Blue Shield investigated his health. Blue Shield then sought to rescind the Haileys' health plan contract, because Mr. Hailey's medical records showed that he had a history of health issues that were not disclosed in the application. The Haileys sued Blue Shield for breach of contract, bad faith, and intentional infliction of emotional distress.

The trial court granted Blue Shield's motion for summary judgment on its right to rescind. The Haileys appealed, arguing that § 1389.3 of California's Health & Safety Code precluded Blue Shield from rescinding the contract unless it could prove that the Haileys willfully misrepresented Mr. Hailey's health when they applied for coverage. Similar to § 10384 of California's Insurance Code (which the *Nieto* court analyzed), § 1389.3 provides that

[n]o health care service plan shall engage in the practice of postclaims underwriting. For purposes of this section, 'postclaims underwriting' means the rescinding, canceling, or limiting of a plan contract due to the plan's failure to complete medical underwriting and resolve all reasonable questions arising from written information submitted on or with an application before issuing the plan contract." n6

However, unlike § 10384 of California's Insurance Code, § 1389.3 further provides that "This section shall not limit a plan's remedies upon a showing of willful misrepresentation." n7 In *Hailey*, the court of appeal held that "section 1389.3 precludes a health services plan from rescinding a contract for a material misrepresentation or omission unless the plan can demonstrate: (1) the misrepresentation or omission was willful, or (2) it had made reasonable efforts to ensure the subscriber's application was accurate and complete as part of the precontract underwriting process." n8 Thus, § 1389.3 essentially amends the general rule that **any** material misrepresentation will justify rescission, by adding the "willful" prerequisite, unless the insurer reasonably investigates the accuracy of the application.

In reaching that conclusion, the *Hailey* court first examined the purpose of the Knox-Keene Health Care Service Plan Act n9 and the purpose of § 1389.3 in particular. The court noted that the purpose of the Act is to transfer the financial risk of health care from patients to providers and health service plans, and hence, that the purpose of § 1389.3 is to prevent plans from shifting the financial risk of health care back to the patients -- which is what Blue Shield was purporting to do by rescinding its coverage.

Next, the court considered the Haileys' argument that Blue Shield had engaged in unlawful "post-claim underwriting, " which the court defined as follows:

In essence, postclaims underwriting occurs when an insurer wait[s] until a claim has been filed to obtain and make underwriting decisions which should have been made when the application [for insurance] was made, not after the policy was issued. In other words, the insurer does not assess an insured's eligibility for insurance, according to the risk he presents, until after the insurance has been purchased and a claim has been made. Although the insurer may ask an applicant for some underwriting information before it issues the policy, it will not follow up on that information until after a significant claim arises. Only after a claim has arisen will the insurer examine the application and request additional information to see whether the applicant could have been excluded from coverage. An insurer relying upon post claim underwriting, instead of looking to pay the claim ... look[s] for all the things in the application that [it] might be able to dig up ... to rescind the policy. n10

The court described the "harm" that results from "post-claim underwriting" as follows:

An insurer has an obligation to its insureds to do its underwriting at the time a policy application is made, not after a claim is filed. It is patently unfair for a claimant to obtain a policy, pay his premiums and operate under the assumption that he is insured against a specified risk, only to learn *after* he submits a claim that he is *not* insured, and, therefore, cannot obtain any other policy to cover the loss. The insurer controls when the underwriting occurs... If the insured is not an acceptable risk, the application should [be] denied up front, not after a policy is issued. This allows the proposed insured to seek other coverage with another company since no company will insurer an individual who has suffered serious illness or injury. n11

Finally, the court focused on whether the phrase "complete medical underwriting" in §1389.3 mandates that a plan investigate application information prior to issuing coverage. Blue Shield asserted that it "completes medical underwriting" by resolving any questions that arise from the answers given by the applicant on the application. The court found that, in order to effectuate the purpose of § 1389.3 and to prevent the unexpected cancellation of health care coverage at a time coverage is needed most, the phrase "complete medical underwriting" must be interpreted to "require a plan to make reasonable efforts to ensure a potential subscriber's application is accurate and complete" **before** issuing the plan contract. n12

Accordingly, the court clarified the duties and rights of applicants and health care service plans under § 1389.3 as follows:

An applicant for a health services plan has a responsibility to exercise care in completing an application. In light of the potentially catastrophic consequences of an applicant's error in filling out an application, however, we believe the Legislature has placed a concurrent duty on the plan to make reasonable efforts to ensure it has all the necessary information to accurately assess the risk before issuing the contract, if the plan wishes to preserve the right to later rescind where it cannot show willful misrepresentation n13.

As such, the court reversed the summary judgment in favor of Blue Shield because Blue Shield failed to show that it made reasonable efforts to ensure the accuracy and completeness of the Haileys' application, and there was a triable issue of fact regarding whether Ms. Hailey willfully misrepresented Mr. Hailey's medical condition when she submitted the application.

Nieto

After analyzing the *Hailey* decision, the *Nieto* court ruled that *Hailey's* "complete medical underwriting" requirement (*i.e.*, that health care service plans must take reasonable efforts to investigate information in applications **before** policy issuance) did not apply to Blue Shield (a health insurance company governed by California's Insurance Code) because it is "limited to health care service plans subject to the Knox-Keene Act." n14

In turn, the court rejected Nieto's "post-claim underwriting" argument, determining that California's Insurance Code permits insurers to rescind policies on the mere basis of an insured's intentional or unintentional failure to disclose material information on an application. Accordingly, insurers need **not** conduct pre-policy issuance investigations into

the information obtained during the application process. n15 The *Nieto* court concluded:

Governing law permits an insurer to rescind a policy when the insured has misrepresented or concealed material information in connection with obtaining insurance... [T]he Insurance Code provides a statutory framework that imposes heavy burdens of disclosure upon both parties to a contract of insurance, and any material misrepresentation or the failure, whether intentional or unintentional, to provide requested information permits rescission by the injured party... Requiring full disclosure at the inception of the insurance contract and granting a statutory right to rescind based on concealment or material misrepresentation at that time safeguard the parties' freedom to contract. [An insurance company] has the unquestioned right to select those whom it will insure and to rely upon him who would be insured for such information as it desires as a basis for its determination to the end that a wise discrimination may be exercised in selecting its risks... Courts have applied Insurance Code sections 331 and 359 to permit rescission of an insurance policy based on an insured's negligent or inadvertent failure to disclose a material fact in the application for insurance. The same result is compelled here. The undisputed evidence established that appellant made material misrepresentations and omissions on the application regarding her medical condition and treatment... On the basis of governing law and the undisputed evidence, we find no basis to disturb the trial court's conclusion: '[Appellant's] application contained material misrepresentations and omissions concerning her medical history and conditions, medications taken, and recent physician visits. Had [appellant] accurately and completely disclosed these matters, she would have been denied coverage. Based on the undisputed facts, Blue Shield Life was and is entitled to rescind [appellant's] policy.' [Citations omitted].

Nieto, 181 Cal. App. 4th at 76, 77, 78.

Implications

The *Nieto* decision is noteworthy because it re-affirmed a health insurance company's ability to rely on information within a prospective insured's application for coverage without also having to engage in a formal investigation of the information contained therein prior to issuing a policy. The *Nieto* court thus confirmed that health insurers (unlike health care service plans governed by § 1389.3 of the California Health & Safety Code) need only show that the prospective insured misrepresented or omitted information that is material to the insured risk in order to substantiate a rescission, regardless of whether such misrepresentation or omission was intentional or unintentional, and that the insurer relied on the misrepresentation or omission.

In turn, the *Nieto* court made it harder for insureds to defend rescission claims and to establish that their health insurer engaged in unlawful "post-claim underwriting." More specifically, the *Nieto* court made it perfectly clear that the *Hailey* two-pronged test that health care service plans must satisfy in order to rescind a policy (and in turn, substantiate that it has not engaged in "post-claim underwriting" under § 1389.3 of the Health & Safety Code) **only** applies to health care service plans that are governed by California's Health and Safety Code and **not** health insurance companies that are governed by California's Insurance Code. Hence, health insurers need not establish: (1) that a particular misrepresentation or omission was willful or (2) that it made reasonable efforts to ensure that the insured's application was accurate and complete as part of the pre-contract underwriting process. n16 Instead, according to *Nieto*, health insurers need only demonstrate the insured's failure to disclose material information during the application process was relied upon -- *i.e.*, that the insurer would not have issued the policy at the rate it did had the information been disclosed (possibly because it would have requested additional information before policy issuance and taken that information into account. n17 It would thus seem that, under Insurance Code § 10384, a health insurer simply needs to follow up on any questions raised by an prospective insured's application to avoid having a rescission treated as "post-claim underwriting."

Nevertheless, insureds may challenge *Nieto*'s reading of § 10384. The court based its rejection of the *Hailey* rule largely on the fact that it involved a health care service plan "subject to the Knox-Keene Health Care Service Plan Act... which was designed 'to ensure the best possible health care for the public at the lowest possible cost by transferring the financial risk of health care from patients to providers ... [and] to prevent providers from shifting the financial risk of

health care back to providers.'" n18 But it can be argued that similar policy considerations should be taken into account vis-à-vis health insurance, particularly when one considers that a health insurance policy provides similar (if not identical) coverage as that provided by a health care service plan. Additionally, the *Nieto* court relied primarily on California common law in reaching its decision, and did not account for the fact that § 10384 of California's Insurance Code contains a virtually identical definition of "postclaims underwriting" to that in § 1389.3 of California's Health and Safety Code. In particular, both definitions contain the "complete medical underwriting" phrase that the *Hailey* court found so important in finding a duty to investigate applicant information.

Accordingly, insured's are likely to raise the "post-claim underwriting" issue again and assert that *Hailey's* requirement of a pre-issuance investigation (*i.e.*, reasonable efforts to ensure that the insured's application is accurate and complete) should be imposed on health insurers, such that a policy cannot be rescinded unless an insurer can demonstrate that it has conducted such an investigation.

[Return to Text](#)

n1 *Nieto v. Blue Shield Life & Health Ins. Co.*, 181 Cal. App. 4th 60 (2010).

n2 CAL. INS. CODE § 10384.

n3 *Id.*

n4 *Hailey v. California Physicians' Serv.*, 158 Cal. App. 4th 452 (2007).

n5 The ability of a health care plan or health insurer to rescind certain contracts will be limited/restricted further once new regulations under the Patient Protection and Affordable Care Act come into effect for group plan or policy years that commence as soon as September 23, 2010. Under those new regulations, rescission will be permitted only where the plan or insurer can establish fraud or an intentional misrepresentation of a material fact. See Public Health Service Act § 2712 (26 C.F.R. 54.9815-2717T, 29 C.F.R. 2590.715-2712, 45 C.F.R. 147.128).

n6 CAL. HEALTH & SAFETY CODE § 1389.3

n7 *Id.*

n8 *Hailey*, 158 Cal. App. 4th at 459; see also *Nazaretyan v. California Physicians' Service*, 182 Cal. App. 4th 1601, 1607 (2010); *Callil v. California Physicians' Service*, 2008 Cal. App. Unpub. LEXIS 8957, at *19-20 (Nov. 18, 2008).

n9 Calif. Health & Safety Code, § 1340 *et seq.*

n10 *Hailey*, 158 Cal. App. 4th at 465 (citations omitted); citing Thomas C. Cady & Georgia Lee Gates, *Post Claim Underwriting*, 102 W. VA. L. REV. 809, 813 (2000).

n11 *Hailey*, 158 Cal. App. 4th at 465 (emphasis in original); citing *Lewis v. Equity National Life Insurance Company*, 637 So.2d 183, 188-89 (Miss. 1994).

n12 *Id.* at 469; *Nazaretyan*, 182 Cal. App. 4th at 1608 ("given the likelihood of inadvertent error, accurate risk assessment requires a reasonable check on the information the insurer uses to evaluate the risk").

n13 *Id.* at 471.

n14 *Nieto*, 181 Cal. App. 4th at 85. The *Nieto* court further found that even if the *Hailey* requirements were to apply, they had been satisfied because Blue Shield's "underwriting process, as applied here, included appropriate steps to ensure the accuracy and completeness of [appellant's] Application." *Id.* at 85. In particular, multiple Blue Shield employees contacted the applicant "to obtain information missing from the application as well as to inquire about specific responses on the application that raised concerns." *Id.*

n15 See also *Kirsh v. UNUM Life Ins. Co. of America, Inc.*, 2002 Cal. App. Unpub. LEXIS 5251, at *19 (Cal. Ct. App. June 12, 2002) (Kirsh's breach of his duty to disclose ... overrides those defenses to rescission. Had Kirsh disclosed the September 9, 1999 test and results, UNUM certainly would have investigated, obviating any problem of 'post-claims underwriting.'" In addition, if such disclosure had been made, the level of [the agent's] imputed knowledge would be irrelevant because UNUM would have had valuable medical information to work with. In short, Kirsh cannot take advantage of his own non-disclosure to manufacture defenses to

rescission").

n16 *See Hailey, 158 Cal. App. 4th at 459.*

n17 *See Nieto, 181 Cal. App. 4th at 77* ("[M]ateriality ... must be determined 'solely by the probable and reasonable influence' which the admittedly undisclosed information would have had upon [the insurer's] decision to issue the policy").

n18 *Nieto, 181 Cal. App. 4th at 84.*

RELATED LINKS: *Nieto v. Blue Shield of California Life & Health Insurance Co.*,
■ 181 Cal. App. 4th 60 (2010)

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The Continuing Debate Over an Insurer's "Right" to Reimbursement

2010 Emerging Issues 5319

The Continuing Debate Over an Insurer's "Right" to Reimbursement: The Pennsylvania Supreme Court Weighs in Against Reimbursement in a Newly-Decided Case

By Sherilyn Pastor and Alissa Pyrich

September 15, 2010

SUMMARY: Courts across the country have taken two distinctly different views about whether insurers are entitled to be reimbursed for the defense of ultimately uncovered claims. This article discusses those approaches and the most current developments in the case law.

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ARTICLE: Because the duty to defend under an insurance policy is interpreted more broadly than the duty to indemnify, insurance companies often provide or pay for the defense of an insured before questions of coverage under the policy are resolved. In some instances, this results in an insurer's paying for the defense of claims that are ultimately determined not to be covered. Courts across the country have taken two distinctly different views about whether an insurer in that situation is entitled to be reimbursed for the defense of ultimately uncovered claims. This article discusses those approaches and the most current developments in the case law.

Basic Principles of the Duty to Defend

Where a policy contains a defense obligation, the insurer is obligated to defend any claim that potentially falls within the scope of coverage under that policy. n1 The duty to defend is not contingent on the insured's ultimately being found liable; the insurer must provide a defense to potentially covered claims even if the claims are groundless, frivolous, illogical, false or fraudulent. n2 Where a lawsuit involves multiple claims, the duty to defend applies as long as at least one of the claims alleged against the insured are potentially covered, and persists until all potentially covered claims are eliminated. n3 The duty to defend is therefore recognized as being broader than the insurer's duty to indemnify.

Often an insurer is presented with a claim upon the filing of a lawsuit against its insured. It must then determine whether it owes a defense, often based on limited and often imperfect information - namely, the facts alleged in the complaint or other pleadings. n4 Since complaints are often not written with the defendant's insurance coverage issues in mind, it is not uncommon for insurers and policyholders to find themselves uncertain about whether the allegations

are covered in whole or part. Faced with this uncertainty, the insurer may: (1) refuse to defend; (2) defend pursuant to a non-waiver and reservation of rights agreement and await more information that might help it determine coverage; (3) file a declaratory judgment action seeking a determination of its duty; or (4) some combination of the above. n5

The insurer's pursuit of its options is shaped by the law. Because of the breadth of the duty to defend *potentially* covered claims, any doubts as to the insurer's defense obligation are generally resolved in favor of the insured. n6 An insurer who elects not to defend when it regards coverage as uncertain runs the risk of breaching its insurance contract and being liable for damages. n7 Accordingly, the usual practice is for the insurer to provide a defense pursuant to a reservation of rights until any uncertainty is resolved, usually by declaratory judgment in a coverage action filed by the insurer. n8 But with increasing frequency, insurers who defend in these circumstances are seeking to be reimbursed for defense costs if it turns out that a claim is not covered.

Demands for Reimbursement of Defense Costs

Demands that an insured reimburse its insurer for defense costs arise when the insurer initially provides or pays for a defense but a court later determines that some or all of the claims were not covered by insurance. The insurer then seeks to recoup amounts spent on the uncovered claims, on the theory that it was never obligated to defend or otherwise pay for them. Courts across the country disagree on whether an insurer has the right to recoupment, and when and how such right arises.

Despite the frequency with which this issue has arisen in recent years, most standard form general liability policies still lack express provisions dealing with the insurer's alleged recoupment rights. n9 Because the insurance contract itself is silent, courts are forced to look to other factors to decide the parties' rights and obligations. Both the decisions allowing and disallowing reimbursement of defense costs base their rulings on such diverse considerations as the perceived purpose of the duty to defend, public policy concerns, and principles of equity. The fundamental difference in the results reached by the two distinct lines of cases in this area arises from how each court views and ultimately weighs these factors.

Cases Permitting Reimbursement

Those courts that have permitted insurers to recoup defense costs from their insureds have done so based on three essential premises. First, these courts reason that an insurer did not bargain for (or receive premiums for) the obligation to defend uncovered claims. n10 Therefore, regardless of when the claim is declared uncovered, once that declaration is made, it would be contrary to the parties' contract and expectations to require the insurer to have ever defended those claims. The second and related rationale is one of unjust enrichment. Unless insurers are allowed to recoup defense costs expended on claims they should not have been defending in the first place, the insureds will receive an unfair benefit. n11

The third line of reasoning invoked by courts that allow recoupment of defense costs posits that the insurer's reservation of rights letter creates an entirely new contract, with new and adequate consideration, between the insurer and the insured with respect to uncovered claims. By the terms of this newly created contract, the insurer has reserved its right to seek reimbursement as a condition of paying for the insured's defense. n12 The insured, by accepting a defense on these terms, is deemed to have accepted this new contract. n13 To establish the right to reimbursement under this approach, the insurer must show: (1) that it had specifically reserved the right to seek reimbursement from the insured; and (2) that it had provided the insured with adequate notice of this potential reimbursement. n14 Express consent from the insured may not be required, nor is there necessarily a requirement of new consideration beyond the insurer's offer and insured's acceptance of the defense. n15

The various courts that have taken a pro-reimbursement stance give different weights to each of these rationales. The leading case allowing reimbursement of defense costs to insurers, *Buss v. Superior Court of Los Angeles County*, n16 for example, decreed that insurers could obtain reimbursement of defense costs expended on claims that were not

even potentially covered, although the insurer bore the burden of proving which costs fell into that category. The underlying case involved 27 causes of action asserted by a sports advertiser against Jerry Buss, the owner of several Los Angeles professional sports teams. n17 Of those 27 counts, both Buss and his insurer agreed that only one count was even potentially covered. n18 Buss and his insurer entered into an agreement which specifically provided that Buss would reimburse the insurer for any costs of the defense that were deemed not covered by a court decision. n19 Notably, most subsequent analyses of *Buss* overlook this significant and distinguishable fact.

The Supreme Court of California acknowledged that the "duty to defend may be as important as the duty to indemnify," and that it applies more broadly than the duty to indemnify. n20 The *Buss* Court also noted that, under California law, when an action involves both covered and uncovered claims, the insurer is obligated to defend the entire action and cannot parse out only the potentially covered ones. n21 Nevertheless, as the court explained:

As to claims that are at least potentially covered, the insurer gives, and the insured gets, just what they bargained for, namely, the mounting and funding of a defense. But as to the claims that are not, the insurer may give, and the insured may get, more than they agreed, depending on whether the defense of these claims necessitates any additional costs. n22

In an effort to effectuate the parties' bargain, the *Buss* Court concluded that the insurer is entitled to reimbursement of defense costs expended on claims that are not even potentially covered, even if they occur in a case with potentially covered claims. "With regard to defense costs for these claims, the insurer has not been paid premiums by the insured. It did not bargain to bear these costs The insurer therefore has a right of reimbursement that is implied in law as quasi-contractual, whether or not it has one that is implied in fact in the policy as contractual." n23

The *Buss* Court found that allowing the insured to retain the benefit of defense payments that were not part of the bargain would be an unjust enrichment. n24 That the law required the insurer to defend the entire action, including the non-covered claims, should not create any expectation on the part of the insured that certain defense costs would not have to be repaid later. n25 In the view of the *Buss* court, reimbursing the insurer for defense costs it had not agreed to assume was most consistent with the insurance contract.

Finally, the *Buss* court found support for its decision in public policy:

Not only is it good law that the insurer may seek reimbursement for defense costs as to the claims that are not even potentially covered, but it also makes good common sense. Without a right of reimbursement, an insurer might be tempted to refuse to defend an action in any part - especially an action with many claims that are not even potentially covered and only a few that are - lest the insurer give, and the insured get, more than they agreed. With such a right, the insurer would not be so tempted, knowing that, if defense of the claims that are not even potentially covered should necessitate any additional costs, it would be able to seek reimbursement. n26

In *United National Ins. Co. v. SST Fitness Corp.*, n27 the Sixth Circuit Court of Appeals reached the same result as *Buss* but from a slightly different vantage. As in *Buss*, the insurer in *SST Fitness* assumed the defense of the underlying case subject to a reservation of rights that specifically and expressly reserved the right to recoup any defense costs expended on claims later found not to be covered. Although Ohio law provided no guidance on the issue, the *SST Fitness* Court found persuasive the line of cases, primarily from the federal courts, allowing an insurer to recoup defense costs where it had timely and explicitly reserved its right to recoupment. n28 The *SST Fitness* court analyzed general contract law of Ohio and determined that, given the insurer's specific reservation of its right to recoup, SST's acceptance of a defense under those terms created an implied in fact contract. Under Ohio law, for an implied in fact contract to be established, "... the plaintiff must prove that the defendant either requested or assented to such conduct under conditions precluding an inference that the plaintiff acted gratuitously." n29 The *SST Fitness* Court concluded that these elements were satisfied because SST was aware that its insurer was defending subject to an express reservation of the right to obtain reimbursement of non-covered defense costs, yet accepted the defense on that condition. n30 Under this newly created implied in fact contract, the insurer was entitled to recoupment.

The United States District Court for the District of Hawaii synthesized all three of the prevailing rationales for allowing reimbursement in its decision in *Scottsdale Ins. Co. v. Sullivan Properties, Inc.* n31 The *Sullivan Properties* court began its analysis with the notion that there is no contractual duty to defend unless there is at least a possibility of coverage. From that premise, the *Sullivan Properties* court found the right to reimbursement followed logically:

An insurer does not have a contractual duty to defend claims that are not possibly covered. Because there is no contractual duty to defend claims that are not possibly covered, the right to seek reimbursement is implied by the terms of the insurance policy. n32

In reaching this conclusion, the *Sullivan Properties* court invoked generic contract law holding that, where an agreement does not specify or fully express all of the non-essential terms, the "usual terms" will be implied in law. n33

The *Sullivan Properties* court's analysis, however, did not end there. It also found a right of reimbursement had been established by the insurer's reservation of rights letter expressly reserving that right and the insured's acceptance of a defense. n34 The fact that the insured did not expressly consent to the insurer's right to reimbursement did not prevent the creation of a new contract. n35

The *Sullivan Properties* court likewise concluded that Hawaiian law would allow insurers a right of reimbursement under equitable principles. "Equitable principles weigh in favor of permitting an insurer to recoup defense costs it was never obligated to pay when the insured is clearly notified of the insurer's intention to do so and nevertheless accepts the defense." n36 Reimbursement of the insurer would not be unfair to the insured; the *Sullivan Properties* court concluded that the insured would be no worse off than if it had assumed its own defense from the beginning. n37

The *Sullivan Properties* court also opined that public policy supported the insurer's right to reimbursement because allowing for reimbursement encourages the insurer to defend in cases where coverage is uncertain. In turn, encouraging the insurer to assume the defense "transfers from the injured party to the insurer the risk that the insured may not be financially able to pay the insured's party's damages." n38 Further, the *Sullivan Properties* court reasoned that other policyholders would benefit from establishing a reimbursement right:

Allowing an insurer to seek reimbursement also makes good policy sense from the perspective of other policyholders. The premium payments of other policyholders subsidize the defense of non-covered claims. In theory, the insurer's savings from reimbursement of defense costs where the insurer never had a duty to defend under the insurance policy will translate into lower premiums for all policyholders. n39

Overall, courts that permit insurers to obtain reimbursement of uncovered defense costs proceed, whether expressly or implicitly, from a view of the insurer and insured as equals in the relationship - financial equals, equals in bargaining power, and equals in their ability to handle risk. The *SST Fitness* court expressed this view most clearly when it suggested that the insured was free to reject a defense on the conditions offered in the insurer's reservation of rights letter: "When faced with a reservation of rights, the insured can choose to: (1) decline the offer, pay for the defense and seek recovery under the policy; (2) decline the offer and file a declaratory judgment action; or (3) accept the offer subject to the reservation of rights." n40 Animated by this view of the insurer-insured dynamic, the jurisdictions treat a reservation of rights letter as a new, freely negotiated contract for the defense of claims. Their assumption that the insured is effectively equal to the insurer also explains their public policy rationales, which tend to be more concerned with protecting the insurers' bargain than with the protection of insureds from litigation.

Cases Rejecting Reimbursement

In recent years, an increasing number of courts - including most recently the Pennsylvania Supreme Court, - have rejected the position exemplified by *Buss*, *SST Fitness* and *Sullivan Properties*, and deny reimbursement of defense costs even where they are expended in connection with uncovered claims. Cases disallowing insurer's claims for reimbursement find such claims to be inconsistent with the broad duty to defend. An insurer is required to defend the entire case as long as there is at least one potentially covered claim. Although that duty expires when the covered claims

are eliminated or all of the claims are found to be uncovered, cases that hold against reimbursement take the position that this expiration should function only prospectively, not retroactively. n41

Another key rationale for rejecting insurer's right to reimbursement is the lack of any provisions in the insurance contract establishing such a right. n42 If insurers, who generally write insurance policies, do not include the right to reimbursement as an express term, they should not be entitled to enforce that right later. Courts following this rationale also reject the notion that the insurer can change or amend the insurance contract through a reservation of rights letter, even if that letter expressly reserves the right to demand reimbursement of uncovered defense costs. n43

A growing number of courts also recognize that the insurer benefits from assuming control of and paying for the entire defense just as much as the insured does. n44 In the words of the Third Circuit in *Terra Nova Ins. Co. Ltd. v. Bar, Inc.*: n45

Faced with uncertainty as to its duty to indemnify, an insurer offers a defense under reservation of rights to avoid the risks that an inept or lackadaisical defense of the underlying action may expose it to if it turns out there is a duty to indemnify. At the same time, the insurer wishes to preserve its right to contest the duty to indemnify if the defense is successful. Thus, such an offer is made at least as much for the insurer's own benefit as for the insured's. If the insurer could recover defense costs, the insured would be required to pay for the insurer's action in protecting itself against the estoppel to deny coverage that would be implied if it undertook the defense without a reservation of rights. n46

Moreover, since defending the entire case serves the insurer's interests, the insured is not unjustly enriched when it receives a defense for claims that are not potentially covered. n47

Among the first significant cases to reject an insurer's claim for reimbursement of defense costs was *General Agents Ins. Co. of America, Inc. v. Midwest Sporting Goods Co.* n48 The Illinois Supreme Court considered and rejected the analysis in *Buss* as well as the notion that an insurer's reservation of rights letter can unilaterally modify the parties' contract. That rejection relied in part on the court's interpretation of public policy:

As a matter of public policy, we cannot condone an arrangement where an insurer can unilaterally modify its contract, through a reservation of rights, to allow for reimbursement of defense costs in the event a court later finds that the insurer owes no duty to defend. . . . [R]ecognizing such an implied agreement effectively places the insured in the position of making a Hobson's choice between accepting the insurer's additional conditions on its defense or losing its right to a defense from the insurer. n49

The lack of an express provision in the insurance contract allowing the insurer to recoup defense costs was also significant. Absent such a provision, the *General Agents* court held that "an insurer cannot later attempt to amend the policy by including the right to reimbursement in its reservation of rights letter." n50 The *General Agents* court reasoned that a reservation of rights letter merely protects the insurer's right to assert the existing defenses under the policy - it does not and should not create a new right such as the right to reimbursement. n51

In addition, the *General Agents* court concurred with the Third Circuit's finding in *Terra Nova* that the insurer, by paying for or providing a defense, was serving its own interests as well as those of the insured. Given the benefit to the insurer, the *General Agents* court concluded that the insured was not being unjustly enriched by receiving a full defense. n52

Further support for its rejection of a right of reimbursement laid in the *General Agents* court's notion of how the duty to defend is supposed to function. The duty to defend, the court explained, arises as soon as the claim against the insured is made. Until a court determined that the underlying claims were not covered, the insurer had a duty to defend and its payments were properly made pursuant to that duty. The *General Agents* court rejected the insurer's effort to re-define that duty retroactively based on the outcome of a later declaratory judgment action. n53

The Fourth Circuit's ruling in *Perdue Farms, Inc. v. Travelers Ins. Co.* n54 hits many of the same notes. The

Perdue Farms court began its analysis by considering Maryland law on the duty to defend and noting that the duty to defend attached at the outset of litigation. n55 It concluded that a right of reimbursement was inconsistent with the duty to defend in several key aspects:

Under Maryland's comprehensive duty to defend, if an insurance policy potentially covers any claim in an underlying complaint, the insurer, as Travelers did here, must typically defend the entire suit, including non-covered claims. Properly considered, a partial right of reimbursement would thus serve only as a backdoor narrowing of the duty to defend, and would appreciably erode Maryland's long-held view that the duty to defend is broader than the duty to indemnify. n56

Allowing insurers to obtain reimbursement after exercising their right and duty to defend would "undermine the bargain that Maryland courts describe insurers reaching with their insureds." n57

The *Perdue Farms* court also defined the duty to defend as benefiting both the insurer and the insured. While the insured receives the most obvious benefit, the *Perdue Farm* court found that the insurer also benefits by controlling the defense because doing so allows it to minimize or perhaps avoid entirely its obligation to indemnify. n58 Allowing insurers to recoup defense costs would be "a substantial rebate on their duty to defend" n59 and would "significantly tip the scales in favor of the insurer." n60 Accordingly, the *Perdue Farms* court held that the Travelers was not entitled to reimbursement of defense costs expended on uncovered claims.

The Texas Supreme Court in *Texas Ass'n of Counties County Gov't Risk Management Pool v. Matagorda County* n61 concluded that the insurer did not have a right to obtain reimbursement of a settlement payment, relying on many of the same rationales use to deny reimbursement of defense costs. n62 As is almost always the case, the policy in question did not provide the insurer with the right of reimbursement. The *Matagorda County* court held that a unilateral reservation of rights letter could not create a right - namely, the insurer's right of reimbursement - not established in the policy itself. n63

The insurer argued that, by accepting a defense subject to its reservation of rights, the insured had consented to reimburse the insurer. The *Matagordo County* court rejected that argument. First, it concluded as a matter of Texas law that the insured's silence in response to a reservation of rights letter did not equate with consent to a new bargain. n64 Second, the *Matagordo County* court distinguished between a true reservation of rights, which can only preserve the insurer's existing rights under the policy, and an offer to create a new contract for defense of an action. It found no evidence of a meeting of the minds regarding the insurer's right to reimbursement, and thus found no new contract had been created. n65

The *Matagordo County* court's consideration of public policy issues surrounding an insurer's right to reimbursement came down squarely in favor of the insured. Recognizing that both insurer and insureds faced a difficult choice when dealing with uncertain coverage rights, the *Matagordo Country* court found that the insurer was best equipped to bear the risk of deciding whether to pay:

Requiring the insurer, rather than insured, to choose a course of action is appropriate because the insurer is in the business of analyzing and allocating risk and is in the best position to assess the viability of the coverage dispute. On balance, insurers are better positioned to handle this risk, either by drafting policies to specifically provide for reimbursement or by accounting for the possibility that they may occasionally pay uncovered claim in their rate structure. n66

The *Matagordo County* court departed from the general trend of cases ruling against reimbursement by suggesting a scenario in which an insurer could establish such a right. An insurer could obtain reimbursement, the *Matagordo Country* Court instructed, if the insured agreed to payments subject to an obligation to reimburse the insurer if the insurer prevailed on its coverage defenses. n67

Unlike the courts that have allowed reimbursement, the courts in *Terra Nova*, *General Agents*, *Perdue Farms* and

elsewhere that have rejected an insurer's right to recoupment do not view the insurer and insured as effective equals. Instead, they recognize that an insured is not necessarily in a position to reject a defense or consent to a fundamental change in the policy at the point when it has just been sued. These courts posit that the insurer, not the insured, is in the expert in its insurance policy, and in the best position to deal with uncertainty because insurers are in the business of doing precisely that. Moreover, these cases effectively acknowledge the superior bargaining power of the insurer - if insurers truly believed they had a right to reimbursement they, and not the insured, are in the position to change the policy to reflect that right. Having opted not to do so, except in rare instances, the insurer should bear the consequences of that choice.

The courts that reject reimbursement also represent a more internally consistent view of the duty to defend. The rule that the insurer must defend all claims as long as even one potentially covered claim exists is effectively gutted when the insurer must later reimburse the costs of the defense. Insureds purchase policies with defense obligations to protect them against litigation risks and uncertainty. That protection is not meaningful if it can be revoked retroactively.

The Pennsylvania Supreme Court Weighs in Against Reimbursement

In *American & Foreign Ins. Co. v. Jerry's Sport Ctr., Inc.*,ⁿ⁶⁸ the Pennsylvania Supreme Court weighed the conflicting arguments represented by cases decided in other jurisdictions and concluded that insurers are not entitled to seek reimbursement of defense costs expended prior to a court's determination that there was no coverage. The Supreme Court found that this position - whether in the majority or minority of other jurisdictions - simply was more in tune with Pennsylvania law on the duty to defend and the nature of the insurer-insured relationship generally.

Jerry's Sport Center, Inc. and its subsidiaries (collectively, "Jerry's") were among a group of firearms wholesalers and distributors named as a defendant in a suit by the National Association for the Advancement of Colored People ("NAACP") and the National Spinal Cord Injury Association alleging the negligent creation of a public nuisance.ⁿ⁶⁹ The complaint alleged that the defendants had caused bodily injury to NAACP members, and sought remedies in the form of injunctive relief and monetary damages.ⁿ⁷⁰

Jerry's notified its insurers of the NAACP lawsuit and demanded a defense and indemnification. Insurers American & Foreign Ins. Co., Royal Ins. Co. of America, Safeguard Ins. Co. and Royal Indemnity Co. (collectively, "Royal") responded by providing Jerry's with a defense subject to a reservation of rights.ⁿ⁷¹ Royal's reservation of rights letter included an express reservation of the right to "seek reimbursement for any and all defense costs ultimately determined not to be covered."ⁿ⁷²

Royal not only offered to pay for Jerry's defense, it retained a law firm to represent Jerry's in the NAACP lawsuit. Royal made the decision that Jerry's would be better served by having independent counsel than by joining in a group defense with the other named defendants.ⁿ⁷³ When Jerry's expressed concern about this tactic, Royal gave Jerry's the choice between retaining its own counsel at its own expense to represent its uninsured interests or continuing with Royal's chosen defense firm.ⁿ⁷⁴ Jerry's opted to continue with Royal's chosen defense firm.ⁿ⁷⁵

In its subsequent correspondence with Jerry's, Royal made it clear that there was uncertainty about whether the claims in the NAACP lawsuit were covered by insurance but it would continue to fund the defense of the lawsuit until the coverage question was resolved.ⁿ⁷⁶ Ultimately, Royal filed a declaratory judgment action in Pennsylvania state court seeking a determination that it had no duty to defend Jerry's against the NAACP lawsuit.ⁿ⁷⁷ The trial court found in Royal's favor on the coverage question on summary judgment, holding that the NAACP lawsuit did not fall within the scope of coverage. This ruling was affirmed on appeal.ⁿ⁷⁸

Once the coverage question was resolved in its favor, Royal sought reimbursement of the defense costs it had expended on Jerry's behalf from the date when Royal filed the declaratory judgment action forwards. The trial court found in Royal's favor on this issue as well, ultimately entering a verdict requiring Jerry's to repay Royal \$309,216 plus pre-judgment interest.ⁿ⁷⁹ Jerry's appealed this ruling to the intermediate appellate court, which reversed the ruling.

n80 The Pennsylvania Supreme Court accepted a discretionary appeal to decide the matter definitively under Pennsylvania law.

After considering closely and at length the differing rationales expressed by courts throughout the country, the Pennsylvania Supreme Court came down squarely against allowing reimbursement of defense costs. n81 As the Supreme Court explained, "we conclude that the reasoning of *General Agents* and *Terra Nova* are more consistent with the broad duty to defend under Pennsylvania law . . . when viewed in the light of the policy language of the parties' insurance contract." n82

The Supreme Court began by noting that in Pennsylvania, as in most jurisdictions, the duty to defend is broader than the insurer's duty to indemnify. n83 An insurer is obligated to defend the insured as long as the complaint "might or might not" fall within the policy's coverage. n84 An insurer "may not justifiably refuse to defend a claim against its insured unless it is clear from an examination of the allegations in the complaint and the language of the policy that the claim does not potentially come within the coverage of the policy." n85

Taking these principles into account, the Pennsylvania Supreme Court concluded that "whether a complaint raises a claim against an insured that is potentially covered is a question to be answered by the insurer in the first instance, upon receiving notice of the complaint by the insured." n86 The Supreme Court placed on the insurer both the onus of making an initial coverage determination and the consequences of that determination: "Although the question of whether the claim is covered (and therefore triggers the insurer's duty to defend) may be difficult, it is the insurer's duty to make that decision. Insurers are in the business of making this decision." n87 If an insurer is truly uncertain about whether there is coverage for a particular claim, the proper avenue, according to the Supreme Court, is for the insurer to provide a defense and then seek a declaratory judgment on the coverage question. n88

In a key holding, the Supreme Court determined that a court's resolution of a disputed coverage question cannot retroactively eliminate the insurer's duty to defend during the period when coverage was uncertain. n89 At most, a court can determine the duty to defend going forward. To eliminate that duty to defend after the fact would undermine the insured's bargained-for rights:

Where the insurance contract is silent about the insurer's right to reimbursement of defense costs, permitting reimbursement for costs the insurer spent exercising its right and duty to defend potentially covered claims prior to a court's determination of coverage would be inconsistent with Pennsylvania law. It would amount to a retroactive erosion of the broad duty to defend in Pennsylvania by making the right and duty to defend contingent upon a court's determination that a complaint alleged covered claims, and would therefore narrow Pennsylvania's long-standing view that the duty to defend is broader than the duty to indemnify. n90

The rest of the Supreme Court's decision follows logically from its essential conclusion that courts cannot retroactively deprive an insured of a defense for disputed claims.

The Supreme Court also found it significant that the insurance policy at issue did not contain provisions permitting the insurer to recoup defense costs under any circumstances. n91 Having no basis in the insurance contract itself, such a right could arise only if the reservation of rights letters sent by Royal to Jerry's created new contracts. The Supreme Court held that they did not:

Royal cannot employ a reservation of rights letter to reserve a right it does not have pursuant to the contract. . . . A reservation of rights letter asserts defenses and exclusions that are already set forth in the policy. We are persuaded that permitting reimbursement by reservation of rights, absent an insurance policy provision authorizing the right in the first place, is tantamount to allowing the insurer to extract a unilateral amendment to the insurance contract. n92

The Supreme Court likewise held that the doctrine of unjust enrichment provides no basis for requiring Jerry's to repay defense costs expended on its behalf. Jerry's was not unjustly enriched by Royal's payment of defense costs, the Supreme Court explained, because both insured and insurer benefited from Royal's assumption of the defense. n93

Royal's decision to provide the defense protected it from bad faith claims in the event that the NAACP lawsuit was later determined to be covered, and allowed Royal to exercise control over the amount of the defense fees that it was required to pay. n94 Given the benefits to Royal, the Supreme Court concluded that Jerry's was not unjustly enriched. Instead, "[i]t would be unjust to require [Jerry's] to reimburse Royal for the cost of the defense where Royal invoked its right to defend in part to protect its own interests." n95

The Supreme Court noted the potential adverse consequences of recognizing a right to reimbursement that existed outside of the policy itself. *Buss* and its progeny effectively permit insurers to re-write the insurance contract unilaterally at the policyholder's expense, an undesirable result in the eyes of the Pennsylvania Supreme Court. n96 The Pennsylvania Supreme Court, therefore, concluded that "an insurer may not obtain reimbursement of defense costs for a claim for which a court later determines there was no duty to defend, even where the insurer attempted to claim a right to reimbursement in a series of reservation of rights letters." n97 Notably, the court's ruling not only prohibits an insurer who elects to control the insured's defense from obtaining reimbursement, but it also prevents that insurer from simply walking away from a defense that it has assumed. The court recognized that making coverage decisions is part of the business of an insurer. The insurer must decide whether it will defend a *potentially* covered claim (or not) and bear the consequences if it is wrong:

If [an insurer] believes there is no possibility of coverage, then it should deny its insured a defense because the insurer will never be liable for any settlement or judgment. ... If, on the other hand, the insurer is uncertain about coverage, then it should provide a defense and seek declaratory judgment about coverage. ...If the insurer is successful in the declaratory judgment action, it is relieved of the continuing obligation to defend. *The court's resolution of the question of coverage does not, however, retroactively eliminate the insurer's duty to defend the insured during the period of uncertainty.* n98

Thus, the court's ruling requires the insurer to live up to its obligations under the policy and to provide the defense for which its policyholder's premiums have already paid.

Conclusion

As in *Jerry's Sport Center*, insurers have traditionally urged that *Buss* and its progeny represent the "majority" view on the recoupment issue. The recent trend in cases, including *Jerry's Sport Center*, suggests the current and prevailing viewing is that insurers are not entitled to reimbursement. But counting the number of written decisions allowing and disallowing insurers to obtain reimbursement of defense costs may not be a particularly useful exercise. Many decisions allowing reimbursement rely on *Buss* without mention of the express reimbursement agreement that drove that decision, and/or were issued by federal courts attempting to predict state law without any guidance from the relevant state's court. Further, resolution of the issue may well depend on the facts presented and the controlling case law (if any). What view will ultimately prevail, thus, remains to be seen on a jurisdiction-by-jurisdiction basis. What is certain, however, is that courts in the various states will continue to grapple with questions of contract interpretation, public policy and the nature of the insured-insurer relationship in order to resolve whether an insurer does and should have a right to demand reimbursement of defense costs.

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n1 *E.g.*, *Fitzpatrick v American Honda Motor Co.*, 571 N.Y.S.2d 672, 674 (1991); *Voorhees v. Preferred Mutual Ins. Co.*, 607 A.2d 1255, 1259 (N.J. 1992); *Buss v. Superior Court of Los Angeles County*, 939 P.2d 766, 773 (Cal. 1997); *General Accident Ins. Co. of America v. Allen*, 692 A.2d 1089, 1095 (Pa. 1997); *Walk v. Hartford Cas. Ins. Co.*, 852 A.2d 98, 106-07 (Md. 2004); *General Agents Ins. Co. of America, Inc. v. Midwest Sporting Goods Co.*, 828 N.E.2d 1092, 1098 (Ill. 2005).

n2 *E.g.*, *Voorhees*, 607 A.2d at 1259; *Sheets v. Bretheren Mut. Ins. Co.* 679 A.2d 540, 544 (Md. 1996); *United States Fidelity & Guaranty Co. v. Wilkin Insulation Co.*, 578 N.E.2d 926, 930 (Ill. 1991); *West Am. Ins. Co. v. Silverman*, 378 So. 2d 28, 30 (Fla. Dist. Ct. App. 1979).

n3 *See, e.g.*, *Buss*, 939 P.2d at 775; *General Agents*, 828 N.E.2d at 1098; *Frontier Insulation Contrs. v. Merchants Mut. Ins. Co.*, 667 N.Y.S.2d 982, 985 (N.Y. 1997); *Stidham v. Millvale Sportsmen's Club*, 618 A.2d 945, 953 (Pa. Super. Ct. 1992).

n4 *See, e.g.*, *Danek v. Hommer*, 100 A.2d 198, 203 (N.J. Super. Ct. App. Div. 1953) ("[T]he complaint should be laid alongside the policy and a determination made as to whether, if the allegations are sustained, the insurer will be required to pay the resulting judgment"), *aff'd*, 105 A.2d 677 (N.J. 1954). Some states also permit consideration of facts outside the four corners of the pleadings to establish the insurer's right to a defense. *E.g.*, *Fitzpatrick*, 571 N.Y.S.2d at 674 (holding that "the insurer must provide a defense if it has knowledge of facts which potentially bring the claim within the policy's indemnity coverage" regardless of how those facts were learned). *See also* *Perdue Farms, Inc. v. Travelers Cas. & Sur. Co. of America*, 448 F.3d 252, 257 (4th Cir. 2006) (applying Maryland law); *Horace Mann Insurance Co. v. Barbara B, et al.*, 847 P.2d 792, 795 (Cal. 1993); *SL Industries, Inc. v. American Motor Ins. Co.*, 607 A.2d 1266, 1272 (N.J. 1992). Other states limit the inquiry strictly to the facts and allegations in the complaint. *E.g.*, *Wilson v. Md. Cas. Co.*, 105 A.2d 304, 307 (Pa. 1954) ("The obligation to defend is determined solely by the allegations of the complaint in the action."). *See also* *State Farm Fire & Cas. Co. v. Edgumbe*, 471 So. 2d 209, 210 (Fla. Dist. Ct. App. 1985); *Missionaries of Company of Mary, Inc. v. Aetna Cas. & Sur. Co.*, 230 A.2d 21, 25 (Conn. 1967).

n5 *See generally* Appleman on Insurance 2d § 136.7; Rowland H. Long, *The Law of Liability Insurance* § 5.04.

n6 *E.g.*, *Voorhees*, 607 A.2d at 1259; *Horace Mann*, 847 P.2d at 796; *Perdue Farms*, 448 F.3d at 257. *See also* *Servidone Constr. Corp. v. Sec. Ins. Co.*, 488 N.Y.S.2d 139, 142 (N.Y. 1985) (holding that an insurer is relieved of the duty to defend only if there is no possible factual or legal basis for coverage).

n7 *See generally* Rowland H. Long, *The Law of Liability Insurance* § 5.05.

n8 *See, e.g.*, *General Agents*, 828 N.E.2d at 1098; *Colony Ins. Co. v. G&E Tires & Service, Inc.*, 777 So.2d 1034, 1037-38 (Fla. Dist. Ct. App. 2000); *Rymal v. Woodcock*, 896 F. Supp. 637, 638 (W.D. La. 1995).

n9 See, e.g., *American & Foreign Ins. Co. v. Jerry's Sport Ctr., Inc.*, 2010 Pa. LEXIS 1803, at *49 (Pa. Aug. 17, 2010) (finding no policy provision addressing the issue of insurer reimbursement).

n10 See, e.g., *Scottsdale Ins. Co. v. Sullivan Properties, Inc.*, 2007 U.S. Dist. LEXIS 57021, at *9-10 (D. Haw. Aug. 2, 2007); *Jim Black & Assocs., Inc. v. Transcontinental Ins. Co.*, 932 So. 2d 516, 518 (Fla. Dist. Ct. App. 2006); *Buss*, 939 P.2d at 775.

n11 See, e.g., *Sullivan Properties*, 2007 U.S. Dist. LEXIS 57021, at *12-14; *St. Paul Fire & Marine Ins. Co. v. Compaq Computer Corp.*, 377 F Supp. 2d 719, 725 (D. Minn. 2005), *aff'd*, 457 F.3d 766 (8th Cir. 2006).

n12 See, e.g., *Travelers Cas. & Sur. Co. v. Ribi Immunochem Research, Inc.*, 108 P.3d 469, 479-80 (Mont. 2005); *United National Ins. Co. v. SST Fitness Corp.*, 309 F.3d 914, 916-21 (6th Cir. 2002); *Colony Ins.*, 777 So. 2d at 1039; *Grinnell Mut. Reinsurance Co. v. Shierk*, 996 F. Supp. 836, 839 (S.D. Ill. 1998); *Knapp v. Commonwealth Land Title Inc. Co.*, 932 F. Supp. 1169, 1172 (D. Minn. 1996).

n13 See, e.g., *Colony Ins.*, 777 So. 2d at 1039 ("In accepting the defense provided by Colony, G&E necessarily agreed to the terms on which Colony provided it."). *Accord SST Fitness*, 309 F.3d at 920-21; *Grinnell*, 996 F. Supp. at 839; *Knapp*, 932 F. Supp. at 1172.

n14 See, e.g., *Ribi Immunochem.*, 108 P.3d at 479-80; *SST Fitness Corp.*, 309 F.3d at 921; *St. Paul Mercury Ins. Co. v. Ralee Eng'g Co.*, 804 F.2d 520, 522 (8th Cir. 1986); *Capital Indem. Corp. v. Blazer*, 51 F. Supp. 2d 1080, 1090-91 (D. Nev. 1999); *Grinnell*, 996 F. Supp. at 839. The failure to reserve a right to reimbursement promptly may result in the waiver of that right, even in states that permit reimbursement generally. See, e.g., *Liberty Mut. Ins. Co. v. Tedford*, 658 F. Supp. 2d 786, 801 (N.D. Miss. 2009); *Nobel Ins. Co. v. Austin Powder Co.*, 256 F. Supp. 2d 937, 940-41 (W.D. Ark. 2003).

n15 *SST Fitness*, 309 F.3d at 919, 920; *Colony Ins.*, 777 So. 2d at 1039. But see *Excess Underwriters at Lloyd's London v. Frank's Casing Crew & Rental Tools, Inc.*, 246 S.W.3d 42, 48-50 (Tex. 2008) (holding that insured must consent to a defense subject to insurer's reimbursement to establish right).

n16 *16 Cal. 4th 35, 939 P.2d 766, 65 Cal. Rptr. 2d 366 (1997).*

n17 *939 P.2d at 769.*

n18 *Id. at 770.*

n19 *Id.*

n20 *Id. at 773*

n21 *Id. at 775.*

n22 *Id.*

n23 *Id. at 776.*

n24 *Id. at 777.*

n25 *Id.*

n26 *Id. at 778.*

n27 *309 F.3d 914 (6th Cir. 2002).*

n28 *Id.* at 917-18.

n29 *Id.* at 920.

n30 *Id.* at 920-21.

n31 2007 U.S. Dist. LEXIS 57021 (D. Haw. Aug. 2, 2007).

n32 *Id.* at *9-10.

n33 *Id.* at *10.

n34 *Id.* at *10-12.

n35 *Id.* at *12.

n36 *Id.* at *14.

n37 *Id.* at *19.

n38 *Id.* at *20, quoting *Blue Ridge Ins. Co. v. Brigitte Jacobsen*, 22 P.3d 313, 321 (Cal. 2001).

n39 *Id.* at *20.

n40 309 F.3d at 921.

n41 *Perdue Farms*, 448 F.3d at 248; *Liberty Mutual Ins. Co. v. FAG Bearings Corp.*, 153 F.2d 919, 924 (8th Cir. 1998).

n42 *Shoshone First Bank v. Pacific Employers Ins. Co.*, 2 P.3d 510, 514 (Wyo. 2000); *Perdue Farms*, 448 F.3d at 258-59; *Westchester Fire Ins. Co. v. Wallerich*, 527 F. Supp. 2d 896, 908 (D. Minn. 2007).

n43 *Shoshone First Bank*, 2 P.3d at 514; *General Star Indemnity Co. v. Virgin Islands Port Authority*, 564 F. Supp. 2d 473 (D.V.I. 2008).

n44 *Terra Nova Ins. Co. Ltd. v. Bar, Inc.*, 887 F.2d 1213, 1219-20 (3d Cir. 1989); *General Agents*, 828 N.E.2d at 1103.

n45 887 F.2d 1213 (3d Cir. 1989).

n46 887 F.2d at 1219-20.

n47 *Utica Mutual Ins. Co. v. Rohm & Haas Co.*, 683 F. Supp. 2d 368, 374-76 (E.D. Pa. 2010); *LA Weight Loss Centers v. Lexington Ins. Co.*, 2006 Phila. Ct. Com. Pl. LEXIS 127, at *21 (Mar. 1, 2006); *Pekin Ins. Co. v. Tysa, Inc.*, 2006 U.S. Dist. LEXIS 93525, at *53-54 (S.D. Iowa Dec. 27, 2006); *General Agents*, 828 N.E.2d at 1103.

n48 215 Ill. 2d 146, 828 N.E.2d 1092 (2005).

n49 828 N.E.2d at 1102.

n50 *Id.* at 1103.

n51 *Id.* at 1103.

n52 *Id.* at 1102-03.

n53 *Id.* at 1103-04.

n54 448 F.3d 252 (4th Cir. 2006).

n55 448 F.3d at 257.

n56 *Id.* at 258 (citations omitted).

n57 *Id.*

n58 *Id.* at 259.

n59 *Id.*

n60 *Id.*

n61 52 S.W.3d 128 (Tex. 2000). Although it has been questioned by some courts, the Texas Supreme Court affirmed its commitment to the *Matagordo County* ruling as recently as 2008. *Excess Underwriters at Lloyd's, London v. Frank's Casing Crew & Rental Tools, Inc.*, 246 S.W.3d 42, 47-48 (Tex. 2008).

n62 The insurance policy permitted the insurer to settle a claim without the insured's input or consent, and it had done so in the underlying case. Despite not having consented to the settlement, the insured did not content the settlement's reasonableness. 52 S.W.3d at 130.

n63 52 S.W.3d at 131-132.

n64 *Id.* at 132.

n65 *Id.* at 133.

n66 *Id.* at 135-36 (citations omitted).

n67 *Id.* at 134-35.

n68 2010 Pa. LEXIS 1803 (Pa. Aug. 17, 2010).

n69 2010 Pa. LEXIS 1803, *3-4.

n70 *Id.* at *4.

n71 *Id.* at *4-5.

n72 *Id.* at 5.

n73 *Id.*, at *4-5.

n74 *Id.* at *5.

n75 *Id.*

n76 *Id.* at *5-6.

n77 *Id.* at *7.

n78 *Id.* at *7-9.

n79 *Id.* at *9.

n80 *Id.* at *10-13.

n81 *Id.* at *37.

n82 *Id.*

n83 *Id.* at *38.

n84 *Id.* at *39.

n85 *Id.* at *39-40.

n86 *Id.* at *41.

n87 *Id.* at *41 (citation omitted).

n88 *Id.* at *42.

n89 *Id.* at *43.

n90 *Id.* at *47-48.

n91 *Id.* at *49.

n92 *Id.* at *49-50 (citations omitted).

n93 *Id.* at *51-52.

n94 *Id.* at *52-53.

n95 *Id.* at *54.

n96 *Id.* at *54-55.

n97 *Id.* at *55.

n98 *Id.* at *42-*43 (emphasis added).

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Reed Smith LLP on Audubon Internal Medicine Group v. Zurich American Ins. Co.

2010 Emerging Issues 4793

Reed Smith LLP on To Stack Or Not To Stack:An Analysis of Audubon Internal Medicine Group, Inc. v. Zurich American Insurance Company

By Jennifer Katz and Michael DiCanio

August 18, 2010

SUMMARY: In Audubon Internal Medicine Group, Inc. v. Zurich American Insurance Company, the District Court in the Eastern District of Louisiana allowed the policyholder to "stack" the applicable insurance coverage. This article analyzes the court's holdings in Audubon, a decision that builds upon the logic developed in several key decisions over the years and its implications for policyholders.

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ARTICLE: Zurich American Insurance Company ("MCC") sold Audubon Internal Medicine Group, Inc. and Audubon Internal Medicine Research (collectively "Audubon" or "Plaintiff") an insurance policy. After suffering a loss as a result of Hurricane Katrina, Audubon filed suit against MCC, arguing that it had at least three insured business income losses and could, therefore, "stack" the applicable coverages. In *Audubon Internal Medicine Group, Inc. v. Zurich American Insurance Company*, n1 the District Court in the Eastern District of Louisiana agreed with Audubon and allowed the policyholder to "stack" the applicable coverage. This commentary examines that decision and its implications for policyholders.

I. The Case

The hurricane loss suffered by Audubon triggered multiple time-element coverages. The policyholder argued that it could "stack" the applicable coverages, thereby maximizing its ultimate coverage. Audubon relied on the language in the Civil Authority provision and the Contingent Business Income provision (or Business Income From Dependent Properties provision). The Civil Authority provision provides, in relevant part, that "[t]his coverage will begin after the action by civil authority for a period of up to three consecutive weeks after coverage begins." n2 The Business Income provision provides, in relevant part, that the insurance company "will only pay for loss of 'business income' that occurs within the lesser of: (1) The 'period of restoration' at the 'dependent property' where the direct loss or damage occurs; or (2) 30 days." n3 Audubon argued that the 21 day maximum under the Civil Authority provision should be stacked with the 30 day maximum for the Business Income because the latter provision did not have a specific inception date. Ostensibly Audubon would have coverage for the first 21 days after the loss under the Civil Authority provision and

then coverage for the following 30 days under the Business Income provision. MCC disagreed. According to MCC, those two coverages ran "concurrently" and it was, therefore, only responsible for 30 days of loss. MCC disputed the idea of stacking by relying on the definition of "Period of Restoration." MCC's argument was essentially that the 30 day Business Income period must run from the date of loss because the Period of Restoration runs from the date of loss:

because the period of restoration beings when damage is sustained, the maximum 30 day period is also measured from the date when damage is sustained [and] the 30-day time period is qualified by its comparison to the period of restoration, which is also measured from the date of loss. n4

The Court, applying Louisiana law, determined that the policy language was "clear and unambiguous" and allowed the stacking of coverages. According to the Court, the 30 day Business Income period was "unambiguously independent" of the "period of restoration" because under the Business Income provision the "lesser of" the 30 days limit or Period of Restoration would be paid. n5 The Court reasoned that the losses "undisputedly triggered two independent coverage provisions" and the policyholder was not seeking double recovery. n6

As a general rule the claimant may recover under all available coverages provided that there is no double recovery. In this policy, different provisions have different trigger and end dates. The MCC's Civil Authority provides the trigger and end time in a single sentence; the definition of "Period of Restoration" provides the beginning time and alternative end times; and the BIDP provision provides two alternative maximum terms of coverage, one with its own begin and end time and the one in dispute, defined only by its duration, 30 days, MCC cannot simply graft a trigger date where none appears. n7

Concluding, the court held that "[t]he plain Policy language specifically grants [the policyholder] the right to choose under which Policy provisions it seeks to recover for losses covered by multiple, overlapping provisions. Louisiana law fully supports the policyholder's right to elect to arrange and "stack" multiple policy provisions so that it is fully indemnified." n8

II. Implications

The Audubon decision will have far reaching implications for policyholders and insurance companies alike. The Audubon decision builds upon the logic developed in several key decisions. n9 In *Archer-Daniels-Midland Co. v. Phoenix Assurance Co.*, n10 the policyholder whose manufacturing operations were severely impacted by flooding, was allowed to seek recovery under multiple overlapping coverages as long as it did not seek a "double recovery." n11 The policy issued by one of the defendant insurance companies provided that "[i]f two or more of this policy's coverages apply to the same loss or damage, we will not pay more than the actual amount of the loss or damage." n12 The Court held that the policies issued by the other insurance companies did not contain similar language and because the policyholder did not seek to recover under both the Extra Expense and Contingent Extra Expense sections, any potential duplication in coverage was irrelevant. n13

In *CII Carbon, L.L.C. v. National Union Fire Insurance Co.*, 918 So.2d 1060 (La. App. 2005), the policyholder's steam manufacturing plant exploded, damaging a neighboring plant and leased equipment. The leased equipment could have been replaced by November 15, 1999, but the policyholder could not being selling steam until the neighboring plan resumed operations on December 31, 2000. The trial court held that the policyholder was entitled to Business Income coverage until November 15, 1999, and entitled to Contingent Business Income coverage from November 15, 1999 until December 31, 2000. n14 Appealing the decision the policyholder argued that it was entitled to Business Income coverage for the entire period. n15 Despite losing this argument on appeal, the court assumed that the explosion triggered both Business Income and Contingent Business Income from the date of the explosion until November 15, 1999, thereby properly "stacking" the coverages triggered by the loss to maximize the policyholder's recovery. n16

Ideally most policyholders in similar situations will recognize that they have the ability and right to structure the

application of coverage provisions to maximize coverage. The policyholder's right to elect to arrange and "stack" multiple policy provisions will serve to alleviate gaps in coverage and provide the policyholder extended coverage for losses suffered. As the case law develops in this area, practitioners should be aware of these decisions and use them to the policyholder's advantage.

[Return to Text](#)

n1 *Audubon Internal Med. Group, Inc. v. Zurich Am. Ins. Co., 2008 U.S. Dist. LEXIS 52583* (E.D. La. July 10, 2008)

n2 *Id.* at *1, n.2.

n3 *Id.* (Emphasis added).

n4 *Id.* at *1 (internal quotes omitted).

n5 The Court was "disturbed" by the fact that defendants misquoted the BIDP provision and omitted the word "or" from that provision. The "single word" was highly relevant to the dispute. *Id.* at *2.

n6 *Id.* at *2.

n7 *Id.* at *2 (Internal quotations omitted, citations omitted).

n8 *Id.* at *3.

n9 Holding to the contrary, the court in ***Pel Hughes Printing, L.L.C. v. Hanover Ins. Group, Inc., 2008 U.S. Dist. LEXIS 31224* (E.D. La. Apr. 16, 2008)**, declined to allow the policyholder to "stack" multiple policy

provisions. Instead, holding that "[t]he Printing Industries Broadening Form explains that if any of the property covered by the form is also covered under any other provisions of the policy, the insured can elect to make a claim under that other provision (in which case none of the provisions of the Printing Industries Broadening Form would apply) or under the provisions of the Printing Industries Broadening Form itself (in which case coverage as provided by the form is the sole coverage on such property).").

n10 936 *F. Supp.* 534 (*S.D. Ill.* 1996)

n11 As a practical matter it is advisable to sue under each and every coverage potentially available, regardless of whether or not the coverages overlap to a degree. The most extreme consequence of not doing this was illustrated in the *Duane Reade, Inc. v. St. Paul Fire & Marine Ins. Co.*, 503 *F.Supp.2d* 699, 703, 705 (*S.D.N.Y.* 2007), decision, wherein the court found that the policyholder was barred on the ground of *res judicata* from seeking recovery under new policy provisions when the policy failed to bring them in the prior action.

n12 *Id.* at 544.

n13 *Id.*

n14 *Id.* at 1062-63.

n15 *Id.* at 1065.

n16 See also *Hit Factory, Inc. v. Royal Ins. Co. of Am.*, 2005 *U.S. Dist. LEXIS* 19050 (*S.D.N.Y.* Aug. 24, 2005) (finding that efficient proximate cause theory applied in situations where there was an excluded and a covered cause, and not where there were two potentially covered causes, and, therefore, that policyholder was entitled to stack limits for flood and backup of sewers.)

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McCarter & English, LLP on Pentair Water Treatment Co. v. Continental Ins. Co.

2010 Emerging Issues 5157

McCarter & English, LLP on the Discovery Rulings in Pentair Water Treatment (OH) Co. v. The Continental Ins. Co.

By Louis A. Chiafullo and David A. Thomas

July 2, 2010

SUMMARY: In *Pentair Water Treatment (OH) Co., et al. v. The Continental Ins. Co., et al.*, Dkt No. 08 Civ. 3604, 2009 U.S. Dist. LEXIS 106424 (Nov. 16, 2009), the court allowed discovery into the insurer's inventory of pollution exclusion clauses used during the relevant time periods of coverage, and also allowed discovery into underwriting practices and the identification of manuals and training procedures.

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ARTICLE: The United States Court for the Southern District of New York in a discovery ruling recently carved out some middle ground in a landscape that too often is heavily skewed in favor of insurers in coverage actions. In *Pentair Water Treatment (OH) Co., et al. v. The Continental Ins. Co., et al.*, Dkt No. 08 Civ. 3604, 2009 U.S. Dist. LEXIS 106424 (Nov. 16, 2009), the policyholders, Pentair Water Treatment (OH) Company and related companies ("Pentair"), sought coverage for a judgment for money damages arising out of an outbreak of Legionnaire's disease on a cruise ship attributed to a faulty water filter manufactured and distributed by the insureds.

The policyholders asked the Court to compel document and deposition discovery in three general areas: affirmative defenses; pollution exclusion clauses; and underwriting. The carrier, Continental Insurance Company ("Continental"), objected to each area of discovery and refused to produce the documents and/or a responsive witness. The Court ordered Continental to produce the discovery but with some modifications. The Court's directives are instructive and may aid in winning discovery motions if the precautions are observed.

Affirmative Defenses. Continental asserted 50 affirmative defenses and, consequently, Pentair served (a) document demands seeking any materials related to each defense and (b) a deposition notice for a Rule 30(b)(6) corporate designee to testify on each defense. The Court rejected Continental's blanket attorney work-product objection with regard to the document demand. However, inasmuch as this was the insured's second document request, the Court ruled that Continental need only produce documents not previously produced in response to the new request. The question not raised or addressed by the Court is whether Continental was required to identify by Bates label which documents were related to each defense.

The Court was more cautious with regard to the deposition notice. Of concern was that some of the defenses relied on complicated legal principles (*e.g.*, *res judicata* and *collateral estoppel*) and that the witness would either have to be trial counsel or be in a position to repeat trial counsel's thoughts about the application of facts to legal theories in the pleadings. Accordingly, the Court denied the discovery request without prejudice and indicated the discovery would be permissible if "Pentair recast[] its requests to seek information about facts rather than about legal issues." *2009 U.S. Dist. LEXIS 106424*, at *7. The Court also observed that certain other defenses (*e.g.*, payment of claims by the insured without Continental's consent) were less troublesome in that the requests "seem more likely to elicit factual information." *Id.*

Pollution Exclusion Clauses. Continental asserted a defense in which it argued that coverage was barred by the pollution exclusion in the policy. The defense relied on the definition of the word "pollutant" which was defined in the policy. Pentair requested documents pertaining to any pollution exclusion clause used by Continental in the relevant time period, as well as any specific clauses containing exclusions for injury caused by viruses, bacteria, or fungi. Continental objected to the extent that the request sought information on pollution exclusion clauses not in the policy at issue. The Court flatly rejected Continental's objection and ruled that information on Continental's inventory of pollution exclusion clauses is relevant to what Continental chose to include in Pentair's policy and how Continental might have altered the pollution exclusion from one policy to the next. The Court stated that examination of such information "could well shed light on the meaning of the exclusion in this case." *Id.* at *9. The Court also noted in a footnote that the policyholder agreed to limit the request to standard form excess liability policies used by the insured.

Clearly, the Court acknowledged the importance to the policyholder of ascertaining the meaning of terms commonly used by insurers by comparing similar policy provisions issued by the same carrier.

Underwriting. Pentair's deposition notices also requested a corporate designee to give testimony on a broad range of underwriting topics including underwriting practices and the identification of manuals and training procedures applicable to both general and excess liability policies in the relevant time period. Again, the insurer refused to provide information beyond the policy at issue. Using the same logic employed with regard to the pollution exclusion clause, the Court ruled that in interpreting the policy, the policyholder is "entitled to explore what risks Continental expected to cover when it used terms similar to those in the Policy." *Id.* at 11.

* * *

With the pollution exclusion and underwriting holdings, the *Pentair* Court provides the policyholder a significant amount of latitude to gather and compare other policies and provisions utilized by its carrier at least during the same period in which the policies were issued. Such comparisons could prove useful. Insurance contracts are not like other commercial contracts. The carrier, or more generally the insurance industry and its trade groups, craft the policy language which can be cryptic and sometimes difficult to decipher. Additionally, policies are often created in parts or by endorsements issued after the body of the contract is delivered and the premium paid, thereby further insulating the policyholder from the inside baseball that is underwriting. By focusing sunlight on this process, the insured may gain insight into terms and conditions which would otherwise appear murky.

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McCarter & English, LLP on NGM Ins. Co. v. Carolina's Power Wash & Painting LLC

2010 Emerging Issues 5158

McCarter & English, LLP on NGM Insurance Co., et al. v. Carolina's Power Wash & Painting LLC, et al. and the Absolute Pollution Exclusion

By Louis A. Chiafullo

July 2, 2010

SUMMARY: In a recent decision from the U.S. District Court for South Carolina, the "absolute pollution exclusion" upon which insurers often rely to deny coverage was dealt another blow when the court held that it was unclear whether the exclusion unambiguously applied to paint fumes generated as a result of the insured's painting business.

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ARTICLE: In the most recent decision on the scope of the so-called "absolute pollution exclusion," the United States District Court for the District of South Carolina refused to apply the exclusion in a case involving alleged injury as a result of exposure to paint fumes. In *NGM Insurance Co., et al. v. Carolina's Power Wash & Painting LLC, et al.*, No. 08-3378, 2010 U.S. Dist. LEXIS 2362 (D. S.C. January 13, 2010), the court held that because it was not clear that the absolute pollution exclusion at issue in the case unambiguously applied to paint fumes generated as a result of the insured's painting business, the insurer could not rely on the absolute pollution exclusion to deny coverage for the underlying personal injury suit.

Plaintiff NGM Insurance Co. ("NGM") issued a contractor's insurance policy to Norman Kuras Jr., doing business as Carolina's Power Wash & Painting LLC ("CPWP"). The policy provided that NGM would pay those sums the CPWP became legally obligated to pay as damages as a result of bodily injury resulting from an occurrence. Slip Op. at 2. The policy also contained an absolute pollution exclusion that excluded from coverage "bodily injury" arising out of the "actual, alleged, or threatened discharge, dispersal, seepage, migration, release or escape of pollutants." "Pollutants" was defined by the policy as any "solid, liquid, gaseous or thermal irritant or contaminant, including smoke, vapor, soot, fumes, acids, alkalis, chemicals and waste." *Id.* at 2-3.

The United States Post Office in Johns Island, South Carolina ("USPS") hired CPWP to paint the exterior and interior of the facility, and required proof of current liability insurance from the company. Several years later, two employees at the USPS filed suite against CPWP alleging they were injured as a result of CPWP's negligence. More particularly, the two employees allege that they suffered permanent, serious and irreparable bodily injury as a result of exposure to paint fumes and vapor dust, as well as other residue. After CPWP sought coverage from NGM, the insurer

brought a declaratory judgment, basing its denial of coverage on the policy's absolute pollution exclusion. *Id.* at 3-4.

After reviewing case law from other jurisdictions, the court held that the absolute pollution exclusion in the NGM policy did not exclude coverage for negligence claims where injury is alleged by virtue of the release of paint fumes during painting. The judge relied heavily on the decision in *Belt Painting Corp. v. TIG Ins. Co.*, 795 N.E.2d 15 (N.Y. 2003), which involved an individual alleging injury as a result of inhaling paint fumes while a contractor painted the interior of an office building. The insurance policy at issue in *Belt Painting* contained an "absolute pollution exclusion" nearly identical to the one in NGM's policy. *Id.* at 6.

The court placed great emphasis on the *Belt Painting* court's reasoning. The *Belt Painting* court was reluctant to adopt an interpretation of the absolute pollution exclusion that would "infinitely enlarge the scope of the term 'pollutants,' and seemingly contradict both a 'common speech' understanding of the relevant terms and the reasonable expectations of a business person." 79 N.E.2d at 20. The NGM court also found reasonable the *Belt Painting* court's reasoning that even were paint of solvent fumes correctly within the definition of "pollutant," the exclusion would apply only if the underlying injury is caused by the "discharge, dispersal, seepage, migration, release or escape" of the fumes. "It cannot be said that this language applies to ordinary paint or solvent fumes that drifted a short distance from the area of the insured's intended use and allegedly caused inhalation injuries to a bystander." *Id.*

The NGM court reasoned in granting the policyholder's Motion for Summary Judgment, the absolute pollution exclusion was subject to more than one interpretation relating to the issue before the court and, therefore, it was to be construed against the insurer. This decision is yet another in a line of cases recognizing that the absolute pollution exclusion was designed not to exclude coverage for anything that could arguably be a "pollutant," but only those circumstances involving "traditional" environmental property damage.

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McCarter & English LLP on Fulton Boiler Works v. American Motorists Ins. Co

2010 Emerging Issues 5159

McCarter & English LLP on Fulton Boiler Works v. American Motorists Ins. Co: Northern District Of New York Holds That Insurers Have A Pro Rata Responsibility To Cover All Defense Costs

By Gita F. Rothschild, Brian J. Osias, Nicholas M. Insua and Anne E. Matthews

July 2, 2010

SUMMARY: In *Fulton Boiler*, insurers argued that their common insured was required to contribute the same pro rata amount towards the defense all of all claims. The U.S. District Court of Northern N.Y. ordered summary judgment and reinforced N.Y. precedent requiring insurers to pay for 100% of defense costs for any potentially covered claims unless the insurer can prove that allegations of complaint involve only occurrences during self-insured periods.

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ARTICLE: Under New York law, an insured may be required to pay a *pro rata* share of defense costs on a case-by-case basis, but only after there has been a showing that the alleged occurrence took place at least in part during an uninsured or self-insured period. n1 Insurers in *Fulton Boiler Works, Inc. v. American Motorists Insurance Co.* n2 attempted to use this narrow rule to require the policyholder, Fulton Boiler Works, Inc. ("Fulton"), to pay a *pro rata* share of both defense and indemnity costs for all claims filed. However, in the United States District Court for Northern District of New York's recent summary judgment decision in that case, n3 the Court made clear that where at least one primary policy is potentially triggered, insurers are collectively responsible for 100% of an insured's defense costs and no share of defense costs may be allocated to the insured.

Fulton is a family-owned boiler manufacturer. It is presently the largest employer in the Village of Pulaski, New York (population 2,398 at the 2000 census), and many of Fulton's employees are second or third generation. Since the early 1990s, Fulton has been named as a defendant in lawsuits in various jurisdictions throughout the country alleging exposure to asbestos allegedly contained in its products. In the thousands of cases filed, there has never been a finding against Fulton by any court in any jurisdiction that any plaintiff has been exposed to asbestos from a Fulton boiler.

Fulton has four comprehensive general liability insurers on the risk for the asbestos claims against it -- American Motorists Insurance Company and American Manufacturers Mutual Insurance Company (collectively "Kemper"), OneBeacon Insurance Company (as successor to Commercial Union Insurance Company, "OneBeacon"), Travelers Casualty and Surety Company (as successor to Aetna Casualty and Surety Company, "Travelers"), and Employers Insurance Company of Wausau ("Wausau"). n4 Each policy at issue in the case provided that defense costs would be

paid in addition to limits and none contained any asbestos exclusions. n5 The insurers never disputed that their policies covered the asbestos claims against Fulton. Nonetheless, they argued that at least some of the defense and indemnity costs they had been paying for more than a decade should be allocated to Fulton.

Fulton filed a Motion for Partial Summary Judgment seeking "(1) a declaratory judgment that [the insurers] have an obligation to pay 100% of its defense costs in connection with the underlying Asbestos Claims as a matter of law, and (2) attorneys fees and costs incurred as a result of the current litigation." n6 With regard to the first point, Fulton argued "(1) the duty to defend must be considered separately than the duty to indemnify; (2) under New York law, the policyholder cannot be required to pay defense costs where primary insurance is triggered; and (3) any requirement that [Fulton] pay a pro rata share (or the entire amount) of defense costs must be determined on a case-by-case basis, after there has been a showing that the alleged occurrence occurred, in full or in part, during an uninsured period." n7 In respect of the second point, Fulton argued "that the insurers are obligated, pursuant to their duty to defend, to reimburse [Fulton] for the attorney's fees and costs that it has incurred as a result of this litigation because this litigation was precipitated by the insurers' attempt to free themselves from their obligations." n8

Kemper, Travelers, Wausau, and OneBeacon cross-moved for summary judgment, arguing "(1) under New York law, [Fulton] is required to contribute an equitable pro rata share to its own defense based upon uninsured or self-insured periods; (2) because the pro rata amount is determined objectively, [Fulton] must contribute the same pro rata amount to each case, regardless of the facts of the particular case; and (3) even if [Fulton] prevails on its motion, it is not entitled to attorney fees." n9

The Court granted in part and denied in part Fulton's motion, finding that the insurers must pay 100% of Fulton's defense costs but that Fulton did not establish its right to attorney fees. n10 The Court denied the insurers' cross-motions. n11

In finding that the insurers are responsible for 100% of Fulton's defense costs, the Court reiterated the rule that "so long as the allegations in a case could conceivably result in liability covered by a policy at issue, the insurer must defend [and t]he insurer thus bears a heavy burden to show that the allegations of the complaint cast the pleadings wholly within the exclusions and that there is no possible factual or legal basis for finding liability covered by the policy." n12 Applying this rule to the Fulton case, the court found not only that Fulton's Amended Complaint alleged "facts plausibly suggesting coverage," but also that the insurers "failed to meet their modest threshold burden ... by adducing at least some admissible record evidence from which a rational fact finder could conclude that the underlying lawsuits involve 'occurrences' solely during self-insured periods, and that there is thus no possible factual or legal basis for finding liability covered by the policy." n13 Finally, the Court noted that "with regard to future defense costs in the underlying lawsuits, ... so long as the allegations in a case could conceivably result in liability covered by a policy at issue, [the insurers] must defend," and allocation amongst the insurers should follow the applicable *pro rata* standard. n14

In sum, the Court's decision reinforced long-standing New York precedent requiring an insurer to pay for 100% of defense costs for any potentially covered claims unless the insurer can prove that allegations of the complaint involve only occurrences during self-insured periods. Unless an insurer can carry that burden, it and any other potentially triggered insurers have a *pro rata* responsibility to pay 100% of an insured's defense costs and cannot allocate any share of those costs to the insured.

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n1 See *Appalachian Ins. Co. v. Gen. Elec. Co.*, 8 N.Y.3d 162, 171 (N.Y. 2007); *Seaboard Sur. Co. v. Gillette Co.*, 64 N.Y.2d 304, 310 (N.Y. 1984).

n2 United States District Court, Northern District of New York, No. 5:06-CV-1117.

n3 See *Fulton Boiler Works, Inc. v. Am. Motorists Ins. Co., et al.*, United States District Court, Northern District of New York, No. 5:06-CV-1117, Docket No. 146.

n4 *Id.* at 5.

n5 *Id.*

n6 *Id.* at 6-7.

n7 *Id.* at 6 (*internal quotations omitted*).

n8 *Id.* (*internal quotations omitted*).

n9 *Id.*

n10 *Id.* at 3, 12-15. For purposes of this case note, discussion will focus on the Court's holding that the insurers' are required to pay all defense costs.

n11 *Id.* at 3-4, 15.

n12 *Id.* at 13 (*internal quotations and citations omitted*).

n13 *Id.*

n14 *Id. at 14 (internal quotations omitted).*

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Sonnenschein Nath & Rosenthal, LLP on World Harvest Church v. GuideOne Mutual

2010 Emerging Issues 5160

Sonnenschein Nath & Rosenthal, LLP on World Harvest Church v. GuideOne Mutual Insurance Co.: Defense Without Reservation Estops Denial of Coverage Without any Showing of Prejudice

By William T. Barker, Paul E.B. Glad and Michael A. Barnes

July 2, 2010

SUMMARY: The GA Supreme Court held that "where an insurer assumes and conducts an initial defense without effectively notifying the insured that it is doing so, the insurer is deemed estopped from asserting the defense of noncoverage regardless of whether the insured can show prejudice." While that is said to be the majority rule, this commentary argues that the court's rationale better supports a requirement that prejudice be shown.

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ARTICLE: In *World Harvest Church, Inc. v. GuideOne Mutual Insurance Co.* n1 the Georgia Supreme Court held that "where ... an insurer assumes and conducts an initial defense without effectively notifying the insured that it is doing so with a reservation of rights, the insurer is deemed estopped from asserting the defense of noncoverage regardless of whether the insured can show prejudice." n2 While that is said to be the majority rule, this commentary argues that the court's rationale better supports a requirement that prejudice be shown, though the showing will often not be difficult. That is also the better rule. On the facts presented, the result might have been the same.

I. The Case

World Harvest Church received large donations from perpetrators of a Ponzi scheme. When sued by a receiver to recover those payments, it sought a defense from its insurer, GuideOne. GuideOne provided a defense without an effective reservation of rights. (That question was litigated but need not be discussed here.) The result was a judgment that admittedly was not within the coverage of GuideOne's policy. The Church then sued in federal court to compel GuideOne to pay the judgment, on the ground that it was estopped from denying coverage. The federal court certified a question as to the need for a showing of prejudice, which the Georgia Supreme Court answered that there was no need for any such showing. That court concluded that:

"Three different views currently exist among the jurisdictions regarding the requirement of demonstrating prejudice: Some jurisdictions take the view that where an insurer, without reservation of rights and with actual or presumed knowledge, assumes the exclusive control of the defense of claims against the insured, it cannot thereafter

withdraw and deny liability under the policy on the ground of noncoverage, prejudice to the insured by virtue of the insurer's assumption of the defense being, in this situation, conclusively presumed. In other jurisdictions, the issue as to prejudice has been met directly, without resort to a presumption, by merely holding that the loss of the right of the insured to control and manage the defense is, in itself, prejudice without any further proof. Under a third view, where an insurer defends an action on behalf of its insured with knowledge of (a) defense to coverage, as (a) general rule it is thereafter estopped from asserting that [the] policy does not cover [the] claim if the insured has demonstrated that it has been prejudiced by [the] insurance carrier's actions." n3

The court correctly observed that the first two views are different ways of saying the same thing: existence of prejudice is immaterial. The court concluded that its own precedents supported that rule. Cases where the insurer had not been estopped were determined to be ones where, while participating in the defense, the insurer had not assumed charge of the defense. n4 The rationale for the estoppel was that:

"the insured has surrendered innumerable rights associated with the control of the defense including choice of counsel, the ability to negotiate a settlement, along with determining the timing of such negotiations, and the ability to decide when and if certain defenses or claims will be asserted." n5

In the case at hand, "GuideOne represented the Church until discovery was almost complete." n6 Under those circumstances, "'The course cannot be rerun, no amount of evidence will prove what might have occurred if a different route had been taken. By its own actions, [GuideOne] irrevocably fixed the course of events concerning the law suit for the first 10 months. Of necessity, this establishes prejudice.'" n7

II. Analysis n8

Jurisdictions requiring prejudice readily agree with the main point of *World Harvest Church*: loss of the right to control the defense can itself constitute prejudice, without any showing that the insurer mishandled the defense. n9 This recognizes that innumerable strategic and tactical decisions shape the defense of a lawsuit. In many cases, these decisions involve no clear right or wrong answers, only choices among various mixes of advantages or disadvantages dependent on unknowable future developments. The right to control these choices is itself a valuable right. If the insurer's decisions made during its exercise of control are significant and irreversible, in the sense that they *materially* limit the insured's options in further conduct of the litigation, then prejudice may be found.

The type of prejudice inherent in loss of control of the defense was emphasized by oft cited dicta in *Merchants' Indemnity Corp. v. Eggleston*, n10 on the basis for an estoppel where an insurer has assumed the insured's defense:

Control of the defense is vitally connected with the obligation to pay the judgment. Carriers contract for control, and to that end require notice of accident and prompt submission of suit papers. Success, absolute or relative, may depend upon skill in investigation, in negotiations for settlement, and in the conduct of the lawsuit. Just as a carrier would hardly agree to pay a judgment after defense by the insured, so it cannot expect the insured to pay for a judgment when it controlled the litigation. A carrier may be more confident of its handling of claims, but an insured may with equal conviction prefer the individualized attention of his own counsel as against the services furnished by an insurer in the mass handling of litigation. Personal counsel may seize opportunities to settle which might be ignored or overlooked by a carrier to which the case is just one of a great number. Moreover, whatever his estimate of lawyers in general, a man usually has faith in "my lawyer." This intangible is a valuable right. n11

If the insurer controls the defense to judgment, or even to the close of discovery, then the insured cannot alter the defense decisions that were made. The insurer's control would necessarily have limited (or entirely eliminated) the insured's ability to make choices about the conduct of the defense. But, as will be discussed, a different situation may be presented if the insurer relinquishes control of the defense at an earlier stage of the litigation.

Arguably, one might require the insured to point to some specific irreversible decision made by the insurer where the insured could show that there were cognizable reasons for adopting a different course. However, this may be

unrealistic because it requires the insured to reconstruct the situation presenting such a choice at a later time despite the lack of detailed information which results from the very fact that the insurer was then controlling the defense. In any event, no case clearly imposes such a requirement. Most courts apparently rely on a more qualitative assessment of the significance of the action taken while the insurer was in control of the defense. n12

Logically, an additional consideration in evaluating prejudice should be the extent to which the insured's own counsel is involved during the period when the insurer is controlling the defense. If the insured's own counsel was not involved, then there may be no meaningful way to determine, after the fact, whether the insured would have made different tactical and strategic choices had it been in control of the litigation. If, on the other hand, the insured's own counsel was associated in the conduct of the defense and fully concurred in all decisions, then there would be no prejudice from the insured's inability to control the choices made. n13

Even if the insured's counsel plays only a monitoring role, it would seem reasonable to require that some objection must be made to choices with which the insured's counsel disagrees before those choices may be claimed as prejudicial to the insured. This would serve the interests of the insured, by allowing the insurer appointed counsel to consider (and perhaps accept) the recommendations of the insured's own counsel. It would also allow a more focused review of whether those choices were significant and irreversible.

While the Georgia court recognizes that there should be no estoppel if the insurer never assumes control of the defense, it fails to consider the possibility that even after control has been assumed, it may be relinquished before the insured's ability to make defense choices has been compromised. Consider *Maryland Casualty Co. v. Peppers*, n14 a case involving lack of coverage for injuries intentionally inflicted by the insured. After Peppers' business insurer declined coverage, Peppers had retained his own counsel, who filed a motion to dismiss. A considerable time later, attorneys retained by Peppers' homeowner's insurer wrote Peppers that they had been retained to defend him and filed an answer on his behalf. Twenty four days later, the counsel selected by the insurer were permitted to withdraw, their answer was stricken, and the motion to dismiss filed by Peppers' own counsel (who apparently had never withdrawn his appearance) was reinstated.

The *Peppers* court found that the brief assumption of the defense by the insurer did not estop it to dispute coverage because there had been no prejudice to Peppers. It recognized that "[i]f, . . . by the insurer's assumption of the defense the insured has been induced to surrender his right to control his own defense, he has suffered a prejudice which will support a finding that the insurer is estopped to deny policy coverage." n15 However, the court found "nothing in the record to establish that Peppers was not at all times represented by his own attorney . . . or that in reliance on the attorneys hired by [the insurer] he was induced to surrender the right to conduct his own defense." n16 To be sure, by filing an answer, the insurer's attorney had assumed the right to withdraw the motion to dismiss. But, because the answer was withdrawn and the motion reinstated, no prejudice resulted.

Similarly, in *King v. Aetna Insurance Co.*, n17 the insurer had retained counsel to enter a defense against a claim that the insured's negligence had caused destruction of a building by fire. Fourteen months later, the insurer[8209]retained counsel withdrew the appearance, citing an exclusion for injury to property rented to the insured. Conceding an initial lack of coverage, the insured claimed that the insurer was now estopped to deny coverage. Apparently, no substantial activity appeared from the record during the period prior to the motion to withdraw. Accordingly, the court affirmed the order permitting the withdrawal, because some proof of prejudice was necessary to support an estoppel. It reasoned that the need for such a showing was

particularly applicable where, as in the instant case, the matter is still at the pleading stage and any defense entered may be amended under the liberal provisions of the Civil Practice Act and the Rules of the Municipal Court of Chicago. In other jurisdictions it has been held under similar facts that no prejudice resulted to the insured by a defense undertaken but withdrawn before trial by the insurer.

The complaint in the instant case does not allege prejudice, damage or injury by reason of the entry of an

appearance and defense in plaintiffs' behalf. Plaintiffs assert that prejudice may be inferred from a commitment to a defense, from the waiver of preliminary motions, and from the difficulty of investigation of a claim at a later date. None of the foregoing matters were pleaded, nor are they necessarily inferable from the mere entry of an appearance and defense alleged in the complaint. n18

The suggestion that there is no prejudice so long as the insurer relinquishes the defense before trial seems out of harmony with more recent cases. n19

Nonetheless, *King* still appears to be good law where there has been no substantial shaping of the defense, even though the period of insurer[8209]controlled representation is more than de minimis.

The point here is not that prejudice is difficult to show. Rather, the point is that if the insured cannot even make a showing that there has been some irreversible shaping of the defense, there is no good basis for an estoppel.

But irreversible shaping of the defense is not the only relevant point. Prejudice flows from an insured's surrender of the right to control the defense. If the insurer has a duty to defend, it usually has the right to control the defense. Insurers have more expertise than most insureds in managing litigation. They have stronger, more immediate incentives to manage litigation efficiently than would insureds who expect their insurers to pay defense counsel's bills. Thus, most liability insurance markets have settled on contract terms that provide for the insurer to manage the defense, and give it the "right and duty to defend."

This standard liability policy provision "gives the insurer the right to control the defense of the claim" and "the insured has no right to interfere with the insurer's control of the defense." n20 Where the insured has no personal exposure, that control "is virtually absolute." n21

But where there is a conflict of interest between insurer and insured regarding the way in which the case will be defended, the insured has a right to independent counsel. n22 A few states authorize the insured to reject the insurer's defense whenever there is a reservation of the right to deny indemnification. n23 If the insured has a right to independent counsel, the insured necessarily has the right to direct the defense, and usurpation of that right by the insurer can be prejudicial, if the defense is irreversibly shaped while the insurer is in control.

If the insurer had a duty to defend, and the coverage defense not raised was not one that would have entitled the insured to independent counsel, then the insured would not have had the right to control the defense without relinquishing both insurer funding for the defense and the possibility of indemnification (if a covered liability were found). Unless the insured could prove that timely notice of the coverage defense would have led to relinquishment of those rights, any delay in notice would not seem to be prejudicial. n24

Similar logic might apply if the coverage defense not raised initially (though not giving rise to any right to independent counsel) would have defeated any duty to defend. While the lack of a duty to defend would mean that the insurer had no right to defend and the insured, accordingly, had the right to control the defense, timely notice of that right would usually not have led the insured to reject an insurer-funded defense.

Of course, a deficient defense, if shown to have occurred, would be prejudicial. And the insured might contend that, had it been properly informed regarding the potential coverage defenses, that it would have hired personal counsel to monitor the litigation, assess the defense strategy being employed, and complain if it found the strategies being employed were inappropriate.

In *World Harvest Church*, if the insurer had a duty to defend and the Church had a right to independent counsel, insurer control of the defense until nearly the close of discovery would have been prejudicial, as the insured's defense options would have been greatly constrained. But there probably never was any right or duty to defend. While that would also mean that the insured was deprived of the right to make defense decisions, that fact alone would not show prejudice. If a showing of prejudice were required, the insured also would have been required to show either (1) that, if

the insurer's rights had been properly reserved, the insured would have foregone insurer funding for the defense in order to make those decisions or (2) that the insurer's defense was deficient.

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n1 *World Harvest Church, Inc. v. Guideone Mutual Insurance Co.*, 2010 Ga. LEXIS 365 (May 3, 2010).

n2 *Id.* at * 15.

n3 *Id.* at *10-11, quoting *Arceneaux v. Amstar Corp.*, 969 S2d 755, 767 (La. App. 2007). For present purposes, we accept the *Arceneaux* court's assessment of the state of the law, without vouching for that assessment.

n4 *Id.* at 12-15.

n5 *Id.* at quoting *Northwestern Nat. Ins. Co. v. R.S. Armstrong & Bros. Co.*, 627 F. Supp. 951, 956 (D.S.C. 1985).

n6 *Id.* at 16.

n7 *Id.* quoting *Safeco Ins. Co. v. Ellinghouse*, 223 Mont. 239, ___ [725 P2d 217, 221] (1986).

n8 Portions of this analysis are drawn from the forthcoming Jeffrey E. Thomas, *The New Appleman on Insurance Law*, § 16.03[3][c][v] (of which we are the chapter authors).

n9 *E.g., Md. Cas. Co. v. Peppers*, 64 Ill. 2d 187, 196 (1976).

n10 *Merchants' Indemn. Corp. v. Eggleston*, 37 N.J. 114, 127, 179 A.2d 505, 511 (1962).

n11 In other dicta on this subject, the *Eggleston* court noted that "most courts . . . find prejudice is inevitable when the insured is denied the right to maintain complete control of the defense Indeed some courts speak of a 'conclusive' presumption of prejudice, doubtless because, since the course cannot be rerun, they believe it futile to attempt to prove or disprove that the insured would have fared better on his own." 37 N.J. at 129. New Jersey has gone as far as these dicta suggest. But this type of statement appears quite common in addressing this issue.

n12 A detailed examination of Illinois cases (and some cases from other jurisdictions) on whether prejudice had or had not been shown may be found in William T. Barker, *Defense Without Reserving Rights: When May Insurer Deny Coverage*, 56 Def. Coun. J. 58, ____ (1989).

n13 See **AK**--*O'Neill Investigs. v. Illinois Empl'rs. Ins. Co.*, 636 P.2d 1170, 1178-79 (Alaska 1981) (no prejudice where insured did not relinquish control, even though insurer offered to reimburse portion of fees for his counsel);

GA--*Prescott's Altama Datsun, Inc. v. Monarch Ins. Co.*, 253 Ga. 317, 318 (1984) (no prejudice where two insurers both provided defenses and other insurer controlled defense until defendant insurer belatedly reserved its rights);

MN--*St. Paul School Dist. No. 625 v. Columbia Transit Corp.*, 321 N.W.2d 41, 46[#8209]47 (Minn. 1982) (no prejudice from disclaimer after three years of defense and when trial was imminent, because insured's own counsel worked with insurer's attorneys in preparing the action, although not actively engaged in defense; "We do not feel that Gulf's rather late reservation of rights prejudiced the ability of the [insured's] counsel to control the defense, had he so chosen, or to make or negotiate a settlement before . . . verdict");

NH--*Am. Ins. Co. v. Nationwide Ins. Co.*, 110 N.H. 192, 195[#8209]96 (1970) (where two insurers jointly undertook defense, no prejudice to insured or other insurer where one insurer later disclaimed; involvement throughout of counsel for remaining insurer required it to demonstrate some prejudice, which it could not do given the early stage at which the disclaimer occurred).

n14 *Md. Cas. Co. v. Peppers*, 64 Ill. 2d 187 (1976).

n15 64 Ill. 2d at 196.

n16 64 Ill. 2d at 196.

n17 *King v. Aetna Insurance Co.*, 31 Ill. App. 2d 462 (1961)

n18 *Id.* a 465[#8209]66 (citations omitted).

n19 This difference can easily be exaggerated. The *King* case was in the Municipal Court, whose jurisdictional limits would indicate that *King* was not a major case. In such cases, especially in 1961, there was likely to be much less in the way of discovery and other formal pretrial practice than is normal in larger cases today. Accordingly, it might well have been perceived that the norm for such cases would involve relatively little irrevocable shaping of the defense before actual commencement of trial. On this basis, *King* may be fully consistent with later cases, with differences in result explained by differences in how extensively the defense actually had been shaped or normally would have been shaped in a case of the particular size and type.

n20 **CA--***Safeco Ins. Co. v. Super. Ct.*, 71 Cal. App. 4th 782, 787 (Cal. Ct. App. 1999);

US/MS--*Davenport v. St. Paul Fire & Marine Ins. Co.*, 978 F.2d 927, 931-32 (5th Cir. 1992) (policy "invest[s] the insurer with the complete control and direction of the defense . . . to the exclusion of the insured") (collecting authorities);

TX--*Unauth. Prac. of Law Comm. v. Amer. Home Assur. Co.*, 261 S.W.3d 24,26 (Tex. 2008)("The right to defend in many policies gives the insurer complete, exclusive control of the defense").

n21 **US/MS--***Davenport*, 978 F.2d. at 932-33 (where policy covered two insureds, with possible cross-claims between them, insurer with full coverage for both could use common attorney to present a common defense); *see also*

CA--*State Farm Mut. Auto. Ins. Co. v. Federal Ins. Co.*, 72 Cal. App. 4th 1422, 1429 (1999) ("it is customary for the insurer to control the defense it provides"); *Spindle v. Chubb/Pacific Indem. Grp.*, 89 Cal. App. 3d 706, 714 (1979).

n22 *See* William T. Barker, *Insurer Control of the Defense: Reservations of Rights and the Right To Independent Counsel*, 71 Def. Coun. J. 16, 21-24 (2004).

n23 States apparently adhering to this rule include Idaho, Kentucky, Massachusetts, Missouri, New Jersey, North Carolina, South Dakota, and Texas.

ID--*Boise Motor Car Co. v. St. Paul Mercury Indem. Co.*, 62 Idaho 438, 448-49 (1941);

KY--*Med. Prot. Co. v. Davis*, 581 S.W.2d 25, 26 (Ky. Ct. App. 1979);

MA--*Three Sons, Inc. v. Phoenix Ins. Co.*, 357 Mass 271, 274-77 (1970);

MO--*State Farm Mut. Auto. Ins. Co. v. Ballmer*, 899 S.W.2d 523, 527 (Mo. 1995);

NJ--*Merchants Indem. Corp. v. Eggleston*, 37 N.J. 114, 127[#8209]28, 179 A.2d 505, 511[#8209]12 (1962);

NC--*National Mort. Corp. v. Am. Title Ins. Co.*, 41 N. C. App 613, 621-23 (1979), *rev'd on other grounds*, 299 N.C. 369 (1980);

SD--*Connolly v. Standard Cas. Co.*, 76 S. D. 95, 100-01 (1955) (dictum); *Kansas Bankers Surety Co. v. Lynass*, 920 F.2d 546, 548 (8th Cir. 1990) (relying on *Connolly* to find insurer guilty of bad faith for attempting to retain control of defense after reserving rights, even though insurer later affirmed coverage unconditionally and settled case);

TX--*Employers Cas. Co. v. Tilley*, 496 S.W.2d 552, 559 (Tex. 1973) (approving quotation from secondary authority obliquely addressing issue not presented in case itself); *YMCA v. Commercial Std. Ins. Co.*, 552 S.W.2d 497, 502[#8209]504 (Tex. Civ. App. Ft. Worth 1977), *writ refused no reversible error*, 563 S.W.2d 246 (Tex. 1978) (following *Tilley* dictum); *Ranger Ins. Co. v. Robertson*, 707 S.W.2d 135, 143 (Tex. Ct. App. Austin 1986).

AK--Alaska takes this position as to certain kinds of reservations. *Cont'l Ins. Co. v. Bayless & Roberts, Inc.*, 608 P.2d 281, 288 (Alaska 1980).

FL--Florida follows a slightly modified rule. Fla. Stat. § 627.426 (requiring that insurer and insured agree upon independent counsel if insurer reserves rights).

n24 See **CA**--*Ringler Associates, Inc. v. Maryland Cas. Co.*, 80 Cal. App. 4th 1165, 1190-91 (2000) (no estoppel, despite insurer's control of defense for two years, when neither insured nor its personal counsel objected to insurer's continued control for a year after the belated reservation and no other prejudice was shown);

MA--*Merrimack Mut. Fire Ins. Co. v. Nonaka*, 414 Mass. 187, 189-90 (1993) (no estoppel, even though insurer controlled defense until shortly before trial, where insured did not complain of any deficiency in handling of case);

Contra **LA**--*Steptore v. Masco Constr. Co.*, 643 So. 2d 1213 (La. 1994) (whenever insurer, with knowledge of facts indicating noncoverage, assumes or continues defense without obtaining a nonwaiver agreement, that coverage defense is barred).

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Reed Smith LLP on PENDERGEST-HOLT V. CERTAIN UNDERWRITERS' AT LLOYD'S OF LONDON

2010 Emerging Issues 5162

Reed Smith LLP on PENDERGEST-HOLT V. CERTAIN UNDERWRITERS' AT LLOYD'S OF LONDON

By John Berringer and Jill Averett

July 2, 2010

SUMMARY: On March 15, 2010, the Fifth Circuit affirmed the decision of the U.S. District Court for the Southern District of Texas at the preliminary injunction stage ordering Lloyd's of London underwriters to immediately commence the advancement of defense costs despite an exclusion which was arguably triggered by the misconduct of the policyholder's officers.

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ARTICLE: On March 15, 2010, the Fifth Circuit affirmed the decision of the U.S. District Court for the Southern District of Texas at the preliminary injunction stage ordering Lloyd's of London underwriters to immediately commence the advancement of defense costs despite an exclusion which was arguably triggered by the misconduct of the policyholder's officers.

The underlying actions involved an alleged Ponzi scheme orchestrated by R. Allen Stanford and the Stanford Financial Group. The \$100 million directors and officers liability policy covering Stanford contained an advancement of defense cost provision. The directors and officers liability policy also contained a money laundering exclusion barring coverage for loss when "it is determined" that such acts did "in fact" occur. A former CFO of the Sanford Financial Group pled guilty in one of the underlying actions to acts which Underwriters argued fell under the policy's broad definition of money laundering.

Based on that plea, Underwriters made the unilateral determination that the exclusion applied and stopped advancing defense costs. Ultimately, the U.S. District Court for the Southern District of Texas ruled that there is no reason to treat a duty to advance defense costs differently from a duty to defend and thus applied the "eight corners" rule. In doing so, the judge disregarded the extrinsic evidence -- the guilty plea -- relied on by Underwriters.

The Fifth Circuit chose not to rule for the policyholder on the basis of the "eight corners" rule. The Fifth Circuit did, however, reject Underwriters' argument that it could unilaterally void the D&O policy's coverage on the basis of the former CFO's guilty plea. The Fifth Circuit called the policy an "awkward instrument", finding the phrase "it is

determined" unclear as to who is to make such a determination under the contract.

"We interpret a "determination" in fact" "absent language unambiguously pointing to the underwriters as decision-makers' as requiring a judicial act," Judge Higginbotham held.

The three-judge panel ordered Underwriters' to continue paying Stanford's lawyers until a lower court can formally decide the coverage issue. Further, the Fifth Circuit held that if the defendants lose their coverage dispute, they will be required to pay back Underwriters certain defense costs advancement, the amount of which would also be determined by the judge on remand.

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Sonnenschein Nath & Rosenthal LLP on Jacobsen v. Allstate Insurance Co.:

2010 Emerging Issues 5163

Sonnenschein Nath & Rosenthal LLP on Jacobsen v. Allstate Insurance Co.: Third-Party Claimant Cannot Recover Attorneys Fees for Bad Faith Regarding Settlement

By Ronald Kent and William Barker

July 2, 2010

SUMMARY: In *Jacobsen v. Allstate Insurance Co.*, the Montana Supreme Court held that a third-party claimant cannot recover attorneys' fees for an insurer's bad faith conduct regarding settlement. In this commentary, the authors examine ways in which Montana law is unique and the reasons why it nonetheless reached the same result on this issue as other jurisdictions.

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ARTICLE: In *Jacobsen v. Allstate Insurance Co.*,ⁿ¹ the Montana Supreme Court held that a third-party claimant cannot recover attorneys' fees for an insurer's bad faith conduct regarding settlement. As we explain in § 2.06 of *Insurance Bad Faith Litigation* (2nd ed. 2010), most jurisdictions hold that a third-party claimant has no rights at all (beyond freedom from fraud and other forms of independently tortious conduct) regarding an insurer's handling of settlement negotiations. But Montana found an implied cause of action for third-party claimants under its version of the NAIC Model Unfair Trade Practices Act ("UTPA"), obliging the insurer to make reasonable efforts to settle claims where liability had become reasonably clear,ⁿ² and this cause of action was then supplanted by an express statutory cause of action.ⁿ³ Of course, mere allowance of a cause of action did not determine whether attorneys' fees would be recoverable.

One aspect of that question came before the court in *Sampson v. National Farmers Union Property & Casualty Insurance Co.*ⁿ⁴ The plaintiffs were injured by the insured and demanded \$125,000 to settle their claims. The insurer first refused, but ultimately agreed, but only after they had incurred \$43,500 in attorneys' fees, which they now sought to recover under the UTPA. The starting point of the court's analysis was the American Rule, under which each party must bear its own litigation expenses, absent a contractual or statutory provision allowing recovery.ⁿ⁵ While some common-law exceptions to this rule are recognized, plaintiffs did not seek to rely on any such exception, instead arguing that the statutory authorization to recover "damages" included attorneys' fees in circumstances like theirs.ⁿ⁶ In construing the statute, the court notedⁿ⁷ its decision in *Tynes v. Bankers Life Co.*,ⁿ⁸ where it had declined to permit recovery as damages of attorneys fees incurred to recover contractual benefits withheld in bad faith.ⁿ⁹ The statutory authorization to award damages for certain violations of the UTPA was enacted at the session just after *Tynes* was

decided and the legislature did not indicate any disagreement with *Tynes*. n10 Accordingly, the court concluded that the statute did not authorize recovery of attorneys' fees. n11

With the statutory route to fee recovery blocked, Jacobsen sought a common-law exception to the American Rule. He had been injured by an Allstate insured. While Jacobsen was unrepresented, an Allstate claim adjuster processed his claim in accord with Allstate's Core Claim Process Redesign and settled it for \$3500 plus 45 days of "open medical" (i.e., payment for necessary medical care during that period). A month later, Jacobsen experienced shoulder pain and asked to rescind the release. Allstate initially refused to agree, but later did so after Jacobsen retained counsel, settling the claim for roughly \$200,000. Jacobsen then sued for bad faith seeking, *inter alia*, recovery of his attorneys' fees, which a jury awarded. n12 The Montana Supreme Court reversed.

The court again began its analysis with the American Rule, also noting its holding in *Sampson*. n13 The district court had relied on two common-law exceptions to that rule: the "insurance exception" and the "equitable exception." n14 The supreme court found neither applicable.

The "equitable exception" could not apply because Jacobsen was a plaintiff:

"The equitable exception to the [American] rule is available in those unique factual situations in which a party is forced into a frivolous lawsuit and must incur attorney's fees to dismiss the claim." This exception has been narrowly construed, and its application is confined to situations in which the individual claiming fees has been forced into litigation through no fault of his own.... [A]n individual's position as the plaintiff in litigation will normally preclude application of the equitable exception to the American Rule.... In contrast to the situations in which we have applied the equitable exception, Jacobsen was not forced into litigation, notwithstanding that he felt compelled to file suit as a result of Allstate's bad faith. Ultimately, Jacobsen presents neither authority nor policy sufficiently compelling for this Court to depart from our practice of "narrowly construing" the equitable exception to the American Rule. n15

The "insurance exception" did not apply because Jacobsen had no contractual relationship with Allstate:

The insurance exception arises where an insurer breaches its duty to defend or indemnify the insured party, forcing the insured "to assume the burden of legal action to obtain the full benefit of the insurance contract" This exception is justified by the contractual relationship between the insurer and the insured, and the enhanced fiduciary obligation which arises therefrom. We refused to extend the insurance exception to third-party claimants, as it would undermine the fundamental precept of the exception and "drive a stake into the heart of the American Rule." Jacobsen argues that [this] holding ... is limited to contract theory--that it does not preclude attorney fees to a third party who proves tortious conduct by the insurer. However, our decision ... was based upon the lack of fiduciary duty running from an insurer to a third-party claimant. The same logic applies here: Allstate did not have a fiduciary duty to Jacobsen, because he was not a party to the insurance contract. The rationale underlying the insurance exception to the American Rule is the existence of a fiduciary duty, and no such duty exists here. n16

The court recognized that it was free to modify existing exceptions to the American Rule or create new ones, but it declined to do so here. "The American Rule is a foundation of our jurisprudence, and we must narrowly construe the exceptions lest they swallow the rule. Jacobsen's argument that attorney fees must be added to his recovery if the award is to truly make him whole is contrary to the generally applicable American Rule." n17

Other jurisdictions also typically deny recovery of attorneys' fees (absent contractual or statutory authorization) in cases involving bad faith regarding settlement of third-party claims, even when the claims are based on the insured's contractual and common-law good faith rights. n18

Montana frequently expands insurer liability, especially in bad faith cases. Insurers will surely be glad it has chosen not to do so on this issue.

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n1 *Jacobsen v. Allstate Insurance Co.*, 2009 MT 248.

n2 *Klaudt v. Flink*, 202 Mont. 247 (1983), discussed in *Insurance Bad Faith Litigation*, § 10.04[2][g][i].

n3 Mont. Code § 33-18-201.

n4 *Sampson v. Nat'l Farmers Union Prop. & Cas. Ins. Co.*, 2006 MT 241.

n5 *Id.* 15.

n6 *Id.*

n7 *Id.* 18-19.

n8 *Tynes v. Bankers Life Co.*, 224 Mont. 399 (1986).

n9 The court thereby disagreed with *Brandt v. Superior Court (Standard Ins. Co.)*, 37 Cal. 3d 813, 817 (1985), which had allowed such fees. Brandt is discussed in *Insurance Bad Faith Litigation*, § 9.05[2].

n10 *Sampson*, 2006 MT 241, 20.

n11 Id. 22.

n12 *Jacobsen*, 2009 MT 248, 2-6.

n13 Id. 18.

n14 Id. 20 (citations omitted).

n15 Id. 21 (citations omitted).

n16 Id. 22.

n17 Id. 23.

n18 *Insurance Bad Faith Litigation*, § 9.05[1].

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Sonnenschein Nath & Rosenthal, LLP on Shin Crest PTE, Ltd. v. AIU Ins. Co.

2010 Emerging Issues 5164

Sonnenschein Nath & Rosenthal, LLP on Shin Crest PTE, Ltd. v. AIU Ins. Co.: Duty To Settle When There Are Multiple Insureds

By Ronald Kent

July 2, 2010

SUMMARY: Shin Crest PTE Ltd. v. AIU Insurance Co. is an unreported decision, but it relies on the reported case of *Contreras v. U.S. Security Insurance Co.* to resolve: what is an insurer's duty when it has two insureds for the same claim and the plaintiff demands the policy limit to settle claims against only one insured?

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ARTICLE: *Shin Crest PTE Ltd. v. AIU Insurance Co.* n1 is an unreported decision, but it relies on the reported case of *Contreras v. U.S. Security Insurance Co.* n2 to resolve a question on which there are only a few cases and a division of authority: what is an insurer's duty when it has two insureds for the same claim and the plaintiff demands the policy limit to settle claims against only one insured? The court holds that the insurer is free, after trying unsuccessfully to get a release for both insureds to settle on behalf of the one insured for whom a settlement is offered, even if the effect is to leave the other insured exposed to liability. This commentary explores the divided authority on that issue.

I. The Case

Doreen Blair was severely injured in a fall from a dock, where she had been sitting on a folding chair manufactured by Shin Crest and sold by Sam's Club. She and her husband sued Sam's Club, alleging that the chair was defective and caused the fall. AIU insured Shin Crest and Sam's Club was an additional insured on the policy. While there was a strong defense that there was no defect and that the injury caused by Blair putting the leg of the chair too close to the edge of the dock, Blair's injuries were so severe that AIU put a settlement value of \$1 million or more on the case. The Blairs' declared strategy was to get as much as they could from Sam's Club and then to sue Shin Crest. Eventually, the Blairs demanded the \$1.8 million remaining policy limits (after erosion by defense costs) to settle the claim against Sam's Club only. After the Blairs refused to release both insureds, AIU paid the remaining limit on behalf of Sam's Club (in part due to fear of excess judgment liability to Sam's Club had it not settled). n3

The Blairs then sued Shin Crest. AIU refused to defend because its limits were exhausted. Shin Crest refused a demand for \$2 million to settle; it eventually agreed to a \$12 million stipulated judgment, not collectible so long as Shin

Crest sued AIU and shared any proceeds with the Blairs. Shin Crest then brought this suit. n4 The district court granted summary judgment for AIU and the Eleventh Circuit affirmed, relying on *Contreras*. "Because the Blairs were unwilling to settle with Shin Crest, " AIU fulfilled its duty to Shin Crest by trying, though unsuccessfully, to obtain a release for it from liability." n5

II. Analysis n6

There is a division of authority on the duties of an insurer with multiple insureds when faced with a limits demand to settle with only one insured. A few courts have held that settling for less than all insureds improperly prefers those benefiting from the settlements (or at least permits the reasonableness of the preference to be examined). n7 But the majority of courts disagree. n8

In *Shin Crest*, the governing law was that of Florida, so the federal courts looked to *Contreras v. U.S. Security Insurance Co.* n9 There, Osterman had been hit and killed by a car owned by Dessanti and driven (with Dessanti's permission) by Dale. Dale had been driving at a high speed and was charged with DUI. The policy covering the car had limits of \$10,000 per person injured and \$20,000 for all persons injured in the same accident. Contreras, the administrator of Osterman's estate demanded the limit to settle with Dessanti, while refusing to settle with Dale. U.S. Security offered the limits, but only for a global settlement, stating that it did not believe it properly could settle on behalf of only one insured. The case went to a \$1 million verdict for compensatory damages against both Dessanti and Dale and a punitive damage verdict against Dale of \$110,000 (remitted to \$5000). Dessanti filed for bankruptcy and her trustee assigned the estate's claims to Contreras. n10

In the bad faith action, U.S. Security argued that its duty to Dale had precluded it from settling on behalf of Dessanti alone. The court of appeals disagreed:

Having attempted to secure a release for Dale without success, U.S. Security fulfilled its obligation of good faith towards Dale. Once it became clear that Contreras was unwilling to settle with Dale and give him a complete release, U.S. Security had no further opportunity to give fair consideration to a reasonable settlement offer for Dale. Since U.S. Security could not force Contreras to settle and release Dale, it did all it could do to avoid excess exposure to Dale.

Having fulfilled its obligation to Dale, U.S. Security thereafter was obligated to take the necessary steps before Contreras's offer expired to protect Dessanti from what was certain to be a judgment far in excess of her policy limits. n11

Cases elsewhere addressing settlements on behalf of less than all insureds hold that such a settlement does terminate the duty to defend the remaining insureds. n12 Under Texas law, it is clear that an insurer need only consider the reasonableness of a proposed settlement in light of the liabilities that will be eliminated, without regard to the interests of other insureds. n13 Otherwise, it is thought that an insurer faced with an offer on behalf of less than all insureds will face a bad faith suit whether it agrees or refuses. n14 Courts elsewhere have also found this consideration persuasive, given the credit to the remaining insured(s) for the settlement payment. n15 Moreover, they have reasoned that any inequality stems not from a preference by the insurer of one insured, but from the differing settlement posture of the claimant with respect to the different insureds. n16 Finally, they have questioned the source of any duty to provide equal protection to different insureds. n17

The latter cases are better reasoned. The typical reason why a claimant refuses to settle with all insureds is that one or more of them have insurance other than the policy whose limits are being offered or substantial noninsurance assets that could be reached to collect any judgment against them. If the expected verdict value of a claim substantially exceeds the offered policy limits, the claimant ordinarily will not release an insured with additional capability of satisfying such a judgment. An insured with that extra capability cannot reasonably expect to be released from such a claim without a contribution reflecting that extra capability. Asking an insurer to expose other insureds to an excess judgment to enhance the bargaining power of an insured able but unwilling to contribute to a higher settlement would

unfairly treat the insureds so exposed.

The cases just discussed have assumed that the insured left exposed will at least get credit for the settlement amount. That assumption would not apply if the liability of the insureds is not joint and several but, at least in part, several and proportional to their individual fault. In such a case, it has been held to be bad faith to expend the entire policy limit to settle on behalf of one insured. n18 While this holding relies on a duty not to prefer one insured to another, such a duty is more defensible in this context than with joint and several liability. Moreover, it is commonly the case that one of the insureds is only vicariously liable for the fault of the other, removing any questions about comparative fault. n19

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n1 *Shin Crest PTE Ltd. v. AIU Ins. Co.*, 2010 U.S. App. LEXIS 3460 (11th Cir. Feb. 19, 2010), *aff?g*, 605 F. Supp. 2d 1234 (M.D. Fla. 2009). The facts are more extensively described in the district court's opinion.

n2 *Contreras v. U.S. Security Insurance Co.*, 927 So. 2d 16 (Fla. Ct. App. 2006).

n3 605 F. Supp. 2d at 1235-39.

n4 605 F. Supp. 2d at 1239.

n5 2010 U.S. App. LEXIS 3460, at *4-5.

n6 Portions of this commentary are drawn from William T. Barker & Ronald D. Kent, *New Appleman Insurance Bad Faith Litigation*, Second Edition, § 2.09[b].

n7 *US/CA--Lehto v. Allstate Ins Co.*, 31 Cal. App. 4th 60, 73 (1994) (refusal to settle for one insured not bad faith because it would have breached duty to other insured); *Strauss v. Farmers Ins. Exch.*, 26 Cal. App. 4th 1017, 1021 (1994) (same); *but see Hartford Cas. Ins. Co. v. Mid-Century Ins. Co.*, 26 Cal. App. 4th 1783, 1787 (1994) (payment of applicable limit on behalf of named insured discharged any further duty to defend or indemnify permissive user and his employer); *Nationwide Ins. Co. v. Hunley*, 915 F.2d 557, 559 (9th Cir. 1990) (insurer that exhausted limits on behalf of named insured owed no further duty to defend or indemnify

permissive user, who would get credit for the payment) (overruled in part by *Haynes v. Farmers Ins. Exch.*, 32 Cal. 4th 1198 (2004));

NY--*Smoral v. Hanover Ins. Co.*, 37 A.D.2d 23, 25 (1971) (settlement on behalf of two insureds breached duty to a third).

Schwartz v. State Farm Fire & Cas. Co., 88 Cal. App. 4th 1329 (2001), is often cited in support of an obligation to treat insureds equally, but the case involves uninsured motorist benefits, governed by first-party bad faith principles not applicable here. (See §§ 5.03, 6.02)

n8 *E.g.*, *Anglo-Am. Ins. Co. v. Molin*, 670 A.2d 194, 198 (Pa. Commw. Ct. 1995).

n9 *Contreras v. U.S. Security Insurance Co.*, 927 So. 2d 16 (Fla. Ct. App. 2006).

n10 927 So. 2d at 17-19.

n11 927 So. 2d at 21.

n12 **CA**--*Hartford Cas. Ins. Co.*, 26 Cal. App. 4th at 1787; *Nationwide Ins. Co. v. Hunley*, 915 F.2d at 559;

FL--*Underwriters Guarantee Ins. Co. v. Nationwide Mut. Fire Ins. Co.*, 578 So. 2d 34, 35-36 (Fla. Dist. Ct. App. 1991);

IL--*Country Mut. Ins. Co. v. Anderson*, 257 Ill. App. 3d 73, 80 (1993); see *Pekin Ins. Co. v. Home Ins. Co.*, 134 Ill. App. 3d 31, 34-35 (1985) (while exhaustion of policy limit did not terminate duty to defend, remaining insured not entitled to independent counsel);

MO--*Millers Mut. Ins. Ass'n v. Shell Oil Co.*, 959 S.W.2d 864, 869-70 (1997);

TX--*Am. States Ins. Co. v. Arnold*, 930 S.W.2d 196, 202-03 (Tex. App. 1996);

n13 *Travelers Indem. Co. v. Citgo Petroleum Corp.*, 166 F.3d 761, 764-768 (5th Cir. 1999).

n14 166 F.3d at 764, 767.

n15 **US/PA**--*In re Rite Aid Corp. Secs. Litig.*, 146 F. Supp. 2d 706, 717-18 (E.D. Pa. 2001) (settlement under directors & officers policy could exclude chief officers);

IL--*Anderson*, 257 Ill. App. 3d at 80;

MO--*Millers Mut.*, 959 S.W.2d at 870.

n16 *Nationwide Ins. Co. v. Hunley*, 915 F.2d 557, 559 (1990) (CA law).

n17 *Homsy v. Floyd (In re Vitek)*, 51 F.3d 530, 536 (5th Cir. 1995) (TX law). *Vitek* was ultimately decided based on bankruptcy law grounds, without actually resolving the insurance law question. 51 F.3d at 538. But the Fifth Circuit has relied on the insurance law analysis in *Vitek. Travelers Indem. Co. v. Citgo Petroleum Corp.*, 166 F.3d at 766.

n18 *Shell Oil Co. v. Nat'l Union Fire Ins. Co.*, 44 Cal. App. 4th 1633, 1644-47 (1996).

n19 605 F. Supp. 2d at 1239.

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Sonnenschein Nath & Rosenthal LLP on Fortner v. Grange Mutual Insurance Co

2010 Emerging Issues 5165

Sonnenschein Nath & Rosenthal LLP on Fortner v. Grange Mutual Insurance Co.: Georgia Supreme Court Defines "Safe Harbor" of Insurers Faced with Settlement Demands Conditional on Acceptance by Other Insurers

By William Barker and Ronald Kent

July 2, 2010

SUMMARY: Where an insured is covered by multiple policies, plaintiffs sometimes make settlement demands that can only be accepted if multiple insurers agree. The Georgia Supreme Court has allowed an insurer wishing to accept such an offer to create a "safe harbor" for itself, leaving the other insurer(s) to make their own decisions. In *Fortner v. Grange Mutual Insurance Co.*, the court limited availability of that "safe harbor."

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ARTICLE: Where an insured is covered by multiple policies, plaintiffs sometimes make settlement demands that can only be accepted if multiple insurers agree. The Georgia Supreme Court has allowed an insurer wishing to accept such an offer to create a "safe harbor" for itself, leaving the other insurer(s) to make their own decisions. In *Fortner v. Grange Mutual Insurance Co.*,ⁿ¹ the court limited availability of that "safe harbor." This commentary reviews those decisions and offers suggestions for how the law ought to treat such offers, drawing on material from Section 2.03[6][d] of our book, *Insurance Bad Faith Litigation* (2nd ed. 2010).

I. *Fortner v. Grange Mutual Insurance Co.*

Fortner was injured in an auto accident with Arnsdorff. Arnsdorff had a Grange personal auto policy with a limit of \$50,000 and his plumbing business had an Auto Owners policy with a \$1 million limit. Fortner offered to settle all claims for \$50,000 from Grange "contingent upon" Auto Owners paying \$750,000. Grange offered \$50,000, contingent upon Fortner giving Arnsdorff a full release with indemnification language. Fortner regarded this as a rejection and went to trial, winning a \$7 million verdict. He obtained an assignment of rights from Arnsdorff and sued Grange. (There is no indication of how Auto Owners responded to the demand nor of whether there was any bad faith claim against it.) The jury rendered a verdict for Grange, Fortner appealed, and the Georgia Supreme Court found instructional error, requiring a new trial. ⁿ²

The challenged instruction, based on *Cotton States Insurance Co. v. Brightman*,ⁿ³ stated that:

In responding to a settlement demand, which demand is conditional upon the response of another insurance company, an insurance company can offer its policy limits in response to the demand and then let the plaintiff negotiate with the remaining insurers. In that situation, the insurance company would have given equal consideration to its insured's financial interest and fulfilled its duty to him. And you would return your verdict in favor of the defendant. n4

In *Brightman*, Brightman was seriously injured in a collision between his car and a van owned by Martin and driven by Cumbo. Before suing, Brightman's counsel informed Cotton States that Brightman had suffered traumatic brain injury, provided medical bills of \$329,457.20, and offered to settle for \$300,000, the limit of Martin's policy with Cotton States. Cotton States declined, based on evidence that Brightman was at fault. In litigation, it was discovered that Cumbo had a \$100,000 policy with State Farm. A nonbinding arbitration found for Brightman and awarded \$2 million. Brightman then offered Cotton States a chance, with a ten-day limit, to settle for its \$300,000 limit, contingent upon State Farm offering its limit. Neither tendered its limit within the ten days, and State Farm continued to deny coverage. About a month after the settlement demand expired, Cotton States offered its limit in exchange for a general release. Brightman went to trial and recovered a verdict of nearly \$1.8 million. n5

After both insurers paid their limits, there remained an excess judgment of \$1,387,500. Martin assigned her rights to Brightman, who sued Cotton States. Brightman recovered a bad faith verdict of more than \$2.1 million against Cotton States, and the Georgia Supreme Court affirmed. It held that "an insurance company in a case involving multiple insurers may be liable to its insured on a bad faith claim when it fails to tender its policy limits in response to a settlement offer solely because the offer also seeks the policy limits from other insurers." n6 It reasoned that Cotton States could have tendered its limits, subject to action by State Farm on the portion of the demand addressed to it. Had Cotton States done this, "it would have done everything within its control to accept the plaintiff's offer and thus protect its policyholder from an excess verdict. In that situation, the insurance company would have given equal consideration to its insured's financial interests and fulfilled its duty to her." n7 Because Cotton States had not done this, there was a jury issue on bad faith, and the evidence was sufficient to support the verdict. n8

The *Brightman* court further explained that it disagreed with language in the court of appeals opinion stating that an insurer had an affirmative duty to engage in settlement negotiations when the insured faced excess liability and declined to impose an obligation to make a counteroffer whenever an insurer received an offer containing conditions beyond its control. n9 However, it concluded that

an insurance company faced with a demand involving multiple insurers can create a safe harbor from liability for an insured's bad faith claim -- by meeting the portion of the demand over which it has control, thus doing what it can to effectuate the settlement of the claims against its insured. This rule is intended to protect the financial interests of policyholders in cases where continued litigation would expose them to a judgment exceeding their policy limits while protecting insurers from bad faith claims when there are conditions involved in the settlement demand over which they have no control. n10

Applying *Brightman*, the *Fortner* court held that Grange had not brought itself within that safe harbor, because it had imposed conditions of its own, requiring a release that would have the effect of precluding Fortner from pursuing Auto Owners. Because Grange had a choice whether to impose these conditions, there was a jury question whether doing so was reasonable, a question which the challenged instruction prevented the jury from considering. n11 Accordingly, a new trial was required. n12

II. Analysis

The result in *Brightman* seems clearly correct. The general rule is that an excess insurer ordinarily has no duty to defend or settle unless and until the primary coverage is exhausted. n13 It seems clear that (putting aside whatever coverage defense it claimed) State Farm's coverage was excess. As such, State Farm had no obligation to respond to a settlement demand until Cotton States tendered its limit. And nothing about the demand called for Cotton States to pay anything unless State Farm also agreed.

Arguably, one might reach a similar conclusion in *Fortner*, without regard to the additional condition imposed by Grange. Neither insurer responded within the time limit imposed by Fortner. Because Fortner had no obligation to entertain further offers, allowing that time limit to expire potentially exposed Arnsdorff to excess liability, n14 and Grange's failure to tender its own limits seemingly obviated any duty of Auto Owners to respond.

The analysis becomes more complex if one assumes that Fortner had reopened negotiations or that Grange had made its counteroffer before expiration of the demand. The demand was contingent on acceptance by both insurers. Had both accepted, it would have been entirely proper to demand a release. And once Grange tendered its limits, any failure to settle would have resulted, not from Grange's condition, but from failure of Auto Owners to also accept. So Grange arguably would not have been the cause of the failure to settle and ought not to be liable.

But there is another consideration that the *Fortner* court does not mention. Georgia has a statute that permits a limited liability release, which releases a settling insurer and also releases the insured tortfeasor *except to the extent of any other applicable insurance coverage*. n15 Had Grange offered its limits in return for such a release, that would have satisfied the purposes of the *Brightman* "safe harbor," and should have protected Grange. In the absence of a general duty to make offers or counteroffers, it might still be open to a jury to conclude that failure to make this kind of offer constituted bad faith, even if it were clear that Auto Owners would not have agreed to settle.

In sum,

Where multiple insurance policies do or may cover the same injuries, a claimant may make a demand requiring acceptance by two or more insurers. Even if one of the insurers refuses the demand, that may not excuse the other insurer from responding: unless the jurisdiction insists strictly on a demand that could have been accepted, there may be a question of fact whether an offer by one insurer might have led to a settlement. If the response by the other insurer is not yet known, the insurer could still accept conditional on joinder of the other insurer; whether such an acceptance would have produced a settlement could be a question of fact. Insofar as the issue is whether another necessary party would agree to the settlement, it has been held that an offer is not impermissibly conditional unless it requires the insurer to make payment without first receiving assurance that the payment will result in full settlement.

If a settlement would require court approval, any acceptance may be conditioned on getting that approval; if the settlement is rejected, there will be a question of fact whether approval would have been granted had the settlement been accepted. n16

A wise primary insurer, faced with a demand calling for participation by an excess insurer or co-insurer should decide on tendering its limits without regard to what the other insurer may do. The tender, if made, should be conditional on either the other insurer's participation in a full settlement or on some form of settlement that protects the insured, without cutting off the claim against the other insurer.

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n1 *Fortner v. Grange Mutual Insurance Co.*, 286 Ga. 189 (2009).

n2 *Id.* at 189-90.

n3 *Cotton States Insurance Co. v. Brightman*, 276 Ga. 683 (2003).

n4 *Fortner*, 286 Ga. at 189.

n5 *Brightman*, 276 Ga. at 683-84.

n6 *Id.* at 683.

n7 *Id.* at 686.

n8 *Id.* at 686-87.

n9 *Id.* at 687 n.2. Jurisdictions are divided on this issue. *Insurance Bad Faith Litigation*, § 2.03[6][d][ii].

n10 *Brightman*, 276 Ga. at 687 n.2.

n11 *Fortner*, 286 Ga. at 191.

n12 *Id.*

n13 *Insurance Bad Faith Litigation*, § 2.08[3].

n14 *Id.* § 2.03[6][d][iv].

n15 Off. Code Ga. § 33-24-41.1.

n16 nsurance Bad Faith Litigation, § 2.03[6][d][vi] (footnotes omitted).

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Sonnenschein Nath & Rosenthal, LLP on Captain v. United Ohio Insurance Co

2010 Emerging Issues 5156

Sonnenschein Nath & Rosenthal, LLP on Captain v. United Ohio Insurance Co.: When Limits Were Inadequate, Interpleading Multiple Claimants Not Bad Faith

By William Barker and Ronald Kent

July 2, 2010

SUMMARY: This commentary discusses the case *Captain v. United Ohio Ins. Co.*, in the context of the law outside of Ohio. United Ohio nonetheless got summary judgment on bad faith. In the case, the insured was clearly at fault in an accident that killed two people and seriously injured two others. The policy limits were \$12,500 per person and \$25,000 per accident. United Ohio defended the insured, resulting in judgments of \$1,200,000 and \$1,000,000.

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ARTICLE: In *Captain v. United Ohio Insurance Co.*, n1 the insured was clearly at fault in an accident that killed two people and seriously injured two others. The policy limits were \$12,500 per person and \$25,000 per accident. United Ohio interpleaded the limits, which were distributed to the claimants, and then defended the insured when two of them pursued tort claims, resulting in judgments of \$1,200,000 and \$1,000,000. United Ohio nonetheless got summary judgment on bad faith. This commentary discusses the case, in the context of the law outside of Ohio.

I. The Case

United Ohio insured Willey, whose car crossed the center line and hit an oncoming car, killing two of Willey's passengers (Everhart and Waddell) and seriously injuring a third passenger (Captain) and the driver of the other car (Harp). United Ohio's adjuster quickly determined that Willey was solely at fault and that the damages far exceeded his \$12,500/25,000 limits. He concluded that they were unlikely to accept offers from him and would be more amenable to a judicial division of the policy limits. Because Willey had few, if any assets, the adjuster thought further litigation unlikely. So he interpleaded the \$25,000 limit and obtained a declaratory judgment that this terminated the duty to defend (pursuant to policy language so providing). The claimants agreed on division of the \$25,000, but Captain and the Everhart estate cross-claimed against Willey and took their tort claims to trial, which United Ohio defended, recovering judgments of \$1,200,000 and \$1,000,000. Willey assigned his rights against United Ohio to them, and they sued for bad faith. A summary judgment for United Ohio was affirmed. n2

The trial court's reasoning was unclear, and the court of appeals assumed that it may have concluded that an

interpleader was per se good faith. That would have been error, as the court concluded that "the appropriate inquiry is whether United Ohio lacked a reasonable justification for its actions (or inaction) in handling the claim against Willey." n3 But any error was harmless, because plaintiffs had failed to create an issue of material fact as to bad faith. n4

They contended that Captain and Hart (who both had underinsured coverage) might have settled for \$1000 each, leaving more for the other claimants and enabling United Ohio to obtain releases from all claimants. But they could not have done that without the consent of the UIM insurers, who had no reason to agree. So it was not unreasonable of United Ohio to refrain from trying to orchestrate such a settlement. n5

Plaintiffs also contended that United Ohio could have obtained a global settlement, with releases, without filing the interpleader. Even if that were true, it would "only reinforce[] the reasonableness of United Ohio's decision." n6 If the claimants would have been willing to accept a voluntary equitable division of the \$25,000 without further litigation, then it was reasonable for United Ohio to think they would be equally willing to accept an equitable division by the interpleader court. n7

II. Analysis n8

Captain deals with a perennial and difficult problem regarding the duty to settle. Multiple claimants with serious claim can cause special problems regarding that duty. n9 Liability insurance policies commonly have both "per person" or "per claim" limits, as well as (usually larger) "per occurrence" and, sometimes, "aggregate" limits. If there are several claims or injured persons, there is no special problem if any "per occurrence" or "aggregate" limits are large enough to cover a "per person" or "per claim" limit for each person or claim. In that event, settlement of one claim does not affect any other. But, if there is no "per person" limit or if the "per occurrence" or "aggregate" limits are not large enough, the settlement of one claim may reduce the funds available to pay others. So, if the policy limits are \$25,000 per person and \$50,000 per occurrence, and five people are injured, three seriously, the insurer might settle the two most serious claims for \$25,000 each, leaving nothing for the others. n10 Or, the insurer might refuse their policy-limits demands in an attempt to equitably resolve all of the claims, possibly exposing the insured to an excess judgment if the spurned claimants choose to take their claims to judgment. Inevitably, someone is going to be unhappy with the result and may sue the insurer for bad faith. n11

In asking whether United Ohio lacked a reasonable justification for its actions, the *Captain* court employed a standard normally used in first-party bad faith cases, where the insurer has delayed or denied payment of benefits to an insured for the insured's own losses. n12 Different standards are normally used where the insurer is alleged to have failed to act properly to protect its insured against an excess judgment. n13 But the latter standards are designed to assess the propriety of a decision not to offer the policy limit (or some lesser amount) in satisfaction of the claim. They are not really appropriate where, as in *Captain*, the insurer is offering the policy limit but faces an obstacle to obtaining full releases in return.

A. Most Courts Give an Insurer Wide Discretion in Handling Multiple Claims with Insufficient Limits

In fact, courts outside Ohio have not applied the usual duty-to-settle standards in multiple claimant cases. The cases are essentially unanimous in holding that an insurer owes no duty to claimants to refrain from depleting the policy limits by disproportionate settlements with other claimants. n14 Any such duty would be inconsistent with the insurer's duties to its insured. n15 Nor can a claimant who has not obtained a judgment obtain an injunction against disproportionate settlements with other claimants. n16

Most courts hold that an insurer acts consistently with its duty to its insured by making reasonable settlements with some claimants, even if that depletes the limits available for other claims. n17 In particular, insurers are generally permitted to make reasonable settlements on a "first come, first served" basis. n18 This is especially true where claimants have deliberately chosen to pursue claims piecemeal. n19 Courts are reluctant to delay settlement with some claimants based on the possibility that other claimants or potential claimants might be adversely affected by depletion of

the policy limits. n20 Nor are they prepared to require insurers to refuse reasonable demands, at the risk that refusal might later be found to be bad faith. n21 Of course, an insurer cannot hastily make excessive settlements that deplete its limits in order to relieve itself of the responsibility of further protecting its insured. n22

Texas expressly holds that the reasonableness of any settlement is to be judged solely on the merits of the particular claim, without regard to its relation to other claims. n23 That appears to be the standard applied in other states, but the cases elsewhere have not articulated the standard for judging reasonableness.

These cases are not exactly apposite in a situation like *Captain*, where the insurer has not obtained any releases. But they are somewhat supportive of an analysis that shields the insurer if it had a reasonable justification for its action.

Under the foregoing standards, it is typically not difficult for insurers to handle multiple claims without incurring bad faith liability. But some courts impose more demanding obligations. The leading case of this sort is *Liberty Mutual Insurance Co. v. Davis*. n24 The policyholder, an itinerant fruit-picker, had injured two couples. The more seriously injured couple demanded the full \$20,000 per-accident limit, but the insurer sought to achieve full resolution of all claims. It refused to leave the policyholder subject to the substantial, though smaller claims of the other couple. Each couple then obtained a judgment in excess of the limit, and the insurer was sued for breach of the duty to settle. The insurer unsuccessfully sought a directed verdict on the ground that it acted properly in seeking a full release by all claimants, and the Fifth Circuit affirmed the resulting verdict against the insurer.

The court recognized that, in a multiple claimant situation, the usual conflict of interest between insurer and policyholder over settlement is not present: "rejection of a single offer to compromise within policy limits does not necessarily conflict with the interest of the insured." n25 Nonetheless it reasoned that the insured would want "the insurance fund used to compromise as much of his potential liability as possible." n26 While settlement of all claims would be ideal, court thought that the insured would be best served, if no such settlement could be achieved, by having "the leverage of his insurance money applied to at least some of the claims, to the end of reducing his ultimate judgment debt." n27 On this analysis, an insurer could be liable for unreasonably failing to effectuate the most favorable possible partial settlement.

But that analysis is fatally flawed. It fails to consider the true interests of a judgment-proof policyholder, like the itinerant fruit-picker in *Davis*. Such a policyholder has no reason to care about the amount of the ultimate judgment debt, so long as it is significantly more than the policy limits. Any significant excess judgment will leave no alternative but bankruptcy, and bankruptcy will wipe out a large judgment just as easily as a small one. (Bankruptcy is not available to wipe out certain nondischargeable debts, notably those for injuries from drunken driving; n28 so this analysis does not apply to those debts.) The only benefit which such a policyholder can hope for is not to have to file for bankruptcy at all, and that benefit can only be obtained if the insurer successfully holds out for a full release from all injured parties. Accordingly, an insurer should at least be free to insist on that when the insured is judgment proof. Allowing that has the further benefit of encouraging an equitable division of the limited funds among the claimants, rather than expending the policy limit on the most serious claims and leaving the others completely uncompensated.

The *Davis* rule is also unfair to insurers in cases where there are many serious claims. n29 The claimants have every incentive to jockey with one another and with the insurer to maximize their recovery, ideally by obtaining a bad faith verdict that will remove the policy limits. An insurer that has no conflict of interest and is simply trying to protect its insured and distribute the meager policy limits fairly ought not to be placed at the mercy of a jury's later decision (aided by self-serving testimony from the claimants) that it could have eliminated more liability by a different settlement strategy. If one seeks to analogize such an insurer to a fiduciary, the appropriate analogy is to a corporate officer or director, trying to outmaneuver other businesses in a competitive market. The latter are not subjected to jury hindsight second-guessing of their business decisions, but are shielded from liability so long as were within the range of reasonable business judgment. n30

These reasons for rejecting a requirement to minimize potential excess judgments add further support to *Captain's*

adoption of a rule that shields the insurer if it had a reasonable justification for its action.

When insurers are unable to negotiate a global settlement, they frequently resort to interpleader actions to allocate the available funds. n31 Indeed, some courts suggest that an insurer should attempt a global settlement and, if unsuccessful, seek judicial assistance by proceedings in the nature of interpleader. n32 There certainly are situations where interpleader could be useful in achieving a global settlement. n33 But, ultimately, interpleader cannot force a settlement where the claimants are unwilling. An interpleader can only enjoin other actions with respect to the fund interpleaded; it cannot enjoin pursuit of other sources of payment, such as the insured. n34

That limitation on interpleader is the source of the problem in *Captain*. But an insurer faced with such a situation would be better advised to offer the claimants a global settlement, if they can agree on a division of the policy limits, rather than immediately interpleading. By doing that, the insurer avoids any later question (like that raised in *Captain*) whether such an offer would have achieved a settlement. If the claimants are unwilling or unable to agree on a settlement, the insurer can then consider whether to interplead or to simply hold out for a global settlement and defend until that is achieved or a judgment is entered.

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n1 *Captain v. United Ohio Ins. Co.*, 2010 Ohio 2691 (Ct. App.).

n2 2010 Ohio 2691, 4-17.

n3 2010 Ohio 2691, 24-32.

n4 2010 Ohio 2691, 33.

n5 2010 Ohio 2691, 35-39.

n6 2010 Ohio 2691, 42.

n7 2010 Ohio 2691, 42.

n8 Some of this analysis is drawn from William T. Barker & Ronald D. Kent, *New Appleman Insurance Bad Faith Litigation*, Second Edition, § 2.03[9][a].

n9 See discussion in William T. Barker, H. Robert Powell, & Michael S. Truesdale, *Too Many Claimants, Too Little Money: The Missed Opportunity of Trinity Universal Insurance Co. v. Bleeker*, 14 *Bad Faith L. Rep.* 123 (1998).

n10 *But see* N.Y. Veh. & Traffic L. § 370(1) (providing for pro rata apportionment among judgment creditors of policy proceeds with respect to vehicles transporting passengers for hire).

n11 Other examples of the complex problems presented by multiple claims are discussed in Robert E. Keeton, *Preferential Settlement of Liability Insurance Claims*, 70 *Harv. L. Rev.* 27, 29-36 (1956).

n12 See William T. Barker & Ronald D. Kent, § 5.03[1]--[2].

n13 See William T. Barker & Ronald D. Kent, § 2.03[2].

n14 *E.g.*, *Gen. Accident Group v. Gagliardi*, 593 *F. Supp.* 1080, 1088 (D. Conn. 1984), *aff'd mem.* 767 *F.2d* 907 (2nd Cir. 1985) (no duty even after insurer filed interpleader action); *Miller v. Ga. Interlocal Risk Mgmt. Agency*, 232 *Ga. App.* 231, 231 (1998) (no duty even to notify re possible depletion of limits); *Bennett v. Conrady*, 180 *Kan.* 485, 491-92 (1957); *but see* *Haas v. Mid-Am. Fire & Marine Ins. Co.*, 35 *Ill. App. 3d* 993, 996 (1976) (there might be circumstances, not present in this case, that would create a duty to notify claimants before settling with others);

Obad v. Allstate Ins. Co., 27 *A.D.2d* 795, 795-96 (1967) (under a policy certified pursuant to statute to establish insured's financial responsibility, a claimant might be able to allege facts whereby pressuring a claimant to reduce its demand by making a threat to deplete the limit by settlement with another claimant could breach a duty to claimant).

n15 *Holtzclaw v. Falco*, 355 *So. 2d* 1279, 1284-85, 1287 (La. 1977) (direct action statute creates no duty to claimant).

n16 *Bruyette v. Sandini*, 291 Mass. 373, 379 (1935); *Ligouri v. Allstate Ins. Co.*, 76 N.J. Super. 204, 214 (Ch. Div. 1962) (cannot enjoin, at least in absence of proof that settlement grossly disproportionate in relation to other claims).

n17 *E.g.*, *Bartlett v. Travelers Ins. Co.*, 117 Conn. 147, 154-58 (1933); *Castoreno v. Western Indem. Co.*, 213 Kan. 103, 794 (1973); *Alford v. Textile Ins. Co.*, 248 N.C. 224, 229 (1958); *Texas Farmers Ins. Co. v. Soriano*, 881 S.W.2d 312, 315 (Tex. 1994) (collecting cases in n.2).

n18 *Voccio v. Reliance Ins. Co.*, 703 F.2d 1, 3 (1st Cir. 1983) (RI law; collecting cases).

n19 *Aetna Cas. & Sur. Co. v. Superior Ct.*, 114 Cal. App. 3d 49, 57-59 (1980) (counsel for gravely injured person's family chose to settle injured person's claim for policy limit, rather than waiting for death to permit consolidated settlement of wrongful death claim).

n20 *E.g.*, *Babcock v. Liedigk*, 198 Mich. App. 354, 360 (1993) ("settlement of claims, would be severely hindered" and might take years).

n21 *Miller v. Ga. Interlocal Risk Mgmt. Agency*, 232 Ga. App. 231, 231 (1998).

A few cases suggest that an insurer can be liable for refusing a favorable demand based on existence of other claims. *Buntin v. Cont. Ins. Co.*, 525 F. Supp. 1077, 1084 (D.V.I. 1981); *Fid. & Cas. Co. v. Cope*, 444 So. 2d 1041, 1046 (Fla. Dist. Ct. App. 1984) (refusal to settle based on unasserted potential claim could be bad faith), *quashed on other grounds*, 462 So. 2d 459 (Fla. 1985).

n22 *Anglo-Am. Ins. Co. v. Molin*, 670 A.2d 194, 197 (Pa. Commw. Ct. 1995).

n23 *Texas Farmers Ins. Co. v. Soriano*, 881 S.W.2d at 316.

n24 *Liberty Mut. Ins. Co. v. Davis*, 412 F.2d 475 (5th Cir. 1969) (FL law).

n25 412 F.2d at 480.

n26 412 F.2d at 480.

n27 412 F.2d at 481; see *Farinas v. Fla. Farm Bureau Gen. Ins. Co.*, 850 So. 2d 555, 560 (Fla. Ct. App. 2003) (in dealing with multiple claims, reasonable settlement with some claimants to the exclusion of others is one that a person of ordinary care and prudence would make in the conduct of his own affairs).

See also *Dairyland Ins. Co. v. Herman*, 124 N.M. 624 (1997); *Fertitta v. Allstate Ins. Co.*, 439 So. 2d 531, 534 (La. Ct. App. 1983) (insurer liable for refusal to settle claim without release of subrogated claim for medical expenses).

n28 See 11 U.S.C.S. § 523(a)(9).

n29 See, e.g., *Trinity Universal Ins. Co. v. Bleeker*, 966 S.W.2d 489, 490 (Tex. 1998) (14 claims, all but one exceeding \$100,000 and totaling over \$11.5 million on policy with limits of \$20,100 per person and \$40,000 per occurrence).

n30 1-4 Corporate Governance: Law and Practice § 4.03(6) (2008).

n31 E.g., *Farmers Ins. Exch. v. Schropp*, 222 Kan. 612, 615-16 (1977).

n32 E.g., *Kinder v. Western Pioneer Ins. Co.*, 231 Cal. App. 2d 894, 901 (1965).

n33 E.g., *State Farm Mut. Auto. Ins. Co. v. Marcum*, 420 S.W.2d 113, 119-20 (Ky. 1967) (evidence showed that, given the insured's lack of assets, interpleader would have resulted in settlement had it been attempted)

(overruled in part by *Manchester Ins. & Indem. Co. v. Grundy*, 531 S.W.2d 493 (1975) and superseded by statute per *Knotts v. Zurich Ins. Co.*, 2004 Ky. App. LEXIS 22 (Ky. Ct. App. Feb. 6, 2004)).

n34 *State Farm Fire & Cas. Co. v. Tashire*, 386 U.S. 523, 533 (1967) (federal procedural law);

Oak Cas. Ins. Co. v. Lechliter, 206 W. Va. 349, 353-57 (1999) (collecting cases).

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Reed Smith LLP on Rivelli v. Twin City Fire Insurance Company

2010 Emerging Issues 5161

Reed Smith LLP on Rivelli v. Twin City Fire Insurance Company

By Mark Hersh

July 2, 2010

SUMMARY: D&O and E&O insurance carriers sometimes require their insureds to provide "warranty letters" in connection with their application for insurance. In one recent case, *Rivelli v. Twin City Fire Insurance Company*, 2009 U.S. App. LEXIS 23559 (10th Cir. Oct. 26, 2009), the Eighth Circuit affirmed a district court ruling that a D&O insurer had properly denied coverage based on a warranty letter.

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ARTICLE: D&O and E&O insurance carriers sometimes require their insureds to provide "warranty letters" in connection with their application for insurance. Though the language of these warranties may vary, they typically warrant that no insured has knowledge of facts that may give rise to a claim under the policy, or a basis to believe that a claim under the policy may be made, and they further provide that if any insured has such knowledge, any claim later arising from such facts will be excluded from coverage. Sometimes this is achieved through a "prior knowledge" policy exclusion, rather than a warranty letter. In either case, the prior knowledge warranties and exclusions have generated some litigation. In one recent case, *Rivelli v. Twin City Fire Insurance Company*, 2009 U.S. App. LEXIS 23559 (10th Cir. Oct. 26, 2009), the Eighth Circuit affirmed a district court ruling that a D&O insurer had properly denied coverage based on a warranty letter. This commentary examines *Rivelli*, and in particular its very questionable reasoning that the exclusion in the warranty was triggered by the mere allegations against the insureds, without any findings of fact.

I. The Case

The plaintiffs in *Rivelli* were directors or officers of Fischer Imaging Co., which was the subject of shareholder class action lawsuits and an SEC enforcement action based on an alleged accounting fraud scheme involved improperly recognized revenue that inflated the company's stock price. The class actions eventually were dismissed and not refiled. The Eighth Circuit decision does not mention any resolution of the SEC matter.

At the time of the lawsuits, the company had a \$5 million primary D&O policy with Federal Insurance Company, and a \$5 million excess policy with defendant Twin City. The top \$2.5 million of the \$5 million in excess coverage had been added when the company renewed its policy in May 2002. In connection with that additional \$2.5 million in

coverage, the company provided Twin City with a warranty letter, representing that "[n]o person or entity for whom this insurance is intended has any knowledge or information of any act, error omission, fact or circumstance which may give rise to a claim which may fall within the scope of the proposed insurance detailed above." The letter further provided: "It is agreed that if such knowledge or information exists, any claim arising therefrom (whether or not disclosed herein), in addition to any other remedy the insurer may have, is excluded from the proposed coverage." n1

The company burned through the first \$7.5 million defending the lawsuits, and when it reached the last \$2.5 million, Twin City denied further coverage based on the warranty letter and the allegations in the SEC's complaint. A coverage lawsuit ensued and, applying Colorado law, the district court granted summary judgment to Twin City. The linchpin of its decision was the application of Colorado's "complaint rule," in which an insurer's duty to defend is determined by the allegations in the complaint. Where an insurer relies on a policy exclusion, the district court stated, "The insurer has a duty to defend unless the insurer can establish that the allegations in the complaint are solely and entirely within the exclusions in the insurance policy." Based on this principle, the district court reasoned that "the applicability of the Warranty Letter's exclusion must be determined based on the 'four corners' of the SEC's Complaint and Amended Complaint, without resort to extrinsic evidence." The court then recounted the SEC's allegations, and concluded as follows: "These allegations and others, when read together, show that Rivelli and Johnson knew of wrongful activities at Fischer that could give rise to a claim under the Twin City Policy before May 1, 2002."

The Eighth Circuit affirmed the district court's ruling in every respect, finding that the district court properly applied the "complaint rule" to the warranty issue. It explained, "The district court held that the exclusion in the Warranty Letter was triggered by the allegations in the SEC's amended complaint," and it agreed that the SEC's claims "when read together-compelled the conclusion that the SEC's allegations were within the exclusion of the Warranty Letter." In finding the warranty exclusion applicable, it clearly and repeatedly relied entirely on the unproven allegations in the SEC's complaints, stating "the allegations in the SEC's amended complaint are overwhelming in outlining what plaintiffs knew at the time they entered into the Warranty Letter."

II. Analysis

The trial and appellate court decisions in *Rivelli* suffer from an egregious flaw in reasoning and are contrary to well-established case law. The courts mechanically misapplied Colorado's "complaint rule" to determine that the warranty exclusion had been triggered.

As the district court observed, in Colorado (and most or all other states) an insurer's duty to defend is determined by the allegations in the underlying complaint. This rule reflects that certain types of claims are designed to be covered or not covered by certain kinds of policies, and this often can be assessed based on the allegations. So, for example, if a claim clearly alleges professional malpractice, it may be plainly excluded from a D&O or CGL policy that has an exclusion for professional errors and omissions claims. Importantly, this rule gives the benefit of any doubt to the insured; as both courts in *Rivelli* observed, unless it is clear from the allegations that the claim is not covered, there is a duty to defend.

While it makes sense to apply the "complaint rule" to many or most policy exclusions, a warranty exclusion is different. It is apparent from the plain language of the warranty exclusion that it is triggered based on what insureds actually knew, not what they were alleged to have known. There is simply no other reasonable interpretation of this provision, and other courts that have interpreted warranty exclusions have agreed. These courts have held that the insurance carrier has the burden of proving that a warranty on an insurance application was false, and to meet that burden the insurer must prove what the insureds actually knew. n2

In *Rivelli*, the district court and court of appeals acknowledged that the proper inquiry was what the insureds subjectively knew at the time of the warranty. However, they then concluded that insureds knew of facts that could give rise to a claim based entirely on unproven allegations by the SEC. As the Eighth Circuit stated, "It does not matter what the insureds believed, only what the SEC's amended complaint alleged they knew." Thus, the insureds lost

valuable insurance coverage not because the claims against them were of a type not covered under the policy, or because they were proven to have engaged in wrongdoing, but because the court essentially accepted unproven allegations of their wrongdoing as true without requiring actual proof. This was a misapplication of the "complaint rule" "which is designed to protect insureds" and an unjust result. n3

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n1 This exclusionary language is in the district court opinion but not the appellate opinion. See *Rivelli v. Twin City Fire Ins. Co.*, No. 08 cv01225-RPM, 2008 U.S. Dist. LEXIS 99678 (November 21, 2008) (unpublished).

n2 For example, in *American Guarantee & Liability Ins. Co. v. Fojanini*, 90 F.Supp. 2d 615 (E.D. Pa. 2000), just four days before the defendant company signed a warranty indicating that there were no claims foreseen, its directors had received a letter from the soon-to-be plaintiff stating that the company had made misrepresentations and breached agreements, though the letter ended in a plea for amicable resolution rather than a threat of litigation. The court held that because there was no "deposition testimony or affidavit on the record as to the state of mind of" any company official, the insurer failed to show that there was a genuine issue of fact regarding whether any insured subjectively knew of an impending claim, and it granted summary judgment for the insured. *Id.* at 622. *Selko v. Home Ins. Co.*, 139 F.3d 146 (3d Cir. Pa. 1998) is often cited for the proposition that a mixed standard is applied to warranty exclusions, in which only the actual facts subjectively known to the insured are considered, but an objective reasonableness test is then used to determine whether the insured reasonably could have expected a claim to arise based on the known facts. See also *Great American Ins. Co. v. Gross*, 2008 U.S. Dist. LEXIS 10079 (E.D. Va. Feb. 11, 2008); *Bank of America Corp v. SR International Bus. Ins. Co.*, 05 Cvs 5564, 2007 NCBC 36; 2007 NCBC Lexis 36 (N.C. Super. 2007). See also *Pereira v. National Union*, 2006 U.S. Dist. LEXIS 49263 (S.D.N.Y. 2006); *Westport Ins. Corp. v. Lilley*, 292 F.Supp.2d 165, 172-74 (D.Me. 2003).

n3 It may well be that the SEC allegations were well-founded and the insureds engaged in an accounting fraud scheme. The point here is that the courts should not have assumed this and deprived the insureds of their coverage based on unproven allegations; the insurer has the burden of proving that the exclusion applies.

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Sonnenschein Nath & Rosenthal on Independent Counsel Rights Under New York Law

2010 Emerging Issues 5166

Sonnenschein Nath & Rosenthal, LLP on *New York Marine & General Insurance Co. v. Lafarge North America, Inc.*: Independent Counsel Rights Under New York Law

By William T. Barker

July 2, 2010

SUMMARY: This commentary examines the limits of an insured's right to be defended by independent counsel, rather than counsel appointed and directed by the insurer, in light of the Second Circuit decision in 2010 applying New York law in *New York Marine & General Insurance Co. v. Lafarge North America, Inc.*

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ARTICLE: In *New York Marine & General Insurance Co. v. Lafarge North America, Inc. ("NYMAGIC")*,ⁿ¹ the Second Circuit pointed out limits to an insured's right to be defended by independent counsel, rather than counsel appointed and directed by the insurer. Some New York cases have overlooked those limits, and the Second Circuit's opinion should help correct such neglect. This commentary examines independent counsel rights under New York law.

I. The Case

Lafarge owned a barge that allegedly smashed through a levee wall during Hurricane Katrina, contributing to the flooding of New Orleans. This created potential liability for Lafarge that threatened Lafarge's existence. It retained national and New Orleans counsel to investigate and preserve evidence. Its primary insurer, NYMAGIC, wished to assign counsel from its panel to defend the ensuing litigation. Lafarge continued to retain its chosen counsel and directed them to cooperate with NYMAGIC's panel counsel. The primary limits were exhausted paying panel counsel and retained experts. The excess insurers refused to pay Lafarge's chosen counsel, whose fees exceeded \$10 million. The district court ordered the excess insurers to pay those fees.ⁿ²

The Second Circuit determined that some, but not all, of the fees in question were covered. Specifically, immediate retention of counsel to investigate, retain experts, and preserve evidence was a covered means of loss mitigation.ⁿ³ But NYMAGIC had the right to retain mutually acceptable counsel to defend the litigation, and Lafarge's refusal to consider any of the firms offered breached the contract.ⁿ⁴ To reach those conclusions, the court construed policy language that differs from that of standard liability policies and different but interacting language of the primary and excess policies. For purposes of this commentary, the details of that policy language and how the court reached those

conclusions is not material.

But Lafarge argued that, even if the contract entitled NYMAGIC to select counsel, Lafarge was nonetheless entitled, pursuant to New York law, to independent counsel of its own selection. Lafarge argued that there was an inherent conflict of interest between itself and its insurers, because Lafarge's exposure was billions of dollars and the insurer's coverage was only \$30 million. The Second Circuit disagreed. n5 The New York Court of Appeals has held that "[i]ndependent counsel is only necessary in cases where the defense attorney's duty to the insured would require that he defeat liability on any ground and his duty to the insurer would require that he defeat liability only upon grounds which would render the insurer liable." n6 In this case, NYMAGIC and Lafarge had a common interest in defeating the entire claim, and there were no grounds that would render Lafarge alone liable. The substantial exposure in excess of limits did not create a conflict: "[W]here multiple claims present no conflict—for example, where the insurance contract provides liability coverage only for personal injuries and the claim against the insured seeks recovery for property damage as well as for personal injuries—no threat of divided loyalty is present and there is no need for the retention of separate counsel. This is so because in such a situation the question of insurance coverage is not intertwined with the question of the insured's liability." n7

Settlement negotiations might create a conflict, but no such issue was presented here. "Lafarge therefore did not have a right to pursue independent counsel whose legal fees would be covered by the primary policy." n8

II. Analysis: Conflicts of Interest and Rights to Independent Counsel n9 A. Under Standard Policies, and Absent a Conflict of Interest Regarding the Defense, the Insurer Has the Right to Select Defense Counsel for the Insured and to Control the Defense

Individuals and businesses purchase insurance to shift financial risk to their insurers. To an insured, the cost of lawyers necessary to defend covered claims is part of the risk to be shifted. To the insurer, defense lawyers are critical to controlling insurance costs by defeating or limiting insureds' liability on covered claims. Even so, the cost of defense counsel is a cost ultimately passed on to the insurance-buying public as part of insurance premiums. Thus, it would be wasteful to spend more on defense activities than those activities are expected to yield in reduced indemnity costs, i.e. the cost of judgments or settlements. Both costs are ultimately borne by the insurance-buying public in premiums.

Insurers have more expertise than most insureds in managing litigation. They have stronger, more immediate incentives to manage litigation efficiently than would insureds who expect their insurers to pay defense counsel's bills. Thus, most liability insurance markets have settled on contract terms that provide for the insurer to manage the defense, and give it the "right and duty to defend."

This standard liability policy provision "gives the insurer the right to control the defense of the claim" and "the insured has no right to interfere with the insurer's control of the defense." n10 Where the insured has no personal exposure, that control "is virtually absolute." n11 The right to select and direct counsel includes the right to change counsel. n12

Except in the unusual case where insurer and insured have a conflict of interest precluding joint representation, the law in most jurisdictions recognizes both as clients of defense counsel. n13 Thus, both as a client and pursuant to the insurance contract, the insurer usually has the right to make expenditure and strategic decisions.

This works well for insureds, who typically have no interest in how a claim is defended, as long as the insurer pays any resulting judgment or settlement. The vast bulk of cases defended by insurers are fully covered. n14 And even where there is some risk of personal financial exposure to an insured, the latter typically relies willingly on the insurer to manage the defense. This is not surprising. The insured has significant protections in situations where the claim is not fully covered. These protections include (1) the insurer's obligation to pay covered settlements or judgments, (2) its duty to accept reasonable settlement demands within policy limits, and (3) its responsibility for any increased liability of the insured resulting from an inadequate defense. n15 (Where the strategy chosen results in collateral damage to the

insured, there may be circumstances where defense counsel or the insurer could be liable for that damage.)

B. Defense Counsel Owes the Insured a Duty of Loyalty

Because the insured is a client (and regardless of whether the insurer is also a client), defense counsel, even if appointed by the insurer, owes the insured undivided loyalty. n16 In ordinary cases this presents no problem, for the insurer's interests in the conduct of the defense will be fully consistent with those of the insured. As a California court has explained:

In the insured-insurer relationship, the attorney characteristically is engaged and paid by the carrier to defend the insured. The insured and the insurer have certain obligations each to the other, as previously noted, arising from the insurance contract. Both the insured and the carrier have a common interest in defeating or settling the third party's claim. If the matter reaches litigation, the attorney appears of record for the insured and at all times represents him in terms measured by the extent of his employment.

In such a situation, the attorney has two clients whose primary, overlapping and common interest is the speedy and successful resolution of the claim and litigation. Conceptually, each member of the trio, attorney, client-insured, and client-insurer has corresponding rights and obligations founded largely on contract, and as to the attorney, by the Rules of Professional Conduct as well. The three parties may be viewed as a loose partnership, coalition or alliance directed toward a common goal, sharing a common purpose which lasts during the pendency of the claim or litigation against the insured. Communications are routinely exchanged between them relating to the joint and common purpose—the successful defense and resolution of the claim. Insured, carrier, and attorney, together form an entity—the defense team—arising from the obligations to defend and to cooperate, imposed by contract and professional duty. This entity may be conceived as comprising a unitary whole with intramural relationships and reciprocal obligations and duties each to the other quite separate and apart from the extramural relations with third parties or with the world at large. Together, the team occupies one side of the litigating arena. n17

While defending the normal case involves only commonality of interests between the insurer and the insured, counsel must be alert for divergences of interests that may occur in particular cases. The duty of undivided loyalty means that defense counsel may do nothing that injures interests of an insured client without informed consent of that client. n18

Because coverage issues inherently involve conflicts between the insurer and the insured, defense counsel must avoid any involvement in those issues. In particular, defense counsel must not assist the insurer in defeating coverage, as such assistance would breach the duty of loyalty to the insured. n19

C. When There Is a Conflict of Interest Regarding the Defense, the Insured Is Entitled to Independent Counsel 1. The Rules of Professional Conduct Preclude a Conflicted Representation

The first question that any lawyer must answer when asked to undertake a representation is whether that representation will involve a conflict of interest. Insurance defense counsel is no different from any other lawyer in this respect. If representing the insured and the insurer jointly would create a conflict of interest, then joint representation is impermissible, absent informed consents by both. Independent counsel, representing only the insured, must be paid by the insurer to discharge its duty to defend. Otherwise, the insured would be put at risk that counsel's advice about the representation might be affected by counsel's loyalty to the insurer. Essentially the same analysis applies even if local law does not consider the insurer to be a co-client. If there is a conflict that would preclude joint representation, that conflict would also preclude, absent informed consent by the insured, acceptance of insurer direction by counsel. n20 And if counsel has an ongoing relationship with the insurer, the lawyer's personal interest in pleasing the insurer may create a conflict in the same way that a legal duty of loyalty does.

The governing standard is stated in ABA Model Rule 1.7, which is substantively identical on this point to the relevant law in all states. That rule provides that:

(a) Except as provided in paragraph (b), a lawyer shall not represent a client if the representation involves a concurrent conflict of interest. A concurrent conflict of interest exists if:

(1) the representation of one client will be directly adverse to another client; or

(2) there is a significant risk that the representation of one or more clients will be materially limited by the lawyer's responsibilities to another client, a former client or a third person or by a personal interest of the lawyer. n21

A material limitation (as that term is used in paragraph (a)(2) of the rule) exists when a lawyer "cannot consider, recommend or carry out an appropriate course of action for the client because of the lawyer's other responsibilities or interests." n22 In applying this standard to insurance representations, courts have demanded special sensitivity to any situation where the choices made by defense counsel could benefit the insurer at the insured's expense.

Where the existence of divergent interests in the conduct of the defense is inherent in the case, the conflict of interest rules require that the representation be declined, unless all affected clients give informed consent.

2. A Disabling Conflict Exists When Insurer and Insured Have Divergent Interests in the Way the Case Is Defended

The primary example in insurance representations occurs when some factual issue bearing on the insured's liability also bears on the existence of coverage. A fact of this sort has been described as a "pivotal fact," n23 whose existence is the most common source of conflicts requiring independent counsel. For example, if the insured is sued on alternative theories of negligence and battery, the former will typically be covered but the latter will not. Of course, the insurer and the insured share an interest in defeating the suit entirely and in minimizing any judgment. But if liability is found, the insured would prefer that it be based on (covered) negligence, while the insurer's interest would be served if it were based on (noncovered) battery. Because the way in which the case is defended has a real possibility of affecting the basis on which any liability would be found, this divergence of interest creates a conflict of interest for any defense counsel seeking to advance the insurer's interest as well as that of the insured. n24 More complicated examples must also be considered. n25

But the mere existence of some question as to coverage does not create a conflict. Only if the way in which the insured's defense is handled would affect the determination of coverage does a conflict exist, n26 and many coverage questions are unrelated to the matters at issue in the tort action.

For example, counsel may be asked to defend a case involving an auto accident in which the insured's cousin was injured when the car operated by the insured ran into a tree. The cousin had been living with the insured while attending a nearby school for a semester, but has returned to his parents' home after being released from the hospital. The claim representative assumes the insured's defense, but reserves the right to deny coverage under the policy's exclusion for injuries to relatives residing in the insured's household. Coverage counsel brings a declaratory judgment action to resolve that issue. Because the resident relative issue does not overlap with the issues in the tort action, it does not create any Rule 1.7 conflict of interest, and independent counsel is not required to comply with Rule 1.7 (or its equivalent). n27 (Moreover, because the insured's residence is irrelevant to the tort action, counsel is under no duty to disclose information on that subject to the claim representative, even if unfavorable to the insured. Any such disclosure would breach the duties of loyalty and confidentiality owed to the insured.)

Excess exposure, standing alone does not create a Rule 1.7 conflict for defense counsel: defense counsel seeks to do either of two things: "either win the case or keep the damages as low as possible. Everything he does in fulfillment of either objective must of necessity benefit both clients." n28 But insurer and insured do have differing interests regarding settlement whenever the insured has excess exposure, and counsel must act carefully in dealing with that subject. n29

But, if the case involves a "pivotal fact," there will typically be an irreconcilable conflict. Counsel must advocate a

position regarding the pivotal fact and any position will be contrary to the interests of one client or the other. By shaping the defense, counsel could thus shift liabilities found by the court between covered and noncovered status. Where the coverage issues present such an opportunity, the insured is entitled to independent counsel unless the insured gives informed consent to the conflict.

Some courts have concluded that conflicts of this sort can also arise in auto accidents where the insured has a claim that the other party is (1) at fault *and* (2) either is an uninsured motorist ("UM") or an underinsured motorist ("UIM"). Because the UM or UIM claim could give the insurer an interest in establishing the insured's contributory or comparative fault, there could be an incentive to defend the claim against the insured less vigorously. n30 Similar problems can arise in situations where two of the insurer's insureds assert covered claims against one another based on the same incident n31 or where two insured defendants have inconsistent defenses. n32 The facts in each case must be carefully analyzed to determine whether there is any substantial basis for concluding that the insurer has an interest that could be served by an impaired defense. If so, independent counsel should be provided. n33

3. Some Jurisdictions Grant the Insured a Right to Independent Counsel Whenever the Insurer Reserves the Right to Deny Indemnification

A few states authorize the insured to reject the insurer's defense whenever there is a reservation of the right to deny indemnification. n34 In jurisdictions which follow this rule, the insured is *never* obliged to accept a defense under reservation of the insurer's rights to deny indemnification for any judgment rendered. Under this view, the insured's rejection of a defense under reservation may require the insurer either to affirm coverage unconditionally and defend or to disclaim coverage and refuse to defend, at the risk of breaching the policy if there actually was a duty to defend. Some jurisdictions permit the insurer to avoid the latter risk by agreeing to pay for a defense conducted by counsel selected and controlled by the insured. But none of the jurisdictions adhering to this rule permit the insurer, over the insured's objection, to control the defense when there is any question of coverage for the liabilities asserted in the action to be defended. The insurer's role is limited to payment of counsel who represents and is directed by the insured alone.

The doctrine just described is sometimes said to be generally accepted. n35 But that is not so. Several states have explicitly rejected the contention that an insurer's reservation of rights is ineffective if the insured objects. n36 Moreover, cases adopting the "reject the defense" rule were mostly decided before development of the more precise conflict of interest rule, so the latter is the clear modern trend. n37

4. The New York Rule a. Independent Counsel Is Required Only Where Coverage and Liability Issues Are Intertwined or There Is Some Other Rule 1.7 Conflict

New York first addressed the right to independent counsel in *Prashker v. United States Guarantee Corp.*, n38 where an insured was alleged to have negligently operated a plane, resulting in a crash which killed both pilot and passenger. Among the grounds of negligence alleged was violation of federal regulations limiting flying in certain conditions to pilots licensed for instrument flying, which the insured was not. Operation in violation of the instrument flight rules was also excluded from coverage (making it a "pivotal fact"). In a declaratory judgment action, the insurer sought to be relieved of both the duty to defend and the duty to indemnify. In support of its request, it urged, *inter alia*, that requiring a defense "would subject to divided loyalty any attorneys who might defend the action, in that their duty to the assureds would be to endeavor to defeat recovery on any ground, whereas their duty to the insurance company would be to defeat recovery only upon such grounds as might render the insurance company liable." n39

The New York Court of Appeals declined to relieve the insurer of the duty to defend plainly imposed by the covered allegations of the complaint or to permit piecemeal adjudication in the declaratory judgment action of the question, properly included in the underlying action, of whether the pilot had violated the instrument flight rules. As to the conflict of interest problem, it pointed out that this could be solved by use of attorneys responsible only to the insured, with the insurer being liable for the reasonable value of their services. n40

The Court of Appeals again addressed the right to independent counsel in *Public Service Mutual Insurance Co. v. Goldfarb*.ⁿ⁴¹ Goldfarb was a dentist sued by a patient who alleged that, in the course of providing dental treatment, he had sexually abused her.ⁿ⁴² The court held that Public Service had a duty to defend, but no duty to indemnify against the alleged intentional wrongdoing. It then held that, "inasmuch as the insurer's interest in defending the lawsuit is in conflict with the defendant's interest-the insurer being liable only upon some of the grounds for recovery asserted and not upon others-defendant Goldfarb is entitled to defense by an attorney of his own choosing, whose reasonable fee is to be paid by the insurer."ⁿ⁴³

In a footnote, the court then summarized the standard for determining whether the insured has a right to independent counsel: "That is not to say that a conflict of interest requiring retention of separate counsel will arise in every case where multiple claims are made. Independent counsel is only necessary in cases where the defense attorney's duty to the insured would require that he defeat liability on any ground and his duty to the insurer would require that he defeat liability only upon grounds which would render the insurer liable. When such a conflict is apparent, the insured must be free to choose his own counsel whose reasonable fee is to be paid by the insurer. On the other hand, where multiple claims present no conflict-for example, where the insurance contract provides liability coverage only for personal injuries and the claim against the insured seeks recovery for property damage as well as for personal injuries-no threat of divided loyalty is present and there is no need for the retention of separate counsel. This is so because in such a situation the question of insurance coverage is not intertwined with the question of the insured's liability."ⁿ⁴⁴

The requirement that the coverage issue be "intertwined with the question of the insured's liability" indicates that disqualification ordinarily should turn on the presence of a "pivotal fact," involved in both questions (or, presumably, on other facts indicating the presence of a Rule 1.7 conflict). This is supported by *Prudential Property & Casualty Insurance Co. v. Godfrey*,ⁿ⁴⁵ where the Appellate Division found independent counsel unnecessary. Charles G. Godfrey, Jr., was injured while riding as a passenger on an all-terrain vehicle ("ATV") driven by the ten-year old son of George and Paula Knapp. The Knapps were sued for both negligent entrustment and negligent operation of the ATV. The Knapps sought a defense from Prudential, their homeowners' insurer. The court held that there was coverage for the negligent entrustment claims (but, apparently, not for the negligent operation claims). But, "[i]nasmuch as [Prudential's] interest in disproving negligent entrustment of the ATV does not conflict with [the Knapps'] interest in defeating both the negligence and negligent entrustment claims, there is no need for independent counsel."ⁿ⁴⁶ That is, Prudential had no interest in the success of the negligent operation claim, even if it did not cover that claim; indeed, defeating the negligent operation claim might defeat, or at least undermine, the negligent entrustment claim.

Nonetheless, there are a number of Appellate Division cases that disregard the requirement of intertwined coverage and liability issues, indicating that *whenever* "an insurer defends under reservation of rights, the insured is entitled to retain its own counsel."ⁿ⁴⁷ Other cases suggest that rule by holding that independent counsel was required, without indicating the nature of the coverage issue or other circumstances creating a Rule 1.7 conflict.ⁿ⁴⁸ Any such suggestions are contrary to the rule announced by the New York Court of Appeals in *Goldfarb* and applied by the Second Circuit in *NYMAGIC*.

And there are some New York decisions that ignore the *Goldfarb* requirement for requirement of intertwined coverage and liability issues. For example, *69th Street & 2nd Avenue Garage Associates, L.P. v. Ticor Title Guarantee Co.*ⁿ⁴⁹ found a conflict based on the insured's business need for a quick resolution, as contrasted with Ticor's ability to proceed in a more leisurely fashion. (The insured's counsel had, by the time the independent counsel issue was litigated, succeeded in obtaining an expedited adjudication that cleared the cloud on the title, in a federal case Ticor's counsel had proposed to dismiss.) The insurer, however, had no interest in delaying the litigation. There was, at most, a difference of opinion on strategy, and such differences do not constitute conflicts under the *Goldfarb* test or Rule 1.7.ⁿ⁵⁰

b. Where Independent Counsel Is Due, the Insured Must Be Notified of That

Elacqua v. Physicians' Reciprocal Insurers n51 held that an insured is entitled to be informed of any right to independent counsel. Elacqua and Hennessey were physicians and members of a partnership which employed nurse practitioner Szary. Hytko was treated by Szary and later sued Elacqua, Hennessey, Szary and the partnership for malpractice. The partnership was an additional insured under the policies of Elacqua and Hennessey, and the insurer provided a defense. But it did not insure Szary individually and claimed that it would have no duty to indemnify the partnership if only she were found negligent. n52 On that basis, if Szary were found liable, the partnership would be better off if one of the doctors were also found liable, whereas the insurer would prefer that Szary alone be found liable. That created a right of independent counsel. n53 The insurer had not informed the insureds of this right in its (belated) partial disclaimer, and the court held that the insurer "was required to advise [the insureds] of that right. To hold otherwise would seriously erode the protection afforded." n54

The facts were presented more fully in a decision after the remand, in which it was held that the failure to advise was an unlawful deceptive trade practice. n55 The insurer did not raise the coverage issue until shortly before trial and did not inform the insureds of their right to independent counsel. When defense counsel perceived a conflict among the insureds, it retained separate counsel for each of them. Counsel for the doctors then made a successful summary judgment motion on their behalf, a motion not opposed by counsel for the partnership. n56 At trial, only Szary was found negligent, n57 and a verdict of \$1,899,100 was rendered against the partnership; by the time of the suit against the insurer, interest had brought this amount to over \$3 million, which the insurer settled for \$2.4 million after the first appeal. n58

Despite the settlement, the insureds amended their complaint to allege that the failure to inform them of their right to independent counsel was a deceptive practice in violation of General Business Law § 349. The trial court then dismissed that claim for failure to show any resulting harm. n59 The Appellate Division reversed.

To establish such a claim, the insureds were required to show an act or practice that is "'consumer-oriented,' that is an act having the potential to affect the public at large, as distinguished from merely a private contractual dispute," n60 and that the practice was "'deceptive or misleading in a material way and that plaintiff has been injured by reason thereof.'" n61 The insurer admitted that it routinely failed to inform insureds of rights to independent counsel, so the trial court properly found the practice "consumer oriented." n62 Given the affirmative obligation to disclose previously found, the practice was also deceptive. n63 Failure to inform "was certainly 'likely to mislead a reasonable consumer acting reasonably under the circumstances.'" n64 Thus, the issue was the one identified by the trial court: harm.

While plaintiffs were required to show harm, it need not be pecuniary. Divided loyalty of the lawyers retained by the insurer to represent the insureds constituted harm for purposes of the statute. In particular, the lawyers for the doctors moved for summary judgment and the lawyer for the partnership joined (despite having grounds to oppose), without anyone pointing out that success on the motion would leave the partnership exposed to uninsured liability. Thus, despite having separate lawyers, the insureds were not protected against the conflict between their own interests and those of the insurer. n65

The case focused on the insurer's duty to inform. But the lawyers also had such a duty. Under the Model Rules, which were not then in effect in New York, a lawyer is required to "promptly inform the client of any fact or circumstance with respect to which the client's informed consent ... is required by these Rules" and to "explain a matter to the extent reasonably necessary to permit the client to make informed decisions regarding the representation." n66 The same requirements existed under the common law apart from the Model Rules. n67 Because making the motion could adversely affect the insureds' interests, doing so implicated counsel's duty of loyalty and required the insureds' informed consent. n68 Moreover, precisely because the insured had a right to independent counsel, the insured's informed consent was required before counsel could proceed with the representation. Thus, the lawyers had a duty to inform. n69 c. Conclusion

Counsel and courts considering independent counsel issues in New York should apply the *Goldberg* test in determining whether independent counsel is necessary. If so, both insurers and defense counsel should inform the

insured of the right.

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n1 *N.Y. Marine & Gen. Ins. Co. v. Lafarge N. Am., Inc.*, 599 F.3d 102 (2d Cir. 2010).

n2 599 F.3d at 107-11.

n3 599 F.3d at 121-23.

n4 599 F.3d at 123-24.

n5 599 F.3d at 124-25.

n6 *Pub. Serv. Mut. Ins. Co. v. Goldfarb*, 53 N.Y.2d 392, 401 n.* (1981), quoted in *NYMAGIC*, 593 F.3d at 124.

n7 599 F.3d at 125, quoting *Goldfarb*, 53 N.Y.2d at 401 n.*.

n8 599 F.3d at 125.

n9 Some of this analysis is drawn from William T. Barker & Ronald D. Kent, *Insurance Bad Faith Litigation*, Second Edition, § 3.05.

n10 *Safeco Ins. Co. v. Superior Ct.*, 71 Cal. App. 4th 782, 787 (Cal. Ct. App. 1999); *Davenport v. St. Paul Fire & Marine Ins. Co.*, 978 F.2d 927, 931-32 (5th Cir. 1992) (policy "invest[s] the insurer with the complete control and direction of the defense . . . to the exclusion of the insured") (collecting authorities); *Unauthorized Practice of Law Comm. v. Am. Home Assurance Co.*, 261 S.W.3d 24,26 (Tex. 2008) ("The right to defend in many policies gives the insurer complete, exclusive control of the defense").

n11 978 F.2d. at 932-33 (where policy covered two insureds, with possible cross-claims between them, insurer with full coverage for both could use common attorney to present a common defense); *see also State Farm Mut. Auto. Ins. Co. v. Federal Ins. Co.*, 72 Cal. App. 4th 1422, 1429 (1999) ("it is customary for the insurer to control the defense it provides"); *Spindle v. Chubb/Pacific Indem. Group*, 89 Cal. App. 3d 706, 714 (1979).

n12 *King v. Guiliani*, No. CV92 0290370 S, 1993 Conn. Super. LEXIS 1889, at *25-28 (Conn. Super. Ct. July 27, 1993).

n13 *See William Barker, Sonnenschein Nath & Rosenthal, LLP on Unauthorized Practice of Law Comm. v. Am. Home Assurance Co.: How Many Clients Does Insurance Defense Counsel Have, and How Can You Tell?*, LexisNexis Emerging Issues Analyses, 2009 Emerging Issues 3219 (Jan. 2009).

n14 Samuel R. Gross & Kent Syverud, *Don't Try: Civil Jury Verdicts in a System Geared to Settlement*, 44 *UCLA L. Rev.* 1, 21-22 (1996) (in sample of litigated cases, insurance was involved in 80%, with lawyers on both sides agreeing that the claim was completely covered in 59%, so that just under 75% of the cases where insurance was involved were fully covered). Of the remainder, some may have involved either *Cumis* counsel or indemnity policies (under which the insured controls the defense as a matter of contract), precluding any tripartite relationship and, so, any possible problems arising from that relationship. Additionally, lawyers are more likely to mention doubts about adequacy of coverage when such doubts are objectively insubstantial than they are to omit mention of doubts that are objectively substantial. So the 75% figure is probably a significant understatement of the fraction of tripartite relationship claims where coverage is, objectively speaking, both clear and clearly adequate. And even when there is a genuine risk of exposure beyond the policy's coverage, cases are normally resolved without any payment by the insured.

n15 *See William T. Barker, The Tripartite Relationship And Protection Of The Insured: Is There A Problem?*, 21 *Ins. Litig. Rptr.* 533, 535-36, 538-40 (1999).

n16 *E.g.*, Restatement of the Law Governing Lawyers, § 16 & cmt. e (perm. vol. 2000) (describing duty);

Cinema 5, Ltd. v. Cinerama, Ltd., 528 F.2d 1384, 1386 (2d Cir. 1976) (attorney owes undivided loyalty to every client).

n17 *Am. Mut. Liab. Ins. Co. v. Superior Court*, 38 Cal. App. 3d 579, 591-92 (1974).

n18 *E.g.*, Restatement § 16, cmt. e (duties of loyalty prohibit the lawyer from harming the client); Ellen S. Pryor & Charles Silver, *Defense Lawyers' Professional Responsibilities: Part I-Excess Exposure Cases*, 78 *Tex. L. Rev.* 599, 634-36 (2000); Charles Silver & Kent Syverud, *The Professional Responsibilities of Insurance Defense Lawyers*, 45 *Duke L.J.* 255, 280-83 (1995).

n19 *See, e.g., Parsons v. Continental Nat'l Am. Group*, 550 P.2d 94 (Ariz. 1976) (disclosure to insurer of confidential information indicating that insured's actions were intentional rather than negligent); *Betts v. Allstate Ins. Co.*, 154 Cal. App. 3d 688 (1984) (defense counsel encouraged insured to adopt "no[settlement]" position which improperly exposed insured to serious risk of personal liability); *Fidelity & Cas. Co. v. McConnaughy*, 228 Md. 1, 9-14 (1962) (taking deposition to establish lack of cooperation); *Employers Cas. Co. v. Tilley*, 496 S.W.2d 552 (Tex. 1973) (exploitation of position as defense counsel to develop late notice defense on behalf of insurer).

n20 *See, e.g.*, ABA Model Rules of Professional Conduct, Rules 1.8(f), 5.5(c).

n21 ABA Model Rules of Professional Conduct, Rule 1.7(a).

n22 Model Rule 1.7, comment [8].

n23 The term is that of Ronald Mallen. *See* Ronald Mallen, *A New Definition of Insurance Defense Counsel*, 53 *Ins. Coun. J.* 108, 114[15] (1986).

n24 *E.g.*, *San Diego Federal Credit Union v. Cumis Ins. Soc'y*, 162 Cal. App. 3d 358, 365 (1984) (suit for both negligent and intentional injuries); *Brohawn v. Transamerica Insurance Co.*, 276 Md. 396, 414-15 (1975) (same); *Maryland Cas. Co. v. Peppers*, 64 Ill. 2d 187, 198-99 (1976) (same).

n25 See William T. Barker, *Insurer Control of the Defense: Reservations of Rights and the Right To Independent Counsel*, 71 Def. Coun. J. 16, 21-24 (2004).

n26 See Restatement of the Law Governing Lawyers, § 123, cmt. c(iii) (perm. vol. 2000) (general antagonism between clients not conflict, as long as conflicting interests not implicated in particular representation).

n27 *McGee v. Superior Court*, 176 Cal. App. 3d. 221, 227-28 (1985).

n28 *Hartford Accident & Indem. Co. v. Foster*, 528 So. 2d 255, 269 (Miss. 1988).

n29 See Ellen S. Pryor & Charles Silver, *Defense Lawyers' Professional Responsibilities: Part I-Excess Exposure Cases*, 78 Tex. L. Rev. 599, 644 (2000).

n30 *Nationwide Mut. Ins. Co. v. Webb*, 291 Md. 721, 739-42 (1981).

n31 *O'Morrow v. Borad*, 27 Cal. 2d 794 (1946).

n32 *Murphy v. Urso*, 88 Ill. 2d 444, 452-55 (1981).

n33 For a more extensive analysis of possible Rule 1.7 conflicts creating a right to independent counsel, see William T. Barker, *Insurer Control of the Defense: Reservations of Rights and the Right To Independent Counsel*, 71 Def. Coun. J. 16, 21-24 (2004).

n34 States apparently adhering to this rule include *Idaho, Kentucky, Massachusetts, Missouri, New Jersey, North Carolina, South Dakota, and Texas*. *Boise Motor Car Co. v. St. Paul Mercury Indem. Co.*, 62 Idaho 438,

448-49 (1941); *Med. Prot. Co. v. Davis*, 581 S.W.2d 25, 26 (Ky. Ct. App. 1979); *Three Sons, Inc. v. Phoenix Ins. Co.*, 357 Mass 271, 274-77 (1970); *State Farm Mut. Auto. Ins. Co. v. Ballmer*, 899 S.W.2d 523, 527 (Mo. 1995); *Merchants Indem. Corp. v. Eggleston*, 37 N.J. 114, 127[#8209]28, 179 A.2d 505, 511[#8209]12 (1962); *National Mortgage Corp. v. Am. Title Ins. Co.*, 41 N.C. App. 613, 621-23 (1979), *rev'd on other grounds*, 299 N.C. 369 (1980); *Connolly v. Standard Cas. Co.*, 76 S.D. 95, 100-01 (1955) (dictum); *Kansas Bankers Sur. Co. v. Lynass*, 920 F.2d 546, 548 (8th Cir. 1990) (relying on *Connolly* to find insurer guilty of bad faith for attempting to retain control of defense after reserving rights, even though insurer later affirmed coverage unconditionally and settled case); *Employers Cas. Co. v. Tilley*, 496 S.W.2d 552, 559 (Tex. 1973) (approving quotation from secondary authority obliquely addressing issue not presented in case itself); *YMCA v. Commercial Std. Ins. Co.*, 552 S.W.2d 497, 502[#8209]504 (Tex. Civ. App. Ft. Worth 1977), *writ refused no reversible error*, 563 S.W.2d 246 (Tex. 1978) (following *Tilley* dictum); *Ranger Ins. Co. v. Robertson*, 707 S.W.2d 135, 143 (Tex. Ct. App. Austin 1986). Alaska takes this position as to certain kinds of reservations. *Cont'l Ins. Co. v. Bayless & Roberts, Inc.*, 608 P.2d 281, 288 (Alaska 1980). Florida follows a slightly modified rule. Fla. Stat. § 627.426 (1984) (requiring that insurer and insured agree upon counsel if insurer reserves rights).

n35 See, e.g., 7C J. Appleman, *Insurance Law & Practice* § 4686, at 169 (Berdal rev. 1979). On this basis, federal courts have sometimes suggested that states which have not addressed the issue would adopt this rule. See, e.g., *Am. Fam. Life Assurance Co. v. United States Fire Co.*, 885 F.2d 826, 831 (11th Cir. 1989) (characterizing any denial of coverage as creating conflict of interest on basis of statement to that effect in Appleman treatise); *City of Carter Lake v. Aetna Cas. & Sur. Co.*, 604 F.2d 1052, 1060 n.7 (8th Cir. 1979) (applying Iowa law) (dictum describing general operation of a reservation of rights); *Mundry v. Great Am. Ins. Co.*, 369 F.2d 678, 682 (2d Cir. 1966) (Connecticut or New York law) (dictum).

n36 E.g., *McGough v. INA*, 143 Ariz. 26, 31-33 (Ct. App. 1984); *Great Sw. Fire Ins. Co. v. H.V. Corp.*, 3 Haw. App. 664, 668 (1983); *Home Indemn. Co. v. Reed*, 381 So. 2d 45, 52 (Ala. 1980); *Am. Home Assurance Co. v. Glenn Estess & Assocs., Inc.*, 763 F.2d 1237, 1239[#8209]40 (11th Cir. 1985); *Ferguson v. Birmingham Fire Ins. Co.*, 254 Or. 496, 508-12 (1969).

n37 *Walbrook Ins. Co. v. Goshgarian & Goshgarian*, 726 F. Supp. 777, 783 (C.D. Cal. 1989) (surveying law and concluding that "the modern trend is to find a unilateral reservation is effective without the insured's consent").

n38 1 N.Y.2d 584 (1956).

n39 1 N.Y.2d at 593.

n40 1 *N.Y.2d* at 593.

n41 *Pub. Serv. Mut. Ins. Co. v. Goldfarb*, 53 *N.Y.2d* 392 (1981).

n42 53 *N.Y.2d* at 396.

n43 53 *N.Y.2d* at 401 (footnote omitted), citing *Hartford Accident & Indem. Co. v. Village of Hempstead*, 48 *N.Y.2d* 218, 228-29 (1979) (police officers alleged to have beaten plaintiff with nightsticks entitled to defense by independent counsel; no explanation).

n44 53 *N.Y.2d* at 401 n.*.

n45 *Prudential Prop. & Cas. Ins. Co. v. Godfrey*, 169 *A.D.2d* 1035 (*N.Y. App. Div.* 1991).

n46 169 *A.D.2d* 1036.

n47 *Federated Dept. Stores, Inc. v. Twin City Fire Ins. Co.*, 28 *A.D.3d* 32, 37 n.1 (*N.Y. App. Div.* 2006) (suggesting undue burden if insurer obliged to speculate on conceivable defenses to coverage and reserve rights as to them); *City of New York v. Clarendon Nat'l Ins. Co.*, 309 *A.D.2d* 779, 779 (*N.Y. App. Div.* 2003) (dictum; right to independent counsel not in dispute); *First Jeffersonian Assocs. v. Ins. Co. of N. Am.*, 262 *A.D.2d* 133, 134 (1999) (reservation of rights entitled insured to independent counsel; no indication of nature of reservation or whether it created a Rule 1.7 conflict).

n48 *Pistolesi v. N. Country Ins. Co.*, 210 *A.D.2d* 961, 962 (*N.Y. App. Div.* 1994); *Major Builders Corp. v. Commercial Union Ins. Co.*, 155 *A.D.2d* 267, 267 (*N.Y. App. Div.* 1989).

n49 *69th Street & 2nd Ave. Garage Assocs., L.P. v. Ticor Title Guarantee Co.*, 207 *A.D.2d* 225 (*N.Y. App. Div.* 1995).

n50 *Roussos v. Allstate Ins. Co.*, 104 Md. App. 80, 90-91, cert. denied, 339 Md. 355 (1995).

n51 *Elacqua v. Physicians' Reciprocal Insurers*, 21 A.D.3d 702 (N.Y. App. Div.) ("*Elacqua I*"), leave to appeal dismissed, 6 N.Y.3d 844 (2006).

n52 21 A.D.3d at 703-04. This coverage defense was arguably not asserted in a timely manner as required by a New York statute which (if the jury so found) would render it barred, even if otherwise meritorious. 21 A.D.3d at 706. Szary herself had other insurance and settled before trial for \$65,000. 21 A.D.3d at 703 nn.1-2.

n53 21 A.D.3d at 706-07.

n54 21 A.D.3d at 707.

n55 *Elacqua v. Physicians' Reciprocal Insurers*, 52 A.D.3d 886 (N.Y. App. Div. 2008) ("*Elacqua II*").

n56 52 A.D.3d at 890.

n57 *Elacqua I*, 21 A.D.3d at 703.

n58 *Elacqua II*, 52 A.D.3d at 887 & n.2.

n59 52 A.D.3d at 886-87.

n60 52 A.D.3d at 887.

n61 52 A.D.3d at 888.

n62 52 A.D.3d at 888.

n63 52 A.D.3d at 888. Indeed, the partial disclaimer letter suggested that the partnership might wish to consult an attorney "at its own expense" regarding its uninsured exposure. 52 A.D.3d at 889 n.4.

n64 52 A.D.3d at 889.

n65 52 A.D.3d at 890-91.

n66 ABA Model Rules of Professional Conduct, Rule 1.4.

n67 *In re Kelly*, 23 N.Y.2d 368, 376 (1968) (to obtain consent for a conflict, "the lawyer must, at the very least, disclose to all affected parties the nature and extent of the conflict"); *In re Tallon*, 86 A.D.2d 897, 898 (N.Y. App. Div. 1982) (lawyer who has failed to bring suit within limitation period "has a professional duty to promptly notify his client of his failure to act and of the possible claim his client may thus have against him"); *Vollgraf v. Block*, 117 Misc. 2d 489, 493 (N.Y. Sup. Ct. 1982) (lawyers obliged to inform client of law firm's dissolution; "the relationship between a law partnership and its clients is not an ordinary business relationship, it is a fiduciary relationship and requires a high degree of fidelity and good faith. An attorney is bound to keep a client informed of the [client's] business"); Restatement (Third) of the Law Governing Lawyers § 20 (perm. vol. 2000).

n68 *E.g.*, Restatement, § 16, cmt. *e* (duties of loyalty prohibit the lawyer from harming the client); Ellen S. Pryor & Charles Silver, *Defense Lawyers' Professional Responsibilities: Part I-Excess Exposure Cases*, 78 Tex. L. Rev. 599, 634-36 (2000); Charles Silver & Kent Syverud, *The Professional Responsibilities of Insurance Defense Lawyers*, 45 Duke L.J. 255, 280-83 (1995).

n69 Ellen S. Pryor & Charles Silver, *Defense Lawyers' Professional Responsibilities: Part II*, 15 *Geo. J. Legal Ethics* 29, 72-74 (2001).

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Sonnenschein Nath & Rosenthal, LLP on Allstate Insurance Co. v. Miller

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Sonnenschein Nath & Rosenthal, LLP on Allstate Insurance Co. v. Miller: Failure to Inform Insured of Settlement Opportunity as a Basis for Excess Judgment Liability

By William T. Barker and Ronald D. Kent

April 5, 2010

SUMMARY: In *Allstate Insurance Co. v. Miller*, the Nevada Supreme Court held that the jury could properly have found Allstate liable for an excess judgment as a result of its failure to adequately inform its insured of a settlement opportunity. This commentary examines the law in Nevada and elsewhere on an insurer's duty to inform the insured of settlement opportunities and when failure to do so can expose the insurer to excess judgment liability.

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ARTICLE: In *Allstate Insurance Co. v. Miller*,ⁿ¹ the Nevada Supreme Court held that the jury could properly have found Allstate liable for an excess judgment as a result of its failure to adequately inform its insured, William Miller, of a settlement opportunity. This commentary examines the law in Nevada and elsewhere on an insurer's duty to inform the insured of settlement opportunities and the circumstances in which failure to do so can be used to impose excess judgment liability on the insurer. It also criticizes a burden of proof rule articulated in *Miller*.

I. THE CASE

Miller had an auto accident in which Mark Hopkins was severely injured. Allstate promptly offered Miller's \$25,000 policy limit. Miller was first represented by Steven Karen but switched to David Sampson. At the time of the switch, Karen notified Allstate of an attorney's lien of \$8,325. The hospital notified Allstate of a lien in the amount of \$67,564.84. Allstate sent a \$25,000 check jointly payable to Hopkins, Karen, Sampson, and the hospital. Sampson rejected this check but offered to release Miller if Allstate would file an interpleader action to determine the rights of all claimants to the policy proceeds. Allstate initially refused to do this; by the time it agreed to do so, the offer had expired. Hopkins then offered Miller an opportunity to stipulate to an excess judgment, in return for a limitation of his liability to the proceeds of any bad faith suit against Allstate. Allstate warned Miller that any settlement without its consent would jeopardize coverage, and Miller did not agree to the judgment. Hopkins later obtained a verdict against Miller of \$703,619.88, and Miller sued for bad faith. ⁿ²

Miller asserted three grounds for liability: (1) Allstate's failure to bring an interpleader action; (2) Allstate's failure

to adequately inform him of the interpleader offer; and (3) Allstate's refusal to agree to allow him to stipulate to an excess judgment. All three theories were submitted to the jury. Allstate asked for special interrogatories to determine, if the jury found liability, which theory or theories it relied on. The trial court refused those interrogatories, and the jury returned a general verdict of \$1,079,784.88 against Allstate. n3

The Nevada Supreme Court determined that Allstate had no duty to bring an interpleader action and was entitled to refuse consent to an excess judgment. n4 But liability could properly have been based on failure to inform. n5 The refusal of the special interrogatories made it impossible to determine the basis of the verdict, so a new trial was required. n6

The fact that Allstate had promptly offered its policy limits did not exhaust its duties to Miller. The court concluded that the duty to defend includes an obligation to adequately inform the insured of settlement opportunities that might avoid or reduce exposure to an excess judgment. n7 This duty attaches when the insurer learns of a settlement demand, even if no suit has yet been brought. n8

Here, Miller claimed that Allstate had told him that Hopkins had made an offer, but did not explain the request for an interpleader, stating only that Hopkins had asked Allstate to do things it does not do; Allstate's file did not document what Miller was told. n9 There was no evidence that Miller could not himself have filed an interpleader action or contributed to the filing of one. n10 Sampson testified that Hopkins would have released Miller if Allstate had either filed the interpleader or paid the funds to Sampson conditioned on his filing the interpleader. n11 Or Allstate might have offered Miller the option of initiating an interpleader after Allstate deposited the funds in court. n12 Miller testified that, if fully informed, he could and would have paid the costs for Allstate to file an interpleader. n13 Failure to follow one of the available courses of action at least might have been the proximate cause of the excess judgment. n14 Thus, there was a viable theory for liability. n15

There remained a question of burden of proof. The court concluded that doubts as to the insured's ability or willingness to settle should be resolved in favor of the insured "unless the insurer can show by affirmative evidence that there was no realistic possibility" of the insured doing so. n16 Here, Sampson testified that Miller would have been released if Allstate had filed or facilitated the filing of an interpleader. Allstate did not refute that evidence. While Allstate established that Miller did not know how much it would have cost to bring an interpleader action, it did not establish what the limit of his capability was or that the cost would have exceeded that limit. Accordingly, there was an issue of fact which the jury could have resolved in favor of liability. n17

II. Analysis n18

A. It Is Generally Agreed That an Insurer Must Keep Its Insured Informed of Developments Regarding Settlement That May Affect any Excess Exposure

The insurer has a duty to provide the insured with certain basic information regarding settlement opportunities. n19 (Defense counsel has an independent, and possibly more extensive duty in that regard. n20) In stressing the importance of informing the insured, one court explained:

An insured who is kept informed may have further information to give the carrier; he may use powers of persuasion upon the carrier to increase its offer; he may engage counsel; he may have other courses of action open to him. n21

Ideally, the insured should be informed whenever there has been a demand for settlement within policy limits if there is any likelihood that the recovery might exceed such limits. But one court has held that an insurer was not in bad faith when it failed to notify the insured of what was then a clearly excessive demand for an amount well within limits. n22 Furthermore, the insured should be told about any demand made for a sum in excess of policy limits so that he may have an opportunity to consider contributing to the excess amount to avoid litigation. n23

The insurer should point out to the insured the conflict of interest between itself and the insured. n24 When the insurer rejects a settlement offer and there is a risk that the judgment might exceed policy limits, the prudent insurer should (1) advise the insured of the risk of an excess judgment, (2) explain how this may affect the insured's rights, and (3) apprise the insured that he may secure private counsel to represent his interest in the litigation. n25 In particular, where a demand is above policy limits, the insured must be advised and given the opportunity to make a contribution sufficient to settle the case. n26 If there is an offer of contribution by another party which would reduce the contribution necessary from the insured, the insured should be told. n27

The information provided to an insured has been found deficient for reasons such as:

- insured never advised regarding exposure to noncovered punitive damages n28
- no evidence that insurer explained that the claimant's injury might not be diagnosed for a long period of time, that the amount of the damages might exceed the policy limits or that the claimant had offered a settlement within the policy limits; n29
- insured was not informed of the (never offered) value the insurer put on the case and, so, could not consider the possibility of supplementing that amount to achieve a settlement; n30 and
- the insured was not told that defense counsel was an insurer employee. n31

The duty of good faith and fair dealing requires an insurer to advise and inform its insured so that the insured will have sufficient information to make intelligent decisions to protect his own interests. n32 The information communicated to the insured must include the extent of the insured's potential exposure in the third party action and the status of settlement negotiations; without this information, the insured will not be able to make a meaningful decision regarding settlement. n33 When the insurer does not keep the insured sufficiently informed, the insurer cannot avoid liability for an excess judgment on the ground that the insured did not consent to settle the action. n34 Furthermore, the insurer must inform the insured in a timely manner so that the insured will be able to use the information effectively. n35 If the insured is unaware of the potential adverse liability to him and what steps the insured may take to protect his own interests, the insurer has not carried out its responsibilities to the policyholder. If an insurer misinforms the insured of facts regarding settlement and harm results, the insurer may expose itself to punitive damages. n36

B. The Duty to Inform Has Its Limits

When the insured has a limited ability to comprehend legal matters, the insurer must carefully explain to the insured the significance of information it conveys. n37 But while the duty to represent the insured in good faith includes the duty to explain clearly and simply the legal choices facing the insured[,] it is not an absolute duty to enlighten where enlightenment may be impossible because of the insured's refusal to listen or his incapacity to understand the most patient and lucid explanation. n38

When an insurer *has* fully informed the insured of the risks involved in litigating a claim as opposed to accepting a settlement, and the insured elects to litigate, a bad faith action against the insurer is normally precluded. n39

If the insured advises defense counsel that the insured is judgment proof and has no interest in contributing to any settlement, the insured may not need to be kept informed. n40

It has been suggested that there is no duty to inform the insured of settlement demands unless the insured faces a serious risk of excess exposure. n41 And one commentator has argued that there should be no obligation to inform the insured of unreasonable settlement demands:

While it is theoretically true that the insured might, at his or her own expense, have accepted an unreasonable settlement offer that the insurer properly rejected, thereby preventing an excess judgment, an insurer should not be held liable for an excess judgment on the basis of an insured's testimony to that effect. If for no other reason, the insurer should not be liable in that event because the insured's damages either would not have been sufficiently foreseeable or

would not have been proximately caused by the insurer's actions. n42

Both of these arguments should be rejected, unless the insured has agreed that no notice is necessary (e.g., because the insured lacks any ability or willingness to contribute to any settlement). The insurer's duty to accept a settlement is generally determined by whether a reasonable insurer, without policy limits, would do so. n43 But an insurer has a diversified portfolio of risks and is therefore assumed to be risk-neutral. An insured typically faces only a single risk and is usually risk averse. So it is to be expected that, if able to do so, insureds will often be willing to contribute to pay somewhat more than the reasonable settlement value of a case (as long as the insurer pays the reasonable value) and that they will sometimes be willing to make some payment to eliminate even a remote risk of excess exposure. An insured who is able and willing to make a contribution for that purpose would be denied the opportunity unless the insurer informed it of every settlement demand. Moreover, doing so involves almost no extra burden on the insurer, and defense counsel is typically obliged to communicate every settlement demand received. n44

It has been held that, where the apparent claim value is close to the policy limit, an insurer bargaining for a settlement modestly below that limit need not keep the insured and excess insurer informed of the details of negotiations. n45 For reasons just stated, this is unsound.

C. No Liability Flows from Failure to Inform Unless Harm Results

Failure to inform the insured of a settlement opportunity, standing alone, is not a basis for liability unless that failure caused harm to the insured. n46 Generally, there is no harm unless the insured would have been able and willing to contribute an amount (in addition to what the insurer was willing to pay) sufficient to induce the plaintiff to settle. n47 Where the insured and the claimant had a familial relationship that would have kept insured informed of settlement offers, the insurer's failure to do so was not prejudicial. n48 But, if the plaintiff asks for information about other insurance or the insured's assets, failure to obtain that information can be a cause of failure to settle and, hence, of an excess judgment. n49

There is authority that, once the insured has been advised of a settlement demand exceeding policy limits, the insurer has no liability unless the insured tells it of willingness to contribute the excess. n50 But, as between primary and excess insurers, the practice (and, arguably the legal rule) is that the primary insurer must tender its limits before the excess insurer is obliged to consider settlement. n51 This seems a logical rule for insureds as well, particularly because, in dealing with primary insurers, excess insurers are typically deemed to stand in the insured's shoes. n52

Failure to inform the insured is routinely listed as a factor that may be considered evidence of bad faith. n53 Analytically, failure to inform says nothing about whether a particular settlement amount would have been objectively reasonable. To the extent that objective reasonableness is the critical inquiry, as it is under the "disregard the limits" standard n54, that would indicate that failure to inform should be irrelevant unless the insured would have been willing and able to make a contribution sufficient to achieve a settlement. But, to the extent that the insurer's subjective intent is relevant, failure to inform could be evidence that the insurer did not properly regard the insured's interest.

D. *Miller's* Result May Be Correct, but Its Burden of Proof Rule Is Not

1. *Miller* Revisited

There is limited authority on who bears the burden of proof on whether a failure to more fully inform the insured caused any harm. Because causation of injury is part of a tort plaintiff's prima facie case, one would think it should be the plaintiff's burden to show that informing the insured would have made a difference. But *Miller* and several other cases not only put that burden on the insurer, but make it a very heavy one: doubts as to the insured's ability or willingness to settle should be resolved in favor of the insured "unless the insurer can show by affirmative evidence that there was no realistic possibility" of the insured doing so. n55 In *Miller* itself, it does not seem to have been necessary to address burden of proof. If there was any evidence that could have supported the verdict on the failure-to-inform theory, Allstate was not entitled to a judgment as a matter of law. Sampson had testified that a release could have been

obtained, without any extra expense to either Allstate or Miller, by paying the funds in a way that would have allowed Sampson to initiate the interpleader. One would think that the jury could have inferred that this possibility would have been discovered had Miller been informed of the possibility of interpleader and attempted to explore the option of funding that himself. The court might also have taken judicial notice that interpleaders where a disinterested stakeholder pays the funds into court are usually not very expensive for the stakeholder. Under either theory, the possibility that Miller might have had limited funds to finance the interpleader might not have created a barrier to recovery for failure to inform.

2. *Young v. American Casualty Co.*

The *Miller* court quotes the Couch treatise as specifying the burden of proof. Based on the cases cited there (and the cases they cite), the quoted language seems to have first appeared in *Young v. American Casualty Co.* n56 Quigley and Walker had operated the York Laundromat as partners, and American Casualty insured York with a limit of \$20,000 per person injured. Flynn slipped and fell on the premises and sued for severe injuries. Her counsel demanded \$40,000, and the lawyer hired by American Casualty responded that York did not have that kind of money or insurance. He never disclosed what the insurance limits was, never made any counter-offer, and never told Quigley and Walker of the demand or gave them any opportunity to contribute to a settlement. Flynn recovered a judgment of \$90,330.25, of which American Casualty paid \$20,000.

Quigley and Walker liquidated the laundromat and applied the proceeds, roughly \$7200 to the judgment. They then filed for bankruptcy and were discharged. The bankruptcy trustee then sued American Casualty for bad faith and recovered a judgment of \$70,330.25, the amount of the judgment, less American Casualty's payment. The Second Circuit affirmed. The jury could have found that the failure to properly investigate, to make any effort to settle within limits, or to inform the insureds of the possibility of a contribution was bad faith. On the issue of causation, the court wrote

American, ... having failed to make any response to Flynn's demand, and having failed to inform the insured of the possibility of settlement, should not now be heard to claim that bad faith cannot be found absent proof by the insured that a settlement within the policy limits was possible, or, in the alternative, that the insureds were willing and able to contribute any excess required to effect a settlement beyond the policy limits. Plaintiffs herein did not offer proof that either alternative could have been attained.

To require the insured to establish his willingness to contribute toward a settlement presupposes a settlement figure toward which contribution may be made. The personal injury plaintiff's initial demand is not the settlement figure against which proof of an insured's willingness to contribute should be measured. Had the insurer attempted to fulfill its responsibility by preliminary negotiations of the initial demand figure, the resultant settlement might well have been within the policy limits or, at worst, within the ability of the insured to make sufficient contribution to effect a settlement. *Any doubt which admittedly exists in speculating on these possibilities should be resolved in favor of the insured unless the insurer, by some affirmative evidence, demonstrates that not only was there no realistic possibility of settlement within the policy limits, but also that the insured would not have contributed to whatever settlement figure could have been obtained.* There was no basis for American to act as if the possibility of settlement was foreclosed by the initial demand of Margaret Flynn's counsel for \$40,000. n57

The court failed to recognize that the evidence before it went a considerable ways toward showing that there was a realistic possibility of settlement. There was only \$20,000 in insurance and, as liquidation of the laundromat and the bankruptcy demonstrated, the insureds had very limited assets. Tort plaintiffs usually have little interest in going to trial solely to obtain judgments for uncollectible amounts. The jury certainly could have inferred that, if informed of the limited funds available to pay any judgment, Flynn would have settled for policy limits (with, at most, a modest contribution from the insureds).

But, if that was not enough to support the verdict, why should the trustees have been excused from proving their

case. The sole creditor of the estate was Flynn, n58 so she had every reason to cooperate in the litigation. If she would have settled for policy limits or with a small contribution from the insureds, she could have so testified. The insureds stood to be reimbursed for the payment they had made on the judgment, so they, too, had an incentive to cooperate. If willing to make a contribution to the settlement, they could have so testified. Why should American Casualty have had the burden of inquiring about those facts? Indeed, one reason why there is so little law on the burden of proof issue may be that it is so easy for bad faith plaintiffs to provide the evidence that a settlement was possible.

A Florida case argues that testimony about what a party would have done had the insurer acted differently is "speculative," and that it is preferable to focus[] not on the mindset of the injured party, but on the conduct of the insurer under the circumstances. That is, rather than trying to conjure the secret intent of the injured party, courts simply ask whether under all the circumstances known to the insurer would reasonable diligence and ordinary care dictate an offer to settle within policy limits. The victim's unwillingness to settle, however, is not completely ignored under Florida law. The unwillingness to settle will become a factor only in the unlikely case where the insurer is able to conclusively prove the unwillingness to settle for the policy limits.

This allocation of the burden by the Florida courts makes sense, since foisting the burden on the plaintiff would make it virtually impossible for plaintiffs to succeed in cases where the insurance company simply chooses to ignore the injured party after an accident. In such cases, if the plaintiff does not make a formal offer to settle, she would (under the defendant's argument) be foreclosed from making a later bad faith claim simply because her testimony of her desire to settle would be perceived as speculative. The result of this would be to put the onus of initiating settlement negotiations back on the plaintiff, rather than the insurer. But ... Florida courts intend the burden to initiate settlement discussions be borne by the insurer, not the injured party. n59

The conduct of the insurer under the circumstances may prove breach of duty. But, standing alone, it says nothing about whether any breach caused harm. It is the insured and the injured party who know the facts that would establish whether any harm was caused. It would be strange to impose on the insurer the burden of eliciting that evidence from them. So, imposing on the insurer a duty to initiate negotiations does not require also giving it the burden of showing whether such negotiations could have succeeded. And, even if one were to impose such a burden, it is almost unheard of to require a party in a civil case to prove anything "conclusively."

In short, the result in *Young*, like that in *Miller*, may be justifiable, but the burden of proof rule announced there is not.

3. *Rova Farms Resort, Inc. v. Investors Insurance Co.*

The burden of proof rule announced in *Young* was quoted approvingly in *Rova Farms Resort, Inc. v. Investors Insurance Co.*, n60 but in dictum. Rova Farms Resort had a \$50,000 liability policy with Investors Insurance. Lawrence McLaughlin had a diving accident which rendered him a quadriplegic and sued Rova. Defense counsel and the court both urged a policy limits offer. On the first day of trial, Investors made its only offer, \$12,500, which was refused. The jury returned a verdict of \$225,000. Investors made no further offer. The New Jersey Superior Court, Appellate Division, granted a new trial. Defense counsel pointed out that this could result in an even larger verdict. Investors made no further offer. The New Jersey Supreme Court reinstated judgment on the verdict. Investors paid its \$50,000 limit, leaving Rova with a judgment of \$197,150.68 (including interest). Rova, which was affiliated with a national membership organization, succeeded in mortgaging its property and raising contributions to pay the judgment, after which it sued, recovering a bad faith judgment. n61 The New Jersey Supreme Court affirmed. n62

Rova was represented by its own counsel, Roth, as well as the defense counsel appointed by Investors. McLaughlin's counsel said he would recommend a policy limits offer to McLaughlin. McLaughlin had authorized his lawyer to accept \$75,000. Rova was cash-poor, but had the ability to raise funds. It authorized Roth to add \$25,000 if Investors offered its limit. (It did not tell Investors lest it be pressed for a contribution to a within-limits settlement, something Investors did anyhow.) So, settlement was possible for \$75,000 had Investors offered its limit. n63 After

describing the litigation and settlement opportunities in detail, the court commented that "the opportunities for settlement were so viable that it took a special genius at intransigence to kill them." n64

Investors argued that it should not be liable because McLaughlin never made a firm demand. The New Jersey Supreme Court rejected that argument: "[w]e ... hold that, that an insurer, having contractually restricted the independent negotiating power of its insured, has a positive fiduciary duty to take the initiative and attempt to negotiate a settlement within the policy coverage." n65 The court continued by stating the burden of proof rule previously stated in *Young*:

Any doubt as to the existence of an opportunity to settle within the face amount of the coverage or as to the ability and willingness of the insured to pay any excess required for settlement must be resolved in favor of the insured unless the insurer, by some affirmative evidence, demonstrates there was not only no realistic possibility of settlement within policy limits, but also that the insured would not have contributed to whatever settlement figure above that sum might have been available. n66

But, as just explained, there was no such doubt in *Rova Farms*. And the court noted this: "[f]rom what has been said it is clear that an opposite pattern of fact existed here." n67 Because the existence of a missed settlement opportunity was clearly established, the comment about burden of proof when that was in doubt was clearly dictum, n68 which merely added emphasis to the refusal to insist on plaintiff making a settlement demand.

Other cases which have employed this language have typically done so in the course of rejecting any requirement of a firm demand from the injured party. n69 Notably, *Alt v. American Family Mutual Insurance Co.* n70 quoted that language n71 in a case whose sole issue was whether a summary judgment had been properly granted to the insurer based on lack of a binding offer on behalf of the injured child. n72

Many jurisdictions do require a demand, and there is a substantial argument in favor of such a requirement. n73 In those states, the burden of proof issue addressed in *Rova Farms* would not arise except with regard to such things as failure to inform the insured of settlement opportunities.

III. CONCLUSION

Miller properly holds, in accord with the law generally, that failure to keep the insured informed regarding settlement opportunities can be a basis for excess judgment liability. But the court articulates a burden of proof rule that has crept into cases and treatises without real analysis. That rule is unsound and relieves the bad faith plaintiff of the obligation to show that harm was caused by an insurer's breach of duty to attempt settlement. Other courts should reexamine and reject that rule.

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n1 *Allstate Ins. Co. v. Miller*, 212 P.3d 318 (Nev. 2009).

n2 *Id.* at 323.

n3 *Id. at* 323-324.

n4 *Id. at* 329-331.

n5 *Id. at* 324-329.

n6 *Id. at* 331-334.

n7 *Id. at* 324-325.

n8 *Id. at* 325.

n9 *Id.*

n10

Id.

n11

Id. at 327.

n12 *Id.*

n13

Id. at 328.

n14 *Id.* at 327-328.

n15 *Id.* at 328.

n16 *Id.*, quoting 14 Couch on Insurance 3d § 203:18 (2005) (emphasis by the court omitted).

n17 *Id.* at 329.

n18 Some of this analysis is drawn from William T. Barker & Ronald D. Kent, Insurance Bad Faith Litigation, Second Edition, § 2.03[4].

n19 See generally *Ging v. American Liberty Ins. Co.*, 423 F.2d 115 (5th Cir. 1970) (FL law); *Herges v. Western Cas. & Sur. Co.*, 408 F.2d 1157 (8th Cir. 1969); (MN law) *Brockstein v. Nationwide Mut. Ins. Co.*, 417 F.2d 703, 708 (2d Cir. 1969) (NY law); 7C John Appleman & Jean Appleman, Insurance law & Practice § 4687 at 194-195 (1979 and Supp. 1991).

n20 E.g., *Miller v. Byrne*, 916 P.2d 566, 574-575 (Colo. Ct. App. 1995) (counsel must relay all settlement offers, even those believed not to be genuine); *Rogers v. Robson, Masters, Ryan, Brumund and Belom*, 74 Ill. App. 3d 467, 474 (1979), judgment *aff'd*, 81 Ill. 2d 201 (1980); *Tank v. State Farm Fire & Cas. Co.*, 105 Wash. 2d 381, 389 (1986). See ABA Model Rules of Prof. Cond., Rules 1.2(a) (lawyer must abide by client decisions about settlement), 1.4 (lawyer must keep client reasonably informed and explain all matters requiring decision by client); ABA Standing Committee on Ethics and Professional Responsibility, Op. 96-403 (1996) (lawyer may not accept insurer's direction to settle unless the insured has consented to doing so). Of course, restrictions on the lawyer's ability to settle do not prevent an adjuster from settling without defense counsel's assistance. See also *Hartford Accident & Indem. Co. v. Foster*, 528 So. 2d 255, 275 (Miss. 1988) (defense counsel was obligated to inform insured of settlement offer, but failure to do so not actionable absent evidence that doing so would have made any difference).

n21 *Martin v. Hartford Accident & Indem. Co.*, 228 Cal. App. 2d 178, 184 (1964).

n22 *Shelton v. Commercial Union Assurance Co.*, 396 So. 2d 1379, 1385 (La. Ct. App. 1981) (affirming summary judgment for insurer, even though plaintiff's condition had deteriorated after rejection of the demand, leading to a settlement requiring contribution by the insured).

n23 See *Kaudern v. Allstate Ins. Co.*, 277 F. Supp. 83, 90 (D.N.J. 1967); *State Farm Mut. Auto. Ins. Co. v. White*, 248 Md. 324, 333 (1967) *Kooyman v. Farm Bur. Mut. Ins. Co.*, 315 N.W.2d 30, 35-36 (Iowa 1982).

n24 See *Herges v. Western Cas. & Sur. Co.*, 408 F.2d 1157, 1162 n.7 (8th Cir. 1969) (MN law).

n25 See *Loudon v. State Farm Mut. Auto. Ins. Co.*, 360 N.W.2d 575, 579-80 (Iowa Ct. App. 1984);

Herges, 408 F.2d at 1162 & n.7 (discussing requirements and customary procedures for satisfying them).

n26 *Merritt v. Reserve Ins. Co.*, 34 Cal. App. 3d 858, 875 (1973); *Kooyman v. Farm Bur. Mut. Ins. Co.*, 315 N.W.2d 30, 36 (Iowa 1982); *State Farm Lloyds Ins. Co. v. Maldonado*, 935 S.W.2d 805, 815 (Tex. Ct. App. 1996), rev'd in part on other grounds, 963 S.W.2d 38 (Tex. 1998); *Truck Ins. Exch. v. Century Indem. Co.*, 76 Wash. App. 527, 534 (1995).

n27 *Kooyman v. Farm Bur. Mut. Ins. Co.*, 315 N.W.2d 30, 36 (Iowa 1982);

n28 *Md. Cas. Co. v. Dixie Ins. Co.*, 622 So. 2d 698, 702 (La. Ct. App. 1993).

n29 *Keith v. Comco Ins. Co.*, 574 So. 2d 1270, 1279 (La. Ct. App. 1991).

n30 *Gibson v. Western Fire Ins. Co.*, 210 Mont. 267, 289 (1984).

n31 *Kaudern v. Allstate Ins. Co.*, 277 F. Supp. 83, 91 (D.N.J. 1967)

n32 See *Bankr. Est. of Morris v. COPIC Ins. Co.*, 192 P.3d 519, 524-27 (Colo. Ct. App. 2008) (summary judgment precluded by disputed issues of material fact whether insurer properly advised the insured doctor as to risks of trial, risks of an excess verdict, the right to retain personal counsel, and the possibilities of settlement); *Menchise v. Liberty Mut. Ins. Co.*, 932 So. 2d 1130 (Fla. Dist. Ct. App. 2d Dist. 2006) (when plaintiff offered to settle the claim for the policy limits if given an affidavit from the insured stating that there was no other insurance and that the accident was not work-related, insurer never checked with the insured about the affidavit); *Myers v. Ambassador Ins. Co.*, 146 Vt. 552, 557-558 (1986) (where insurer kept insured completely in the dark regarding major developments, court found bad faith as a matter of law).

n33 *Limor v. Travelers Ins.*, 463 F. Supp. 2d 813, 817-818 (M.D. Tenn. 2006); *Loudon v. State Farm Mut. Auto. Ins. Co.*, 360 N.W.2d 575 (Iowa Ct. App. 1984); *Ins. Co. of N. Am. v. Med. Prot. Co.*, 570 F. Supp. 964, 972-973 (D. Kan. 1983), *aff'd*, 768 F.2d 315 (10th Cir. 1985); *Truck Ins. Exch. v. Bishara*, 128 Idaho 550, 555 (1996) (factual issue whether the settlement offer had been communicated to the insured precluded judgment for the insurer as a matter of law).

n34 *Ins. Co. of N. Am. v. Med. Prot. Co.*, 768 F.2d 315, 319-320 (10th Cir. 1985); *Schlossberg v. Epstein*, 73 Md. App. 415, 434 (1988).

n35 *Yeomans v. Allstate Ins Co.*, 130 N.J. Super. 48, 51-52 (App. Div. 1974).

n36 *Am. Physicians Assurance Corp. v. Schmidt*, 187 S.W.3d 313, 318 (Ky. 2006).

n37 See *Kinder v. Western Pioneer Ins. Co.*, 231 Cal. App. 2d 894, 898 (1965) (insured was a person of "below-average intelligence").

n38 *Steele v. Hartford Fire Ins. Co.*, 788 F.2d 441, 447 (7th Cir. 1986) (IL law) (Posner, J.).

n39 See William T. Barker & Ronald D. Kent, *Insurance Bad Faith Litigation*, Second Edition, § 2.04[2].

n40 *Murach v. Mass. Bonding & Ins. Co.*, 339 Mass. 184, 189 (1959).

n41 *Hodges v. Standard Accident Ins. Co.*, 198 Cal. App. 2d 564, 577 (1961).

n42 1 Allen D. Windt, *Insurance Claims & Disputes*, § 5:8, at 5:45 (5th ed. 2007).

n43 See William T. Barker & Ronald D. Kent, *Insurance Bad Faith Litigation*, Second Edition, § 2.02[2][d].

n44 *E.g.*, Model Rules of Prof. Cond., Rule 1.4(A)(1) & cmt. [2] (2008); Restatement (Third) of the Law Governing Lawyers § 20(3) & cmt *e* (perm. vol. 2000).

n45 *Bohn v. Sentry Ins. Co.*, 681 F. Supp. 357, 364-365 (E.D. La. 1988).

n46 See *Shelton v. Commercial Union Assurance Co.*, 396 So. 2d 1379, 1385 (La. Ct. App. 1981) (affirming summary judgment for insurer; failure to inform did not prejudice the insured); *Teague v. St. Paul Fire & Marine Ins. Co.*, 974 So. 2d 1266, 1276 (La. Ct. App. 2009) (insurer-selected defense counsel is not liable for failure to inform unless that failure was the legal cause of some harm to the insured); *State Farm Mut. Auto. Ins. Co. v. Floyd*, 235 Va. 136 (1988) (no causation as matter of law; personal counsel had advised insured that any judgment would likely be within limits and insured would not have wanted to contribute). *But see Insurance Co. of N. Am. v. Medical Protective Co.*, 768 F.2d 315 (10th Cir. 1985) (KS law) (if insurer fails to properly inform insured, it cannot escape the consequences by saying that doing so would have made no difference); *Myers v. Ambassador Ins. Co.*, 146 Vt. 552, 557-558 (1986) (where insurer kept insured completely in the dark regarding major developments, court found bad faith as a matter of law, and insurer could not escape consequences by saying that informing insured would have made no difference; insured could have contributed, but no indication whether he would have).

n47 See *McChristian v. State Farm Mut. Auto. Ins. Co.*, 304 F. Supp. 748, 755 (W.D. Ark. 1969) (insured judgment proof); *Merritt v. Reserve Ins. Co.*, 34 Cal. App. 3d 858, 875 (1973) (if insured lacks the resources to add to the insurer's offer, nothing the insurer can do in informing the insured will make any difference), 34 Cal. App. 3d. at 879 (failure to inform no basis for liability where it had no causal connection to failure to settle);

Norwood v. Travelers Ins. Co., 204 Minn. 595, 598 (1939) (insured had no substantial assets) (overruled in part by *Lange v. Fidelity Ins. Co.*, 290 Minn. 61 (1971)).

n48 *Smith v. Audubon Ins. Co.*, 679 So. 2d 372, 377 n.10 (La. 1996).

n49 *E.g., Menchise v. Liberty Mut. Ins. Co.*, 932 So. 2d 1130 (Fla. Dist. Ct. App. 2006);

see Sobus v. Lumbermen Mut. Cas. Co., 393 F. Supp. 661, 679 (D. Md. 1975) (insurer responded adequately), *aff'd without opinion*, 532 F.2d 751 (4th Cir. 1976).

n50 *State Farm Lloyds Ins. Co. v. Maldonado*, 963 S.W.2d 38, 41 (Tex. 1998).

n51 *See* William T. Barker & Ronald D. Kent, *Insurance Bad Faith Litigation*, Second Edition, § 2.08[3].

n52 *See id.* § 2.08[1].

n53 *See id.* § 2.02[4][a].

n54 *See id.* § 2.02[d].

n55 *Allstate Ins. Co. v. Miller*, 212 P.3d 318, 328 (Nev. 2009), *quoting* 14 Couch on Insurance 3d § 203:18 (2005) (emphasis by the court omitted).

n56 *Young v. Am. Cas. Co.*, 416 F.2d 906, 910-11 (2d Cir. 1969) (NY law).

n57 *Id.* at 911 (emphasis added).

n58 *Id.* at 909.

n59 *Snowden v. Lumbermens Mut. Cas. Co.*, 358 F. Supp. 2d 1125, 1129 (N.D. Fla. 2003). The court relied on *Powell v. Prudential Prop. & Cas. Ins. Co.*, 584 So. 2d 12, 14 (Fla. Ct. App. 1984), which noted that Florida rejects any requirement of a demand from the injured party and quoted the language on burden of proof, even though there was no burden of proof issue in the case. Even though the language was dictum in *Powell*, *Snowden* treated it as authoritative.

n60 *Rova Farms Resort, Inc. v. Investors Ins. Co.*, 65 N.J. 474, 496 (1974).

n61 *Id.* at 478-783.

n62 *Id.* at 507.

n63 *Id.* at 485-486.

n64 *Id.* at 494.

n65 *Id.* at 495.

n66 *Id.*

n67 *Id.*

n68 While theoretically dictum, the *Rova Farms* language was quoted as authoritative on a bad faith issue arising in the context of liability for prejudgment interest. *New Jersey Mfrs. Ins. Co. v. Nat'l Cas. Co.*, 393 N.J. Super. 340, 353 (App. Div. 2007). The issue was not whether a settlement could have been reached, but whether the primary insurer was obliged to offer its limit, allowing negotiations with the excess insurer. So, burden of proof was not an issue and the language on that subject was, again, dictum.

The *Rova Farms* language on burden of proof was also quoted as authoritative in *Venetsanos v. Zucker, Facher & Zucker*, 271 N.J. Super. 459, 474-475 (App. Div. 1994), also primarily on the point that no demand was necessary. Moreover, the documentary evidence "leans heavily to the belief that a tender [of the primary limits] would have materially enhanced settlement possibilities" and there was no contrary evidence. *Id.* But, because summary judgment had been entered for the plaintiff, the affirmance may have rested on the burden of producing evidence set forth in the *Rova Farms* language.

n69 *E.g., Morrell Constr., Inc. v. Home Ins. Co.*, 920 F.2d 576, 580-581 (9th Cir. 1990) (ID law).

n70 *Alt v. American Family Mutual Insurance Co.* 71 Wis. 2d 340 (Sup. Ct. 1976).

n71 *Id.* at 351-352.

n72 *See id.* at 342.

n73 *See* William T. Barker & Ronald D. Kent, *Insurance Bad Faith Litigation*, Second Edition, § 2.03[6][d][iii]. The *Rova Farms* language on burden of proof is sometimes quoted when the subject of the discussion is not burden of proof, but merely whether a demand by the tort plaintiff is necessary to create a duty to settle. *E.g., Venetsanos v. Zucker, Facher & Zucker*, 271 N.J. Super. 459, 474-475 (App. Div. 1994); *Alt*, 71 Wis. 2d at 351-352.

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McCarter & English LLP on Limiting the "Absolute" Pollution Exclusion

2010 Emerging Issues 4926

McCarter & English LLP on Limiting the "Absolute" Pollution Exclusion to "Traditional" Pollution

By Louis A. Chiafullo and David C. Kane

March 24, 2010

SUMMARY: A growing number of courts are refusing to construe the breadth of pollution exclusions in insurance liability policies beyond "traditional" environmental pollution. Those courts have found that pollution exclusions do not bar coverage for claims arising from exposure to painting and sealing fumes, toxic chemicals, carbon monoxide, and pesticides.

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ARTICLE: The scope of pollution exclusions has been in dispute for decades, centering first on the "sudden and accidental" pollution exclusion that appeared in the 1970s, and next on the so-called "absolute" pollution exclusions that became relatively standard in liability policies in the mid-1980s. The latest battles have centered on whether claims arising out of "non-traditional" pollution -- that is, not the traditional property damage caused by hazardous waste -- come within the purview of the exclusion.

Carriers argue the "plain language" of the exclusion, when read broadly, includes both "traditional" and "non-traditional" pollution. A growing number of courts, however, refuse to construe the breadth of pollution exclusions beyond "traditional" environmental pollution. Courts generally reach this conclusion based on the originally stated purpose of the exclusion and policyholders' reasonable expectations, though some rely solely on the language of the exclusion. This article addresses recent judicial opinions in which courts refused to apply the exclusion to specific types of "non-traditional" pollution, such as: (1) painting and sealing fumes; (2) toxic chemicals; (3) carbon monoxide; and (4) pesticides.

I. Painting & Sealing Fumes

The New Jersey Supreme Court addressed the "traditional" versus "non-traditional" issue squarely in the 2005 case *Nav-Its, Inc. v. Selective Insurance Co. of America*. n1 The issue addressed by the court was "whether we should limit the applicability of the pollution exclusion clause to traditional environmental pollution claims." n2 The court

concluded the pollution exclusion precluded recovery only for "traditional" types of pollution and refused to find that the exclusion was applicable to the claims by the policyholder.

The policyholder, a construction contractor, hired a painting subcontractor to perform painting, coating and floor sealing work in an office building. n3 A physician within the office space suffered "nausea, vomiting, light-headedness, loss of equilibrium, and headaches" during performance of the work. n4 The physician subsequently filed a complaint against the insured for personal injuries from exposure to fumes. n5 The insurer relied on the pollution exclusion as a basis for denying coverage under its comprehensive general liability ("CGL") policy. n6

The policy's pollution exclusion barred coverage for damage "to persons or property" arising out of, or which would not have occurred but for, the "pollution hazard." n7 The policy defined "pollution hazard" as "an actual exposure or threat of exposure to the corrosive, toxic or other harmful properties of any 'pollutants' arising out of the discharge, dispersal, seepage, migration, release or escape of such pollutants." n8 Pollutants included "any solid, liquid, gaseous, or thermal irritant or contaminant, including smoke, vapor, soot, fumes, acids, alkalis, chemicals and waste." n9 The insurer argued the fumes constituted a "pollutant" within the scope of the pollution exclusion.

The trial court disagreed and granted summary judgment in favor of the policyholder. n10 As the trial court explained, "the pollution exclusion clause in the policy applied only to traditional environmental pollution claims." n11 The Appellate Division reversed, finding the pollution exclusion was not limited to the cleanup of traditional environmental damage. n12

The Supreme Court of New Jersey began its analysis with a review of the drafting history and purposes behind pollution exclusions. It cited to assurances by the insurance industry to New Jersey insurance regulators during the approval process for the absolute pollution exclusion that "[the purpose of the change in policy language in the absolute pollution exclusion] is to introduce a complete on-site emission and partial off-site exclusion for some operations" and "the exclusion would not preclude coverage for liability for a policyholder's products and completed operations." n13 Also persuasive to the Supreme Court was the fact that carriers developed the absolute pollution exclusion to address expanding liability under the Comprehensive Environmental Response, Compensation and Liability Act ("CERCLA"). n14 The Supreme Court concluded that the pollution exclusion clause "in its various forms demonstrates that its purpose was to have a broad exclusion for traditional environmentally related damages." n15

According to the court, painting and sealing fumes did not constitute "traditional" forms of pollution. Thus, it considered the insurer's interpretation of the pollution exclusion "overly broad, unfair, and contrary to the objectively reasonable expectations of the New Jersey and other state regulatory authorities that were presented with an opportunity to disapprove the clause." n16 The pollution exclusion therefore did not bar coverage for the bodily injury resulting from exposure to fumes.

In *Belt Painting Corp. v. TIG Insurance Company*, the Court of Appeals of New York similarly refused to apply the pollution exclusion to bodily injury resulting from fumes. n17 One of the policyholder's workers alleged injury due to inhalation of paint or solvent fumes while performing work in an office space. n18 In the insurance coverage declaratory judgment action that followed, the trial court granted summary judgment to the insurer on the ground that the claim fell within the pollution exclusion. n19 The Appellate Division reversed, finding the pollution exclusion "applies only where the damages alleged 'are truly environmental in nature' or result from 'pollution of the environment.'" n20

The Court of Appeals surveyed nationwide judicial interpretation of the pollution exclusion, noting courts have split on whether it applies to "non-traditional" pollution. n21 The Court of Appeals fell in line with case law denying application of the exclusion to "non-traditional" pollution, finding the exclusion ambiguous as applied to the fumes at issue. n22 Though the policy broadly defined "pollutants" to include "fumes," the Court of Appeals was "reluctant to adopt an interpretation that would infinitely enlarge the scope of the term 'pollutants,' and seemingly contradict both a 'common speech' understanding of the relevant terms and the reasonable expectations of a business person." n23 The

Court of Appeals ultimately held "[i]t cannot be said that this language unambiguously applies to ordinary paint or solvent fumes that drifted a short distance from the area of the insured's intended use and allegedly caused inhalation injuries to a bystander." n24

In a recent decision, the federal court for the District of South Carolina dealt with application of the absolute pollution exclusion in a contractor's insurance policy to bodily injuries arising from paint fumes. In *NGM Insurance Co. v. Carolina's Power Wash & Painting, LLC*, the policyholder faced potential liability for alleged injuries suffered by postal workers during painting of a post office. n25 The definition of "pollutant" included any "irritant or contaminant" as well as "fumes." n26 The insurer argued the paint fumes constituted a "pollutant" within the exclusion.

Under South Carolina law, the reasonable expectations of a policyholder have no bearing on the interpretation of an insurance policy. n27 Furthermore, no South Carolina case law addressed the "traditional" versus "non-traditional" pollution issue. Thus, the District Court reviewed judicial opinions nationwide and relied most heavily on *Belt Painting, above*, which involved a nearly identical exclusion, to reach its conclusion that the pollution exclusion did not bar coverage. It focused on the New York Court of Appeals' analysis that the insurer's interpretation of the exclusion was over inclusive. n28 It also found persuasive the New York court's finding that when fumes drift a short distance from the work area, no "discharge, dispersal, seepage, migration, release or escape" unambiguously occurs. n29 As a result, the District Court found the exclusion ambiguous and, in accordance with basic tenets of policy interpretation, construed it in favor of the policyholder.

Though it did not frame the issue this way, the federal court for the Southern District of Texas recently refused to apply the pollution exclusion to "non-traditional" pollution, addressing the issue from a purely textual approach. In *National Casualty Insurance Co. v. Orion Transport, Inc.*, the policyholder's trailer exploded and killed a maintenance worker. n30 The estate filed suit, alleging the trailer had been used to transfer oil that left a "dangerous and potentially explosive residue" in the trailer." n31 The insurer filed a declaratory judgment action, alleging it had no coverage obligations because of the pollution exclusion. n32

The District Court focused on the language of the policy, stating:

"Pollutant" is defined by the Policy to mean "any solid, liquid, gaseous or thermal irritant or contaminant, including smoke, vapor, soot, fumes, acids, alkalis, chemicals and waste. Waste includes materials to be recycled, reconditioned or reclaimed." There is no dispute that the "dangerous and potentially explosive residue" that [the underlying complaint alleges] "remained in the trailer" is a "pollutant" under the Policy. n33

Nonetheless, the District Court held the pollution exclusion did not bar coverage. By its language, the exclusion applied to "bodily injury or property damage arising out of the...discharge, dispersal, seepage, migration, release or escape of pollutants." n34 The underlying injury did not involve a "discharge, dispersal, seepage, migration, release or escape." n35 The pollution exclusion therefore was inapplicable. Though the opinion rests solely on policy language, it is in agreement with cases finding the exclusion applies only to "traditional" pollution discharged into the environment.

Similarly, the Sixth Circuit held in *Meridian Mutual Insurance Co. v. Kellman* that the absolute pollution exclusion did not preclude coverage for injuries caused by toxic substances confined within the general area of their intended use. n36 In that case, a teacher sued a contractor for alleged injuries arising out of fumes from chemicals used to seal a floor in the school where the teacher worked. n37 The insurer denied coverage to the contractor based on the absolute pollution exclusion. n38

The parties agreed the sealer constituted a pollutant. n39 Nonetheless, the trial court ruled for the insured, stating:

[T]he pollution exclusion clause is intended to protect the insurer from liability for the enforcement of environmental laws. The exclusion contains environmental terms of art because it is intended to exclude coverage only as it relates to environmental pollution. When a toxic substance is confined to an area of intended use it does not come within the exclusion clause. n40

The Sixth Circuit agreed, stating "no reasonable person could find that the insurance policy at issue unambiguously excluded coverage for injuries suffered by an employee who was legitimately in the immediate vicinity of the chemicals, and where the injury occurred only a few feet from where the chemicals were being used." n41

II. Toxic Chemicals

In perhaps the most recent opinion to address the "traditional" versus "non-traditional" issue, the federal court for the Northern District of Illinois denied application of the pollution exclusion to toxic chemicals. *Pacific Employers Insurance Co. v. Clean Harbors Environmental Services, Inc.* involved an underlying complaint for bodily injury due to inhalation of poisonous and toxic fumes emitted from fuel at the insured's facility. n42 In the coverage action, the District Court was bound by an Illinois decision that found, based on the drafting history and over-inclusiveness of the pollution exclusions, the exclusion applied "to only those hazards traditionally associated with environmental pollution." n43

Thus, the issue before the court was whether fumes from toxic chemicals constituted "traditional" pollution. n44 The District Court drew a distinction between environmental pollution and injuries sustained during day-to-day operations of a company, even if they arguably resulted from pollutants. n45 The injuries at issue occurred during the day-to-day duties of the injured party. n46 Hence, the pollution exclusion had no bearing upon the insured's claim for coverage because the toxic chemicals did not constitute "traditional" pollution. n47

III. Carbon Monoxide

The United States Bankruptcy Court for the District of Delaware's recent opinion in *In re IdleAire Technologies Corp.* reached a similar conclusion in a case involving bodily injury arising from carbon monoxide. n48 The insured produced HVAC delivery systems that provided heating, cooling, and ventilation for trucks at rest stops while drivers slept. n49 Two drivers suffered injuries from carbon monoxide that allegedly resulted from the insured's HVAC unit. n50 The insurer argued the pollution exclusions in its CGL and umbrella/excess policies precluded coverage. n51

Like the New Jersey Supreme Court, the court began with a review of the history of pollution exclusions. n52 During the approval process of the absolute pollution exclusion, regulators were aware of "the possibility of over-broad application of the exclusion." n53 In response, the insurance industry represented that "coverage would not be denied for events outside of the traditional understanding of environmental pollution." n54 Approval of the exclusion was based in part upon these reassurances. n55

The court then addressed the policyholder's reasonable expectations. It concluded the policyholder had a reasonable expectation of coverage for two reasons: (1) the insurance industry's representations during approval of the exclusion; and (2) the fact that the policyholder was not a "polluter" but rather an HVAC producer. n56 Next, the court found the exclusion ambiguous because the terms "irritant" and "contaminant," excluded from coverage under the pollution exclusion, "are virtually boundless in their inclusion, for there is virtually no substance or chemical in existence that would not irritate or damage some person or property." n57 Thus, it applied a "limiting principle," which it termed the "common sense approach," to conclude "the circumstances are too far removed from the common understanding of pollution and applying the exclusion here would lead to an absurd result." n58

On March 4, 2010, the federal court for the District of Nevada, applying Nevada law, construed a pollution exclusion in favor of coverage when the insurer attempted to apply it to bodily injury resulting from carbon monoxide exposure. In *Century Surety Co. v. Casino West, Inc.*, four individuals died from inhalation of carbon monoxide in a hotel room. n59 The carbon monoxide arose from the motel's pool heater and entered the room because the air intake openings were blocked. n60 The motel's insurer denied coverage under a CGL policy and filed a declaratory judgment action. n61

The pollution exclusion barred coverage for bodily injury "arising out of the actual, alleged or threatened discharge, dispersal, seepage, migration, release or escape of 'pollutants.'" n62 The exclusion contained an exception

for bodily injury "sustained within a building and caused by smoke, fumes, vapor or soot from equipment used to heat that building." n63 The insurer argued the exception evidenced "an intent to apply the pollution exclusion to all indoor air quality issues *except* when the fumes are generated by the building's heater." n64

The District Court directly refuted the insurer's argument, holding:

While a reasonable person of ordinary intelligence might understand carbon monoxide is a pollutant when emitted in some settings, an ordinary policyholder may not reasonably characterize carbon monoxide emitted from a motel pool heater as pollution. Additionally, a reasonable policyholder might not view the exception regarding fumes from the building's heater as an indication that all other possible types of indoor fumes would be excluded as "pollutants." n65

Concluding the exclusion was subject to more than one reasonable interpretation, the District Court found it ambiguous and construed it against the insurer. n66

Langone v. American Family Mutual Insurance Company also involved the potential application of the pollution exclusion to carbon monoxide. The Langone brothers suffered injury, and one died, after they inhaled carbon monoxide in a residential apartment. n67 The Langones sued the building's owner and the owner's insurer. n68 The insurer contended it had no coverage obligation as a result of the absolute pollution exclusion in the policy, arguing carbon monoxide constituted a "pollutant." n69

The policy defined "pollutant" as "any...gaseous or thermal irritant or contaminant, including...vapor [and] fumes." n70 Even with this broad definition, the court found "[t]he policy and dictionary definitions of the term 'pollutant' do not suffice to unambiguously categorize carbon monoxide as pollution under the facts of this case." n71 Essential to the court's decision was its recognition that:

...most people are exposed to carbon monoxide in small quantities every day. Like carbon dioxide, carbon monoxide is colorless, odorless, and present in the air around us. According to the Environmental Protection Agency, homes without a gas stove have average carbon monoxide levels between .5 and 5 parts per million while areas near a properly adjusted gas stove may have levels as high as 5 to 15 parts per million. Thus the concentrated level of carbon monoxide in the Longones' apartment could be described as a normal condition gone awry. n72

The court concluded carbon monoxide "becomes harmful when levels are abnormally high or exposure is unusually extended" and the extraordinary concentration of carbon monoxide at the residence "would not ordinarily be characterized as a 'pollutant.'" n73 Thus, the pollution exclusion did not bar coverage.

IV. Pesticides

In *MacKinnon v. Truck Insurance Exchange*, the policyholder's tenant died from exposure to pesticides during extermination of bees. n74 The insurer argued the pollution exclusion applied because pesticides are "chemicals" that may constitute an "irritant" and "pollutant," and the spraying constituted a "discharge" or "dispersal," within the exclusion. The Supreme Court of California, however, refused to apply the pollution exclusion to permit the insurer to avoid coverage.

In its review of the pollution exclusion's purpose, the court found "[e]ven commentators who represent the insurance industry recognize that the broadening of the pollution exclusion [from the 'sudden and accidental' to 'absolute'] was intended primarily to exclude traditional environmental pollution rather than all injuries from toxic substances." n75 Like the New Jersey Supreme Court, the California court noted the broadening of the exclusion arose largely from the passage of CERCLA, which addressed remediation of environmental pollution. n76

The court then recognized the absurdity of the insurer's position, finding "[v]irtually any substance can act under

the proper circumstances as an 'irritant or contaminant.'" n77 Next, the court found that neither dictionary definitions nor common usage of "disperse" or "discharge" included "spray" or "apply." n78 Thus, the court held that "the plain meaning of the pollution exclusion...turns on the meaning of the term 'pollutant.'" n79 In the court's view, this term did not include pesticides. Therefore, the court limited the pollution exclusion to "traditional" pollution in accordance with "the purpose of CGL policies -- which 'is to provide the insured with the broadest spectrum of protection against liability for unintentional and unexpected personal injury or property damage arising out of the conduct of the insured's business.'" n80

V. Conclusion

Although courts are still split on application of the pollution exclusion to "non-traditional" pollution, a broad consensus has emerged that the exclusion applies only to "traditional" environmental pollution. Courts recognize that while the language of the exclusion may be broad, the purpose, as evidenced by the insurance industry's assurances, was to preclude coverage for "traditional" pollution. Furthermore, inclusion of "non-traditional" pollution within the purview of the exclusion does not comport with the reasonable expectations of policyholders and often defies the text of the exclusion.

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n1 869 A.2d 929, 930 (N.J. 2005).

n2 *Id.* at 933.

n3 *Id.*

n4 *Id.*

n5 *Id.*

n6 *Id.*

n7 *Id. at 931.*

n8 *Id.*

n9 *Id. at 932.*

n10 *Id. at 930.*

n11 *Id. at 931.*

n12 *Id.*

n13 *Id. at 936.*

n14 *Id.*

n15 *Id. at 936-37.*

n16 *Id. at 937.*

n17 *100 N.Y.2d 377 (2003).*

n18 *Id. at 382.*

n19 *Id. at 383.*

n20 *Id.*

n21 *Id. at 384-87.*

n22 *Id. at 387.*

n23 *Id.*

n24 *Id. at 387-88.*

n25 No. 2:08-cv-3378-DCN, 2010 U.S. Dist. LEXIS 2362 (D.S.C. Jan. 12, 2010).

n26 *Id. at *6.*

n27 *Id. at *17.*

n28 *Id. at *19.*

n29 *Id.*

n30 *No. H-09-1539, 2010 U.S. Dist. LEXIS 15004* (S.D. Tex. Feb. 22, 2010).

n31 *Id.* at *16.

n32 *Id.* at *4.

n33 *Id.* at *17.

n34 *Id.*

n35 *Id.* at 21.

n36 *197 F.3d 1178 (6th Cir. 1999)*.

n37 *Id.* at 1180.

n38 *Id.*

n39 *Id.*

n40 *Id.* at 1180-81.

n41 *Id.* at 1183.

n42 No. 08 C 2180, 2010 U.S. Dist. LEXIS 10668, at *4-5 (N.D. Ill. Feb. 4, 2010).

n43 *Id.* at *10 (citing *Am. States Ins. Co. v. Koloms*, 177 Ill. 2d 473 (1997)).

n44 *Id.* at *11.

n45 *Id.* at *14.

n46 *Id.* at *15.

n47 *Id.*

n48 No. 08-10960(KG), 2009 Bankr. LEXIS 343 (Bankr. D. Del. Feb. 18, 2009).

n49 *Id.* at *2-3.

n50 *Id.* at *3.

n51 *Id.* at *3-4.

n52 *Id.* at *12-24.

n53 *Id.* at *17.

n54 *Id.* at *18.

n55 *Id.*

n56 *Id.* at *27-28.

n57 *Id.* at *30-31.

n58 *Id.* at *36-37.

n59 No. 3:07-cv-00636-RCJ-RAM, 2010 U.S. Dist. LEXIS 19807, at *2 (D. Nev. March 4, 2010).

n60 *Id.*

n61 *Id.* at *4.

n62 *Id.* at *3.

n63 *Id.* at *9.

n64 *Id.* (emphasis in original).

n65 *Id.* at *12.

n66 *Id.*

n67 731 N.W.2d 334, 335 (Wis. Ct. App. 2007).

n68 *Id.*

n69 *Id.* at 335-36.

n70 *Id.* 337.

n71 *Id.* at 338.

n72 *Id.*

n73 *Id.* at 340.

n74 3 Cal. Rptr. 3d 228, 252 (Cal. 2003).

n75 *Id.* at 235.

n76 *Id.* at 236.

n77 *Id.* at 240.

n78 *Id.* at 241.

n79 *Id.* at 242.

n80 *Id.* at 243 (citing *Westchester Fire Ins. Co. v. City of Pittsburg*, 768 F. Supp. 1463, 1468 (D. Kan. 1991)).

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Reed Smith LLP on The Duty to Pay Defense Costs Under D&O Insurance Policies

2010 Emerging Issues 4921

Reed Smith LLP on the "Four Corners" Rule and the Duty to Pay Defense Costs -- A Potent Tool for Policyholders Under D&O Insurance Policies

By John B. Berringer and Jill N. Averett

March 19, 2010

SUMMARY: Courts around the country have refused to allow D&O insurance companies to walk away from their defense obligations based upon their unilateral conclusion that the allegation of officer or director misconduct triggering an exclusion has "in fact" taken place.

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ARTICLE: INTRODUCTION

Officers, directors and their corporations routinely are denied the full benefits of the D&O Insurance Policies they purchased at great cost when lawsuits naming them as defendants include allegations of intentional wrongdoing which arguably trigger policy exclusions. Even though such exclusions routinely provide that coverage will not be forfeited until it can be shown that the wrongdoing triggering the exclusion has "in fact" occurred, insurance companies will often refuse to honor their contractual promise to pay defense costs based upon their unilateral conclusion that the allegations of misconduct are well-founded. Courts around the country, however, have refused to allow insurance companies to walk away from their defense obligations based upon the insurance company's unilateral conclusion that the allegation misconduct triggering an exclusion has "in fact" taken place.

REASONING

The decision by these courts is firmly rooted in traditional black-letter law in many states concerning the defense obligations of liability insurers. In fact, it is black-letter law in jurisdictions around the country, including Texas and New York that, Texas' "eight corners" ⁿ¹ rule, as long as "the complaint alleges at least one cause of action within the Policy's coverage, the insurer must defend the insured". ⁿ²

This result is consistent with the law in other jurisdictions applying the "eight corners" rule. ⁿ³ Neither can an insurer argue that the "eight corners" rule does not apply, or should be applied in a different fashion, because D&O policies generally impose a duty to pay defense costs, in contrast with a duty to defend, in connection with the

underlying claims. As noted by the New York Appellate Court in *Federal Insurance Co. v. Kozlowski*, the "effective difference between [these] two defense obligations is who chooses and pays the defense attorney, not whether a defense obligation lies with the insurer." n4 Accordingly, both an insurer's duty to defend and to pay defense costs must be construed broadly in favor of the policyholder. n5 Indeed, in *Julio & Sons*, a case involving the duty to advance defense costs under a D&O insurance policy, the court noted that

[it] has found no decisions by the Texas courts concerning a different standard for a duty to advance defense costs, and the reasons for applying the eight corners rule to duty to defend disputes appear to apply equally to the duty to advance described in the Policy. n6

In determining coverage under the "eight corners" rule, Texas courts "focus on the factual allegations that show the origin of the damages rather than on the legal theories alleged." n7 Furthermore, Texas courts have acknowledged that the factual allegations in an underlying case should be given a liberal reading to protect a policyholder from the vagaries of a plaintiff's choice of terminology: "[I]n case of doubt as to whether or not the allegations of a complaint against the insured state a cause of action within the coverage of a liability policy sufficient to compel the insurer to defend the action, such doubt will be resolved in the insured's favor." n8 "[I]f the pleadings do not state facts sufficient to bring the case clearly within or without the coverage, the general rule is that the insurer is obligated to defend if *potentially* there is a case under the pleadings within the coverage of the policy." n9

Insurers bear the burden of proving that coverage is precluded under a policy exclusion. n10 And unlike coverage grants, Texas, like most other states, requires that exclusions be narrowly construed. n11 With respect to exclusions, "[t]he court must adopt the construction of an exclusionary clause urged by the insured as long as that construction is not unreasonable, even if the construction urged by the insurer appears to be more reasonable or a more accurate reflection of the parties' intent." n12

Thus, if the underlying allegations could even potentially trigger coverage, and do not on their face **conclusively** activate a coverage exclusion, then the insurer must defend the insured against the underlying lawsuit. n13 It is only when the underlying complaint alleges facts that, **prima facie**, exclude the insured from coverage that there is no duty to defend. n14

It is well established that an insurer's obligation to contemporaneously fund the defense of litigation - whether through a duty to defend or a duty to advance defense costs - is crucial to the coverage offered by a D&O Policy. As the court observed in *In re WorldCom, Inc. Securities Litigation*, "where a contract of insurance includes the duty to defend or to pay for the defense of its insured, that duty is a 'heavy' one." n15 It added: "the duty to pay defense costs is 'construed liberally and any doubts about coverage are resolved in the insured's favor.'" n16

In *National Union Fire Insurance Co. v. Brown*, the court reasoned that allowing insurers to defer payment "is unreasonably favorable to the insurers, who may blithely disclaim responsibility for the insured's enormous financial burdens while the insured must fight on." n17 Hence, an insurer's obligation to pay defense costs as they are incurred exists whether the policy is a "duty to defend" or a "duty to advance" policy. n18

Thus, where the allegations of a complaint in an underlying action fall squarely within the terms of a D&O Policy, and the insurer's duty to advance defense costs thereby is triggered, courts have consistently held that an insurer cannot walk away from that obligation with impunity merely because of unproven allegations of wrongdoing. Indeed, authority nationwide squarely rejects any rule that would permit an insurer to unilaterally relieve itself of its defense obligation to its policyholder.

In the *Adelphia* n19 case, the court found a duty to advance defense costs at least until the coverage issues were resolved. The insurers in that case had raised two exclusions, the Prior Knowledge Exclusion and the Fraud Exclusion. The policy provided that the Fraud Exclusion could not be triggered without a "final adjudication," but the Prior Knowledge Exclusion contained no such explicit requirement. The court concluded that in the absence of policy

language indicating how and when the determination of "prior knowledge" must be made, the policy was ambiguous and must be construed in favor of the insured. It stressed that "the Carriers have a duty to contemporaneously pay defense costs, unless altered by other language in the policy." n20 It reasoned: "It would be possible for carriers issuing D&O policies to explicitly reserve to themselves the unfettered discretion whether to advance defense costs - but that language does not appear in these policies." n21 It further noted, quite sensibly, that "a policy with such a draconian power" might be hard to sell. n22

The court's decision in *In re WorldCom* is instructive in that regard. n23 There, the insurer sought to rescind the policy and avoid coverage *ab initio* and on that basis to avoid its duty to pay defense costs. The District Court for the Southern District of New York found that "[u]ntil the issue of rescission is adjudicated, a contract of insurance remains in effect and the duty to pay defense costs is enforceable." n24 The court rejected the insurers' arguments that the insureds were not entitled to payment of defense costs while the rescission claim was pending, or alternatively, that the insureds should have to post a bond for the amount of the defense cost payments. Holding, instead, that "the obligation to pay . . . arises as soon as the insured incurs the liability for the loss," the court ruled that the insurer is required to pay the insured's defense costs until the insurer's rescission claim is litigated and resolved. n25[25] The court also noted that "[a]ny cases interpreting New York law and arriving at a different conclusion are readily distinguishable based on their specific policy language." n26

The *In re WorldCom* court relied in part on the New York Appellate Division's decision in *Federal Insurance Co. v. Kozlowski*. n27 In that case, the policyholder, Dennis Kozlowski, sought defense coverage under D&O insurance policies sold to Tyco International, Ltd. ("Tyco"). The insurance company had responded to the request by purporting to unilaterally rescind the policies, tendering the premium to Tyco, and filing a declaratory judgment action seeking "a declaration confirming that the Policies are rescinded and void *ab initio*" because of alleged misrepresentations made in the applications for the policies. n28

The trial court found, and the New York Appellate Division affirmed, that an insurance company could not avoid its obligation to advance defense costs merely by issuing a notice of rescission prior to obtaining a judicial determination of rescission. The insurer asserted that, by issuing a notice of rescission based on fraudulent misrepresentations made by the company in public financial statements, it was relieved of its duty to defend actions alleging breach of fiduciary duties. Distinguishing cases in which common-law rescission by notice had been held to be effective, the court pointed out that those cases involved rescissions that took place shortly after the contracts were made, before any change in the respective positions of the parties. In contrast, in the instant case the insurer attempted to rescind the policy by notice two years after its inception, after claims had been filed against the insured. The court concluded that the company that issued the policy was required to advance defense costs during the pendency of its action for rescission. n29

Finally, this duty to advance defense costs exists even where an exclusion only requires that the wrongdoing "in fact" occurred, and does not explicitly require a "final adjudication." Indeed, several courts have held that the "in fact" requirement in many D&O policies is functionally the same as a "final adjudication" requirement. n30 In *PMI Mortgage Insurance Co. v. AISLIC*, plaintiffs asked the court to find that the "in fact" language required a final adjudication and cited to *Alstrin* and *American Chemical Society*. n31 The defendants urged that mere allegations were sufficient to trigger the "in fact" exclusions, relying principally on *Brown & Lacounte L.L.P. v. Westport Insurance Corp.* n32 In rejecting *Brown* and adopting the reasoning of *Alstrin* and *American Chemical Society*, the *PMI Mortgage* court held:

On balance, the court is persuaded that the instant case fits more within the contours of the cases cited by PMI than it does within those cited by defendants[9472]e.g., *Brown*. . . . The court finds that the reasoning in cases such as *St. Paul Mercury Ins. Co.* and *Am. Chem. Soc'y*, which require an actual adjudication or determination of fact prior to application of the profit or advantage exclusion, more appropriately effectuate the goal of giving the phrase "in fact" its ordinary and popular meaning. This reasoning is further strengthened by the fact that the phrase "in fact" is not to be found in every exclusion enumerated within the AISLIC policy, a factor that counsels in favor of investing the phrase

with some added meaning and by extension, with the added requirement of a final adjudication or determination. n33

In addition, the court noted that, as in *St. Paul Mercury Insurance Co.* and *American Chemical Society*, the existence of the excluded conduct was at issue in the underlying litigation, which further supported the holding that "in fact" requires a final adjudication or determination. n34

The insurer in *PMI Mortgage* argued against interpreting "in fact" language as requiring a "final adjudication" because another, different clause in the insurance policy at issue used the phrase "judicially determined." The insurer thus argued that reading "in fact" to mean "final adjudication" would render the phrase "judicially determined" unneeded surplusage. n35 In rejecting the insurer's argument, the court stated:

[W]hen read according to its ordinary and popular meaning, the phrase "judicially determined" necessarily limits any final adjudication or factual determination to one that is made by the judiciary, whereas the term "in fact" includes adjudications or determinations that are not made judicially, and is therefore broader in scope. In short, the court holds that the term "in fact" within the context of the exclusion here should be read to require *either* a final adjudication, including a judicial adjudication, *or* at a minimum, at least some evidentiary proof that the insured reaped an illegal profit or gain. n36

CONCLUSION

Policyholders have a right, under most D&O insurance policies, to be reimbursed on a current basis for their legal expenses in defending lawsuits triggering coverage under their policies. This right should not be subject to unilateral termination based upon an insurer's determination that misconduct triggering an exclusion has "in fact" occurred, but should continue until it has been objectively determined that such an exclusion applies.

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n1 In New York and elsewhere, this rule is referred to as the "four corners" rule.

n2 *Essex Ins. Co. v. Hines*, Civ. A. No. C-08-125, 2009 U.S. Dist. LEXIS 20865, at *3 (S.D. Tex. Mar. 16, 2009), *aff'd*, 2010 U.S. App. LEXIS 98 (5th Cir. Jan. 4, 2010) (citing *Canutillo Indep. Sch. Dist. v. Nat'l Union Fire Ins. Co.*, 99 F.3d 695, 701(5th Cir. 1996) ("An insurer is obligated to defend an insured as long as the complaint alleges at least one cause of action within the policy's coverage")). *Accord Trinity Universal Ins. Co. v. Employees Mut. Cas. Co.*, 592 F.3d 687, 690 (5th Cir. 2010)) (It is the "uniform holdings of Texas courts that if even a single claim in a lawsuit potentially falls within an insurance policy's coverage, the insurer has a duty to provide a *complete* defense") (emphasis in original); *General Star Indem. Co. v. Gulf Coast Marine Assocs.*, 252 S.W.3d 450, 455 (Tex. App.-Houston 2008) ("If an insurer has a duty to defend its insured against any portion of the underlying suit, then the insurer is required to defend the entire suit").

n3 *See, e.g., Federal Ins. Co. v. Kozlowski*, 792 N.Y.S.2d 397, 402-403 (App. Div. 1st Dep't 2005); *Coleman v. School Bd. of Richland Parish*, 418 F.3d 511 (5th Cir. 2005) (La. Law); *Am. Guarantee & Liab. Ins. Co. v. 1906 Co.*, 273 F.3d 605 (5th Cir. 2001)) (Miss. Law).

n4 *Federal Ins. Co.*, 792 N.Y.S.2d at 403, n.10 (citing *In re WorldCom, Inc., Sec. Litig.*, 354 F. Supp. 2d 455, 464 n.11 (S.D.N.Y. 2005)).

n5 *Id.* at 402. See also *Nat'l Union Fire Ins. Co. v. Willis*, 139 F. Supp. 2d 827, 833 (S.D. Tex. 2001), *aff'd without op.*, 296 F.3d 336 (5th Cir. 2002) (without discussion, court applies the Texas "eight corners" rule to D&O insurance policy with a "duty to pay defense costs" provision); *Travelers Prop. Cas. Corp. v. Winterthur Int'l*, No. 02 Civ. 2406(SAS), 2002 U.S. Dist. LEXIS 11342 at *5 (S.D.N.Y. June 25, 2002) (Furthermore, the "same allegations that trigger a duty to defend trigger an obligation to pay defense costs.").

n6 *Julio & Sons Co. v. Travelers Cas. & Sun Co. of Am.*, 591 F. Supp. 2d 651, 659 (S.D.N.Y. 2008).

n7 *Am. Home Assurance Co. v. United Space Alliance, LLC*, 378 F.3d 482, 487 (5th Cir. 2004).

n8 *Heyden Newport Chem. Corp. v. Southern Gen. Ins. Co.*, 387 S.W.2d 22, 26 (Tex. 1965).

n9 *Gehan Homes, Ltd. v. Employers Mut. Cas. Co.*, 146 S.W.3d 833, 838 (Tex. App.-Dallas 2004) (emphasis added).

n10 *Canutillo Indep. Sch. Dist.*, 99 F.3d at 701.

n11 *Nat'l Union Fire Ins. Co. v. Hudson Energy Co.*, 811 S.W.2d 552, 555 (Tex. 1991).

n12 *Utica Nat'l Ins. Co. v. Am. Indem. Co.*, 141 S.W.3d 198, 202 (Tex. 2004).

n13 See *Westport Ins. Corp. v. Atchley, Russell, Waldrop & Hlavinka, LLP*, 267 F. Supp. 2d 601, 612 (E.D. Tex. 2003).

n14 See *Taylor v. Travelers Ins. Co.*, 40 F.3d 79, 81 (5th Cir. 1994).

n15 *In re WorldCom*, 354 F. Supp. 2d 455, 464 (S.D.N.Y. 2005).

n16 *Id.* (quoting *Fed. Ins. Co. v. Tyco Int'l Ltd.*, 784 N.Y.S.2d 920 (Sup. Ct. N.Y. County 2004)). See also *Hoechst Celanese Corp. v. Nat'l Union Fire Ins. Co.*, C. A. No. 89C-SE-35, 1994 Del. Super. LEXIS 566, at * 8 (Del. Super. Ct. Apr. 8, 1994) ("any doubt as to an insurer's obligation to defend a claim against an insured should be resolved in favor of the insured").

n17 *Nat'l Union Fire Ins. Co. v. Brown*, 787 F. Supp. 1424, 1433 (S.D. Fla. 1991), *aff'd without op.*, 963 F.2d 385 (11th Cir. 1992) (quoting *Little v. MGIC Indem. Corp.*, 649 F. Supp. 1460 (W.D. Pa. 1986), *aff'd*, 836 F.2d 789 (3d Cir. 1987)).

n18 See, e.g., *United States v. Weissman*, No. S294 CR. 760(CSH), 1997 U.S. Dist. LEXIS 8540, at *12 (S.D.N.Y. June 16, 1997) (Holding that provision in D&O Policy to 'advance' defense costs would be null if the insurer "could simply wait out the results of an action before deciding whether to pay the requisite costs; if the ultimate judgment was adverse to the defendant, Empire could claim that it was no longer required to pay the expenses previously incurred."). See also *Gon v. First State Ins. Co.*, 871 F.2d 863, 868 (9th Cir. 1989); *Nat'l Union Fire Ins. Co. v. Brown*, 787 F. Supp. at 1430.

n19 *Associated Elec. & Gas Ins. Servs. v. Rigas*, 382 F. Supp. 2d 685 (E.D. Pa. 2004) (the "Adelphia" case).

n20 *Id.* at 700.

n21 *Id.* at 701.

n22 *Id.*

n23 *In re WorldCom*, 354 F. Supp. 2d at 462-463.

n24 *Id.* at 465. See also, e.g., *Wedtech Corp. v. Federal Ins. Co.*, 740 F. Supp. 214, 221 (S.D.N.Y. 1990) (insurer required to reimburse attorneys' fees pending litigation of right to rescind).

n25 *Id.* at 464.

n26 *Id.* at 467.

n27 *Federal Insurance Co. v. Kozlowski*, 792 N.Y.S.2d 397 (App. Div. 1st Dep't 2005).

n28 *Kozlowski*, 792 N.Y.S.2d at 400.

n29 *Id.* at 401-402.

n30 See e.g., *Am. Chem. Soc'y v. Leadscope, Inc.*, No. 04AP-305, 2005 Ohio App. LEXIS 2428 at *12 (Ohio Ct. App. May 24, 2005) ("[T]hat the policy language in the present case did not include the 'in fact' language in other provisions that required only alleged activity is persuasive that 'in fact' requires a final determination."); *Alstrin v. St. Paul Mercury Ins. Co.*, 179 F. Supp. 2d 376, 400 (D. Del. 2002) (finding that illegal profit exclusion with "in fact" language can only be applied where "an element of the cause of action that must be proved required that the insured gained a profit or advantage to which he was not legally entitled" and that such element actually was proved).

n31 *PMI Mortgage Insurance Co. v. AISLIC*, No. C 02-1774 PJH, 2006 U.S. Dist. LEXIS 24853 (N.D. Cal. Mar. 29, 2006).

n32 *PMI*, 2006 U.S. Dist. LEXIS 24853, at *11 (citing *Brown & Lacounte L.L.P. v. Westport Ins.*, 307 F.3d 660 (7th Cir. 2002)).

n33 *PMI Mortgage*, 2006 U.S. Dist. LEXIS 24853, at *15.

n34 *PMI Mortgage*, 2006 U.S. Dist. LEXIS 24853, at *15-16.

n35 *PMI Mortgage*, 2006 U.S. Dist. LEXIS 24853, at *18-19.

n36 *Id.* (emphasis in original).

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Sonnenschein Nath & Rosenthal, L.L.P. on First-Party Bad Faith in Maryland

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Sonnenschein Nath & Rosenthal, L.L.P. on First-Party Bad Faith in Maryland

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January 16, 2010

SUMMARY: Maryland common law never recognized a cause of action for first-party insurance bad faith. But Maryland created private statutory rights, effective October 1, 2007. A federal district court has recently decided the first significant case under the statute. This commentary reviews that case and analyzes the statutory standard of liability in light of the case.

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ARTICLE: Maryland common law never recognized a cause of action for first-party insurance bad faith. n1 But Maryland created private statutory rights, effective October 1, 2007. A federal district court has recently decided the first significant case under the statute. n2 This commentary reviews that case and analyzes the statutory standard of liability in light of the case. n3

THE MARYLAND BAD FAITH STATUTE

The Maryland first-party insurance bad faith statute ("Statute"), Senate Bill 389, was entitled "Civil Actions [#9472] Liability of Insurer Failure to Act in Good Faith." Among other things, the Statute: (a) amended the Courts Article to provide jurisdiction for actions to be brought in Circuit Court for first-party insurance claims, including claims that the insurer failed to act in good faith; (b) amended the Insurance Article to make it an unfair claim settlement practice for an insurer to fail to act in good faith in settling a first-party claim under a property and casualty policy; and (c) created an administrative procedure by which the administrator can determine whether an insurer has properly adjusted a claim in good faith and authorizes the administrator to determine the amount that should be paid for the claim and grant other specified relief to the insured.

Amendments to the Courts Article

As amended, the Courts Article provides that:

"Notwithstanding any other provision of the law, if the trier of fact in an action under this section finds in favor of

the insured and finds that the insurer failed to act in good faith, that insured may recover from the insurer:

"(1) Actual damages, which actual damages may not exceed the limits of the limits of the applicable policy;

"(2) Expenses and litigation costs incurred by the insured in an action under this section or under § 27-1001 of the Insurance Article or both, including reasonable attorney's fees; and

"(3) Interest on all actual damages, expenses, and litigation costs incurred by the insured, computed:

"(I) At the rate allowed under § 11-107(A) of this article; and

"(II) From the date on which the insured's claim would have been paid if the insurer acted in good faith." n4

"Good faith means an informed judgment based on honesty and diligence supported by evidence the insurer knew or should have known at the time the insurer made a decision on a claim." n5 The Statute also provides that: "An insurer may not be found to have failed to act in good faith under this section solely on the basis of delay in determining coverage or the extent of payment to which the insured is entitled if the insurer acted within the time period specified by statute or regulation for investigation of a claim by an insurer." n6

Amendments to the Insurance Article

The Insurance Article was amended to make it an unfair claim settlement practice and a violation of the subtitle, for an insurer to: "fail to act in good faith, as defined under § 27-1001 of this title, in settling a first-party claim under a policy of property and casualty insurance." n7 The Statute also makes it an unfair claim settlement practice for an insurer or nonprofit health service plan, "when committed with the frequency to indicate a general business practice," to: "fail to act in good faith, as defined under § 27-1001 of this title, in settling a first-party claim under a policy of property and casualty insurance." n8 Good faith is defined in the same way as in the Courts Article. n9

Section 27-305 of the statute authorizes various remedies, including penalties not exceeding \$125,000 for each violation and restitution including (1) actual damages, not exceeding limits of the policy; (2) expenses and litigation costs, including reasonable attorneys fees, and (3) interest, at the rate allowed under § 11-107(A) of the Courts Article, from the date on which the insureds claim would have been paid if the insurer acted in good faith.

The Statute creates an administrative procedure for processing claims under the Statute. Specifically, it creates an administrative procedure for considering complaints from insureds to determine (1) whether the claim is covered, (2) the amount the insured is entitled to for the first-party claim, (3) whether the insurer breached its obligation to pay the underlying covered first-party claim, (4) whether an insurer that breached its obligation failed to act in good faith, and (5) the amount of damages, expenses, litigation costs, and interest due the insured. n10 There is a right to appeal an adverse decision to a circuit court. n11

CECLILA SCHWABER TRUST TWO V. HARTFORD ACCIDENT & INDEMNITY CO.

Ceclila Schwaber Trust Two v. Hartford Accident & Indemnity Co. n12 sought benefits for snow and ice damage to a warehouse roof in 2003 and for bad faith in adjusting the claim. Initially, Hartford denied the claim on the ground that the damage resulted from long-term water damage. It later agreed that about 5% of the damage was covered but concluded that the remainder of the loss was attributable to faulty workmanship, maintenance, and wear and tear. The property was then sold at a discount in the amount of the estimated cost of replacing the roof, and suit was filed. n13 The court found material issues of fact on coverage, precluding summary judgment for either party. n14

When the case was filed, Maryland law did not authorize recovery for bad faith. But, in conjunction with the summary judgment motion on coverage, a claim was asserted under the new Statute. At the time of the amendment, the court reserved the issue of retroactivity (and related constitutional issues). Following completion of discovery, Hartford

moved for summary judgment on the grounds that, (1) because there was a genuine dispute as to coverage, there was no bad faith, (2) that the Statute did not apply retroactively, and (3) that retroactive application would be unconstitutional. n15 The court reserved the issue of whether retroactivity was prohibited under the Maryland constitution (to be reached, only if necessary, after trial of the case) and otherwise denied the motion. (Apart from describing the court's ruling, this commentary will not address the retroactivity issue.)

The Fact That the Claim Was Fairly Debatable Did Not Preclude a Finding of Bad Faith

The court recognized that other jurisdictions generally hold that when a claim is fairly debatable, then "the insurer is entitled to debate it' and will not be subject to liability for acting in bad faith." n16 But the court found no indication that the Maryland General Assembly intended this narrow construction of the Statute. In its view, the statutory definition "focuses on the actions taken by the insurer in forming a judgment as to coverage, as well as what the insurer knew or should have known at the time it denied coverage to its insured. In the cases cited above, the fairly debatable standard was created by courts simultaneously with the creation of a common law cause of action for bad faith; there was no controlling statute. In this case, however, the cause of action arises pursuant to a statute, and the court must follow the statutory language. Moreover, the action here is for failure to act in 'good faith,' as opposed to an action for 'bad faith.' Maryland courts have indicated that the two are not the same." n17

It found an apt comparison in a "Florida first-party bad faith statute providing that an insurer has not acted in bad faith if the insurer has 'acted fairly and honestly toward its insured and with due regard for [the insured's] interest.'" n18 Under that statute, the Florida Supreme Court rejected the "fairly debatable" standard and adopted a "totality of the circumstances" approach requiring consideration of the following factors: "[(1) efforts or measures taken by the insurer to resolve the coverage dispute promptly or in such a way as to limit any potential prejudice to the insureds; [(2)] the substance of the coverage dispute or the weight of legal authority on the coverage issue; [and] [(3)] the insurer's diligence and thoroughness in investigating the facts specifically pertinent to coverage." n19

The court found this comparable to the Maryland standard, because "[a]n evaluation of whether an insurer made an 'informed judgment based on honesty and diligence supported by evidence the insurer knew or should have known at the time' of its coverage decision requires, for example, an evaluation of the insurer's efforts to obtain information related to the loss, [to] accurately and honestly assess this information, and [to] support its conclusion regarding coverage with evidence obtained or reasonably available." n20

The court observed that its conclusion that there was a genuine issue of fact did not evaluate what Hartford knew or should have known when it made the claim decision, did not evaluate its investigation, the reasons for any delays, and what the Trust alleged was "selective use of expert witnesses, failure to interview crucial witnesses, [and] failure to handle the claim in accordance with industry standards." n21 The fact that Hartford's decision was justifiable at the time of the court's decision did not mean that this was so when Hartford made its decision. n22 While the jury would not be permitted to find bad faith unless it found coverage, n23 if it did find coverage then the fact that the claim was fairly debatable would not preclude a finding of bad faith. n24

The General Assembly Intended Retroactive Application

Turning to the issue of retroactive application, the court noted that Maryland applies a four-part test:

"(1) statutes are presumed to operate prospectively unless a contrary intent appears; (2) a statute governing procedure or remedy will be applied to cases pending in court when the statute becomes effective; (3) a statute will be given retroactive effect if that is the legislative intent; but (4) even if intended to apply retroactively, a statute will not be given that effect if it would impair vested rights, deny due process, or violate the prohibition against *ex post facto* laws." n25

Based on the text and history of the Statute, the court found a legislative intent to apply the Statute retroactively to damage claims. n26 The Statute precluded retroactive application in imposition of civil penalties: "the provisions of this Act providing for administrative penalties and license sanctions that may be imposed by the Maryland Insurance Commissioner apply *only to an act or omission occurring on or after the effective date* of this Act." n27 In the court's view, the absence of any similar restriction as to other provisions of the Statute implied a legislative intent that those provisions apply retroactively. n28 Moreover, the Maryland Senate rejected an amendment that would have explicitly limited the Statute to prospective application. n29

Retroactive Application Did Not Impair the Contract in Violation of the United States Constitution

The United States Constitution forbids any state to "pass any . . . Law impairing the Obligation of Contracts" n30 While the Statute increased Hartford's exposure to an award of litigation costs and expenses for conduct under a preexisting insurance contract, no provision of that contract immunized Hartford against such awards. Accordingly, the court did not find any impairment of contract. n31 Because Maryland law had always imposed a duty of good faith and fair dealing in every insurance contract, the court concluded that "[t]he substantive rights and obligations of the parties [under their contract] were not altered by the statute." n32

Moreover, even if there were some impairment of the contract, to find a constitutional violation, the court would also have needed to find that any impairment was substantial and was not, even so, a legitimate exercise of state power. n33 Given the extensive regulation of insurance already existing in Maryland, any impairment might not be substantial. n34 And, even if there were a substantial impairment, courts would defer to the legislature as to the need for the statute. n35

THE "FAIRLY DEBATABLE" RULE

In order to evaluate the court's holding that the Statute permits liability even when the insured's claim is "fairly debatable," it is necessary to understand why the contrary rule is a bedrock principle of bad faith law almost everywhere. This section examines the nature and basis of that rule.

The Bad Faith Tort Seeks to Protect Insureds with Valid Claims Against Abuse of the Insurer's Power to Force Them to Litigate

The purposes underlying the bad faith tort dictate the substantive standard of liability. That standard specifies what facts must be proven. The law of bad faith represents a balance between two competing interests: "the right of an insurer to reject an invalid claim and the duty of the carrier to investigate and pay compensable claims." n36 The tort is recognized to protect the insured's right to payment. But the insurer's right to challenge validity limits the circumstances in which liability may be imposed for non-payment, even if the claim ultimately proves meritorious. Both interests must be considered in defining the substantive legal standard.

An insurance contract is one where an insurer, in return for an agreed premium, assumes specified risks of financial loss which might otherwise befall the insured. n37 The insured usually has paid all premiums due before the insurer is ever asked to compensate a loss. Once a loss occurs, the insured can no longer seek to buy protection from competing insurers, which might have been willing to provide similar coverage. In this sense, "[a]n insurance company has exclusive control over the evaluation, processing and denial of claims." n38

Of course, an insured can overcome an ill-founded denial by litigating with the insurer. But risks which are insured are normally ones which an insured cannot afford to bear without insurance, so the occurrence of such a loss exerts pressure on an insured to obtain a prompt settlement, even if that may mean foregoing full compensation: for example, under a policy of disability insurance, "[t]he very risks insured against presuppose that if and when a claim is made, the insured will be disabled and in strait financial circumstances and, therefore, particularly vulnerable to oppressive tactics

on the part of an economically powerful entity" n39 So, it is little help to the insured that the usual right to prejudgment interest (even at a penalty rate n40) would cover the cost of the borrowing, because the insured is often unable to borrow.

The pressure created by an unaffordable loss is increased by the fact that many of the consequential losses that the insured might suffer while payment is delayed are ordinarily not recoverable in an action for breach of contract. n41 Not only does this limitation on recovery leave the insured uncompensated for some harms caused by an erroneous denial, but it also limits the incentive of the insurer to avoid such harms by prompt payment. n42 Moreover, litigation is expensive, although, in some states, that expense might be recoverable should the insured prevail in any suit. n43 And, because of the expense, effort and risk required to bring suit, even insureds whose claims are meritorious may not sue.

These concerns have led many courts to conclude that it is necessary to provide protection against the risk that "unscrupulous insurers [could] take advantage of their insureds' misfortunes in bargaining for settlement or resolution of claims." n44 Surely, as courts have repeatedly found, it would be abusive for an insurer to deny a claim and force an insured to settle or litigate when it knows that the claim is payable:

. It was bad faith to refuse any payment on a \$15,000 uninsured motorist claim when the insurer knew that the only real issue was a possible \$5,000 offset for prior medical payments benefits, and the insured offered to accept \$10,000 and litigate about the offset. n45

. It would be bad faith if, as alleged, the insurer deliberately sought to evade payment of a claim it knew was valid by making unfounded accusations of arson and then exploited the insured's unwillingness to submit to an examination under oath until the criminal charges were dismissed. n46

. It was bad faith for the insurer to withhold payment it knew was due, force an arbitration hearing despite that knowledge, and then demand a compromise settlement after an award in the insured's favor. n47

. It was intentional infliction of emotional distress where the insurer withheld payment on a disability insurance claim it knew was valid, trumped up charge of application misrepresentations for which it had no probable cause, and sought to exploit insured's need for funds to coerce surrender of policy in settlement of the nonexistent dispute. n48

And an insurer should not be permitted to avoid the obligation to pay by simply ignoring readily available information that would establish the insured's right to payment. n49 Starting from this core concept of unscrupulous and abusive conduct, bad faith law has somewhat eased the burden of proving abuse and regulated some less culpable misconduct which insurers have no legitimate reason to engage in.

So liability based on constructive knowledge is not limited to facts the insurer willfully avoided knowing. All courts recognizing any version of the bad faith tort extend this by holding the insurer responsible for considering all information supporting the insured's claim that it would have obtained by a reasonable investigation. n50 This creates an incentive to investigate properly and provides compensation for harms resulting from failure to do so.

And no jurisdiction recognizing the bad faith tort limits it to cases where the insurer actually knew the claim was payable. Most extend it to cases where the insurer recklessly disregarded its lack of any reasonable basis for withholding payment. n51 Some extend it to cases where the insurer was no more than negligent in failing to know that a reasonable basis was lacking. n52

Because Paying Unmeritorious Claims Would Inflate Insurance Costs, Insurers Are Given Wide Latitude to Challenge Claims Without Fear of Tort Liability

An insurer's right to contest questionable claims is more than an ordinary contractual right: it serves an important

public interest. Insurance rates are based on insurers' predictions of the claims they will be required to pay. If erroneous denial of a claim can result in expensive tort remedies, insurers may feel compelled to pay questionable claims rather than risk such liability. This is a particular concern with possibly fraudulent claims, where any impropriety of the claim will have been assiduously concealed and may only be detectable by expensive investigation and resort to circumstantial evidence. n53 Such payments, or the expectation of having to make them, would tend to inflate costs for those wishing only coverage for the risks specified in the contract.

In the leading bad faith case of *Anderson v. Continental Insurance Co.*, n54 the court recognized the undesirability of inflating insurance rates by "scaring insurers into paying questionable claims because of the threat of a bad faith suit and its excessive damages." n55 The *Anderson* court was confident it had prevented this by adopting a standard that protects any insurer which "makes an investigation of the facts and law and concludes on a reasonable basis that the claim is at least debatable." n56 Similarly, in *Travelers Insurance Co. v. Savio*, n57 the court emphasized the need to accord an insurer "wide latitude in its ability to investigate claims and to resist false or unfounded efforts to obtain funds not available under the contract of insurance." n58

Accordingly, in all but a few jurisdictions, an insurer is allowed to withhold payment of a claim as long as there is a genuine issue or (to use different words for the same concept) a bona fide dispute as to the insured's entitlement to payment. n59 As the *Anderson* court put the point, "when a claim is 'fairly debatable' the insurer is entitled to debate it, whether the debate concerns a matter of fact or law." n60 As the Texas Supreme Court has put the point, "[e]vidence that merely shows a bona fide dispute about the insurer's liability on the contract does not rise to the level of bad faith." n61 This rule recognizes that "the parties to an insurance contract will sometimes have a good faith disagreement about coverage. Under such circumstances, the parties may require a court to interpret the policy language for them, or a jury to resolve factual disputes." n62 Stated otherwise, a "reasonable basis" for denying a claim is one that warrants testing the claim in court. n63

Sometimes this point is expressed by saying that an insurer has a "right to be wrong" n64 or a "right to disagree" with the insured. The Indiana Supreme Court has used the latter phrase to summarize the balance of interests limiting the bad faith tort: "It is evident that the exercise of this right [to disagree] may directly result in the intentional infliction of temporal damage, including the damage of interference with an insured's business (which an insured will undoubtedly consider to be oppressive). The infliction of this damage has generally been regarded as privileged, and not compensable for the simple reason that it is worth more to society than it costs, *i.e.*, the insurer is permitted to dispute its liability in good faith because of the prohibitive social costs of a rule that would make claims nondisputable. Insurance companies burdened with such liability would either close their doors or increase premium rates to the point where only the rich could afford insurance." n65

THE MEANING OF THE MARYLAND STANDARD

The Statutory Language Supports the "Fairly Debatable" Rule

To repeat, the Statute provides that "[g]ood faith means an informed judgment based on honesty and diligence supported by evidence the insurer knew or should have known at the time the insurer made a decision on a claim." n66 One thing that this clearly means is that, as all jurisdictions recognizing extracontractual liability for bad faith hold, a first-party insurer must investigate possible grounds that might support an insured's claim. A requirement of an "informed judgment based on ... diligence supported by evidence the insurer knew or should have known at the time the insurer made a decision on a claim" makes such a duty crystal clear.

Once the necessary information has been gathered, the insurer is required to make a "judgment based on honesty." That language indicates that bad faith must involve something in the nature of dishonesty. True dishonesty would involve denial of a claim that the insurer knew was valid. But it is certainly arguable that an insurer might be liable

without actual subjective knowledge that the claim was valid, perhaps under the standard enunciated by the Wisconsin Supreme Court in *Anderson v. Continental Insurance Co.*,ⁿ⁶⁷ and which is now the majority standard for bad faith liability: "To show a claim for bad faith, a plaintiff must show the absence of a reasonable basis for denying benefits of the policy and the defendant's knowledge or reckless disregard of the lack of a reasonable basis for denying the claim."ⁿ⁶⁸

In administering the *Anderson* test, two rules assist the insured in carrying the burden of proof of the subjective element. First, "knowledge of the lack of a reasonable basis may be inferred and imputed to an insurance company where there is a reckless disregard of a lack of a reasonable basis for denial or a reckless indifference to facts or proofs submitted by the insured."ⁿ⁶⁹ Similarly, a knowing or reckless failure of the insurer to ascertain with diligence the facts pertinent to the coverage decision may be used to infer an improper state of mind. Relying on *Hilker v. Western Automobile Insurance Co.*,ⁿ⁷⁰ the *Anderson* court reasoned: "*Hilker* emphasizes that bad faith is the absence of honest, intelligent action or consideration based upon a knowledge of the facts and circumstances upon which a decision in respect to liability is predicated. While *Hilker* emphasizes the duty of ordinary care and reasonable diligence on the part of an insurer in handling claims, it is apparent from *Hilker* that the knowing failure to exercise an honest and informed judgment constitutes the tort of bad faith."ⁿ⁷¹

In light of its reliance on *Hilker*, *Anderson* appears to reflect the same concerns as the Maryland Statute. Reckless disregard of the lack of a reasonable basis for denying a claim could be seen as inconsistent with a "judgment based on honesty," so the statute could be interpreted to accord with the *Anderson* standard. But the statutory language could hardly permit an insurer to be held liable for a truly honest mistake, even one that was objectively unreasonable. Certainly it does not seem possible that a jury could be permitted to find dishonesty where there truly was a reasonable basis to challenge the insured's right to the benefits at issue. So, no matter where along this continuum the statutory line might be found, existence of such a reasonable basis should preclude a finding of bad faith. Stated otherwise (and contrary to the holding in *Cecilila Schwaber Trust Two*), the statutory language seems to compel acceptance of the "fairly debatable" rule followed in almost all jurisdictions recognizing extracontractual liability for bad faith.

That conclusion is further supported by the fact that failure to act in good faith subjects an insurer, not only to increased interest and an award of attorneys' fees, but to actual penalties in the administrative process. Penal statutes must be narrowly construed.ⁿ⁷² At a minimum, that precludes any construction that permits an insurer to be penalized for denying a claim whose merit was, after proper investigation, fairly debatable.

Prior Maryland Law Also Supports the "Fairly Debatable" Rule

According to the legislative history, as explained in the General Assembly's 90 Day Report, the lack of good faith standard created in Senate Bill 389 is the "same test for good faith established by the Court of Appeals for determining the duty owed, in another context, by insurance companies to their policyholders under *State Farm Mutual Automobile Insurance Company v. White*, 248 Md. 324 (1966)."ⁿ⁷³ *White* deals with an insurer's duty to settle claims against its insured in order to protect the insured against an unjustified risk of personal liability in excess of the policy limits.

White expressed the standard governing the duty to settle in the same words as the Statute: "for an insurer to measure up to the good faith test, its action in refusing to settle must consist of an informed judgment based on honesty and diligence. Furthermore, the insurer's negligence, if any there be, is relevant in determining whether or not it acted in good faith."ⁿ⁷⁴ The court discussed approvingly the standard predicted in *Gaskill v. Preferred Risk Mutual Insurance Co.*ⁿ⁷⁵: "It seems clear that the duty includes elements both of good faith and of reasonable care. This Court concludes that the proper test of liability in such a case as this (and the test which this Court believes the Maryland Court will probably apply when required to decide the question) is the good faith test, with the amplifications and limitations suggested by the quotations from the New Jersey Court [*Radio Taxi Service, Inc. v. Lincoln Mutual Insurance Co.*, 31 N.J. 299, 157 A.2d 319 (1960)], the Fourth Circuit [*American Casualty Company of Reading, Pa. v. Howard*, 187 F.2d 322 (4th Cir. 1951)] and Judge Watkins [*Lee v. Nationwide Mutual Insurance Co.*, 184 F. Supp. 634, 368 (D.Md.1960)], set out above."ⁿ⁷⁶

White rejected any suggestion that "dishonesty, misrepresentation or a species of fraud must be present" for the insurer to be liable. n77 It approvingly quoted the Appleman treatise: "The expression 'in good faith' has been held to refer to a lack of a good moral intent as the basis for refusing to pay a loss. *Conversely, 'bad faith' means any frivolous or unfounded refusal to pay*; it is not necessary that such refusal be fraudulent. And if probable cause is shown why payment should have been made, an inference of bad faith might thereby be raised. n78

Radio Taxi is quoted as saying that "[t]hose gifted with expertise in the field of judging issues of liability and extent of injury actually suffered by a plaintiff, would probably be the first to admit that an informed judgment arrived at in good faith after reasonably diligent investigation represents the limit that should be demanded of human capacity." n79 *American Casualty* is quoted as saying that "an insurer is obligated to exercise a reserved power to negotiate and settle with proper regard for the interest of the insured, and is liable for damage resulting from wrongful failure to settle within policy limits." n80

White also offered a familiar list of factors relevant in assessing the duty to settle (but of limited relevance to first-party claims): "In applying the 'good faith' theory the courts have found that the presence of one or more of the following acts or circumstances may affect the 'good faith' posture of the insurer: the severity of the plaintiff's injuries giving rise to the likelihood of a verdict greatly in excess of the policy limits; lack of proper and adequate investigation of the circumstances surrounding the accident; lack of skillful evaluation of plaintiff's disability; failure of the insurer to inform the insured of a compromise offer within or near the policy limits; pressure by the insurer on the insured to make a contribution towards a compromise settlement within the policy limits, as an inducement to settlement by the insurer; and actions which demonstrate a greater concern for the insurer's monetary interests than the financial risk attendant to the insured's predicament." n81

These factors address the special concern in duty to settle cases, whether the risks of judgment in the case against the insured justified a settlement in an amount demanded by the plaintiff (or, perhaps, in an amount that the insured contends should have been offered and would have prevented any excess judgment). First-party cases are very different, for there is no risk of excess liability: there is only a question whether the loss suffered by the insured is covered and, if so, what amount is necessary to compensate that loss.

But even putting that difference aside, one point that *White* makes perfectly clear is that an insurer need do no more than act reasonably to avoid liability. This is shown by the statement that "'bad faith' means any frivolous or unfounded refusal to pay" n82 A "frivolous or unfounded refusal to pay" is one that necessarily lacks a reasonable basis. Applying that standard to a first-party claim indicates, as did the analysis of the Statute's language, that a claim where the insured's right to payment is "fairly debatable" is one that an insurer can safely deny, without subjecting itself to liability under the Statute (including liability for penalties).

That is also consistent with the way in which later cases have applied *White* to the settlement of third-party claims. The Maryland Court of Appeals (the state's highest court) refused to extend *White* beyond the excess judgment situation. In particular, it has held that when an insurer refused a (supposedly) reasonable demand to settle (whose acceptance was recommended by defense counsel), but prevented any excess judgment by a later settlement, it has no liability to the insured, even for the fees of personal counsel hired after the refusal to settle. n83

Additionally, at least one Maryland Court of Special Appeals decision would require significant culpability to create liability for failure to settle. *Republic Ins. Co. v. Prince George's County* n84 was an action by a surety to recover from the contractor-principal obligor. It had an opportunity to settle with the obligee for less than the judgment it suffered and the court held that where it had no good faith basis to refuse to settle, it could not recover more than the

amount of the rejected settlement. (This could be viewed as a simple mitigation of damages issue, but that is not how the court treated it.) Relying on *White* and the duty to settle third-party claims within limits, it quoted approvingly from the Michigan case of *City of Wakefield v. Globe Indemnity Co.* n85 Undoubtedly the insurer does not act in bad faith if it refuses settlement in the honest belief that it has a fair chance of victory, or of keeping the verdict within the policy limit, or, upon reasonable grounds, that the compromise amount is excessive, or if it has legal defenses, as yet undetermined by a court of last resort, which fairly seem applicable... There may be other bona fide reasons for refusal to compromise. On the other hand, arbitrary refusal to settle for a reasonable amount, ... failure to fairly consider a compromise and facts presented and pass honest judgment thereon, or refusal upon grounds which depart from the contract and the purpose of the grant of power, would tend to show bad faith." n86

Thus any "bona fide reason" for refusing to settle should prevent bad faith liability.

The Florida Statute Is Not a Good Analogy

The *Cecilia Schwaber Trust Two* court erred in regarding the Florida statute as a proper guide to interpretation of the Maryland Statute. To begin with, the foregoing analysis shows that there was no need to look to an out-of-state statute (particularly one at odds with the overwhelming majority rule under bad faith law) for guidance. But even if that were proper, the two statutes are dissimilar. The Maryland Statute requires a "judgment based on honesty." But the court looked to a "Florida first-party bad faith statute providing that an insurer has not acted in bad faith if the insurer has "acted fairly and honestly toward its insured and with due regard for [the insured's] interest."" n87 A requirement that the insurer act "fairly and honestly" demands more than simply a "judgment based on honesty." Florida seems to conclude that "fairness" require the insurer to provide benefits even in circumstances where there is some genuine dispute as to the insured's right to those benefits. But a requirement only of a "judgment based on honesty" does not require the insurer to concede bona fide questions as to the insured's right to payment.

The Other Maryland Cases Cited by Cecilia Schwaber Trust Two Are Inapposite

The *Cecilia Schwaber Trust Two* court also reasoned that "the action here is for failure to act in 'good faith,' as opposed to an action for 'bad faith.' Maryland courts have indicated that the two are not the same." n88 But the cases it cites for that point lend no support to its construction of the Statute. In *Zdravkovich*, the Court of Appeals reversed sanctions imposed on a lawyer for failure to appear at a hearing, without providing the lawyer an opportunity to be heard in opposition to the sanctions; the court criticized the claim that, merely by failing to appear at the original hearing the lawyer "ha[d] not shown good faith." n89 In *Art Form Interiors, Inc.*, the court reversed a sanction imposed on an attorney based on a rule requiring litigation conduct "in bad faith or without substantial justification"; the appellate court found adequate justification for the sanctioned conduct and criticized the court below for basing the sanction in part on a "lack of good faith" in communications with opposing counsel. n90 *State v. Booze* involved a question of whether the State had impermissibly withheld material that should have been introduced in its case-in-chief for use as rebuttal evidence. None of those cases has anything to do with determining when an insurer has improperly refused to pay first-party benefits.

CONCLUSION

The Maryland Statute should be construed to adopt the "fairly debatable" rule. Other courts should not follow *Cecilia Schwaber Trust Two* on that question.

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n1 *Johnson v. Federal Kemper Ins. Co.*, 74 Md. App. 243 (1988).

n2 *Ceclila Schwaber Trust Two v. Hartford Accident & Indem. Co.*, 2009 U.S. Dist. LEXIS 59788 (D. Md. July 14, 2009).

n3 Portions of this commentary are drawn from William T. Barker & Ronald D. Kent, *The New Appleman Insurance Bad Faith Litigation* (2009) (in press).

n4 Md. Code, Ann. Cts. & Jud. Proc. § 3-1701(d) (emphasis added). This statute increased the previously applicable prejudgment interest rate from 6% to 10%. Based on the Maryland constitution, the interest rate for pre-judgment interest is 6%, unless otherwise provided by the General Assembly. *See Harford County v. Saks Fifth Ave. Distrib. Co.*, 399 Md. 73, 96 (2007) ("pre-judgment interest shall be calculated at the legal rate of six percent per annum") *citing* Md. Const. art. III, § 57 ("[t]he Legal Rate of Interest shall be Six per cent. per annum; unless otherwise provided by the General Assembly"); *see also Crystal v. West & Callahan, Inc.*, 328 Md. 318 (1992) (absent statute, the legal rate of prejudgment interest is equal to the general legal rate of six percent) and *Dua v. Comcast Cable, Inc.*, 370 Md. 604, 612 (Md. 2002) (same). The Statute declares the applicable rate is that under § 11-107, the post-judgment statute, which is 10%. The legislature can authorize the higher interest rate found in § 11-107 for the Senate Bill 389, but may only do so prospectively. As *Dua* explains, if there is not a legislatively imposed interest rate in excess of six percent, the legislative imposition of a new higher interest rate will not have retroactive application because the imposition would deprive the defendant of a vested right. Even "a remedial or procedural statute may not be applied retroactively if it will interfere with vested or substantive rights." *Dua v. Comcast Cable, Inc.*, 370 Md. 604, 625 (2002). Even if the Statute may otherwise have retroactive effect, the imposition of the ten percent interest rate can only apply prospectively because it impacts a vested right prior to the effective date of the statute.

n5 Md. Code, Cts. & Jud. Proc. § 3-1701(a)(4).

n6 Md. Code, Cts. & Jud. Proc. § 3-1701(f).

n7 Md. Code, Ins. § 27-303(9).

n8 Md. Code, Ins. § 27-304(18).

n9 Md. Code, Ins. § 27-1001(e)(2)(ii).

n10 Md. Code, Ins. § 27-1001.

n11 Md. Code, Ins. §§ 27-1001(G) & 2-215; Md. Code, State Gov't tit. 10, subtit. 2.

n12 *Cecilia Schwaber Trust Two v. Hartford Accident & Indem. Co.*, 2009 U.S. Dist. LEXIS 59788 (D. Md. July 14, 2009).

n13 *Id.* at *2-3.

n14 *Id.* at *3-4, citing *Cecilia Schwaber Trust Two v. Hartford Accident & Indem. Co.*, 2007 U.S. Dist. LEXIS 94197 (D. Md. Dec. 17, 2007).

n15 2009 U.S. Dist. LEXIS 59788, at *5-7.

n16 *Id.* at *11, quoting *Anderson v. Cont'l Ins. Co.*, 85 Wis. 2d 675, 691 (Sup. Ct. 1978), and citing other cases.

n17 *Id.* at *13-14, citing "*State v. Booze*, 334 Md. 64, 637 A.2d 1214, 1222 (Md. 1994) (noting that 'not acting in bad faith is not the same as acting in good faith and/or with good cause'); *Zdravkovich v. Bell Atlantic-Tricon Leasing, Corp.*, 323 Md. 200, 592 A.2d 498, 503 (Md. 1991) ('The District Court's finding that Zdravkovich "has not shown good faith" is not the equivalent of a finding of "bad faith"'); *Art Form Interiors, Inc. v. Columbia Homes, Inc.*, 92 Md. App. 587, 609 A.2d 370, 376 (Md. Ct. Spec. App. 1992) (noting that 'a finding that a party has not shown good faith is not the functional equivalent of a finding of bad faith'). But see *Catterton v. Coale*, 84 Md. App. 337, 579 A.2d 781, 783 (Md. Ct. Spec. App. 1990) ('To further illuminate the definition of "good-faith," we found it most instructive to compare the definition of "bad-faith." "Bad-faith" is the opposite of good faith')."

n18 *Id.* at *15, quoting *State Farm Mut. Auto. Ins. Co. v. Laforet*, 658 So. 2d 55, 63 (Fla. 1995) (quoting Fla. Stat. § 624.155(1)(b)) (alteration in *Laforet*).

n19 *Id.* at *15-16, quoting *LaForet*, 658 So. 2d at 63.

n20 *Id.* at *16.

n21 *Id.* at *17.

n22 *Id.* at *17-18.

n23 *Id.* at *18 n.6.

n24 *Id.* at *17-18.

n25 *Id.* at *19-20, quoting *Allstate Ins. Co. v. Kim*, 829 A.2d 611, 618 (Md. 2003).

n26 Indeed, Hartford conceded this. *Id.* at *21 n.7.

n27 *Id.* at *20, quoting 2007 Md. Laws 150, § 2 (emphasis by the court).

n28 *Id.* at *21.

n29 *Id.* at *21-22 & n.8.

n30 U.S. Const. art. I, § 10.

n31 *Cecilia Schwaber Trust Two*, 2009 U.S. Dist. LEXIS 59788, at *24-26.

n32 *Id.* at *25.

n33 *Id.* at *23-24.

n34 *Id.* at *27-28.

n35 *Id.* at *28.

n36 *Aranda v. Insurance Co. of N. Am.*, 748 S.W.2d 210, 213 (Tex. 1988). This view is generally accepted by jurisdictions recognizing the bad faith tort or other forms of expanded liability.

n37 See, e.g., *Group Life & Health Ins. Co. v. Royal Drug Co., Inc.*, 440 U.S. 205, 211 (1979); Cal. Ins. Code §§ 22, 250.

n38 *Arnold v. Nat'l County Mut. Fire Ins. Co.*, 725 S.W.2d 165, 167 (Tex. 1987).

n39 *Fletcher v. W. Nat'l Life Ins. Co.*, 10 Cal. App. 3d 376, 404, 89 Cal. Rptr. 78, 95 (1970).

n40 See, e.g., Tex. Ins. Code Ann. art. 21.55 (allowing a recovery of 18% per annum for wrongful and untimely denials of claims).

n41 See, e.g., *Paulson v. State Farm Mut. Auto. Ins. Co.*, 867 F. Supp. 911, 917-18 (C.D. Cal. 1994) (emotional distress not compensable on contract claim). See also William T. Barker, *Damages for Insurance Policy Breaches: A Reply to Ashley*, 13 *Bad Faith L. Rep.* 109 (1997) (examining propriety of this limitation on compensatory damages for ordinary breaches of insurance contracts).

n42 See *Arnold v. Nat'l County Mut. Fire Ins. Co.*, 725 S.W.2d 165, 167 (Tex. 1987) (in the absence of a tort cause of action, "insurers can arbitrarily deny coverage and delay payment of a claim with no more penalty than interest on the amount owed"). This is an overstatement, because the insurer must pay the costs of its own defense no matter how the suit turns out, and, in some states, must pay the insured's attorneys fees if the insured prevails.

n43 See, e.g., Tex. Ins. Code Ann. arts. 21.21, 21.55; Tex. Civ. Prac. & Rem. Code Ann. § 38.006(5).

n44 *Arnold*, 725 S.W.2d at 167. See also *Universe Ins. Co. v. Giles*, 950 S.W.2d 48, 52 (Tex. 1997) (Spector, J.) (relying on these same concerns to retain the bad faith tort); *id.* at 60-63 (Hecht, J., concurring); *Lyons v. Miller Cas. Ins. Co.*, 866 S.W.2d 597, 600 (Tex. 1993) (referring to insurer's "disproportionately favorable bargaining posture in the claims handling process"); Roger C. Henderson, *The Tort of Bad Faith in First-Party Insurance Transactions: Refining the Standard of Culpability and Reformulating the Remedies by Statute*, 26 *U. Mich. J.L. Reform* 1, 9 (1993) (noting social importance of reliable performance of insurance contracts); 26 *U. Mich. J.L. Reform* at 13-15 (burdens on insureds created by coverage disputes and barriers to obtaining fair resolutions of such disputes).

n45 *Neal v. Farmers Ins. Exch.*, 21 *Cal. 3d* 910 (1978).

n46 *Gruenberg v. Aetna Ins. Co.*, 9 *Cal. 3d* 566 (1973).

n47 *Richardson v. Employers Liab. Assurance Corp.*, 25 *Cal. App. 3d* 232 (1972).

n48 *Fletcher v. W. Nat'l Life Ins. Co.*, 10 Cal. App. 3d 376 (1970).

n49 *E.g., Mariscal v. Old Republic Life Ins. Co.*, 42 Cal. App. 4th 1617, 1623 (1996).

n50 William T. Barker & Ronald D. Kent, *The New Appleman Insurance Bad Faith Litigation* § 5.04 (2009) (in press).

n51 *Id.* § 5.03[2].

n52 *Id.* § 5.03[1].

n53 Detection and prevention of fraud is an interest strongly shared by all honest purchasers of insurance, who would object to paying higher premiums merely to enrich the perpetrators of fraud. *See* Alan O. Sykes, "Bad Faith" Breach of Contract by First-Party Insurers, 25 *J. Legal Stud.* 405, 425-29 (1996). Anything which inhibits insurers from challenging potentially fraudulent claims will not only permit the success of frauds which go undetected as a result, but will also tend to encourage additional fraudulent claims.

n54 *Anderson v. Cont'l Ins. Co.*, 85 Wis. 2d 675 (Wis. 1978).

n55 *Id.* at 693, quoting John W. Thornton & Milton S. Blacot, *Bad Faith and Insurers: Compensatory and Punitive Damages*, 12 *Forum* 699, 719 (1977). *See also* *Paulson v. State Farm Mut. Auto. Ins. Co.*, 867 F. Supp. 911, 913-14 (C.D. Cal. 1994) (insurance rates are based on estimates of the costs of performance and breach, but tort liabilities are too vague to be accounted for in advance, so scope of tort must be narrowly and precisely defined, lest "[t]he ability of an insured to create a tort lawsuit out of a good faith denial of insurance coverage create[] settlement value . . . out of proportion to the merits of the underlying contract dispute[s].")(second alteration in original).

n56 *Id.* at 693.

n57 *Travelers Ins. Co. v. Savio*, 706 P.2d 1258 (Colo. 1985) (en banc).

n58 *Id.* at 1274. See also *Blue Cross & Blue Shield v. Campbell*, 466 So. 2d 833, 841 (Miss. 1984) (court recognizes "an obligation to support any insurance company fulfilling its lawful responsibility of investigating any claim which is dubious"); *Aranda v. Ins. Co. of N. Am.*, 748 S.W.2d 210, 213 (Tex. 1988). (bad faith law must allow insurers to "maintain the right to deny invalid or questionable claims and will not be subject to liability for an erroneous denial of a claim."); Robert E. Keeton & Allan I. Widiss, *Insurance Law* § 7.10(a), at 918 (1988) ("Policyholders and insureds clearly have an interest . . . in not discouraging insurers from contesting claims when there are reasonable questions about whether the insured's claim is within the scope of the coverage").

n59 E.g., *Dalrymple v. United States Auto. Ass'n*, 40 Cal. App. 4th 497, 506-508 (1995); *Transportation Ins. Co. v. Moriel*, 879 S.W.2d 10, 17 (Tex. 1994) ("Evidence that merely shows a bona fide dispute about the insurer's liability on the contract does not rise to the level of bad faith."); See William T. Barker, *Evidentiary Sufficiency in Insurance Bad Faith Suits*, 6 Conn. Ins. L.J. 82, 99-101 (1999-2000); William T. Barker & Paul E.B. Glad, *Use of Summary Judgment in Defense of Bad Faith Actions Involving First-Party Bad Faith*, 30 Tort & Ins. L.J. 49, 52-53 (1994).

n60 *Anderson v. Cont'l Ins. Co.*, 85 Wis. 2d 675, 691 (Wis. 1978).

n61 *Moriel*, 879 S.W.2d at 17.

n62 879 S.W.2d. at 18 n.8.

n63 *Union Bankers Ins. Co. v. Shelton*, 889 S.W.2d 278, 287 (Tex. 1994) (Cornyn, J., dissenting).

n64 *Hudson Universal Ltd. v. Aetna Ins. Co.*, 987 F. Supp. 337, 341 (D.N.J. 1997); Douglas G. Houser, *Good Faith as a Matter of Law: The Insurance Company's Right to Be Wrong*, 27 Tort & Ins. L.J. 665, 673 (1992).

n65 *Vernon Fire & Cas. Ins. Co. v. Sharp*, 349 N.E.2d 173, 181 (Ind. 1976).

n66 Md. Code, Cts & Jud. Proc. § 3-1701(a)(4).

n67 *Anderson v. Cont'l Ins. Co.*, 85 Wis. 2d 675 (Wis. 1978).

n68 *Id.* at 691.

n69 *Id.* at 693.

n70 *Hilker v. Western Auto. Ins. Co.*, 204 Wis. 1 (Wis. 1930), *aff'd on rehearing*, 204 Wis. 1 (Wis. 1931).

n71 *Anderson*, 85 Wis. 2d at 692.

n72 *Ishola v. State*, 945 A.2d 1273, 1277, 404 Md. 155, 162 (2008); *Tribbitt v. State*, 943 A.2d 1260, 1264-65, 403 Md. 638, 646, *cert. denied*, 129 S. Ct. 132, 172 L. Ed. 2d 38 (2008); *Boffen v. State*, 816 A.2d 88, 94, 372 Md. 724, 735 (2003).

n73 Maryland General Assem., Dep't of Legis. Servs., *The 90 Day Report -- A Review of the 2007 Legislative Session*, at F-3 (Apr. 13, 2007).

n74 *White*, 248 Md. at 333 (emphasis added).

n75 *Gaskill v. Preferred Risk Mut. Ins. Co.*, 251 F. Supp. 66 (D. Md. 1966).

n76 248 Md. at 330, quoting 251 F. Supp. at 68 (bracketed inserts by White).

n77 *Id.* at 331.

n78 *Id.*, quoting John Alan Appleman & Jean Appleman, Insurance Law & Practice § 1612 (1967) (emphasis added).

n79 *Id.* at 330, quoting 157 A.2d at 327.

n80 *Id.* at 330-31, quoting 184 F. Supp. at 638.

n81 *Id.* at 332.

n82 *Id.* at 331.

n83 *Allstate Ins. Co. v. Campbell*, 334 Md. 381 (1994).

n84 *Republic Ins. Co. v. Prince George's County*, 92 Md. App. 528 (1992)

n85 *City of Wakefield v. Globe Indem. Co.*, 246 Mich. 645, 652-53 (1929).

n86 92 Md. App. at 537-38.

n87 *Cecil Schwaber Trust Two v. Hartford Accident & Indem. Co.*, 2009 U.S. Dist. LEXIS 59788, at *15 (D. Md. July 14, 2009), quoting *State Farm Mut. Auto. Ins. Co. v. Laforet*, 658 So. 2d 55, 63 (Fla. 1995) (quoting Fla. Stat. § 624.155(1)(b)) (alteration in *Laforet*).

n88 *Id.* at *13-14, citing "*State v. Booze*, 334 Md. 64, 637 A.2d 1214, 1222 (Md. 1994) (noting that 'not acting in bad faith is not the same as acting in good faith and/or with good cause'); *Zdravkovich v. Bell Atlantic-Tricon Leasing, Corp.*, 323 Md. 200, 592 A.2d 498, 503 (Md. 1991) ('The District Court's finding that Zdravkovich "has not shown good faith" is not the equivalent of a finding of "bad faith" . . .'); *Art Form Interiors, Inc. v. Columbia Homes, Inc.*, 92 Md. App. 587, 609 A.2d 370, 376 (Md. Ct. Spec. App. 1992) (noting that 'a finding that a party has not shown good faith is not the functional equivalent of a finding of bad faith'). But see *Catterton v. Coale*, 84 Md. App. 337, 579 A.2d 781, 783 (Md. Ct. Spec. App. 1990) ('To further illuminate the definition of "good-faith," we found it most instructive to compare the definition of "bad-faith." "Bad-faith" is the opposite of good faith . . .')."

n89 *Zdravkovich*, 323 Md. at 210-11.

n90 *Art Form Interiors, Inc.*, 92 Md. App. at 596-97.

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For more than 70 years, Sonnenschein has partnered with insurance companies to understand their business and legal needs. Recent confirmation of Sonnenschein's outstanding insurance industry qualifications came in *Chambers USA: Americas Leading Lawyers for Business*. The 2007 edition identifies Sonnenschein as one of the top firms in the country representing insurers on their most complex matters. The Chambers description speaks for itself:

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Reed Smith on Automobile Ins. Assoc. v. St. Paul Mercury Ins. Co.

2010 Emerging Issues 4801

Reed Smith on Contra Proferentem and the Not So "Hapless" Sophisticated Insured: An Analysis of Farmers Automobile Insurance Association v. St. Paul Mercury Insurance Company

By Mark Hersh and Roxanne Garibay

January 7, 2010

SUMMARY: In Farmers Automobile Ins. Assoc. v. St. Paul Mercury Ins. Co., the Seventh Circuit, in interpreting Illinois law, applied the rule of contra proferentem, but questioned the validity of the rule when applied to a sophisticated commercial entity. This commentary examines and discusses several reasons that contra proferentem should remain applicable to sophisticated commercial entities.

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ARTICLE: Under the doctrine of contra proferentem, insurance policy ambiguities are construed against the insurer, in favor of coverage. In Farmers Automobile Insurance Association v. St. Paul Mercury Insurance Company n1, the Seventh Circuit, in interpreting Illinois law, applied the rule of contra proferentem, but questioned the validity of the rule when applied to a sophisticated commercial entity. This commentary examines Farmers, and discusses several reasons that contra proferentem should remain applicable to sophisticated commercial entities.

I. The Case

Farmers bought an insurance policy from St. Paul that covered employment wrongful acts, which was defined to include any breach of duty in connection with the unlawful treatment of an employee. The policy had an exclusion for "any [] violation of the Fair Labor Standards Act... [or] other similar provisions of any federal, state or local [] law..." n2 (emphasis added). Farmers alleged that coverage was triggered when its claims adjusters filed a class action seeking overtime pay pursuant to the Illinois Minimum Wage Law. n3 St. Paul refused coverage on the basis that the Illinois Minimum Wage Law was "similar" to the Fair Labor Standards Act, and thereby the class action did not trigger coverage under the policy's exclusion. n4

The district court agreed with St. Paul, and found that Illinois's minimum wage law was "similar" to the federal act. n5 Although Farmers used the word "similar" in its own policies, it appealed, and argued, that the word was vague, and should be construed against St. Paul as the insurer under contra proferentem. n6

The Seventh Circuit, in an opinion written by Judge Richard A. Posner, recognized that contra proferentem is based on judicial reluctance to require the "hapless insured to unravel [the] mysteries" of insurance policies. n7 The court observed, however, that the rationale for contra proferentem is "feeble," when it comes to a sophisticated commercial entity, and in the case of Farmers, a sophisticated insurer, even more so. n8 The court criticized the Illinois Supreme Court's opinion in *Outboard Marine Corporation v. Liberty Mutual Insurance Company*, which had declined to limit contra proferentem to commercially unsophisticated individuals on the basis that the insurer has "total control" of the terms and the drafting of the contract. n9 The Seventh Circuit opined that "'total control' is an exaggeration. n10 It nevertheless applied the rule of contra proferentem, because sitting in diversity, it was bound by the holding of the Illinois Supreme Court. Ultimately, Farmers disagreed that the word "similar" was vague, and affirmed the trial court's ruling. n11

II. Analysis

At first glance, the fact pattern in *Farmers* is a prime example of why contra proferentem fails when the insured is sophisticated. Farmers, a large sophisticated insurance company, was allowed to take advantage of a legal doctrine it had likely argued against, in order to claim as vague, a policy term that it had used in its own policies. Upon closer examination, however, contra proferentem is justified when applied to sophisticated insureds.

As Farmers acknowledged, the traditional justification for applying contra proferentem in insurance cases is that there is little opportunity for the insured to bargain over terms. n12 This consideration can apply with equal force to a sophisticated insured. n13 Because insurers are better able to forecast the risks associated with standard policy language n14, and raise premiums accordingly, they often do not allow even sophisticated commercial insureds to negotiate policy language. As a result, a sophisticated insured may have little bargaining power. n15

But even where this is not the case - for example, key terms in a directors and officers policy often are negotiated - contra proferentem is justified based on additional policy considerations. First, even if some insurance terms are tailored by the insured, the insurer still sells thousands of basically the same policies to customers. Construing ambiguities in favor of coverage makes it difficult for the insurer to exploit ambiguities in the policies. For example, a number of published cases concern the issue of what constitutes a "claim" in a claims-made policy. n16 An insurer typically will argue for a narrow definition of "claim" to avoid providing coverage. But an insurer may try to construe "claim" broadly when the insured has failed to report the matter in the time period prescribed by the policy, thus enabling the insurer to deny coverage based on late notice. Allowing insurers to take inconsistent positions from case to case is bad public policy, and at odds with insurers' obligations of good faith to their insureds.

Second, the insurance industry's profit model is based on being able to deny or delay paying out claims. To maximize profit, insurance companies must maximize the time between receiving premiums and making a payment. As a result, insurers benefit from ambiguities and have a huge financial incentive to draft ambiguous policy terms. Sophisticated insureds are not immune to such strategic ambiguity, and as a result, should not be immune from the benefits of contra proferentem.

Finally, and a related point, a bright line rule facilitates quicker resolution of the coverage dispute, and encourages a more uniform body of law. While Farmers may clearly be a sophisticated insured, in many cases the sophistication of an insured regarding insurance may be a disputed fact that requires an expenditure of judicial resources. n17 (The same may also be true of the question whether policy terms were negotiated.) Again, such delay nearly always benefits the insurer. In addition, courts and commentators have pointed out that upholding a strict contra proferentem rule in favor of coverage ensures that common insurance policy terms do not have meanings that fluctuate depending on the identity of the insured. n18 Accordingly, contra proferentem should be no less applicable to a sophisticated insured than it is to the "hapless insured."

Sophisticated policyholders should be aware that case law, such as *Farmers*, may make the application of contra proferentem increasingly more difficult. But there are a number of considerations supporting application of the doctrine

to sophisticated commercial entities. Sophisticated policyholders should be prepared to make these arguments for application of the doctrine when seeking insurance coverage.

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n1 *Farmers Automobile Ins. Ass. v. St. Paul Mercury Ins. Co.*, 482 F.3d 976 (7th Cir. 2007).

n2 *Id.* at 976-77.

n3 *Id.*

n4 *Id.* at 977.

n5 *Id.*

n6 *Id.* at 977-78.

n7 *Id.*

n8 *Id.*

n9 *Id.* (citing *Outboard Marine Corp. v. Liberty Mutual Ins. Co.*, 154 Ill.2d 90, 121-22 (Ill. 1992)).

n10 *Id.* at 978.

n11 *Id.* at 978-79.

n12 *Farmers*, 482 F.3d at 977.

n13 *See Outboard*, 154 Ill.2d at 121.

n14 David Horton, *Flipping the Script: Contra Proferentem and Standard Form Contracts*, 80 U. Colo. L. Rev. 431, 461 (Spring 2009).

n15 Horton, *supra* note 14, at 461.

n16 *See, e.g., St. Paul Mercury Ins. Co. v. Foster*, 268 F. Supp. 2d 1035, 1047-48 (C.D. Ill. 2003).

n17 *See, e.g., John M Bjorkman, et al.*, 1 Law and Prac. of Ins. Coverage Litig. § 1:12 (Jun. 2009).

n18 Horton, *supra* note 14, at 480-81; *see also Boeing Co. v. Aetna Cas. and Sur. Co.*, 113 Wash. 2d 869, 883 (Wash. 1990) (stating, "[I]t would be incongruous for the court to apply different rules of construction based on the policyholder because once the court construes the standard form coverage clause as a matter of law, the court's construction will bind policyholders throughout the state regardless of the size of their business").

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McCarter & English LLP on Viking Pump, Inc. v. Century Indemnity Company

2010 Emerging Issues 4803

McCarter & English LLP on Viking Pump, Inc. v. Century Indemnity Company: Delaware Court Offers Significant Coverage Rulings Relating to Assignment of Insurance Rights & Allocation of Loss Under New York Law

By Sherilyn Pastor

January 7, 2010

SUMMARY: A Delaware decision supports application, under New York law, of an "all sums" allocation methodology to long-tail losses. It distinguishes prior New York "pro rata" allocation rulings favorable to insurers, and finds policies' "non-cumulation," and "prior insurance" provisions cannot "sensibly be applied within a pro-rata allocation scheme. The Court also upheld policyholders' rights to transfer coverage post-loss.

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ARTICLE: In *Viking Pump, Inc. v. Century Indemnity Company*, a Delaware Court addressed post-loss assignment of insurance rights and allocation of loss under New York law. *See 2009 Del. Ch. LEXIS 180* (Del. Ch. Oct. 14, 2009). The Court ruled that plaintiff policyholders were entitled to insurance coverage for liabilities they accepted upon their acquisition of another company's assets. More importantly, the Court held that insurers were liable for losses based on an "all sums" allocation approach. *Id.* The Court's decision is significant in this regard because it relied on principles of insurance contract interpretation to distinguish prior New York "pro rata" allocation rulings.

Transfer of Post-Loss Insurance Rights

Plaintiffs acquired another company's manufacturing businesses and assets, and now face asbestos bodily injury liabilities arising from certain pre-acquisition asbestos exposures. When the plaintiffs sought coverage from their predecessor's insurers, the insurers claimed that the predecessor had not transferred its insurance rights to plaintiffs and, even if it had, their insurance policies' anti-assignment provisions voided such transfers. The Delaware Chancery Court resolved the issues under New York law and in plaintiff policyholders' favor. *Id.* at *8-9, 70-73.

The Court determined that the parties intended the successor companies to be liable for pre-acquisition asbestos exposures and to have insurance necessary to respond to such losses. *Id.* at *3-8. The Court disagreed that the insurance policies' anti-assignment provisions voided these transfers of insurance benefits, finding anti-assignment provisions are unenforceable under New York law for losses arising prior to the transfer of coverage. According to the Court, the policyholder is transferring only the right to collect under its policies following a compensable loss, not its policies

themselves. The insurer therefore is simply paying the amount due to a different party. *Id.* at *8-9, 70-73.

The Court rejected the insurers' arguments that the anti-assignment clauses should be enforced because the asbestos liabilities at the time of transfer were too speculative and not reduced to a fixed loss amount. It concluded that the insured risk was no greater post-assignment than pre-assignment. It also opined that enforcing anti-assignment provisions in these circumstances could negatively impact the market for the sale of corporate assets and lead to insufficient recoveries for tort plaintiffs. *Id.* at *70-73.

"All Sums" Allocation of Loss

Allocation refers to distributing responsibility for losses among multiple triggered policy periods, and between and among insurers. Three general approaches to allocation have developed: all sums; pro rata; and, pro rata by years and limits. Under an all sums approach, a policyholder can elect to collapse all costs into a single policy year. That policy year's insurers must then reimburse the entire loss up to their limits and subject to their contribution rights against other triggered years' insurers. *See, e.g., Keene Corp. v. Ins. Co. of N. Am.*, 667 F.2d 1034 (D.C. Cir. 1981), *cert. den.*, 455 U.S. 1007 (1982), *reh'g den.*, 456 U.S. 951 (1982); *Zurich Ins. Co. v. Raymark Indus., Inc.*, 118 Ill.2d 23, 514 N.E.2d 150 (1987); *Allstate Ins. Co. v. Dana Corp.*, 759 N.E.2d 1049 (Ind. 2001); *Rubenstein v. Royal Ins. Co.*, 694 N.E.2d 381 (Mass. App. Ct. 1998); *Carter-Wallace, Inc. v. Admiral Ins. Co.*, 154 N.J. 312, 712 A.2d 1121 (1998); *J.H. France Refractories Co. v. Allstate Ins. Co.*, 534 Pa. 29, 626 A.2d 502 (1993).

Under a pro rata approach, the loss is spread evenly over all triggered policy years. *See, e.g., Ins. Co. of N. Am. v. Forty-Eight Insulations, Inc.*, 657 F.2d 814 (6th Cir. 1981), *cert. den.*, 454 U.S. 1109 (1981); *Gulf Chem. & Metallurgical Corp. v. Assoc. Metals & Minerals Corp.*, 1 F.3d 365 (5th Cir. 1993); *Consol. Edison Co. v. Allstate Ins. Co.*, 98 N.Y.2d 208, 774 N.E.2d 687 (2002). Under a modified pro rata by years and limits approach, losses are spread horizontally among triggered insurance policies in proportion to the degree of risks transferred during the policy period. *E.g., Carter-Wallace*, 154 N.J. 312, 712 A.2d 1116; *Owens-Illinois, Inc. v. United Ins. Co.*, 138 N.J. 437, 650 A.2d 974 (1994).

The *Viking Pump* Court was faced with the "usual" allocation dispute, with insurers arguing for a pro-rata method and the policyholders arguing for an all-sums approach. *See 2009 Del. Ch. LEXIS 180*, at *83. After analyzing New York law, the Court concluded that rules of contract interpretation; the excess policies' plain language; and, the extrinsic evidence required application of an all sums allocation. The Court observed that all of the excess policies' terms could only be given effect under this approach. It also noted that principles of *contra proferentem* required resolving any uncertainty in the policies' language against the insurers' preferred pro-rata allocation method. *Id.* at *123.

The Court acknowledged the prior and seemingly inconsistent New York Court of Appeals' ruling in *Consolidated Edison Co. of New York v. Allstate Insurance Co.*, 774 N.E.2d 687 (N.Y. 2002), which applied a pro rata allocation approach. *Id.* at *116-23. The *Viking Pump* Court, however, found *Consolidated Edison's* facts distinguishable and concluded that the *Consolidated Edison* decision did not establish a bright-line rule in favor of a pro rata methodology. *Id.* Rather, the *Consolidated Edison* decision was limited to the interpretation of the policies there involved, and risks then before the court.

The *Viking Pump* Court emphasized that the *Consolidated Edison* allocation decision was not based on broad public policy considerations. *Id.* It therefore criticized those prior federal court decisions purporting to apply New York law, but ordering an allocation methodology based on evaluation of equitable and public policy concerns. These decisions offer "well-reasoned arguments on one side of [the] controverted legal policy" but "involve a free-wheeling consideration of what New York policy should be, in a manner that is rather surprising given the *Erie* doctrine." *Id.* at *111-12 (distinguishing *Olin Corp. v. Ins. Co. of N. Am.*, 221 F.3d 307 (2d Cir. 2000) (employing a pro rata allocation methodology for asbestos losses); *In re Prudential Lines*, 158 F.3d 65 (2d Cir. 1998) (employing an all sums methodology for asbestos losses)). Preferring to "stick to the method of contract interpretation that New York courts generally apply to insurance coverage disputes, and not to adopt a tie-breaking rule based on judge-made policy

determinations," the *Viking Pump* Court held that the policies' "non-cumulation," or "prior insurance" provisions were of "paramount importance" and could not "sensibly be applied within a pro-rata allocation scheme." *Id.* at *128, 133.

The Delaware Court's decision offers policyholders substantial and thoughtful support for an all sums allocation of long-tail losses -- such as asbestos and environmental liabilities -- under New York law. By adhering to established rules of contract interpretation, the Court's ruling holds insurers to their contractual bargains and accountable up to their policy limits for long-tail losses. How New York state and federal courts applying New York allocation law will respond (if at all) to the decision remains to be seen.

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McCarter & English LLO on Martco Ltd. Partnership v. Wellons, Inc.

2010 Emerging Issues 4804

McCarter & English LLO on Martco Ltd. Partnership v. Wellons, Inc., The Fifth Circuit Applied Basic Rules Of Insurance Policy Construction To Find Coverage For Breach Of Contract Claims

By Joann M. Lytle, Nicholas M. Insua and Anne E. Matthews

January 7, 2010

SUMMARY: In *Martco Ltd. Partnership v. Wellons, Inc.*, the United States Court of Appeals for the Fifth Circuit recently rejected an insurance carrier's argument that a commercial general liability ("CGL") policy allegedly did not provide coverage for a breach of contract claim. The Fifth Circuit, however, applied basic rules of contract interpretation to find coverage for property damage resulting from the insured's malfunctioning product.

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ARTICLE: A thorny topic for policyholders and insurance recovery practitioners is obtaining coverage for claims that are or can be characterized as arising from a breach of contract or breach of warranty. Some courts (indeed, an increasing number) take the view that such claims are not covered by general liability policies, usually not because of what the insurance policy actually says, but because of what insurance companies or their lawyers argue it says. But the recent decision of the United States Court of Appeals for the Fifth Circuit in *Martco Ltd. Partnership v. Wellons, Inc.*, n1 gives hope that Courts will follow basic rules of insurance policy construction when analyzing questions concerning the duties to defend and indemnify such claims. This article will focus on three aspects of the Court's lengthy and thoughtful ruling: whether (1) the claim involved "property damage" (2) caused by an "occurrence", and (3) whether the "impaired property exclusion" barred coverage.

Martco Ltd. ("Martco"), a manufacturing company, contracted with Wellons, Inc. ("Wellons"), to design, fabricate, and install certain improvements to an existing Wellons wood-fired thermal oil heating system located in one of Martco's plants. n2 Wellons timely completed the improvements to the system, but when it was put into service, several problems arose: "the new expansion tank imploded, a circulation pump isolation valve failed, fires developed in the dry bins, a valve stem leaked, more ash than anticipated was generated by the new system, the computerized control system did not function properly, and wires burnt off the thermocouples." n3 As a result of these problems, Martco was unable to operate the system at times, forcing periodic shutdowns of the plant and causing Martco to suffer lost production, profits, and business opportunities valued at approximately \$4.4 million. n4

Martco filed suit against Wellons, asserting six separate contractual claims. n5 Wellons, in turn, cross-claimed

against Admiral Insurance Company ("Admiral") for coverage under its commercial general liability policy ("Policy"). "The liability issues as between Martco and Wellons and the insurance issues as between Wellons and Admiral were bifurcated." n6 The liability issues were tried to a jury, which found in favor of Martco. n7

Once the liability phase of the trial concluded, Admiral filed a motion for summary judgment, in which it asserted that, under the Policy, it had no duty to indemnify Wellons for Martco's claims. n8 Wellons, together with Martco, filed a cross-motion, arguing the contrary. n9 The district court ruled in favor of Wellons and Martco, holding that the Policy did require Admiral to indemnify Wellons for Martco's claims for lost productivity, earnings, and profits. n10 Admiral appealed this decision. n11

A second round of summary judgment motions followed when Wellons and Martco filed a joint motion asserting that Admiral had a duty to defend Wellons under the Policy. n12 "Admiral responded by claiming that there was no duty to defend under the policy because there was no 'property damage' caused by an 'occurrence' evident in the original Martco complaint and because numerous exclusions applied." n13 The district court found that there was "property damage" n14 but that the Policy's "impaired property" exclusion n15 applied, such that Admiral did not have a duty to defend Wellons in the underlying suit. n16 Wellons appealed this decision. n17

The appeals were consolidated for review by the Fifth Circuit. n18 On appeal, the Fifth Circuit first considered the question whether Admiral had a duty to defend Wellons, and then analyzed separately the duty to indemnify. Rather than address the court's discussions of each of those duties separately, this article is organized around three of the coverage defenses addressed by both courts: (1) was there "property damage" (2) caused by an "occurrence" (3) that did not implicate the "impaired property" exclusion?

(1) "Property Damage"

Regarding "property damage," the court observed: "to satisfy its burden, Wellons must show that Martco's complaint alleges 'property damage' within the meaning of the Policy." n19 The Policy defined "property damage ... as '[p]hysical injury to tangible property, including all resulting loss of use of that property.'" n20 In analyzing the duty to defend, the Court, under Louisiana jurisprudence, construed liberally the allegations of underlying complaint against the definition of "property damage" (the "eight-corners rule"), and found that at least one of the paragraphs (Paragraph 12) in the underlying complaint potentially alleged "property damage" under the Policy: "WELLONS' efforts have produced negative results so far and the operation of the Wellons unit has caused physical degrading of the infrastructure through excessive ash carryover." n21 The court found that, in determining the duty to defend, the allegation of "physical degrading" in Paragraph 12, coupled with the complaint's "demand for damages for repairs" could "be construed as making a claim for an injury to tangible property caused by the insured," and thus found "Wellons met its burden with respect to this portion." n22

On the duty to indemnify, Admiral argued first, "as a matter of law, [that] a claim for breach of contract cannot constitute a claim for 'property damage.' Admiral reason[ed] that any recovery derived from such claims would involve purely economic damages and, as such, Martco failed to prove the necessary injury." n23 The Fifth Circuit upheld the district court's interpretation of Louisiana jurisprudence on this point, opining that "CGL policies would simply not make sense if the court held otherwise" because "CGL provisions and exclusions carefully address situations arising from contractual breaches producing property damage." n24 Thus, the underlying claims did involve covered "property damage" under the Policy. n25

Second, Admiral argued that Wellons had "not proven 'property damage' as defined under the Policy." n26 The Fifth Circuit also rejected this argument, concluding that the jury verdict "show[ed] Martco demonstrated 'loss of use' [and, a]s such, Wellons, by way of Martco, adequately demonstrated 'property damage' as that term is defined in the Policy." n27

(2) "Occurrence"

The Policy defined the term "occurrence" as "an accident, including continuous or repeated exposure to substantially the same general harmful conditions." n28 In rejecting Admiral's contention that there was no duty to defend because "Martco did not affirmatively plead sufficient facts to allow Wellons to assert coverage using Paragraph 12," n29 the Court held:

[Admiral's contention] would require an inversion of Louisiana's standard for assessing the duty to defend issue. Rather, we must ask whether the allegations do not unambiguously prevent a conclusion that coverage could exist.... Here, Paragraph 12 is ambiguous. It does not define "excessive ash carryover." It does not state how often "excessive ash carryover" occurred. All it states is that Wellons's efforts at repair (which the preceding and following paragraphs suggest lasted months) created additional harm and the resulting ash carryover led to degradation of some undefined infrastructure. Again, liberally construing the allegations, injury by "excessive ash carryover" can reasonably be understood to involve repeated exposure over the long period in which Wellons fruitlessly attempted to make repairs. While this may not be affirmatively clear on the pleadings, it is sufficient to conclude that the allegations do not unambiguously preclude a finding that there was an "occurrence." Consequently, we conclude that the allegations of the complaint state claims that may be covered by the insuring clause of the Policy. n30

The Court similarly concluded that the underlying action triggered Admiral's duty to indemnify. As with the definition of "property damage," Admiral argued that Louisiana jurisprudence "categorically exclude[d] construction defects as possible 'occurrences.'" n31 And as with Admiral's assertion that a claim for breach of contract could not give rise to "property damage," so too did the Court reject Admiral's argument that the underlying action did not arise from an "occurrence." n32

(3) "Impaired Property" Exclusion

Regarding the "impaired property" exclusion, in its discussion of the duty to defend, the Fifth Circuit first relied heavily on the Louisiana Court of Appeal decision in *Gaylord Chem. Corp. v. ProPump, Inc.*, 753 So. 2d 349 (La. Ct. App. 2000), in which the court reasoned that:

[T]he "impaired property" exclusion only excludes damage to property that has not been physically injured or for which the claimed damages are only for loss of use of that property. Therefore, any damages based on actual physical injury to Gaylord's plant, equipment, or other property would not be excluded under this provision. n33

The Fifth Circuit found that "interpretation of an identical 'impaired property' provision... convincing and, arguably, under *Gaylord*, the 'impaired property' exclusion should not apply" n34 to the claim of Wellons. The court also held that the definition of "impaired property" was not met because the damaged property could not unambiguously be fully restored "by repairing, replacing, adjusting, or removing the insured's 'work' or the insured's 'product.'" n35 Thus, the "impaired property" exclusion would not obviate Admirals' duty to defend. n36

On the duty to indemnify, the Court focused on an exception to the exclusion for "loss of use of other property arising out of sudden and accidental physical injury to 'your product' or 'your work' after it has been put to its intended use." n37 The Fifth Circuit found that the District Court had "ample evidence" to conclude that the "sudden and accidental" exception to the exclusion was met. n38 Accordingly, the Fifth Circuit determined that the impaired property exclusion did not relieve Admiral of its duty to indemnify Martco. n39

In sum, the Fifth Circuit in *Martco* dealt a significant blow to the insurance industry's burgeoning attempts to deny coverage under a general liability policy for property damage caused by an occurrence, simply because the property damage arose in the context of a contractual relationship. More courts should follow the Fifth Circuit's lead, by fairly reading the policy language and remembering that "the purpose of insurance is to insure." n40

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n1 *No. 08-31247 & No. 08-31248, 2009 U.S. App. LEXIS 25428* (5th Cir. Nov. 19, 2009).

n2 *Id.* at *2-3.

n3 *Id.* at *3.

n4 *Id.* at *3-4.

n5 *Id.* at *4.

n6 *Id.* at *4-5.

n7 *Id.* at *4.

n8 *Id.* at *5.

n9 *Id.*

n10 *Id.*

n11 *Id.*

n12 *Id.*

n13 *Id.*

n14 The district court did not examine whether there was an "occurrence." *Id.*

n15 The impaired property exclusion (Exclusion (m)) states in relevant part:

m. Damage To Impaired Property or Property Not Physically Injured

"Property damage" to "impaired property" or property that has not been physically injured, arising out of:

(1) A defect, deficiency, inadequacy or dangerous condition in "your product" or "your work"; or

(2) A delay or failure by you or anyone acting on your behalf to perform a contract or agreement in accordance with its terms.

Id. at *18 n. 7.

n16 *Id.* at *5-6.

n17 *Id.* at *2.

n18 *Id.*

n19 *Id.* at *11.

n20 *Id.*

n21 *Id.*

n22 *Id.* at *12.

n23 *Id.* at *27.

n24 *Id.* at *28.

n25 *Id.*

n26 *Id.* at *29.

n27 *Id.*

n28 *Id.* at *12.

n29 *Id.* at *14.

n30 *Id.* at *14-15.

n31 *Id.* at *29.

n32 *Id.* at *30.

n33 *Id.* at *20.

n34 *Id.*

n35 *Id.* at *21.

n36 *Id.*

n37 *Id.* at *37.

n38 *Id.*

n39 *Id.* at *40.

n40 *Phil Schroeder, Inc. v. Royal Globe Ins. Co.*, 659 P.2d 509, 511 (1983).

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McCarter & English LLP on Fasso v. Doerr

2010 Emerging Issues 4802

McCarter & English LLP on Fasso v. Doerr, Did The New York Court Of Appeals Clarify -- Or Confuse -- Equitable Subrogation Principles And Procedures?

By Charles Allen Yuen and Jessica S. Berk

January 7, 2010

SUMMARY: New York courts often disagree in subrogation cases. The 2009 decision of *Fasso v. Doerr* shows how sharply judicial minds may differ on the equities. *Fasso* clarified aspects of equitable subrogation, such as the "made whole" doctrine, in favor of health insurers; but dicta in the decision has clouded health insurers' right to intervene in underlying actions to enforce their subrogation rights.

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ARTICLE: In New York, the right to assert a subrogation claim against a tortfeasor may arise by equity or by contract. n1 Common law equitable subrogation is based generally upon the "dual objective" that a tortfeasor should bear loss by reimbursing an injured party's insurer and the injured party should not recover twice for the same harm -- once from an insurer and again from a wrongdoer. n2 Although the general concepts underlying equitable subrogation and its limitations are simple, n3 New York courts often disagree in subrogation cases on how to reconcile the specific competing equitable rights and obligations. *Fasso v. Doerr* n4 is an example of the how sharply judicial minds may differ on the equities. In *Fasso*, the Appellate Division, Fourth Department, affirmed a trial court decision unanimously. Unanimously, the Court of Appeals then reversed the Appellate Division.

The courts in *Fasso* considered the potential effect of the "made whole" doctrine, a common law limitation on equitable subrogation, on the oft-litigated issue of whether the terms of a settlement agreement between an injured party and a tortfeasor may extinguish an insurer's subrogation right. In *Fasso*, a patient asserted a malpractice claim against a physician in New York Supreme Court, Erie County. The patient's health insurer had paid \$780,000 in medical expenses allegedly as a result of the physician's malpractice. n5 The insurer sought and was granted, absent any objection from the parties, intervenor party status to assert a subrogation claim against the physician. n6

The patient later moved to dismiss the insurer's subrogation claim. She argued that the insurer was not entitled to subrogation because the claimed monetary value of her injuries exceeded the \$2 million limit of the doctor's malpractice insurance. n7 She asserted that she therefore could not be "made whole," even absent a reimbursement to the insurer. n8 The trial court denied the motion. n9

On the second day of trial in Supreme Court, the patient and the physician settled. Under the settlement agreement, the patient and her co-plaintiff husband received \$900,000, the doctor admitted no wrongdoing, and the settling parties sought dismissal of the insurer's subrogation claim. n10 The settling parties agreed among themselves that the patient was not "made whole" by the settlement amount. n11

The insurer contested dismissal of its subrogation claim. It argued that the physician's malpractice insurance limit of \$2 million left a remaining \$1.1 million available, after subtracting the \$900,000 settlement payment, to fund the insurer's potential subrogation recovery of its prior payments to the patient. n12 The insurer also requested a mistrial in order to obtain witnesses and evidence to prove its subrogation claim in the absence of the settling patient. n13

Over the insurer's objections, the trial court dismissed the insurer's subrogation claim, *sua sponte*, and denied the insurer's request for a mistrial. The court reasoned, "it is abundantly clear that [the patient] is not made whole by this sum. As such, it does not give rise to any claim of equitable subrogation on the part of [the insurer]." n14

In affirming on a different ground, the unanimous Fourth Department panel reasoned that "[t]he rights of a health insurer in an equitable subrogation action are derived from the injured plaintiff," n15 and "a health insurer therefore has no right to control the settlement of the injured plaintiff's action." n16 The panel explained that "[t]he continuation of [the insurer's] action against [the physician] would have nullified that settlement." n17

Reversing, the Court of Appeals held that in construing equitable subrogation principles, both the Supreme Court and the Appellate Division had erred in their reasoning. n18 The Court of Appeals first agreed with the health insurer that its subrogation claim could be satisfied from the physician's remaining malpractice insurance limit, as well as the physician's other assets. n19 The Court of Appeals held that in light of the physician's available assets, including its malpractice insurance, the "made whole" doctrine would not limit the insurer's subrogation recovery. n20 The Court of Appeals specifically limited application of the "made whole" doctrine to situations where the recovery the injured party is entitled to receive is greater than the total of a tortfeasor's assets and insurance coverage, stating: "If the recovery the injured party receives, whether determined by settlement or verdict, is greater than the wrongdoer's assets and available insurance coverage, there is nothing left for the insurer to execute its subrogation rights against and the made whole rule prevents the insurer from sharing in the insured's judgment or recovery." n21

The Court of Appeals further held that the Fourth Department had erred in viewing the settling parties as having the right to limit the subrogation rights of the health insurer over its objection. n22 The settling parties did not have such a right even where, as in *Fasso*, the insurer was an intervening party in the action *and* the parties executed a general release in order to preclude such subrogation. n23 The Court of Appeals thus rejected application, to the specific settlement facts in *Fasso*, of the well-recognized general principle that because "[t]he rights of a health insurer in an equitable subrogation action are derived from the injured plaintiff . . . a health insurer . . . has no right to control the settlement of the injured plaintiff's action." n24 The Fourth Department, relying upon decisions which distinguished equitable and contractual subrogation, had reasoned that the rights of an insurer in an action for equitable subrogation were derived from an insured and therefore were limited by the insured's settlement. n25

The Court of Appeals decision in *Fasso*, in rejecting that view, did not provide the subrogating insurer with a right to impede settlements between an injured party and a tortfeasor. It simply limited the enforceability of certain settlement provisions which impede the insurer's subrogation rights. However, in so limiting enforceability of such settlement provisions, *Fasso* clearly reduces incentives for tortfeasors to settle. n26

Although it appears that *Fasso* "clarified" the equitable subrogation doctrine to the extent discussed above, the Court of Appeals further opined, to a certain extent, on whether an insurer may intervene in an injured party's action against a tortfeasor to enforce subrogation rights. n27 In *Fasso*, none of the parties had objected to the health insurer's intervention motion. Even though the intervention motion was thus not before it for adjudication, the Court of Appeals questioned the procedure. It stated that "New York courts have disagreed on the issue of whether it is permissible to grant intervention to health insurers of injured parties in tort cases. The predominant view is that the participation by

insurers in settlement negotiations creates conflicts of interests with plaintiffs" n28 The Court of Appeals further proclaimed that "allowing an insurer to intervene inevitably complicates settlement negotiations over the tortfeasor's insurance coverage," and called for the New York Legislature to clarify intervention rights in the light of "competing policy concerns." n29

The Court of Appeal's questioning *dicta* on intervention procedure casts doubt upon whether a health insurer has a right to intervene to enforce its subrogation rights. It has highlighted potential barriers on whether insurers may assert their claims by way of intervention. Injured parties and tortfeasors may now cite *Fasso* as authority for the proposition that health insurers should not be permitted to intervene in their cases. Health insurers may therefore find their intervention motions denied by courts identifying the conflicts of interest considerations mentioned in *Fasso* and relying on *Fasso*. As a consequence, they may find more of their potential subrogation claims barred by the running of statutes of limitations. n30

The Court of Appeals further commented briefly upon another issue which appears to have had no relevance at all to the claims at issue in *Fasso* -- the Legislature's limitation of the common law collateral source rule in tort actions. n31 The Court of Appeals opined that "nothing in the language or legislative history of [the Legislature's action] indicates that the Legislature intended to alter the established rules of equitable subrogation." n32 Although this comment was apparently intended only to influence the scope of future legislative action, a federal trial court has relied precisely upon it in ruling that despite limiting the common law collateral source rule, the Legislature did not affect an insurer's subrogation rights. n33

In sum, it is clear that the Court of Appeals in *Fasso* clarified aspects of equitable subrogation, such as the "made whole" doctrine, in favor of health insurers. On the other hand, *Fasso's dicta* has clearly clouded health insurers' right to intervene to enforce their subrogation rights.

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n1 In contractual subrogation, an agreement between an insurer and its injured policyholder specifically allows the insurer to assert the policyholder's action against the tortfeasor. *See, e.g., Fed. Ins. Co. v. Arthur Andersen & Co.*, 552 N.E.2d 870, 872 (N.Y. 1990).

n2 *Winkelmann v. Excelsior Ins. Co.*, 650 N.E.2d 841, 843 (N.Y. 1990).

n3 Subrogation is not a recent concept but rather is a well-established doctrine based in equity. *Allstate Ins. Co. v. Stein*, 807 N.E.2d 268, 272 (N.Y. 2004). In fact, the Court of Appeals stated eight-five years ago that "[i]t is so well settled as not to require discussion that an insurer who pays claims against the insured for damages caused by the default or wrongdoing of a third party is entitled to be subrogated to the rights which the insured would have had against such third party for its default or wrongdoing." *Ocean Accident & Guar. Corp. v. Hooker Electrochem. Co.*, 147 N.E. 351, 353 (N.Y. 1925).

n4 903 *N.E.2d* 1167 (N.Y. 2009).

n5 *Id.* at 1168.

n6 *Id.* at 1169.

n7 *Id.*

n8 *Id.*

n9 *Id.*

n10 *Id.*

n11 *Id.*

n12 *Id.*

n13 *Id.*

n14 *Fasso v. Doerr*, 848 *N.Y.S.2d* 799, 800 (App. Div. 4th Dep't 2007).

n15 *Id.* (citing *Fed. Ins. Co. v. Arthur Andersen & Co.*, 552 *N.E.2d* 870 (N.Y. 1990)).

n16 *Id.*

n17 *Id.*

n18 *Fasso, 903 N.E.2d at 1170-71.*

n19 *Id.*

n20 *Id.*

n21 *Id. at 1170.*

n22 *Id. at 1171.*

n23 *Id.*

n24 *See Fasso, 848 N.Y.S.2d at 800.*

n25 *Id.*

n26 *See Fasso, 903 N.E.2d at 1171. Fasso* has been cited by the Appellate Division in finding that an insurer's equitable subrogation claim cannot be barred by a general release executed between the insured and the tortfeasor. *N. Y. Cent. Mut. Fire Ins. Co. v. Barry, 884 N.Y.S.2d 61* (App. Div. 2d Dep't 2009).

n27 See *Fasso*, 903 N.E.2d at 1171-73.

n28 *Id.* at 1172.

n29 *Id.*

n30 In *Fasso*, for example, the Court of Appeals observed that when the health insurer sought intervention in the patient's action, the statute of limitations had already run on the health insurer's right to assert any direct subrogation claim against the physician. *Fasso*, 903 N.E.2d at 1172. The dangers are amply illustrated by *Allstate Insurance Co. v. Stein*, 807 N.E.2d 268, 272 (N.Y. 2004), where the Court of Appeals held that the statute of limitations applicable to a subrogation claim was the same one which governed the underlying claim of an injured party against a tortfeasor.

n31 N.Y. C.P.L.R. § 4545 (2009)(allowing consideration of evidence submitted to establish that a plaintiff will obtain indemnification for a loss from sources other than tortfeasor).

n32 *Fasso*, 903 N.E.2d at 1172.

n33 *In Re Sept. 11 Litig.*, No. 21 MC 101 (AKH), 2009 U.S. Dist. LEXIS 73223 at *58-*59 (S.D.N.Y. Aug. 13, 2009)("[t]his plain language [from *Fasso*] demonstrates that [N.Y. C.P.L.R.] § 4545 does not affect the equitable subrogation rights of plaintiff's insurers").

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Sonnenschein Nath & Rosenthal on In re Professionals Direct Insurance Co.

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Sonnenschein Nath & Rosenthal on In re Professionals Direct Insurance Co.: The Sixth Circuit Interprets Boone v. Vanliner

By William Barker and Ronald Kent

January 6, 2010

SUMMARY: In re Professionals Direct Ins.Co., passed on the scope of Ohio's uniquely constricted attorney-client privilege in bad faith cases, as well as on the scope of federal work product protection, finding no clear error in the magistrate's order that the documents in question be produced. It addressed the nature and extent of the review that a trial court must do to determine whether the privilege has been divested by Boone v. Vanliner Insurance Co.

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ARTICLE: *In re Professionals Direct Insurance Co.* n1 passed on the scope of Ohio's uniquely constricted attorney-client privilege for insurance companies in bad faith cases, as well as on the scope of federal work product protection, finding no clear error in the magistrate's order that the documents in question be produced. In doing so, it addressed the nature and extent of the review that a trial court must do to determine whether the privilege has been divested by the rule of *Boone v. Vanliner Insurance Co.* n2

This commentary examines the new decision against the background of the law elsewhere on attorney-client privilege in bad faith cases, examines the unique special rule adopted in *Vanliner*, and assesses the impact of the new decision in light of *Vanliner*. (Portions of this commentary are drawn from § 16.04 of the forthcoming William T. Barker & Ronald D. Kent, *The New Appleman Insurance Bad Faith Litigation*.)

I. The Case

Professionals Direct Insurance Co. ("PDIC") provided malpractice insurance to Wiles, Boyle, Burkholder, & Brindgardner. Illinois National Insurance Company retained Wiles to defend an employee of one of its insureds, in which the plaintiffs obtained a verdict that left Illinois National responsible for over \$8.5 million in damages. Wiles filed a post-judgment motion on January 15, 2003, which the trial court denied as untimely, a decision ultimately affirmed by both the Ohio Court of Appeals and the Ohio Supreme Court. In late 2003, while awaiting a decision from the supreme court, Wiles applied for renewal of its malpractice policy, stating that it was not aware of any circumstances, acts, or omissions in the prior 12 months that "could reasonably be expected to result in a claim to

Professionals Direct." After the supreme court affirmed the denial of the post-trial motion, Wiles notified PDIC on September 1, 2004 of a potential malpractice claim by Illinois National. n3

PDIC reserved the right to deny this claim, pending an investigation. It retained counsel to advise on potential coverage and on a possible action for a declaration that Wiles was not entitled to coverage. In October, 2004, Illinois National settled the underlying claim and initially offered to settle the malpractice claim for \$5 million, later raised to \$10 million; Illinois National filed suit on May 19, 2006. n4

On August, 19, 2005, PDIC wrote to Wiles asking for an explanation of the delay in reporting and the failure to identify the circumstances of the claim in the renewal application. In December, PDIC notified Wiles that it was planning to file a declaratory judgment action. On March 23, 2006, PDIC notified Wiles that it deemed the claim excluded. It sued six days later. Wiles counterclaimed for bad faith and demanded all documents relevant to that claim. When PDIC withheld documents based on attorney-client privilege and work product, Wiles moved to compel. n5

A magistrate judge conducted an in-camera review of the documents. He found that litigation could not reasonably have been expected before the August 19, 2005 request for an explanation of the delay in reporting. From that point on, the lawyers were both advising PDIC on coverage and preparing for litigation. As to documents prepared while the lawyers were performing a dual function, the magistrate judge made a document-by-document decision whether coverage advice or litigation preparation was the "driving force" for creation of the document, denying production of those where litigation was the reason for creating the document. n6 As to privilege, the magistrate judge determined that March 23, 2006 was the date of constructive denial of the claim and that no privilege would attach to any documents prepared before that date. n7 The district court adopted the magistrate judge's order, and PDIC sought mandamus.

The Sixth Circuit found that PDIC had shown that it lacked any other adequate means of relief and that the harm it would suffer from the order would be irreparable, but it found no clear error in the magistrate judge's rulings. n8 The magistrate judge had applied the correct test to determine what was protected work product, and PDIC showed no any clear error in the fact-intensive application of the standard. n9 Ohio has a testimonial privilege statute regarding attorney testimony, n10 but the court found this inapplicable to document production. n11 That left the common-law attorney-client privilege, which was the main issue in the case.

In *Boone v. Vanliner Insurance Co.*, the Ohio Supreme Court had declared that "'documents and other things showing the lack of a good faith effort to settle by a party or attorneys acting on his behalf are wholly unworthy of the protections of any claimed privilege.'" n12 PDIC argued that this required individual review of each document to determine whether the document showed lack of good faith.. The magistrate judge disagreed and the Sixth Circuit found no clear error. It relied on *Garg v. State Automobile Mutual Insurance Co.*, n13 which it described as the leading Ohio case on the issue. *Garg* read *Boone* to require disclosure of all pre-denial documents that "may cast light" on whether the insurer acted in bad faith. n14 While some Ohio courts have applied *Boone* more narrowly, the magistrate judge's reading was "a reasonable application of *Boone*" and could not be set aside on mandamus. n15

II. Analysis

A. Background: Attorney-Client Privilege in Bad Faith Cases

Lawyers are ubiquitous in the claim settlement process: defending insureds and providing coverage advice. The lawyers may be in-house or outside counsel, and both may be involved. And, as soon as a problem appears, lawyers get involved in that (possibly lawyers who were involved before, but not always).

Those with bad faith claims against insurers commonly view the insurer's communications with its lawyers and the lawyers' work product as especially valuable evidence for proving bad faith. Indeed, when trying to compel production, they commonly describe this information as essential to proof of their claims. Yet attorney-client communications and attorney work product are generally protected from discovery. While bad faith plaintiffs have made substantial efforts to

pierce these protections, sometimes successfully, insurers continue to resist discovery of privileged and work product materials, also with considerable success.

In most cases, the ability to force disclosure of an insurer's privileged materials in a bad faith case will depend on whether the court will hold that the insurer waived the privilege by placing privileged communications "at issue," n16 an issue where the legal standards vary among jurisdictions. A few courts have allowed discovery in bad faith cases of attorney-client communications under the crime-fraud exception to the attorney-client privilege. That exception provides that the privilege does not attach to communications where the client seeks advice to assist in committing or concealing illegal conduct. n17 But, under that exception to the privilege, mere allegations of crime or fraud do not divest the privilege, rather there must be *prima facie* evidence that the attorney has been consulted for the purpose of furthering such wrongdoing:

""It is obvious that it would be absurd to say that the privilege could be gotten rid of merely by making a charge of fraud" To drive the privilege away, there must be "something to give color to the charge;" there must be "prima facie evidence that it has some foundation in fact." When that evidence is supplied, the seal of secrecy is broken."" n18

In *United States v. Zolin*, n19 the United States Supreme Court adopted a widely followed procedure for determining when the crime-fraud exception applies. n20 The final decision on privilege may be based on an *in camera* review of the communications. But permitting routine use of *in camera* inspections to screen for possible applications of the crime-fraud exception "would place the policy of protecting open and legitimate disclosure between attorneys and clients at undue risk" n21 It would also burden courts called upon to review large records. n22 "There is no reason to permit opponents of the privilege to engage in groundless fishing expeditions." n23 Accordingly, "[b]efore engaging in *in camera* review to determine the applicability of the crime-fraud exception, 'the judge should require a showing of a factual basis adequate to support a good faith belief by a reasonable person' that *in camera* review of the materials may reveal evidence to establish the claim that the crime-fraud exception applies." n24

Nothing in the usual bad faith case involves anything remotely similar to a crime or fraud. So the exception cannot apply unless the exception is extended to some broader class of wrongdoing. The Restatement rejects such an extension and describes the current state of the law on this subject:

The evidence codes and judicial decisions are divided on the question of extending the exception to other wrongs such as intentional torts, which although not criminal or fraudulent, have hallmarks of clear illegality and the threat of serious harm. Legislatures and courts classify illegal acts as crimes and frauds for purposes and policies different from those defining the scope of the privilege. Thus, limiting the exception to crimes and frauds produces an exception narrower than principle and policy would otherwise indicate. *Nonetheless, the prevailing view limits the exception to crimes and frauds. The actual instances in which a broader exception might apply are probably few and isolated, and it would be difficult to formulate a broader exception that is not objectionably vague.* n25

Jurisdictions extending the exception beyond fraud are said to be a substantial minority. n26 Many of these jurisdictions have adopted "crime or tort" exceptions in codifying evidence law. n27 Even were courts inclined to extend the exception as a matter of common law, insurance bad faith does not appear the sort of wrongdoing that should be included. It usually does not require any wrongful intent and, in most jurisdictions, is more akin to negligence than to fraud. Even where wrongful intent is required, the required intent is far less culpable than fraud. Insurance bad faith has been held *not* the equivalent of fraud for privilege purposes. n28

Nonetheless, the Alaska Supreme Court held, in *United Services Automobile Ass'n v. Werley*, n29 held that "bad faith legal defense to a legitimate claim by one's insured" is a form of civil fraud for purposes of the privilege. n30 To establish a *prima facie* case enabling the privilege to be pierced, the insured must show that none of the grounds offered for nonpayment of the claim provided an objectively reasonable basis for refusal to pay. n31 Bad faith in Alaska apparently requires the same combination as in Arizona of objectively baseless refusal to pay *and* knowledge or reckless disregard of the absence of a reasonable basis. n32 Thus, showing the objective baselessness of the insurer's conduct

permits discovery of its attorney-client communications for the purpose of attempting to show the required subjective culpability. There is simply no need for such a procedure in bad faith actions where subjective culpability need not be shown. So there is no occasion for courts to follow *Werley* unless, at a minimum, subjective culpability is relevant. But even if it is required, the fact that the insurer's claim handling was objectively unreasonable would not, standing alone, support an inference that the insurer had an improper purpose in consulting counsel.

The Ohio Supreme Court held, in *Boone v. Vanliner Insurance Co.*,ⁿ³³ that "documents and other things showing the lack of a good faith effort to settle by a party or attorneys acting on his behalf are wholly unworthy of the protections of any claimed privilege." Thus, a mere allegation of bad faith required the trial court to conduct an *in camera* inspection and order production of any claim file material, even if other requirements for privilege were met, if it tended to show bad faith. This eliminates from the traditional crime-fraud exception both the requirement of an improper purpose in seeking the attorney's assistance and the safeguard of a preliminary showing before an *in camera* inspection can be held. As such, it is contrary to settled law throughout the country, and no case elsewhere has yet followed *Boone*.

Precisely because *Boone* departs so far from the law elsewhere, it would seem appropriate to read it narrowly, as the Sixth Circuit acknowledges that Ohio courts other than *Garg* have done. And perhaps that might have been done on an appeal, not subject to the requirement of clear error applicable on mandamus. In particular, with the mere allegation of fraud opening the way to an *in camera* inspection, it would seem that ordering disclosure should require that the court, after making such an inspection, should have to find at least a prima facie case of bad faith. That might make it tactically desirable for plaintiffs to defer the *in camera* inspection until they had developed any other evidence supporting the bad faith claim, so that this might be presented to the court along with its *in camera* review of the allegedly privileged materials.

A narrower reading may also be appropriate under the statutory amendment that was too recent to be applicable in *Professionals Direct*. As the Sixth Circuit described the amendment:

The amendment created § 2317.02(A)(2), which reads: "A person shall not testify in certain respects: . . . An attorney, concerning a communication made to the attorney by a client in that relationship or the attorney's advice to a client, except that if the client is an insurance company, the attorney may be compelled to testify, subject to an *in camera* inspection by a court, about communications made by the client to the attorney or by the attorney to the client that are related to the attorney's aiding or furthering an ongoing or future commission of bad faith by the client, if the party seeking disclosure of the communications has made a prima facie showing of bad faith, fraud, or criminal misconduct by the client." The explanatory note to this amendment states: "The common law established in *Boone v. Vanliner Ins. Co.* (2001), 91 Ohio St.3d 209, ... *Moskovitz v. Mt. Sinai Med. Ctr.* (1994), 69 Ohio St.3d 638, ... and *Peyko v. Frederick* (1986), 25 Ohio St.3d 164, .. is modified accordingly to provide for judicial review regarding the privilege."

Literally read, the amendment may only affect attorney testimony. But the legislative intent appears to have been broader. It is unclear how the Ohio courts will read the amendment.

In Ohio's courts, insurers have one protection that may not be available in the federal courts. *Garg* held that it is an abuse of discretion not to bifurcate the coverage claim from the bad faith claim and stay discovery on bad faith until the coverage question has been resolved.ⁿ³⁴ Federal district courts may, of course, bifurcate a case that way.ⁿ³⁵ But they are not obliged to do so.ⁿ³⁶

III. Conclusion

Where Ohio law does not govern, courts are unlikely to follow *Boone* (and should not do so). Ohio courts should read *Boone* narrowly.

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n1 *In re Professionals Direct Ins. Co.*, 578 F.3d 432 (6th Cir. 2009).

n2 *Boone v. Vanliner Ins. Co.*, 91 Ohio St. 3d 209 (Ohio 2001).

n3 *Id.* at 435.

n4 *Id.* at 435-36.

n5 *Id.* at 436.

n6 *Id.* at 439-40.

n7 *Id.* at 442.

n8 *Id.* at 438-42.

n9 *Id.* at 440.

n10 Ohio Rev. Code § 2317.02(A)

n11 578 F.3d at 441. An amendment to that statute might be read to modify the common law standard for

attorney-client privilege, but it was not effective until after the events here. *Id.*

n12 *Boone v. Vanliner Ins. Co.*, 91 Ohio St. 3d 209, 212 (Ohio 2001).

n13 *Garg v. State Auto. Mut. Ins. Co.*, 155 Ohio App. 3d 258 (2003).

n14 *Id.* at 265, quoted 578 F.3d at 442 (emphasis by the Sixth Circuit).

n15 578 F.3d at 442.

n16 Compare **CT**--*Hutchinson v. Farm Family Cas. Ins. Co.*, 273 Conn. 33, 44-45 (2005) (no waiver), with

AZ--*State Farm Mut. Auto. Ins. Co v. Lee*, 199 Ariz. 52, 15-16 (Sup. Ct. 2000) (waiver).

n17 *E.g.*, *In re Marriage of Granger*, 197 Ill. App. 3d 363, 374-75 (1990).

n18 *E.g.*, *Radiac Abrasives, Ltd. v. Diamond Technology, Inc.*, 177 Ill. App. 3d 628, 635-36 (1988), quoting *Clark v. United States*, 289 U.S. 1, 15 ((1933) (citations omitted).

n19 *United States v. Zolin*, 491 U.S. 554 (1989)

n20 *In re Marriage of Decker*, 153 Ill. 2d 298, 323 (1992), is one of the many state cases adopting the *Zolin* procedure.

n21 *Zolin*, 491 U.S. at 571.

n22 491 U.S. at 571.

n23 491 U.S. at 571.

n24 491 U.S. at 572 (citation omitted).

n25 Restatement (Third) of the Law Governing Lawyers, § 82, cmt. d. (perm. vol. 2000).

n26 Edward J. Imwinkelreid, *The New Wigmore: A Treatise on Evidence*, § 6.13.2, at 970 (2002).

n27 *E.g.* Kan. Stat. § 60-426(b)(1).

n28 *E.g.*, *Freedom Trust v. Chubb Group of Ins. Cos.*, 38 F. Supp. 2d 1170, 1173 (C.D. Cal. 1999).

n29 *United Servs. Auto. Ass'n v. Werley*, 526 P.2d 28 (Alaska 1974).

n30 526 P.2d at 33.

n31 526 P.2d

See **CT**--*Hutchinson v. Farm Family Cas. Ins. Co.*, 273 Conn. 33, 42-43 (2005) (following *Werley* as to characterization of bad faith as a form of fraud for privilege purposes);

WA--*Escalante v. Sentry Ins. Co.*, 49 Wa. App. 375, 397 (1987).

n32 *Hillman v. Nationwide Mut. Fire Ins. Co.*, 855 P.2d 1321, 1323-24 (Alaska 1993).

n33 *Boone v. Vanliner Ins. Co.*, 91 Ohio St. 3d 209, 212 (Ohio 2001).

n34 *Garg v. State Auto. Mut. Ins. Co.*, 155 Ohio App. 3d 258, 266-67 (2003).

n35 *Smith v. Allstate Ins. Co.*, 403 F.3d 401, 407 (6th Cir. 2005).

n36 *Chubb Custom Ins. Co. v. Grange Mut. Cas.*, 2008 U.S. Dist. LEXIS 91496, at *8-9 (S.D. Ohio 2008).

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About the Law Firm. Sonnenschein Nath & Rosenthal, LLP, regularly handles high-risk and complex matters for financial and insurance industry clients. Staffed with seasoned litigators and former insurance regulators, Sonnenschein lawyers are relentless advocates for its clients interests. For more than 70 years, Sonnenschein has partnered with insurance companies to understand their business and legal needs. Recent confirmation of Sonnenschein's outstanding insurance industry qualifications came in *Chambers USA: Americas Leading Lawyers for Business*. The 2007 edition identifies Sonnenschein as one of the top firms in the country representing insurers on their most complex matters. The Chambers description speaks for itself: This powerhouse litigation firm is known for its sophisticated and thorough work in insurance and its ability to pull together a sterling set of resources. The firm fields a wide range of specialists, which it can use to staff complex cases. Its recent track record ranges from involvement in the WTC litigation to Hurricane Katrina-related issues. Matters are handled by a number of offices at any one time and practitioners are said to work tirelessly and creatively to help manage disputes and create briefings that are strong and impressive. Key areas of interest are bankruptcy and insolvency in insurance companies, class actions and catastrophic loss in both appeals and litigation. The firm also has strength in personal lines insurance and in regulatory proceedings. When products are attacked, when lawsuits go national, when regulators join the fray, when reputations are on the line, leading businesses turn to Sonnenschein).

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Sonnenschein Nath & Rosenthal on SwedishAmerican Hospital v. Sari Ins. Co.

2010 Emerging Issues 4796

Sonnenschein Nath & Rosenthal, L.L.P., on SwedishAmerican Hospital Association v. Sari Insurance Co.: Breach of Duty To Settle Frees Insured To Do So

By William T. Barker and Gauri Chopra

January 6, 2010

SUMMARY: SwedishAmerican Hosp. Ass'n v. Sari Ins. Co. held that an insurer's breach of duty to settle frees its insured to do so. There was no controlling Illinois law, and there is a division of authority elsewhere. The case also presented, but did not resolve, a novel question about the effect of a policy mechanism to resolve disputes about whether to settle. This commentary examines the case and the varying results reached elsewhere.

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ARTICLE: *SwedishAmerican Hospital Ass'n v. Sari Insurance Co.* n1 held that an insurer that breaches its duty to settle frees its insured (and another insurer) to do so. The court found no prior controlling Illinois law on this point, and the issue is one on which there is a division of authority elsewhere. The case also presented a novel question about the effect of a policy provision creating a mechanism to resolve disputes about whether to settle, though the court determined that factual issues remained to be resolved on that issue. This commentary examines the case and the varying results reached elsewhere. It offers some thoughts on the issues presented. (Portions of this commentary are drawn from § 4.03 of the forthcoming William T. Barker & Ronald D. Kent, *The New Appleman Insurance Bad Faith Litigation*.)

I. The Case

Illinois State Medical Inter-Insurance Exchange ("ISMIE") provided \$1 million in malpractice insurance to Dr. Bruce Hecht, who treated Wanique Tripp at SwedishAmerican Hospital. Tripp, a child, suffered severe complications and her family sued both Hecht and the Hospital. As the case developed, any liability of the Hospital would be vicarious, based on the negligence of Hecht. The Hospital had a self-insured retention for itself and its employees (including Dr. Hecht) of \$1.5 million and Sari Insurance Co. provided \$25 million in coverage excess to that. n2

ISMIE defended Dr. Hecht, under reservation of rights. After extensive discovery the case settled for \$5 million, but ISMIE refused to participate, even though it admitted that (in a vicarious liability situation) it would be obliged to pay the first \$1 million. The Hospital and Sari agreed to fund the settlement and received an assignment of Dr. Hecht's

rights against ISMIE. They sued ISMIE seeking the \$1 million they contended it should have contributed to the settlement. n3

Both the Hospital and Dr. Hecht wished to settle, and there was considerable evidence indicating that there would be a verdict against Dr. Hecht and that the amount of any verdict would exceed \$1 million. ISMIE's adjuster's notes at the time showed that she felt that there would be a 95% chance of prevailing before a jury of doctors, but only a 50% chance with a lay jury and agreed that any verdict or settlement would exceed \$1 million. Based on Dr. Hecht's desires and the high exposure, she recommended that the case be settled. The physician review committee decided that the case should be tried. n4

In the suit by the Hospital and Sari, ISMIE contended that the settlement violated the no-action provision of its policy and was a voluntary payment that it was not obliged to reimburse. ISMIE also relied on a policy provision that disputes about settlement would be resolved by the physician review committee. The circuit court granted ISMIE summary judgment based on the no-action provision. n5 The Appellate Court found factual issues and remanded for further proceedings.

As to the no-action provision, the court reasoned that:

The purpose of a no-action provision is to protect the insurer from collusive or overly generous or unnecessary settlement by the insured at the expense of the insurance carrier. "It is, however, unfair to the insured to enforce the clause against him when the insurer has erroneously refused to perform the insurance contract." n6

While most cases applying that principle involve insurers that have refused to defend, the court concluded that

it follows that it would be unfair to enforce the no-action clause against the insured where the insurer has similarly breached the contract by breaching the duty to settle. In fact, the supreme court has stated that "[a]n insurer who undertakes the defense of a suit against the insured, where the damages sought are in excess of policy limits, cannot arbitrarily refuse a settlement within policy limits," and in such circumstances, the "insured may effect a reasonable settlement himself without breaching any conditions of the policy." *Krutsinger v. Illinois Casualty Co.*, 10 Ill. 2d 518, 527, 141 N.E.2d 16 (1957). n7

While there was no controlling authority on the point (the *Krutsinger* language being dictum in a case where the insurer had refused to defend), the court was persuaded by authority elsewhere supporting that conclusion. n8 Accordingly, Dr. Hecht's compliance with the no-action provision would have been excused if ISMIE had breached its duty to settle. While the payments by the Hospital and Sari had prevented any out-of-pocket costs to Dr. Hecht, the Hospital and Sari could complain of any breach, as Dr. Hecht's assignees. n9 But whether ISMIE breached a duty to settle was a question of fact, so summary judgment was inappropriate. n10

ISMIE also relied on the following provision in its policy:

"(d) The Exchange will not settle any claim or suit without having first obtained the written consent of the named insured. If the named insured and the Exchange are in disagreement as to whether or not a claim or suit should be settled or defended, either party may request that the matter be submitted to a committee of physician members of the Exchange whose decision regarding disposition of the claim or suit shall be binding." n11

While the physician review committee had recommended against settling, the court was not convinced that this contractual provision had been properly triggered. Dr. Hecht, his private counsel, the defense counsel appointed by ISMIE, and ISMIE's adjuster had all recommended that the case be settled. So, it appeared that there may have been no disagreement between ISMIE and Dr. Hecht requiring resolution by the physician review committee. But other documents, not in the record might also bear on that issue, so the issue could not be resolved on that record. But the court went on to say that "even if this provision was triggered, this provision does not relieve ISMIE of its good-faith duty to settle, as the good-faith duty is to be determined in a court of law, not by a panel of physicians." n12

II. Analysis

A. The No-Action Provision

The no-action provision and its companion, the voluntary payment provision, are standard provisions of liability insurance policies that restrict the freedom of the insured to settle without the insurer's consent while seeking to require the insurer to pay for the settlement. It is universally agreed that an insurer's breach of its duty to defend excuses the insured's compliance with these settlement restrictions. ⁿ¹³ But there is a division of authority on the effect of a failure to settle when the insurer is defending.

Many courts agree with *SwedishAmerican Hospital* that refusal to seize an advantageous opportunity to settle is a breach of contract, excusing the insured's compliance with the settlement restrictions. ⁿ¹⁴ On the other hand, the California Supreme Court has held that, ordinarily, "[a]s long as the insurer is providing a defense, the insurer is allowed to proceed through trial to judgment." ⁿ¹⁵ Under that rule, an insurer will be held responsible if refusal of a reasonable settlement results in a judgment in excess of limits, but the insured cannot simply cut off the insurer's right to try the case by agreeing to a noncash settlement that the insurer may then be forced to pay. California does permit an insured to make a cash settlement and then sue for reimbursement, ⁿ¹⁶ a rule that would support the result in *SwedishAmerican Hospital*. Other courts have held that a defending insurer's failure to settle does not free the insured to settle and have not indicated any exception for cash settlements by the insured. ⁿ¹⁷ This approach effectively treats the duty to settle as a duty to protect the insured from an excess judgment, if that is reasonably possible. Because such a duty is not breached unless and until an excess judgment occurs, a mere failure to settle does not free the insured from the settlement restrictions.

There is no indication in *SwedishAmerican Hospital* that this alternate line of authority was brought to the court's attention. Advocates for insurers should make use of that line of authority in appropriate cases.

B. The Physician Review Committee

Based on the (admittedly incomplete) facts recounted in the court's opinion, it is indeed unclear why the case was referred to the physician review committee. But if there truly was no dispute about the desirability of settling (and the stated facts make that possibility plausible), then it would seem doubtful that a committee recommendation to try the case would excuse the duty to settle. On the other hand, the agreement to submit disputes to the committee for a binding decision would appear to be an agreement to arbitrate, a point the court does not appear to have considered in its dictum rejecting binding effect. Even if not binding, a committee decision to litigate would seem potent evidence that a decision not to settle was reasonable.

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ⁿ¹ *SwedishAmerican Hosp. Ass'n v. Sari Ins. Co.*, 2009 Ill. App. LEXIS 911.

ⁿ² *Id.* at *2-3.

n3 *Id.* at *3-4.

n4 *Id.* at *4-8.

n5 *Id.* at *17-21.

n6 *Id.* at *32-33 (citations omitted)..

n7 *Id.* at *33-34.

n8 *Id.* at *35-44.

n9 *Id.* at *45-51.

n10 *Id.* at *51-53.

n11 *Id.* at *28 (emphasis omitted).

n12 *Id.* at *57.

n13 *E.g., St. Louis Dressed Beef & Provision Co. v. Maryland Cas. Co., 201 U.S. 173, 182-83 (1906).*

n14 *E.g., Traders & General Ins. Co. v. Rudco Oil & Gas Co., 129 F.2d 621, 628 (10th Cir. 1942).*

n15 *Hamilton v. Maryland Cas. Co.*, 27 Cal. 4th 718, 728-29 (2002).

n16 *Id.* at 728-29.

n17 *E.g., Trinity Outdoor, LLC v. Central Mut. Ins. Co.*, 285 Ga. 583, 585-87 (2009).

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Sonnenschein Nath & Rosenthal on Griffin Dewatering Corp. v. Northern Ins. Co.

2010 Emerging Issues 4797

Sonnenschein Nath & Rosenthal, L.L.P. on Griffin Dewatering Corp. v. Northern Insurance Co.: A Reservation of Rights Cannot Be Actionable Bad Faith

By William Barker

January 6, 2010

SUMMARY: Griffin Dewatering Corp. v. Northern Insurance Co. held that an insurer's reasonable refusal to defend did not become bad faith when a later supreme court decision established that the refusal was incorrect. But it also held that the insurer's reservation of a right to seek reimbursement of the amounts it paid could not be the basis for a bad faith claim. This commentary examines the latter holding and its implications.

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ARTICLE: *Griffin Dewatering Corp. v. Northern Insurance Co.* n1 held that an insurer's reasonable refusal to defend did not become bad faith when a later supreme court decision established that the refusal was incorrect. But it also held that the insurer's reservation of a right to seek reimbursement of the amounts it paid could not be the basis for a bad faith claim. This commentary examines the latter holding and its implications.

I. Griffin Dewatering

Griffin Dewatering was a complex and confusing case. The court of appeal wrote that "[a]t first, we did not know what to make of this case." n2 It took the court two rounds of supplemental briefing, a second oral argument, and nearly 50 pages of opinion to sort it out. But, because the focus here is limited to the reservation of rights point, much of the complexity can be omitted. The bad faith case resulted in a judgment for \$1 million in compensatory damages (all attorneys fees for prosecution of the claim) and \$10 million in punitive damages, which judgment was reversed in its entirety.

The bad faith claim arose from a request by Griffin that Northern, its liability insurer, provide coverage for a claim asserted by Dr. & Mrs. Ron Waters relating to a sewage backup in their home that had caused extensive damage. The backup related to work Griffin was doing at the time for the South Coast Water District. Northern denied coverage on the basis of a Total Pollution Exclusion. The District paid Dr. & Mrs. Waters \$417,000 to settle their claim and then sued Griffin in September, 1999. n3

Northern initially denied a defense. But Griffin had excess insurance with AIG. AIG undertook to retain defense counsel and invoice Griffin for the cost, avoiding any immediate out-of-pocket cost to Griffin for defense expenses. In April, 2000, Griffin sued Northern for bad faith breach of its insurance contract. In September, 2000, Northern changed its mind, and agreed to defend the suit, reserving its right to seek reimbursement if there were no coverage. It then settled the District's suit for \$350,000, and paid the fees incurred by AIG before AIG had invoiced any of those fees to Griffin. As a result, Griffin never suffered any out-of-pocket cost for defense of the District lawsuit. n4

Griffin had incurred \$8,921.40 in fees for its suit against Northern. Northern offered to reimburse these as well (actually to pay a flat \$10,000, but that makes no difference here), but (at least as Griffin viewed the situation) reserved its right to seek reimbursement of its payments for defense and indemnity. n5

The coverage/bad faith litigation continued, with Griffin incurring over \$1 million in fees for that litigation. n6 In early 2002, there were two court of appeal decisions construing pollution exclusions in a way that favored Northern's position, but the supreme court granted review, depriving them of precedential effect. Northern had moved for summary judgment on coverage, which was denied after the supreme court granted review. On October 8, 2002, Northern unilaterally withdrew its reservation of the right to seek reimbursement. n7

The supreme court later decided, in *MacKinnon v. Truck Insurance Exchange*, n8 that a literal interpretation of absolute or total pollution exclusions would yield an absurd result and that, to prevent that, such exclusions would be limited to "conventional environmental pollution." n9 It thus became clear that Northern's denial of coverage (and of a defense) had been incorrect. Because the issue had been unsettled at the time of the denial, the trial court in *Griffin Dewatering* held that the denial was bad faith as a matter of law. n10 The court of appeal reversed on that point, holding that (given the state of the law at the time Northern refused to defend), Northern's refusal to defend had, as a matter of law, been reasonable and not bad faith. n11 While there is much interesting law in that portion of the opinion, it is beyond the scope of this commentary.

Griffin also contended that Northern's reservation of the right to seek reimbursement of its payments had deprived Griffin of the full benefit of the insurance, requiring Griffin to litigate coverage. On this basis, Griffin contended that its litigation costs were a form of damage for Northern's alleged bad faith. n12 The court of appeal disagreed, for two reasons. First, there was no bad faith: Northern's coverage position, though incorrect, was reasonable (for reasons already expounded at length). n13 But the reservation also could not deprive Griffin of any of the benefits of the contract, because Northern could not recover unless it could show that Griffin had never had any contractual right to the payments Northern had made. n14

II. A Reservation of Rights Is Merely a Notice, Does Not Require the Insured To Relinquish Anything, and Cannot Deprive an Insured of Anything the Insured Is Entitled To Under the Contract.

The right to seek reimbursement of noncovered defense costs and settlement payments is a noncontractual right rooted in the law of unjust enrichment. n15 As it applies to defense costs, "the right of recoupment ... is necessarily predicated on the proposition that the insurance company has expended funds on the policyholder's behalf that were never 'even potentially covered' under the insurance contract." n16 "That is, by definition and as a matter of law, an insurance company's only hope of reimbursement is if the policyholder *has received a benefit that the policyholder never paid for in the first place.*" n17

The *Griffin Dewatering* court relied on *Prichard v. Liberty Mutual Insurance Co.* n18 In *Prichard*, Prichard was sued on numerous claims that were clearly not covered and a defamation claim that was potentially covered. Liberty Mutual and two other insurers defended under reservation of rights. Undisputed testimony at trial indicated that the defamatory material was first published before the inception of the policy, and the policy excluded coverage for defamatory statements so published. Liberty Mutual informed Prichard's independent defense counsel of the apparent coverage defense. After judgment, Liberty Mutual contended that its duty to defend was now terminated by the undisputed evidence that the claim was excluded. It nonetheless offered to pay for appellate counsel, reserving the right

to seek reimbursement. The trial court ruled (and the court of appeal agreed) that Liberty Mutual's duty to defend had not terminated. The trial court further ruled that by "conditioning" an appellate defense on the reservation of rights, Liberty Mutual had breached its duty to defend, precluding it from asserting the first-publication defense to indemnification. The court of appeal found no breach of the duty to defend. n19

The *Prichard* court concluded that the finding of breach rested on the assumption that any right of reimbursement would have been contractual, requiring both agreement and new consideration. Because Liberty Mutual's offer to pay appellate counsel merely performed its duty to defend, the trial court had believed that it was attempting to extract a concession from the insured without offering anything in return. After explaining Prichard's argument to that effect, the court responded: "Wrong, wrong, wrong. The whole point of the *Buss* case is that an insurer's right to reimbursement for defense costs for never-even-potentially-covered-claims is predicated on a legal right 'implied in law as quasi-contractual,' not a matter of any agreement between the parties." n20 Because Liberty Mutual was not seeking any concession from the insured, its offer of a defense under reservation was not "conditioned" at all, let alone "unlawfully conditioned." n21 While Prichard tried to characterize Liberty Mutual's position as a "retroactive termination of its [defense] obligation," the court observed that this phrase "is simply an ominous phrase for 'reimbursement right.'" n22

Relying on *Prichard*, the court in *Griffin Dewatering* concluded that because the rights the insurer sought to reserve were "necessarily not a matter of [new] contract, the insurer's assertion of a reimbursement right could not deprive the insured of any 'benefits' under the [insurance] contract. It could only deprive the insured of benefits that the law gave [the insurer] independent of contract." n23 To be sure, the insurer's claimed right was not unrelated to the contract. The right of reimbursement would be based on the fact that the contract had never obliged the insurer to make the original payment. Stated differently, the insurance contract would have meant that the insurer had a right not to have made that payment. But the right to reimbursement (which is what Northern was trying to reserve) is not itself contractual.

That point is significant, because that means the rule applied in *Griffin Dewatering* is not limited to reservations of rights to seek reimbursement. It is equally applicable to the more common reservations of the right to deny indemnification. Such reservations seek no concession from the insured, but simply provide notice that the contract may not obligate the insurer to indemnify against any judgment and that it reserves the right not to go beyond what the contract requires.

Bottom line: a reservation of rights, even if unfounded, cannot constitute actionable bad faith without some further action or inaction that deprives an insured of contractual benefits.

[Return to Text](#)

n1 *Griffin Dewatering Corp. v. N. Ins. Co.*, 176 Cal. App. 4th 172 (2009).

n2 *Id.* at 177.

n3 *Id.* at 181-83.

n4 *Id.* at 184-86.

n5 *Id.* at 186-87.

n6 *Id.* at 177.

n7 *Id.* at 188-90.

n8 *MacKinnon v. Truck Insurance Exchange*, 31 Cal. 4th 635 (2003).

n9 *Id.* at 655.

n10 *Griffin Dewatering*, 176 Cal. App. 4th at 191-92.

n11 *Id.* at 194-209.

n12 *Id.* at 211-12. That claim was based on *Brandt v. Superior Ct.*, 37 Cal. 3d 813 (1985). See William T. Barker & Ronald D. Kent, *The New Appleman Insurance Bad Faith Litigation* § 9.05[2] (2009) (in press).

n13 *Griffin Dewatering*, 176 Cal. App. 4th at 218, 194-209.

n14 *Id.* at 212-17.

n15 *Buss v. Super. Ct.*, 16 Cal. 4th 35, 50-51 (1997) (defense costs); *Blue Ridge Ins. Co. v. Jacobsen*, 25 Cal. 4th 489, 502-03 (2001) (settlement payments).

n16 *Griffin Dewatering*, 176 Cal. App. 4th at 213, quoting *Buss*, 16 Cal. 4th at 50.

n17 *Id.* (emphasis original).

n18 *Prichard v. Liberty Mut.l Ins. Co.*, 84 Cal. App. 4th 890 (2000).

n19 *Id.* at 894-900.

n20 *Id.* at 905.

n21 *Id.* at 907.

n22 *Id.* at 908.

n23 *Griffin Dewatering*, 176 Cal. App. 4th at 216.

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Reed Smith on United Guaranty Mortgage Ins. Co. v. Countrywide Financial Corp.

2010 Emerging Issues 4799

Reed Smith LLP on Mortgage Insurers Cannot Cry Insurance Fraud: An analysis of United Guaranty Mortgage Ins. Co., v. Countrywide Financial Corp., et al.

By Lilit Asadourian

January 6, 2010

SUMMARY: In United Guaranty Mortgage, the District Court for the Central District of California dismissed with prejudice United's tort and statutory claims against Countrywide, holding that United could not seek "poolwide" rescission of its mortgage insurance policies, and instead must show breach of contract on a loan-by-loan basis. This article analyzes the court's decision in United Guaranty, and the impact it will have on mortgage insurers.

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ARTICLE: A recent decision by the Central District Court of California rejecting a mortgage insurer's attempts to rescind mortgage insurance policies on a poolwide basis is expected to have significant ramifications nationwide. In better economic times, United Guaranty Mortgage Ins. Co., sold thousands of mortgage insurance policies to Countrywide Financial Corp. and Countrywide Home Loans Inc. ("Countrywide") to insure mortgage loans that Countrywide originated and then securitized and sold on the secondary market to investors. When the underlying mortgages began to default, Countrywide called upon United Guaranty to pay on the policies. Instead of paying, however, United Guaranty filed a lawsuit against Countrywide in the Central District of California seeking poolwide rescission of coverage for thousands of loans insured under 11 master policies, altogether encompassing approximately \$13 billion in mortgage loans. n1 United Guaranty claimed that Countrywide had engaged in systemic fraud in the underwriting of the mortgage loans and the insurance intended to protect against the risk of default. On that basis, United Guaranty brought contract, tort and statutory claims against Countrywide including fraudulent inducement, negligence, negligent misrepresentation, rescission, and California Business and Professions Code section 17200 claims.

Following motions to dismiss by Countrywide, Judge Pfaelzer of the Central District Court dismissed all of United Guaranty's tort and statutory claims with prejudice, leaving only claims for breach of contract and breach of the implied covenant of good faith and fair dealing. The Court held that United Guaranty's claims could not sound in tort where sophisticated parties entered into sophisticated agreements and transactions that contemplated contractual remedies for the breaches United Guaranty alleged. In addition, the Court held that nothing in the policies contemplated that United Guaranty could rescind the policies on a "poolwide" basis. Instead, to avoid liability, United Guaranty will have to

demonstrate on a loan-by-loan basis for thousands of loans that there was some breach by Countrywide sufficient under the language of the policies to justify rescission of coverage as to a particular loan.

1. United Guaranty's allegations.

Even though United Guaranty had "extensive experience in mortgage insurance having sold it to a wide variety of clients since 1963," and "United Guaranty and Countrywide have done business for over forty years," United Guaranty maintained in its Amended Complaint n2 that it had little experience "in the subprime [mortgage] market" and relied upon Countrywide through a process known as "delegated underwriting" to underwrite coverage for the loans. n3 United Guaranty further claimed that it had relied on Countrywide's alleged representations that Countrywide had originated the loans in strict compliance with Countrywide's underwriting guidelines, and relied on "false information [provided by Countrywide] on the individual loans, including misrepresentations regarding characteristics of the loans and the creditworthiness of the borrowers." n4 Based on the foregoing, "United Guaranty priced and issued" the policies in what the parties refer to as "bulk" or "pool" transactions. n5 United Guaranty further asserted that Countrywide had, in reality, "abandoned any reasonable and prudent underwriting standard." After the loans at issue allegedly started showing a "high number of delinquencies," United Guaranty conducted an audit which supposedly "revealed that over 55% of the loans either failed to comply with the guidelines or contained some material defect." n6 On this basis, United Guaranty sought "poolwide" rescission of the policies.

2. Countrywide's Motion to Dismiss

Countrywide moved to dismiss United Guaranty's tort and statutory claims pursuant to *Federal Rules of Civil Procedure* 12b(6) and 9(b). Countrywide asserted that the economic loss rule which "generally bars tort claims for contract breaches, thereby limiting contracting parties to contract damages," barred United Guaranty's tort claims. n7 Countrywide also argued that United Guaranty could not seek global rescission as to all the insured mortgages, and United Guaranty had no basis for its Unfair Competition claim.

Judge Pfaelzer agreed. In a well-considered, 46-page opinion, Judge Pfaelzer found that the economic loss rule barred United Guaranty's tort claims and no exception to the rule applied. n8 Further, the Court found no discernable inducements that satisfied the Rule 9(b) heightened pleading standard for fraud, noting that even if United Guaranty could plead fraud with the particularity required, "nothing in the Amended Complaint makes reasonable reliance on the alleged inducements facially plausible." n9 In the Court's view, "[n]o reasonable insurer would rely upon generalized representations about "quality" underwriting-especially oral representations." n10

The Court further held that the "global rescission claim must be dismissed" because "nothing in the policy documents contemplates cancellation, rescission, or termination of coverage for an entire loan pool-not even for fraud." n11 Instead, the Court found that the parties bargained for rescission on a loan-by-loan basis and that allocating risks of fraud in this fashion makes sense when "insuring pools of mortgage that were originated by different loan officers, in different offices-and perhaps even by mortgage companies other than Countrywide." n12 Based on the severability factors articulated in *Coca-Cola Bottling Co. of San Diego v. Columbia Cas. Inc. Co.*, n13 Judge Pfaelzer held that coverage on each loan is severable from the other and "United Guaranty cannot articulate any limiting principle for when misrepresentations as to some loans would entitle it to global rescission for all loans." n14 In sum, the Court said:

Contract law allows parties to estimate costs and allocate risks in advance. Where sophisticated parties expressly agree about how to handle the risk of misrepresentations, they face a particularly difficult time asserting negligence and negligent misrepresentation. As for fraudulent inducement, reliance on some types of misrepresentations becomes less reasonable when the parties are more sophisticated. Likewise, the Insurance Code includes numerous provisions codifying default contract rules, procedures, and remedies. But in complex insurance transactions those provisions are likely to be displaced by the parties' bargain. Such is the present case, which remains a contract action. n15

Thus, United Guaranty is left only with its claims for breach of contract and breach of the implied covenant of

good faith and fair dealing and, to succeed, will have to demonstrate loan by loan that Countrywide breached the policy so as to rescind coverage on a particular loan.

3. Implications

The United Guaranty decision will likely have far reaching implications for mortgage insurers and policyholders across the country. In the wake of the tumbling housing market, mortgage insurers have similarly sought to rescind "poolwide" coverage in many jurisdictions, alleging fraud or misrepresentation by the mortgage originator in order to avoid billions of dollars in liability. The Central District Court's opinion in United Guaranty will guide other courts considering whether a mortgage insurer can recover in tort for breach of contractually obligated representations, or whether global rescission is appropriate for mortgage insurance policies that provide insurance on a loan-by-loan basis. Based on Judge Pfaelzer's opinion, the short answer is "no." Thus, following this ruling, mortgage insurers searching for a quick fix for their mortgage insurance liabilities should be more circumspect about bringing an action for fraud or global rescission.

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n1 United Guaranty also filed another action in the North Carolina federal Court. Countrywide also filed a state court action against United Guaranty for breach of contract, breach of the covenant of good faith and fair dealing, and declaratory judgment which United Guaranty removed to the California Central District court.

n2 Judge Pfaelzer initially dismissed United Guaranty's tort and statutory claims with leave to amend.

n3 *United Guar. Mortgage Ins. Co., v. Countrywide Financial Corp., et al.*, 2009 U.S. Dist. Lexis 96283 (C.D. Cal. 2009) at *9-*11.

n4 *Id.* at *11.

n5 *Id.* at *11-*12.

n6 *Id.* at *12-*13.

n7 *Id.* at *32-*33.

n8 *Id.* at *45*-46

n9 *Id.* at *60.

n10 *Id.*

n11 *Id.* at *28 and *66.

n12 *Id.* at *29-*30.

n13 11 *Cal. App. 4th* 1176 (1992)

n14 *Id.* at *68.

n15 *Id.* at *74

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Reed Smith LLP on The Fifth Circuit's Decision in Safety National

2010 Emerging Issues 4794

Reed Smith LLP on The Fifth Circuit's Decision in Safety National: Significant Implications for the Future Enforceability of Foreign Arbitration Provisions Conflicting with State Insurance Statutes

By Evan Knott

January 6, 2010

SUMMARY: In *Safety Nat'l Cas. Corp. v. Certain Underwriters At Lloyd's, London*, an en banc panel of the U.S. Court of Appeals for the Fifth Cir. held that a Louisiana anti-arbitration statute did not "reverse-preempt" the Convention on the Recognition and Enforcement of Foreign Arbitral Awards (the "New York Convention") under the McCarran-Ferguson Act.

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ARTICLE: An *en banc* panel of the United States Court of Appeals for the Fifth Circuit held that a Louisiana anti-arbitration statute did not "reverse-preempt" the Convention on the Recognition and Enforcement of Foreign Arbitral Awards (the "New York Convention") under the McCarran-Ferguson Act. *See Safety Nat'l Cas. Corp. v. Certain Underwriters At Lloyd's, London*, --- F.3d ----, 2009 U.S. App. LEXIS 24585 (5th Cir. Nov. 9, 2009)). The Fifth Circuit's *en banc* ruling presents an unexpected setback for policyholders invoking the protections of state statutes regulating insurance as a means to overcome provisions mandating arbitration of coverage disputes in foreign tribunals that increasingly appear in insurance policies issued by London and Bermuda market insurers. Moreover, the Fifth Circuit's ruling in *Safety National* creates a split with the Second Circuit's decision in *Stephens v. Nat'l Distillers & Chem. Corp.*, 66 F.3d 41 (2d Cir. 1995). The appellee in *Safety National* has applied to the United States Supreme Court for a Writ of Certiorari, the conflicting decisions between the Fifth and Second Circuits may now pave the way for review of this issue by the high court.

Procedural History and Factual Background of Safety National

The Louisiana Safety Association of Timbermen-Self Insurers Fund ("LSAT") procured excess worker's compensation reinsurance coverage from Lloyd's of London. LSAT attempted to assign the reinsurance agreement to an assignee, to which Lloyd's refused to consent. The assignee subsequently brought suit against Lloyd's in the Eastern District of Louisiana. The reinsurance agreement included an arbitration provision requiring arbitration of disputes arising under the agreement. The district court granted Lloyd's unopposed motion to stay and compel arbitration. Lloyd's sought to compel arbitration pursuant to the New York Convention, a federal treaty enacted in 1958. The New

York Convention treaty provides that each signatory nation "shall recognize an agreement in writing under which the parties undertake to submit to arbitration" any dispute "concerning a subject matter capable of settlement by arbitration." See Convention on the Recognition and Enforcement of Foreign Arbitral Awards, art. II(1), June 10, 1958, 21 U.S.T. 2517, 330 U.N.T.S. 3. The New York Convention contemplates enforcement in a signatory nation's courts, directing that courts "shall" compel arbitration when requested by a party to an international arbitration agreement, subject to certain exceptions that were not at issue in *Safety National*. *Id.*, art. II(3). The New York Convention treaty is the subject of an enabling Act included in the Federal Arbitration Act (the "Convention Act"). See 9 U.S.C. § 201 *et seq.* The Convention Act states that the New York Convention "shall be enforced in United States courts in accordance with this chapter." *Id.* at § 202. The Act additionally establishes federal court jurisdiction and venue. *Id.*, §§ 203-204.

After the district court granted Lloyd's unopposed motion to compel arbitration, the parties were unable to agree on the selection of an arbitrator, and Lloyd's moved to lift the district court's stay in order to join LSAT as a party and compel it to arbitrate. LSAT then intervened and moved to lift the stay and to quash arbitration, arguing that the arbitration provision was unenforceable under section 22:868 of the Louisiana Revised Statutes. The Louisiana statute in question provides:

No insurance contract delivered or issued for delivery in this state and covering subjects located, resident, or to be performed in this state . . . shall contain any condition, stipulation, or agreement: . . . (2) Depriving the courts of this state of the jurisdiction of action against the insurer. . . . C. Any such condition, stipulation, or agreement in violation of this Section shall be void, but such voiding shall not affect the validity of the other provisions of the contract.

See La. Rev. Stat. Ann. § 22:868.

The district court granted LSAT's motion to quash the arbitration proceedings. In so ruling, the district court held that pursuant to the McCarran-Ferguson Act, the New York Convention was reverse-preempted by the Louisiana statute because the statute plainly prohibited arbitration provisions in insurance contracts. The McCarran-Ferguson Act, which was enacted in 1945, provides that the "business of insurance" shall be regulated by the individual states. 15 U.S.C. § 1012(a). The McCarran-Ferguson Act further provides that, "No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance. . . ." *Id.* § 1012(b). Accordingly, the McCarran-Ferguson Act prevents federal preemption of a state statute, and effectuates "reverse preemption" by the state statute, when a three-part test is satisfied: (1) the federal law must not specifically relate to the business of insurance; (2) the federal law would invalidate, impair, or supersede the state statute if applied; and (3) the state statute was enacted for the purpose of regulating insurance. *Am. Bankers Ins. Co. of Florida v. Inman*, 436 F.3d 490, 493 (5th Cir. 2006); *Munich Am. Reins. Co. v. Crawford*, 141 F.3d 585, 590 (5th Cir. 1998).

After quashing the order compelling arbitration, the district court in *Safety National* certified its ruling for an immediate appeal to the Fifth Circuit. The Fifth Circuit reversed the trial court, holding that the McCarran-Ferguson Act did not reverse preempt the New York Convention. An *en banc* panel of the Fifth Circuit subsequently affirmed the prior appellate ruling by a vote of 15 to 3, and held that the New York Convention preempts and nullifies the Louisiana state statute from stopping the insurer from enforcing a policy provision depriving a Louisiana state court with jurisdiction over a coverage dispute.

The Fifth Circuit En Banc Holds that McCarran-Ferguson Does Not Reverse Preempt the New York Convention

In holding that the New York Convention was not reverse preempted by the Louisiana statute prohibiting insurers from requiring foreign arbitration of coverage disputes, the majority determined that Congress did not intend to include a federal treaty such as the New York Convention within the scope of an "Act of Congress" as set forth in the McCarran-Ferguson Act. The majority rejected LSAT's argument that because the New York Convention was not self-executing, but rather took effect through the Convention Act, an enabling Act that constituted an "Act of Congress" under the McCarran-Ferguson Act. Instead, the majority found that while it was "unclear" whether the New York

Convention was self-executing, the "fact that a treaty is implemented by Congress does not mean that it ceases to be a treaty and becomes an 'Act of Congress'" under the McCarran-Ferguson Act.

The majority additionally reasoned that the New York Convention treaty, rather than the provisions of the Convention Act implementing it, determined the parties' respective rights and obligations, and whether the state law at issue would be reversed preempted. Moreover, the majority noted, nothing in the Convention Act conflicted with or overrode the parties rights and obligations under the New York Convention treaty.

In so ruling, the majority's decision in *Safety National* is in apparent conflict with the Second Circuit's decision in *Stephens*, which held that the New York Convention was not a self-executing treaty and therefore relied on the Convention Act, an "Act of Congress," under the McCarran-Ferguson Act.

The three dissenting judges in *Safety National* emphasized that the New York Convention treaty has no legal effect in the United States in the absence of the enabling provisions of the Convention Act. The significance of this dynamic, according to the dissent, is that courts previously have preempted state laws based on treaties that were not self-executing because the federal statutes implementing the treaties, rather than the treaties themselves, have been found to have a preemptive effect under the Supremacy Clause of the Constitution. The dissent therefore concluded that the Louisiana statute could not be preempted without construing an "Act of Congress" in violation of the McCarran-Ferguson Act prohibitions against federal Acts from interfering with state statutes regulating the business of insurance.

Implications of the Safety National Decision for Policyholders and Foreign Insurers

The *Safety National* decision presents several significant implications for policyholders and foreign insurers, especially for those involved in imminent coverage disputes in courts within the Fifth Circuit. Unless and until the United States Supreme Court reverses the *en banc* ruling in *Safety National*, foreign insurers whose policies include London arbitration provisions may seek to compel foreign arbitration of coverage disputes with their policyholders falling within the Fifth Circuit's jurisdiction even where doing so would prevent the policyholder from invoking the protections of a state statute regulating the business of insurance.

If the United States Supreme Court grants *certiorari* and affirms the *Safety National* decision, policyholders stand to lose much more than their ability to litigate coverage disputes in U.S. state or federal courts and thus utilize the benefits of formalized fact and expert discovery, transparency of dispute resolution proceedings, and the appellate process typically absent from foreign arbitration proceedings. Policyholders also are at risk of losing crucial rights to litigate and recover for insurer bad faith, which is essentially non-existent under the insurance laws of the United Kingdom and other foreign jurisdictions. Indeed, policyholders in the absence of a ruling affirming *Safety National* may be able to invoke the forfeiture of their rights under state bad faith statutes as a means to "reverse preempt" enforcement of London arbitration provisions in their insurance policies.

The United States Supreme Court could affirm *Safety National* on the different and narrower grounds that the Louisiana statute (and others like it) prohibiting insurers from depriving courts from resolving insurance policy disputes does not regulate the business of insurance, and therefore does not fall under the McCarran-Ferguson Act's reverse preemption provisions. Such a result would likely leave a considerable amount of uncertainty for both policyholders and foreign insurers as to whether other types of state statutes (such as those creating a private right of action for insurer bad faith) could reverse preempt an insurer's attempt to enforce a foreign arbitration provision.

On the other hand, a reversal of *Safety National* by the Supreme Court may provide policyholders considerable latitude to invoke a wide array of state statutes regulating the business of insurance as a means for stopping foreign insurers from enforcing foreign arbitration clauses. Given the significance of these varying implications, the *Safety National* decision undoubtedly will be closely watched by counsel representing both policyholders and insurers in coverage disputes.

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Locke Lord Bissell & Liddell LLP on Social Media and the Business of Insurance

2009 Emerging Issues 4746

Locke Lord Bissell & Liddell LLP on Social Media and the Business of Insurance

By Bruce W. Foudree, Patrick J. Hatfield and Sean C. Fifield

December 21, 2009

SUMMARY: Insurers and their employees are increasingly communicating using social media. The speed and expanded reach of such communication magnify the chances that insurers and their employees and agents could violate laws that potentially apply to the use of social media. This commentary identifies and applies some of those laws as well as initial steps insurers can take to protect themselves.

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ARTICLE: INTRODUCTION

Internet-based social networking services and platforms, or "social media," are rapidly becoming the ultimate way to communicate instantly with friends and contacts around the world. As one expert has observed, "The field of marketing communications is rapidly moving to a new model in which online communication plays a dominant role, and social media are the latest development in that trend." n1 While Facebook, Twitter, LinkedIn and MySpace are some of the best-known social media, there are, in fact, hundreds of social media sites. Furthermore, the technology of social networking is rapidly evolving as users create their own innovations and conventions that modify how the social media sites are used. n2

Insurance companies have only recently begun using social media, and their adoption of this new form of communication has been relatively limited and experimental to date. However, there is little doubt that, as with other businesses, social media will become mainstream in the insurance industry. This will be driven by the simple fact that younger and older generations alike are using social media heavily, n3 and if insurers are not participating, their messages will not be heard, and they will not hear what their insureds and employees are saying about them.

Those insurers who have begun using social media are communicating with insureds to provide news and information about coverages, rates, ratings, jobs, etc. Much of what we are seeing still amounts to marketing. However, it is changing from the traditional one-way marketing of insurer to insured to the two-way and "multi-directional" interaction on social media among insurers and their followers. Social media are often referred to as powerful communication tools, but this power can be a two-way street. Just as social media greatly enhance the ability of insurers

to convey their messages, they also make it possible for consumers to rapidly convey their thoughts and opinions about insurers on a large scale and even launch grass roots protests. n4

Current laws do not specifically contemplate the technology of social networking, and it will take time for regulators, courts and legislators to address new issues that arise. However, the speed and expanded reach of social media communication greatly magnify the chances that insurers could violate existing laws that potentially apply to the use of social media. This commentary outlines some of those laws as well as initial steps insurers can take to protect themselves.

Some insurers have decided that they will not participate in using social media because they view the legal and communication risks as too great. Others have blocked their employees' access to Facebook and Twitter on company systems. However, in reality insurers will not be able to avoid social media. Their employees and agents are using these networking sites and can freely access them on their own mobile communication devices. Furthermore, they are setting up their own company-related Web sites to communicate with each other and even former employees. n5 Agents are setting up their own Web sites as well with advertising and company logos and trademarks on them. n6

KEY AREAS OF LAW THAT POTENTIALLY APPLY TO INSURERS USING SOCIAL MEDIA

Litigation and E-Discovery. As we have seen in recent years, e-mails have become prime sources of evidence as lawyers focus on them to make their cases. We can expect that the insurance industry's use of social media will be even more fruitful sources of litigation discovery by lawyers. Such impromptu and informal communications by insurers' employees with each other and with insureds will be subjected to the same level of scrutiny as e-mails have been, and they are likely to be even richer sources of information. As one commentator observed, "Lawyers ... love these sites, which can be evidentiary gold mines." n7 Domestic relations and family lawyers now actively scrutinize MySpace and Twitter for revealing and helpful information to make their clients' cases in divorce situations. n8 We can expect these same tactics to be used against insurers by plaintiffs' lawyers.

With social media, the potential damage is even greater than with e-mails because by nature social media communications are often real time. People typically express themselves "in-the-moment" n9 without any thought to how their comments can later be used against them and their companies. It is this immediate nature of the communications that can be very revealing and, therefore, extremely valuable or damaging, depending on one's position. As a result, social media postings can become self-inflicted wounds. Put another way, "It's permanent. It's indexed. It's searchable. If it's inappropriate or even illegal, you've shot yourself in the foot." n10

Further complicating matters is the challenge of complying with litigation hold orders. Where a company's business is conducted through the alternative channels of social media using company-provided or company-supported hand-held devices, these records may fall within the scope of a litigation hold order and the company may be required to prevent such records from being lost. Companies should, at the very least, consider their litigation hold order forms.

Market Conduct and Insurance Trade Practices; Advertising. Many provisions of state insurance trade practices and advertising laws arguably apply to social media communications such as "tweets" by company employees as well as the posting of photos and videos. Among the insurance trade practice laws most likely to be applied to social media communications are those proscribing misleading and false statements (e.g., misrepresentations of benefits, advantages, and terms of coverage or insurance products), defamation (e.g., making disparaging comments about competitors), and unfair claims practices.

Furthermore, a number of states have laws and rules governing marketing and advertising by insurers. For example, one state requires that advertising be truthful, complete, and clear. n11 If an insurance company sponsors a Facebook page, that is likely to be considered "marketing" or "advertising," and such a company has an obligation to monitor this and make sure it is accurate.

Record and Document Retention. State insurance codes usually require insurers to maintain their records and

documents for a specified period of time. This allows regulators to examine companies' operations for both their financial condition and their business conduct in the market. These laws very broadly define which records and documents must be retained, and insurers must assume that such laws apply to their communications via social media. It follows that regulators would therefore be entitled to access social media communications engaged in by insurers. However, there are questions of who owns or has custody and control of the information. n12

Privacy. Numerous state and federal laws governing privacy potentially apply when insurers use social media. Insurers should recognize that these laws are generally triggered when there is a transmission of unencrypted non-public personal information (NPI). So tweeting, even over a private channel of Twitter, could be subject to scrutiny under the law.

One of the principal laws in this area is the Gramm-Leach-Bliley Act (GLBA) n13 enacted by Congress in 1999. Insurers must beware of communicating individuals' names in combination with personal information related to those persons. For example, an individual's name and driver's license number n14 or Social Security number n15 generally would be considered sensitive information protected by statute.

Privacy laws can be triggered when insurers' employees and agents use social media to communicate with insureds in claims situations. For example, using unsecured Web sites or unencrypted e-mail to exchange personally identifiable data (such as name, address, driver's license number and account/policy number) could subject insurers to the privacy laws. n16

Some states have adopted the National Association of Insurance Commissioners (NAIC) Insurance Information and Privacy Protection Model Act of 1982. This Act regulates all "personal information" which is broadly defined and includes virtually all individually identifiable information about insureds. n17

Personal health information also is protected by the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996. n18 Title II of this Act protects the privacy of patient information. n19 While it currently may seem unlikely that such information would be disclosed through social media, as insurers and employees expand their use of social media, the potential for inadvertent disclosure increases. Insurers should ensure that their current systems for accessing and using patient information are adequate to cover such communications. Insurers may, for example, opt to totally prohibit the communication of any patient information by employees over social media networks.

A number of states, such as Nevada and Massachusetts, also have security breach laws which require NPI transmissions to be encrypted.

The federal Fair Credit Reporting Act (FCRA) may also apply. For example, when an auto insurer obtains an insured's driving history or credit report for underwriting purposes, the FCRA restricts the subsequent use and distribution of such information. n20 The insurer cannot share that information with others, including the insured. A careless employee who inadvertently discloses information obtained from a credit report via a tweet could subject the company to liability under the FCRA.

Lastly, insurers must keep in mind that they are also held accountable to the standards and requirements that they themselves establish under company privacy policies. Thus, if employees violate privacy policies that their employer-insurers have posted on their Web sites and mailed out to customers, those insurers are at risk of being sanctioned by the Federal Trade Commission and/or state insurance departments which regulate trade practices generally. Further, a company that fails to comply with its own privacy policies posted on its Web sites might have liability to a consumer who claims he or she relied on that Web site's privacy policy.

Employment Law. Employers need to address concerns about employees' use of social media. For example, insurance company employees who make comments about their fellow employees or employers can potentially expose themselves and their employers to liability. This includes the exchange of comments between supervisors about the character and conduct of their subordinates. Problems can arise when employees use social media outside of work if

they mention the company in their postings.

Insurers should review their employment policies on electronic communications and revise them to cover the use of social media, just as they have adopted policies on the use of cell phones, e-mail and the Internet. They should consider including guidelines prohibiting comments that are defamatory, harassing, disparaging or discriminatory, or which disclose confidential company information. In addition, they should provide guidance about employees' use of social media at work.

Specifically, employers may also choose to address employees' use of social media for personal matters while on the job. Social media have the potential to be far more time-consuming than just e-mailing and occasionally surfing the Web. As employees compulsively check their iPhones and Blackberries for news of other people's lives, their use of social media can consume large amounts of time and adversely affect their productivity.

Privilege and Trade Secrets. The unintentional loss of privileged information and trade secrets can occur as a result of careless disclosures employees make when using social media to communicate with outsiders, including friends and even regulators. Companies need to make sure their employees are educated about this risk and instructed on how to avoid it. Insurers' employees must be aware of and assume that a communication containing sensitive information that is intended for one person could be subsequently redistributed to others, thereby resulting in a loss of protection and a waiver of privilege through public disclosure.

Company guidelines should specifically inform employees that information transmitted using company hardware and software is the property of the company.

Intellectual Property. There can be issues of ownership and rights to the use of material that is generated by employees and third parties and posted on social media sites such as Twitter, Facebook and MySpace. This includes copyrighted material, patented designs or material, trademarks, trade names, trade dress, trade secrets, and trade slogans and phrases. The use of third parties' trademarks, copyrighted material or other intellectual property in postings or other communications on social media sites could infringe third parties' intellectual property rights. Licensing issues may also arise. If employees engage in such actions while performing their jobs, whether in the context of a company-sponsored Web page or otherwise, their employers could be liable for any infringement caused by such actions.

The fact that many social media sites allow for the creation of customized Web pages on a variety of topics, coupled with the informal nature of much of the use of such social media sites, may result in employees or third parties creating pages about an insurer which utilize trademarks, copyrighted material and other intellectual property of the insurer that the insurer will want to control. Accordingly, insurers should take steps to ensure that Web pages on social media sites which appear to be authorized by the insurer are, in fact, authorized and controlled by the insurer.

When creating authorized "fan pages" or other media channels on social media sites, insurers will need to address issues similar to those arising in other media channels. For example, like any other Web page, if company trademarks, copyrighted material or other intellectual property are placed on a social media site, there is a risk that such material may be subsequently redistributed and used by third parties in ways that the company does not want and cannot control.

Antitrust. Insurers must be constantly vigilant about violating state and federal antitrust laws when it comes to the use of social media. Member insurers of trade associates who communicate with each other via social media about matters of mutual interest and concern could end up violating antitrust laws if they discuss rates and pricing.

Contracts. Statements by insurance agents/producers in social media communications with insureds regarding insurance products could be used as the basis for arguing that a modification of the insurance contract occurred as a result of representations about the scope and nature of coverage.

WHAT TO DO? INITIAL STEPS INSURERS CAN TAKE TO PROTECT THEMSELVES

With so many potential legal issues and risks, the task of protecting against violations and resulting liability can be daunting. Insurers may well ask, "How can we afford the time and cost of covering all of the bases?" However, doing nothing places a company at risk for larger costs down the road in the form of damages and legal fees.

The first and most important step an insurer can take is to adopt policies and guidelines, or review and revise existing ones, on the use of social media in communicating with insureds and the public. Insurers who adopt a clear social media plan that incorporates such guidelines will be in a much better position to successfully meet the operating and legal challenges of this new communications environment.

Second, insurers should implement those policies and guidelines. This includes educating and training employees about those policies and guidelines.

Third, insurers should monitor and enforce compliance with the policies and guidelines. While there are differences of opinion about this, with some arguing that monitoring adversely affects employee morale and productivity, a company that adopts guidelines and does nothing to implement and monitor their compliance leaves itself vulnerable to attack.

An insurer will never have a perfect compliance program. However, taking immediate steps to adopt company policies and guidelines on social media will provide strong protection (and a defense) in the future if the insurer is sued or charged with violating the law.

Return to Text

n1 Thomas Wetzel, with Thomas H. Wetzel & Associates, Inc., an insurance marketing communications firm.

n2 In the two years since Facebook opened its platform to outside developers, approximately 300,000 applications have been created. Id.

n3 There are an estimated 200 million Facebook users worldwide, and both Facebook and MySpace each have about 70 million users in the United States. Chicago Tribune, July 6, 2009 at 21.

n4 As a recent report noted, "The British furniture company Habitat was mercilessly scolded . . . by Twitter users (death by a thousand tweets, you might say) after it tried to connect its offer of a chance to win [#8356]1,000 gift card with the deadly protests in Iran after the disputed presidential election." N.Y. Times, June 29, 2009 at B4.

n5 For example, employees of the Progressive Insurance Company established a Facebook page just for

themselves. It states, "This is a group for all Progressive employees to network, share common experiences, and become friends with other co-workers around the world. Former employees are also welcome!"

See <http://www.facebook.com/group.php?gid=1383864970>.

n6 See, e.g., a site set up by an agent who holds herself out as "CEO and agency owner of Farmers Insurance Group."

<http://www.facebook.com/pages/Salem-VA/Alli-Pickle-Farmers-Insurance-Group/21036486406>.

n7 Time, June 22, 2009 at 94.

n8 Id.

n9 Time, June 15, 2009 at 35.

n10 Jason Falls, March 30, 2009 on Social Media Explorer Blog, as quoted in The Iowa Lawyer, June 2009 at 27.

n11 See, e.g, Iowa Admin. Code § 191-15.3.

n12 Under these laws, insurers are obligated to maintain their records. This raises the question, however, of exactly who owns the information when it is communicated through and stored in a social media site's servers such as Twitter's. Technically, Twitter owns the site and servers. And sites are constantly being modified and updated. Nevertheless, one can expect regulators to argue that the law would extend to requiring insurers to retain copies of that information and make it available to insurance examiners when requested.

n13 Pub. L. No. 106-102, *113 Stat. 1338*, enacted Nov. 12, 1999.

n14 See, e.g., Drivers Privacy Protection Act of 1994, *18 U.S.C. §§ 2721 and 2725*.

n15 See, e.g., Michigan's Social Security Number Privacy Act, Act 454 of 2004, Mich. Comp. Laws §§ 445.81 - 445.87.

n16 See, e.g., Massachusetts' Standards for The Protection of Personal Information of Residents of the Commonwealth, 201 Mass. Code Regs. 17.04(3).

n17 "Personal information" means any individually identifiable information gathered in connection with an insurance transaction from which judgments can be made about an individual's character, habits, avocations, finances, occupation, general reputation, credit, health or any other personal characteristics. 'Personal information' includes an individual's name and address and 'medical record information'...

'Medical record information' means personal information which:

(1) Relates to an individual's physical or mental condition, medical history or medical treatment; and

(2) Is obtained from a medical professional or medical care institution, from the individual, or from the individual's spouse, parent or legal guardian."

NAIC Model Laws, Regulations and Guidelines, Model 670, Sec. 2. The Act's provisions arguably apply when insurers are communicating personal information they have obtained from insureds. In addition, the NAIC prepared the Privacy of Consumer Financial and Health Information Regulation in response to requirements set forth in Title V of the Graham-Leach-Bliley Act, *15 U.S.C. §§ 6801- 6809*, related to the privacy of consumers' personal information. See, e.g., *15 U.S.C. § 6809(4)* (defining "Nonpublic Personal Information" as generally any personally identifiable financial information provided to a financial institution by a consumer).

n18 Pub. Law No. 104-191, *110 Stat. 1936*, enacted August 21, 1996.

n19 Id., § 1177(a)(3).

n20 Under the law, the use of information is in effect restricted to permissible purposes. See FCRA §§ 604(a)(3)(C) and 604(f).

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Douglas R. Richmond on Selecting Independent Counsel in Insurance

2009 Emerging Issues 4725

Douglas R. Richmond on Selecting Independent Counsel in Insurance

By Douglas R. Richmond

December 11, 2009

SUMMARY: A liability insurer required to defend an insured against a suit by a third party may face an alleged conflict of interest. Where the conflict does exist, the insured is entitled to independent counsel. Courts are split on whether the insurer retains the right to select independent counsel notwithstanding the alleged conflict of interest, or whether the insured is entitled to choose its own lawyer.

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ARTICLE: INTRODUCTION

Occasionally, a liability insurer required to defend an insured against a suit by a third party faces an alleged conflict of interest that it deprives the insurer of its contractual right to control the insured's defense. This is most often the case where the insurer has reserved its right to deny coverage and the insured contends that the manner in which the third-party action is defended could defeat or limit coverage. In such a case, the argument goes, the insurer may be more interested in defeating or confining coverage than in defending the insured. Thus, from the insured's standpoint, leaving the insurer in control of the defense is unacceptable.

While one might debate the validity of this reasoning in many instances, it is true in any event that the insurer's loss of defense control in such a case does not eliminate its duty to defend the insured. Rather, the insurer must cure the conflict to fulfill its duty. n1 An insurer typically does so by allocating control of the defense to "independent counsel." n2 The lawyers selected as independent counsel make all tactical decisions concerning the insured's defense, share an attorney-client relationship solely with the insured, and are loyal only to the insured; the insurer simply pays independent counsel's fees. n3 Independent counsel in insurance are commonly referred to as "Cumis counsel" in recognition of the seminal California case on the subject, *San Diego Navy Federal Credit Union v. Cumis Insurance Society, Inc.* n4

The concept of independent counsel in insurance raises several important questions, but the principal and most

controversial one is simple: Who selects independent counsel? Does the insurer retain the right to select independent counsel notwithstanding the alleged conflict of interest, or is the insured entitled to choose its own lawyer? Courts are split on the answers to these questions.

SELECTING INDEPENDENT COUNSEL

The selection of the lawyers to serve as independent counsel is often a contentious issue. The clear implication is that the insured must have the exclusive right to select independent counsel because affording the insurance company a role in the process will necessarily impair or compromise the loyalty of any lawyer ultimately selected. Indeed, a number of courts hold that the insured alone is entitled to select independent counsel. n5 This approach has been described as the majority rule. n6 Courts adhering to this rule essentially reason that an insurer's instructions to a defense lawyer functioning as independent counsel that she is to represent the insured alone and to act exclusively for the insured's benefit cannot overcome the lawyer's "human nature" to treat the insurance company as a client. n7

CHI of Alaska, Inc. v. Employers Reinsurance Corp. n8 is a leading case recognizing insureds' right to select independent counsel. There, Employers Reinsurance Corp. ("ERC") offered to defend CHI in a serious personal injury action under a reservation of rights. CHI protested that the reservation of rights created a conflict of interest entitling it to independent counsel under Alaska law, and insisted that its personal attorney, Brett von Gemmingen, defend it. ERC expressed concern about von Gemmingen's experience in handling cases of this nature and suggested that CHI provide it with the names of more experienced lawyers that ERC might engage as independent counsel. CHI refused the offer. In response, ERC offered to allow von Gemmingen to represent CHI on the uncovered claim triggering the reservation, while ERC retained a firm of its choosing to act as co-counsel and to assume responsibility for the overall defense of the suit. CHI declined that offer, as well. CHI then filed a declaratory judgment action to vindicate its position on retaining independent counsel of its choice.

ERC and CHI both moved for summary judgment. CHI argued that ERC should have no role in selecting defense counsel because "any attorney selected by an insurance company '[would] attempt to help his real client, the insurance company, at the expense of the insured.'" n9 Retaining von Gemmingen to defend claims outside of coverage would not resolve the conflict, CHI reasoned, because the dual representation that ERC proposed would permit the law firm hired by ERC "to work against the interests of the insured and would cause confusion concerning who [was] to control various litigation decisions." n10 ERC argued that it had eliminated any potential conflicts of interest by allowing von Gemmingen to defend the uncovered claim at its expense. The trial court found for ERC and CHI appealed to the Alaska Supreme Court. The state supreme court was asked to answer two key questions. First, did the co-counsel scheme ERC proposed satisfy CHI's right to independent counsel? Second, did CHI have the unilateral right to select independent counsel?

The court concluded that ERC's proposed co-counsel arrangement did not satisfy its duty to provide independent counsel for CHI because it did not cure the conflict of interest. There were two reasons for this. First, the law firm selected by ERC would have access to information known to or held by CHI that could be used against CHI in subsequent coverage litigation. Second, the law firm selected by ERC would be able to direct the defense and, in doing so, might be able to influence the ultimate coverage determination.

With respect to CHI's right to select independent counsel, the court began its analysis by noting that "most cases" on the subject "express the view that the insured has the right to select independent counsel of its choice." n11 The court agreed that an insured has the unilateral right to select independent counsel of its choice, but tempered by its implied duty of good faith and fair dealing. In this context, the insured's duty of good faith and fair dealing requires it to select as independent counsel a lawyer "who is, by experience and training, reasonably thought to be competent" to conduct the defense. n12 As the court explained its reasoning:

Such a result . . . fairly balances the interest of the insured-being defended by competent counsel of undivided loyalty-with the interests of the insurer-having the defense of the insured conducted by competent counsel. The insurer is only required to pay the reasonable cost of the defense. . . . This provides a measure of protection for insurers against overbilling-and overlitigating-by independent counsel. n13

It was unclear whether von Gemmingham was qualified to defend CHI in the underlying case. There was at least some evidence that he might not be, since it was a serious case and he had been out of law school for only four years at the time the controversy arose. On remand, it would be necessary for the trial court to determine his qualifications. If von Gemmingham was qualified to handle the case, then the defense could go forward with him in charge; if he was not qualified, however, CHI would be required to select different independent counsel. n14

The *CHI of Alaska* decision was not unanimous; there was a reasoned dissent by Justice Daniel A. Moore, Jr. While agreeing that the insured should be entitled to select independent counsel, Justice Moore expressed concern that allowing the insured to do so unilaterally did not adequately respect the insurer's contractual right to defend the insured. He would have thus qualified insureds' right to select independent counsel by allowing insurers a "right of reasonable approval" over the insured's choice. n15 Under his proposed regime, an insurer would not be able to "unreasonably withhold" approval of an insured's proposed independent counsel. n16

Justice Moore was also bothered by the majority's requirement that an insured employ as independent counsel a lawyer "reasonably thought to be competent to conduct the defense" of the underlying litigation, because the majority failed to specify by whose standards competency should be measured. n17 Absent any objective criteria for determining independent counsel's competency, the measure of protection the majority thought it was affording to insurers was "both inadequate and unworkable." n18 In light of von Gemmingham's relative inexperience, ERC's reluctance to accept him as defense counsel was understandable.

Finally, Justice Moore reasoned that the majority's concern that allowing insurers a voice in the selection of independent counsel would somehow taint the defense were either speculative or exaggerated. n19 If an insurer-selected defense lawyer were to breach her duties to the insured as part of a scheme to further the insurer's interests, the lawyer would potentially expose herself to professional discipline and malpractice liability, and the insurer would face liability for bad faith. Those remedies adequately protect insureds and serve "as a strong disincentive to both insurers and defense counsel to compromise the insured's interest." n20

Justice Allen Compton also dissented. He observed that a lawyer hired by an insured was just as subject to ethical pressures as was a lawyer hired by an insurer, and that a lawyer selected by an insured might still be tempted to favor the insurer's interests if the lawyer thought that the insurer might ultimately offer a more rewarding financial relationship than that provided by the insured. n21 Justice Compton recognized that the insured should be allowed to select independent counsel, but he proposed that an insured's right to appoint independent counsel should be subject to the insured's contractual duty to cooperate.

Naturally, there is another side to the independent counsel selection coin. Proponents of this differing view contend that lawyers hired by insurers regularly defend insureds in cases in which the insured's and insurer's interests are not neatly aligned. The overwhelming majority of insurance defense lawyers vigorously defend the insureds they are hired to represent regardless of insurers' coverage positions. Defense lawyers who subordinate insureds' interests to insurers' interests risk professional discipline and malpractice liability. Insurers that tolerate such conduct risk bad faith liability. In light of these factors, it is reasonable to conclude that an insurer should be permitted to select independent counsel, provided that the defense lawyer understands that the insured is her sole client and the insurer acts honestly and responsibly in the process. Several courts have adopted this approach. n22

In *Federal Insurance Co. v. X-Rite, Inc.*, n23 for example, X-Rite and its CEO, Darrell Thompson, were sued on several theories in a case known as the "O'Connor litigation." n24 X-Rite engaged Varnum, Riddering, Schmidt & Howlett ("Varnum"), to defend the O'Connor litigation, and notified its insurer, Federal, of the suit and of Varnum's

retention two months later. Federal responded with a letter acknowledging its duty to defend the O'Connor litigation; declining to allow Varnum to continue as defense counsel; proposing to substitute the firm of Vandever, Garzia, Tonkin, Kerr & Heaphy ("Vandever") for Varnum; and reserving its rights to deny coverage with respect to three of the causes of action. Neither X-Rite nor Thompson responded to Federal, and the O'Connor litigation went on with Varnum handling the defense. Months later, when Federal insisted that Vandever be substituted as defense counsel for Varnum, X-Rite revealed that it had received a \$125,000 settlement offer through mediation that would soon expire. The next communication of any significance came when Varnum informed Federal that the O'Connor litigation had settled for \$125,000, requested that Federal indemnify X-Rite for the settlement, and sought reimbursement of roughly \$71,000 in attorneys' fees. Federal responded by filing a declaratory judgment action in a Michigan federal court.

The parties filed cross-motions for summary judgment. One of the issues for the court to decide was whether X-Rite was entitled to insist on counsel of its choice at Federal's expense. After surveying the law from various jurisdictions, the court concluded that it was not. n25 In a footnote, the court explained the meaning of "independent counsel":

"Independent counsel" is a term which has not been defined in the case law. The representation of Vandever . . . was tendered to X-Rite with a clear explanation of the firm's role, designed to assure X-Rite of its independence. Federal assured X-Rite that Vandever . . . would handle the defense of all claims asserted against X-Rite; that it would represent X-Rite only, not Federal, and would direct its efforts only to the best interests of X-Rite; and that it would not be involved directly or indirectly in coverage issues. These assurances are reasonable and, absent any contrary showing, effective to establish [Vandever's] independence. n26

The *X-Rite* court detailed the pertinent facts:

When Federal received notice of the action against X-Rite, it proceeded in accordance with black letter Michigan law by undertaking the defense with a reservation of rights. Further, Federal tendered the representation of "independent counsel," the Vandever . . . firm. . . . X-Rite objected not because it believed Vandever . . . was not "independent," but because it questioned the qualifications of . . . Vandever . . . to competently defend [two of the] claims [asserted against it], and because it believed the conflict created by Federal's reservation of rights gave it the absolute right to retain counsel of its choice at Federal's expense. n27

Furthermore, X-Rite's conduct evidenced "a cavalier disregard" for the language in the Federal policy granting Federal the right to defend its insureds and thus protect its own interests in any litigation implicating its duty to defend. n28 Unless Federal's contractual right to defend X-Rite was to be deemed mere surplusage, it had to be viewed as granting the insurance company some prerogative with respect to the O'Connor litigation beyond simply paying defense costs. The fact that Federal was not entitled to absolute control over X-Rite's and Thompson's defenses in the O'Connor litigation by virtue of its conflict of interest did not compel the conclusion that it lost its right to defend entirely. In the absence of some public policy to the contrary, Federal's contractual right to defend X-Rite and Thompson could hardly contemplate anything less than its participation in the selection of defense counsel. As for public policy, the court observed: "Public policy requires the insurer to act with utmost good faith. As long as this standard is observed, the [c]ourt may not interfere with the terms of the parties' agreement." n29

The *X-Rite* court was unwilling to conclude that an insurer defending under a reservation of rights automatically breaches its duty of good faith and fair dealing by selecting defense counsel. To do so would be to presume that defense counsel are unable to represent their client, i.e., the insured, without consciously or subconsciously compromising the insured's interests. n30 The court reasoned that the defense bar deserved greater confidence and respect than that presumption would accommodate. n31

In summary, the court determined that the conflict of interest attributable to Federal's reservation of rights did not automatically entitle X-Rite to counsel of its choice at Federal's expense. There being no evidence that Vandever was not independent or that by insisting on Vandever's representation Federal acted in bad faith, created an actual conflict

of interest, or otherwise prejudiced X-Rite's interests, X-Rite acted unreasonably in refusing a defense by Vandever in the O'Connor litigation. Federal was thus entitled to summary judgment on X-Rite's claimed right to independent counsel and reimbursement of Varnum's fees. SUMMARY AND SYNTHESIS

Regardless of whether one favors vesting the right to select independent counsel in the insured or leaving the task to the insurer, it is important to recognize that both approaches are default mechanisms. Insurers and insureds are free to select independent counsel cooperatively, or to formulate other approaches to choosing counsel. For example, an insurer might submit a list of lawyers to the insured, who could then select one. Alternatively, the insured might propose a list of lawyers to the insurer, which would then pick one. Either approach allows the party making the selection to satisfy itself as to the lawyer's suitability for the independent counsel role. Some insurance companies include selection of counsel clauses in their policies. Such clauses are desirable from insurers' perspective and should generally be enforceable.

Furthermore, there are logical limits on both the pro-insured and pro-insurer approaches to selecting independent counsel. Consider, for example, the settled principle that an insurer required to accept independent counsel chosen by the insured "is under a duty to provide only an impartial defense-not to sacrifice its own interests." n32 If independent counsel selected by the insured perhaps represent the insured in a coverage or bad faith dispute with the insurer, or might attempt to slant coverage in the insured's favor in the course of the defense, the insurer would have the right to reject those lawyers. n33 An insurer cannot reasonably be expected to tolerate antagonistic behavior by lawyers with whom it must interact in their capacity as defense counsel. n34 This is true even where the insurer's interactions with independent counsel are or will be limited. n35 On the other hand, an insurer cannot be permitted to select as independent counsel a lawyer whom it employs as staff counsel, or who practices in a captive law firm that the insurer controls. n36 As a practical matter, it is impossible to describe an insurance company employee as "independent" of the insurer, no matter how conscientious or honorable the employed lawyer may be.

Curiously, and despite the pervasiveness of state insurance regulation, few states regulate independent counsel in any fashion. California and Alaska have gone the farthest. In the wake of *Cumis*, California enacted *Civil Code* § 2860, which is a relatively comprehensive statute controlling independent counsel relationships. n37 The Alaska statute is also thorough. n38 Within its insurance claims administration statute, Florida more modestly addresses compensation for independent counsel. n39

In the end, the split in authority on the selection of independent counsel and the lack of state insurance regulations on the subject mean that there remains ample opportunity for disputes between insureds and insurers over this key issue. Both insurers and insureds have valid arguments for retaining the right to select independent counsel.

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n1 *W. Cas. & Sur. Co. v. Herman*, 405 F.2d 121, 124 (8th Cir. 1968); *All-Star Ins. Corp. v. Steel Bar, Inc.*, 324 F. Supp. 160, 165 (N.D. Ind. 1971).

n2 *MetLife Capital Corp. v. Water Quality Ins. Synd.*, 100 F. Supp. 2d 90, 95-96 (D.P.R. 2000) (applying law from various jurisdictions in the absence of Puerto Rican law).

n3 Robert H. Jerry, II & Douglas R. Richmond, *Understanding Insurance Law* 911-12 (4th ed. 2007).

n4 208 Cal. Rptr. 494 (Cal. Ct. App. 1984), superseded by statute as stated in *Dynamic Concepts, Inc. v. Truck Ins. Exch.*, 71 Cal. Rptr. 2d 882, 883 n.1 (Cal. Ct. App. 1998).

n5 See, e.g., *Union Ins. Co. v. Knife Co.*, 902 F. Supp. 877, 880-82 (W.D. Ark. 1995) (predicting Arkansas law); *Cunniff v. Westfield, Inc.*, 829 F. Supp. 55, 57 (E.D.N.Y. 1993) (applying New York law); *Great Divide Ins. Co. v. Carpenter ex rel. Reed*, 79 P.3d 599, 604 (Alaska 2003); *Joseph v. Markovitz*, 551 P.2d 571, 576-77 (Ariz. Ct. App. 1976); *Compulink Mgmt. Ctr., Inc. v. St. Paul Fire & Marine Ins. Co.*, 87 Cal. Rptr. 3d 72, 75 (Cal. Ct. App. 2008); *Am. Family Mut. Ins. Co. v. W.H. McNaughton Builders, Inc.*, 843 N.E.2d 492, 498 (Ill. App. Ct. 2006); *Belanger v. Gabriel Chems., Inc.*, 787 So. 2d 559, 565 (La. Ct. App. 2001); *Moeller v. Am. Guar. & Liab. Ins. Co.*, 707 So. 2d 1062, 1070 (Miss. 1996).

n6 *Union Ins. Co.*, 902 F. Supp. at 881.

n7 *Union Ins. Co.*, 902 F. Supp. at 881.

n8 844 P.2d 1113 (Alaska 1993).

n9 *CHI of Alaska, Inc.*, 844 P.2d at 1114 (quoting CHI's court papers).

n10 *CHI of Alaska, Inc.*, 844 P.2d at 1114-15.

n11 *CHI of Alaska, Inc.*, 844 P.2d at 1120.

n12 *CHI of Alaska, Inc.*, 844 P.2d at 1121.

n13 *CHI of Alaska, Inc.*, 844 P.2d at 1121 (citations omitted).

n14 *CHI of Alaska, Inc.*, 844 P.2d at 1121.

n15 *CHI of Alaska, Inc.*, 844 P.2d at 1122 (Moore, J., concurring and dissenting).

n16 *CHI of Alaska, Inc.*, 844 P.2d at 1122 (Moore, J., concurring and dissenting).

n17 *CHI of Alaska, Inc.*, 844 P.2d at 1125 (Moore, J., concurring and dissenting).

n18 *CHI of Alaska, Inc.*, 844 P.2d at 1126 (Moore, J., concurring and dissenting).

n19 *CHI of Alaska, Inc.*, 844 P.2d at 1127-28 (Moore, J., concurring and dissenting).

n20 *CHI of Alaska, Inc.*, 844 P.2d at 1128-29 (Moore, J., concurring and dissenting).

n21 *CHI of Alaska, Inc.*, 844 P.2d at 1130 (Compton, J., dissenting).

n22 See, e.g., *Twin City Fire Ins. Co. v. Ben Arnold-Sunbelt Beverage Co. of S.C.*, 433 F.3d 365, 371-74 (4th Cir. 2005) (interpreting South Carolina law); *H.K. Sys., Inc. v. Admiral Ins. Co.*, No. 03 C 0795, 2005 U.S. Dist. LEXIS, at *48-51 (E.D. Wis. June 27, 2005) (predicting Wisconsin law); *Travelers Indem. Co. v. Royal Oak Enters., Inc.*, 344 F. Supp. 2d 1358, 1374-76 (M.D. Fla. 2004) (predicting Florida law); *United States v. Daniels*, 163 F. Supp. 2d 1288, 1290 (D. Kan. 2001) (interpreting Kansas law); *Cent. Mich. Bd. of Trustees v. Employers Reins. Corp.*, 117 F. Supp. 2d 627, 633-37 (E.D. Mich. 2000) (interpreting Michigan law); *Cardin v. Pac. Employers Ins. Co.*, 745 F. Supp. 330, 335-37 (D. Md. 1990) (discussing Maryland law); *Fed. Ins. Co. v. X-Rite, Inc.*, 748 F. Supp. 1223, 1228-30 (W.D. Mich. 1990); *Finley v. Home Ins. Co.*, 975 P.2d 1145, 1154 (Haw. 1998).

n23 748 F. Supp. 1223 (W.D. Mich. 1990).

n24 *X-Rite, Inc.*, 748 F. Supp. at 1224-25.

n25 *X-Rite, Inc.*, 748 F. Supp. at 1228.

n26 *X-Rite, Inc.*, 748 F. Supp. at 1228 n.1.

n27 *X-Rite, Inc.*, 748 F. Supp. at 1228 (footnote omitted).

n28 *X-Rite, Inc.*, 748 F. Supp. at 1229.

n29 *X-Rite, Inc.*, 748 F. Supp. at 1229.

n30 *X-Rite, Inc.*, 748 F. Supp. at 1229.

n31 *X-Rite, Inc.*, 748 F. Supp. at 1229 ("The [c]ourt is unable to conclude that Michigan law professes to little confidence in the integrity of the bar of this state.").

n32 *N.Y. State Urban Dev. Corp. v. VSL Corp.*, 863 F. Supp. 187, 190 n.1 (S.D.N.Y. 1983).

n33 See, e.g., *Maddox v. St. Paul Fire & Marine Ins. Co.*, Civ. Action No. 01-1264, 2002 U.S. Dist. LEXIS, at *10 (W.D. Pa. May 29, 2002) (allowing insurer to reject insured's chosen independent counsel where those

lawyers intended to represent the insured in a bad faith claim against the insurer and who fostered "a high level of acrimony" with the insurer in the case they were defending); *N.Y. State Urban Dev. Corp.*, 863 F. Supp. at 190 n.1 (noting that insurer acted reasonably in refusing to approve independent counsel who were hostile to it).

n34 *Maddox*, 2002 U.S. Dist. LEXIS, at *10 n.6.

n35 *Maddox*, 2002 U.S. Dist. LEXIS, at *10 n.6.

n36 *Hartford Cas. Ins. Co. v. A & M Assocs., Ltd.*, 200 F. Supp. 2d 84, 90 (D.R.I. 2002).

n37 Cal. Civ. Code § 2860 (2009).

n38 Alaska Stat. § 21.89.100 (2007).

n39 Fla. Stat. § 627.426(2)(b)(3) (2006).

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Sonnenschein Nath & Rosenthal on 21st Century Insurance Co. v. Superior Court

2009 Emerging Issues 4550

Sonnenschein Nath & Rosenthal on 21st Century Insurance Co. v. Superior Court: Insurance Subrogation, the Made-Whole Requirement, and Attorneys Fees

By William Barker

November 6, 2009

SUMMARY: Insurance subrogation or reimbursement rights are often qualified by requiring that the insured must be made whole before the insurer is entitled to recover. The California Supreme Court recently held that the insured need not be made whole for attorneys fees. Rather, the common-fund doctrine charges a share of the attorneys fees against the insurers portion of the recovery. This EIA analyzes the law elsewhere and the cases impact.

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ARTICLE: Insurance policies commonly provide that, when benefits are paid for losses like damage to property or medical expenses, then the insurer is subrogated to the insured's rights to recover from any responsible tortfeasor and/or is entitled to be reimbursed out of any recovery the insured might obtain from any tortfeasor. Even without express provisions in the policy, the common law often would grant similar rights, but typically qualified by a requirement that the insured must be made whole before the insurer is entitled to any recovery. In *21st Century Insurance Co. v. Superior Court*, n1 the California Supreme Court (1) followed prior California precedent presumptively applying the "made-whole" rule to a contractual subrogation/reimbursement provision n2 and (2) held that, in deciding whether the insured has been made whole, one does not consider attorneys' fees the insured incurred to obtain any recovery. Rather, one utilizes the common-fund doctrine to charge a share of the attorneys' fees against the insurer's portion of the recovery.

There is a diversity of views among jurisdictions on the role of attorneys' fees in determining whether the insured has been made whole. This commentary analyzes the various rules and the impact of this case.

THE CASE

Silvia Quintana was insured by 21st Century, with coverage that included benefits for up to \$1000 in medical payments resulting from any auto accident. That coverage provided that "[i]f we make any payment under this Part and

the person insured .. recovers damages .., the person insured shall 1. hold in trust for us the proceeds of the recovery; and 2. reimburse us to the extent of our payment." n3

Quintana had an auto accident, was paid \$1000, and then settled her tort claim for \$6000, of which she was obliged to pay \$2106.50 in attorneys' fees and costs ("fees"). 21st Century then sought reimbursement. Quintana paid \$600, with the \$400 deduction representing an allocation of the fees she had incurred, an allocation accepted by 21st Century. She then filed a class action seeking to recover the payment, on the ground that no recovery could lawfully have been requested unless she had been made whole, which she said she had not been (because of the amounts she had paid for fees). n4 21st Century demurred to the complaint, the superior court overruled the demurrer, and court of appeal issued on writ of mandate directing the superior court to sustain the demurrer. The supreme court affirmed.

BACKGROUND: INSURANCE SUBROGATION AND THE MADE-WHOLE REQUIREMENT

The Made-Whole Requirement, the Principle of Indemnity, and the Collateral Source Rule. One of the doctrines of insurance law is the "principle of indemnity," "[t]he concept that insurance contracts shall confer a benefit no greater in value than the loss suffered by an insured." n5 As a leading treatise explains:

"[I]t is now a generally accepted fundamental tenet of insurance law that opportunities for net gain to an insured through the receipt of insurance proceeds exceeding a loss should be regarded as inimical to the public interest. In other words, insurance arrangements are structured to provide funds to offset a loss, either wholly or partly, and the payments made by an insurer generally are limited to an amount that does not exceed what is required to restore the insured to a condition relatively equivalent to that which existed before the loss occurred." n6

The principle of indemnity coexists with the collateral source rule, whereby a tortfeasor is liable for all damages suffered by the injured party, whether or not those damages have been compensated by insurance or some other collateral source. n7 Allowing subrogation or reimbursement reconciles those two rules, by compensating the injured party's loss, but allowing the collateral source to recover any payments made that would exceed the net loss after the tort recovery. n8 Thus, the primary burden of compensating tortious injuries is placed on the tortfeasor, with collateral sources playing a secondary role, only to the extent necessary.

The principle of indemnity serves two purposes of current significance. First, by eliminating any profit from suffering an insured loss, it avoids creating any incentive to cause such losses (as by arson) and it minimizes the incentives to take less care to avoid such losses. Second, by limiting the net amount the insurer must pay and allowing the insurer to set premiums appropriate for that net payment level, it avoids the need to charge higher premiums that would create double-recovery windfalls for some insureds at the expense of those who have no opportunity for such a double recovery. Such double recoveries are regarded as a form of unjust enrichment: while the insured has paid a premium for compensation of losses, premiums should take account of the principle of indemnity and should not include the costs of providing a net recovery in excess of the loss. n9 Paying higher premiums for a chance at a double recovery would have some elements of a lottery; rational insureds would not want to participate in such a lottery, because charges for the insurer's expenses and profits would make any expected recovery less than the cost. n10

The Seventh Circuit has summarized the case for allowing subrogation or reimbursement rights to insurers (whether or not subject to a requirement that the insured be made whole):

"In the usual case the insured incurs a medical expense for which he is promptly reimbursed by the insurance company (or equivalent), which then exercises its right of subrogation and goes off on what sometimes proves to be a wild goose chase after a possible tortfeasor to whom the expense can be shifted. The insured is out of the picture—well, not entirely, because he is entitled to any excess recovery by the insurance company. Subject to this qualification, of which more later, the risk of an uncertain recovery is shifted from the individual to a specialist in bearing risk and enforcing claims—the insurance company. The price of the insurance is thereby reduced (or, equivalently, the insured can

buy more insurance for the same price) because the insurance company acquires a contingent claim by virtue of the subrogation clause. Without subrogation, a part of the risk is shifted back to the insured. He pays more for the insurance because he retains, rather than (in effect) sells, a right to obtain through litigation a recovery that may actually exceed the actual loss that (after receiving the insurance proceeds) he suffered. This is because, by virtue of the collateral benefits rule, a tort plaintiff need not deduct from the judgment he receives in his tort suit compensation for the same loss which he may have obtained from another source, such as an insurance policy."

A legal right, for example a tort victim's right to sue his tortfeasor for damages, is like a lottery ticket. Its payoff is highly uncertain. Subrogation, consistent with the objective of insurance, transfers the lottery ticket from the individual policyholder to the collectivity of policyholders. The risk is spread, and by being spread eliminated or at least greatly reduced. Subrogation also eliminates the incentive to careless behavior created by the collateral benefits rule, which by enabling the insured victim of a tort to recover for the same loss from both the insurance company and the tortfeasor may (depending on the adequacy of tort damages) make the tort victim better off than he would have been had there been no accident. n11

A common-law rule providing insurers a right to subrogation or reimbursement, absent specific provision in the policy on that subject, both implements the public policy expressed in the principle of indemnity and fills a contractual gap by effectively implying contractual terms that probably correspond with what most buyers of insurance would want, if they were fully informed and asked to make a choice. n12 Such a rule is widely followed. n13

The Made-Whole Requirement in California Law. The law of subrogation derived from the law of suretyship n14 and, where the relevant contract was silent, California law effectively treated the subrogee as a surety for the debt owed by the tortfeasor to the insured/injured party: "'The general rule is that an insurer that pays a portion of the debt owed to the insured is not entitled to subrogation for that portion of the debt until the debt is fully discharged... Until the creditor has been made whole for its loss, the subrogee may not enforce its claim based on the rights of subrogation.'" n15 The court assumed "that the parties *could*, explicitly, provide in their contract that the insurer has a priority, regardless whether the insured is first made whole." n16 But that could not be done by contract language providing: "only in *general terms* that the rights to recover damages from another are 'transferred to us.' Although it substitutes plain language ('transferred') for legalistic jargon ('subrogated'), it is no more specific or explicit than language used in older policies stating that the insured 'shall be subrogated' to the insured's rights against another. The clause does not *specifically* address the [priority] issue in this case." n17

The court contrasted that general language with more specific language that had been held sufficient in another case: "" Health Plan .. shall be entitled to the payment, reimbursement, and subrogation as provided in section C(1) *regardless of whether the total amount of the recovery of the Member .. on account of the injury or illness is less than the actual loss suffered by the Member ...*"" n18

While language of that sort is generally enforceable, enforcement may be denied when the particular circumstances render enforcement unconscionable. n19

The Exception for "Personal Insurance." The principle of indemnity presupposes a clearly defined economic loss, which can serve both as a measure of compensation and as a limit on any insurance recovery. Such a sharply defined loss is frequently absent in what is sometimes called "personal" insurance, that is, insurance on the person of the insured. Prototype examples are life insurance, accidental dismemberment insurance, and some types of disability insurance which provide for payment of a specified sum on the happening of an insured event. n20 The principal of indemnity is not applied to policies of that sort. n21

While policies providing for indemnity against medical expenses do involve the sort of sharply defined loss that

typically invokes the principle of indemnity, they are commonly treated as policies of "personal" insurance. n22 As a result, it is commonly held that an insurer under such a policy has no right of subrogation unless provided in the policy. n23 That result is said to be supported by the following reasoning:

"Subrogation rights are common under policies of property or casualty insurance, wherein the insured sustains a fixed financial loss, and the purpose is to place that loss ultimately on the wrongdoer. To permit the insured in such instances to recover from both the insurer and the wrongdoer would permit him to profit unduly thereby.

"In personal insurance contracts, however, the exact loss is never capable of ascertainment. Life and death, health, physical well being, and such matters are incapable of exact financial estimation. There are, accordingly, not the same reasons militating against a double recovery. The general rule is, therefore, that the insurer is not subrogated to the insured's rights or to the beneficiary's rights under contracts of personal insurance, at least in the absence of a policy provision so providing. Nor would a settlement by the insured with the wrongdoer bar his cause of action against the insurer. However, if a subrogation provision were expressly contained in such contracts, it probably would be enforced quite uniformly. Such a provision cannot be read into a policy by calling it an indemnity contract, however." n24

Analytically, this appears to be incorrect, as applied to coverage for medical payments. If the insured obtains a full tort recovery, by adjudication or settlement, the law considers that full compensation (putting aside for the moment any attorneys' fees and other expenses incurred in obtaining that recovery). So the recovery necessarily includes compensation for any medical expenses, and that is necessarily duplicative of the compensation provided by medical payments insurance. Such a duplicative recovery creates the sort of unjust enrichment which the principle of indemnity seeks to bar and which a right of subrogation or reimbursement could prevent. n25 But the analytic error has few practical consequences, as policies providing coverage for medical expenses almost always include subrogation or reimbursement provisions.

Implications of Tort Law Rules. A right to subrogation normally operates as a partial assignment by operation of law, entitling the subrogee to step into the shoes of the subrogor and sue the tortfeasor based on the subrogor's rights. Of course, the tortfeasor is entitled not to have the claim split between two lawsuits, but that problem can be avoided by having the insured and the insurer join in a single suit, each seeking recovery of its own portion of the claim. n26 More fundamentally, tort claims for personal injury are commonly held not assignable, a limit that would also preclude true subrogation. n27 One may question the rule against assignment, as applied to claims for medical expenses, n28 but even assuming that assignment is impermissible, the insurer should at least have a common-law right (absent a contrary policy provision) to reimbursement out of any recovery the insured may obtain, subject to the requirement that the insured be made whole, and equivalent contractual rights should be enforceable. n29 Contractual rights to reimbursement are usually enforced. n30

FURTHER BACKGROUND: THE COMMON FUND RULE

The usual rule in the United States (sometimes called the "American Rule") is that, absent a contractual or statutory provision to the contrary, each litigant must pay that litigant's own attorneys' fees incurred in the litigation. n31 One exception to this rule is the "common fund" doctrine, which "provides that when a party through active litigation creates, preserves or increases a fund, others sharing in the fund must bear a portion of the litigation costs including reasonable attorney fees. The doctrine is employed to spread the cost of litigation among all beneficiaries so that the active beneficiary is not forced to bear the burden alone and the 'stranger' (i.e. passive) beneficiaries do not receive their benefits at no cost to themselves." n32

This rule was developed in class actions by bondholders and extended to class actions generally, as well as actions by shareholders, trust beneficiaries and others pursuing common rights against third parties. n33 It is now broadly recognized. n34 It was extended to insurance subrogation/reimbursement claims: an insurer must share in the insured's

attorneys' fees if the insurer has been benefited by the services of the insured's attorney in recovering a fund from which the subrogation/reimbursement claim could be paid. n35

HOW DO ATTORNEYS' FEES AFFECT THE ANALYSIS OF WHETHER THE INSURED HAS BEEN MADE WHOLE?

Prior Law. There is not an extensive body of law addressing the impact of attorneys' fees on determination whether an insured has been made whole, permitting an insurer to proceed with recovery by subrogation or reimbursement. Much of what there is involves unanalyzed pronouncements, sometimes as dictum in cases where the precise issue was not raised. Some such cases require that the insured be made whole for both damages and attorneys' fees. n36 Other cases impose no such requirement, but do apply the common fund rule to require the insurer to share in the insured's attorneys' fees and expenses incurred in recovering from the tortfeasor. n37 In each of these cases, the court exhibits no awareness that the other rule might be applicable, so the court cannot be said to have made a choice between them. In one case, the insured was required to bear the full burden of the fees for recovering from the tortfeasor, because the common fund rule was found not to apply and the made-whole requirement was not urged. n38

Wisconsin has rejected application of the made-whole requirement in favor of applying the common fund rule: "Under Wisconsin law, [the insured] is 'made whole' even if he must pay attorney's fees out of the funds he recovers from [the tortfeasor and its insurers]. Therefore, failing to require [the subrogated insurer] to make a contribution toward [the insured's] attorney's fees does not place [the subrogated insurer] in competition with [the insured] for funds which are insufficient to make [the insured] whole." n39

Before *21st Century*, the most extensive consideration of the issue was by Montana, which requires that the insured be made whole for both damages and attorneys' fees before the insurer can recover. One reason for this choice is the premise of the made-whole requirement itself: when either insurer or insured must suffer a loss, "the loss should be borne by the insurer for that is a risk the insured has paid it to assume." n40 In affirming that this rule effectively requires the insurer to reimburse the insured for the insured's own fees out of any recovery for the subrogated claim, the court reasoned that the insurer might control the costs by having its own counsel participate in the suit against the tortfeasor. n41 The court has also supported the made-whole requirement generally by reasoning that "the insured is the person most likely to suffer most if medical payments received must be repaid out of a third-party recovery; and .. the tortfeasor's carrier may consider that the injured person has already been paid medical expenses and can make a smaller offer which allows that such payment has already been made." n42 The latter reasons have no specific relevance to the attorneys' fees issue.

A California federal court has supported including attorneys' fees in the made-whole calculation on the basis that forcing the insured to fund the litigation while the insurer waits to see if there is a recovery allows the insurer to gamble with the insured's money. n43 But that reasoning would apply only if the insured were paying a noncontingent fee. If the lawyer is hired on a contingent fee, the lawyer willingly assumes the risk of nonrecovery. Moreover, if the insurer does not participate by its own counsel and if the common-fund rule is applied, the insured's lawyer will be compensated for both the insured's and the insurer's portion of the recovery. So the suggested inequity simply will not arise in ordinary cases. Moreover, California medical payment insurers have no choice but to sit out the tort case, and lawyers for insureds would not want them to participate. n44

The California Supreme Court's Decision in *21st Century*. Addressing the argument that the insurer is the party that has been paid to assume a risk, the California Supreme Court responded that "in the context of med-pay insurance the insured has not contracted for the insurer to assume any risk beyond the insured's medical payments. Quintana's lower premiums provide her only with medical payments in the event of an accident. If she decides to pursue a claim against the tortfeasor for her uninsured damages, she should be responsible for the attorney fees and costs necessary to recover those damages. In sum, Quintana has not paid *21st Century* to assume the risk of paying attorney fees for

uninsured losses on her behalf." n45

Other arguments were equally unavailing. While Quintana, the insured, argued that the collateral source rule effectively allowed collateral source payments to partially supply the compensation to the injured party consumed by attorneys' fees, the California Supreme Court responded that that rule "addresses the distribution of attorney fees between a plaintiff and a tortfeasor defendant, not between an insured and an insurance company." n46 Nor did the insurer's duty of good faith and fair dealing require it to limit its reimbursement claim, because the contract expressly authorized that claim. n47

The court summarized its reasons for concluding that the attorneys' fees were best dealt with by the common-fund rule, not the made-whole requirement. First, "were we to adopt Quintana's position we would effectively shift the burden of paying attorney fees in personal injury actions from insureds to first party insurers because insurers would have to forgo reimbursement in order to account for the insureds' attorney fees." n48 This would presumably result in higher premiums for medical payment insurance. Second, "pro rata allocation of attorney fees that is made under the common fund doctrine is equally applicable in the med-pay context because it adequately balances the interests of insureds and insurers. The insured receives the benefit of expedient medical payments at lower premiums, and he or she may retain the insurance payments if he or she does not recover directly from the third party tortfeasor." n49

Where, as in Quintana's case, the insured does recover full tort compensation, "a pro rata apportionment requires the insurer to account for its fair share of the attorney fees by reducing the amount of reimbursement to cover some portion of those fees. The responsibility for attorney fees is therefore properly allocated according to what the parties contracted for and the risks each party agreed to bear." n50

Justice Kennard concurred, relying both on the normal rule that each litigant must bear its own litigation costs and on the fact that the insured's proposed rule would "convert medical payment coverage into legal expense coverage, and it would result in higher premiums for California purchasers of automobile insurance coverage." n51 Because medical payments coverage is typically for much smaller amounts than the cost of tort litigation, the insured's proposed rule would essentially nullify the subrogation right. n52

The premise of the American Rule against fee shifting is that "full compensation for a wrongful injury ordinarily does not include reimbursement of litigation costs." n53 There was no greater reason to shift the burden of litigation costs to a medical payments insurer than to the tortfeasor. Rather, "[e]quitably apportioning attorney fees between insurer and insured, so that the insurer pays only the litigation expenses attributable to recovery of the benefits it was contractually obligated to provide, more appropriately complies with the dictate of the American rule that parties must bear their own litigation expenses." n54 This also corresponded to California's statutory rule regarding sharing by subrogated workers compensation insurers in the fees for tort recoveries. n55

Under the rule applied by the court, Quintana retained the full \$1000 in payment for the insured loss, and 21st Century paid the full litigation costs attributable to recovering that amount. Quintana had to absorb the litigation costs associated with the \$5000 of uninsured loss, but she was no worse off in that regard than if she had not had the medical payments insurance. n56

Justice Werdegar also concurred. n57 She reasoned that, if the insurer were permitted to participate in the tort action, as a subrogation right would ostensibly entitle it to do, it would also be entitled to share in any tort recovery. Subrogation and reimbursement should produce equivalent results, and the rule Quintana advocated would make them different. Like the majority and Justice Kennard, she concluded that Quintana's rule would improperly convert medical payment insurance into legal expense insurance. n58

CONCLUSION

The California Supreme Court is the first court to fully analyze the role of attorneys' fees in the made-whole requirement. It has correctly gone beyond observing that the insurer was paid to bear risk and considered *what risk* the

insurer was paid to bear. In that light, the common-fund rule, not the made-whole requirement is the proper way to equitably apportion attorneys' fees between insurer and insured. This persuasive opinion should and likely will be followed in many future cases.

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n1 *21st Century Ins. Co. v. Super. Ct.*, 98 Cal. Rptr. 3d 516 (Cal. 2009).

n2 That aspect of the case is discussed in Barker, William T., "Sonnenschein Nath & Rosenthal on Insurance Subrogation and the Made-Whole Rule: When Does and Should It Apply Under State Law," *LexisNexis Emerging Issues Analysis*, 2009 *Emerging Issues* 4529 (Oct., 2009).

n3 *21st Century Ins. Co.*, at 519 & n.2.

n4 *Id.* at 519-20.

n5 Robert E. Keeton & Alan I. Widiss, *Insurance Law* § 3.1, at 135 (1988).

n6 *Id.*

n7 Restatement (Second) of Torts § 920A(2) ("Payments made to or benefits conferred on the injured party from other sources [than the tortfeasor or others acting on the tortfeasor's behalf] are not credited against the tortfeasor's liability, although they cover all or a part of the harm for which the tortfeasor is liable.").

n8 John G. Fleming, *The Collateral Source Rule and Contract Damages*, 71 Cal. L. Rev. 56, 82 (1983) (recognizing that availability of subrogation "is widely considered the optimal solution for the whole problem of collateral benefits on the ground that it prevents both the defendant from taking an undeserved advantage of the benefit and the plaintiff from being overcompensated"); see also *Lake Erie & W.R. Co. v. Falk*, 56 N.E. 1020 (Ohio 1900) (The plaintiff's assertion that he was entitled to recover for his full loss against the defendant railroad and also retain the proceeds that his insurance carrier sought by way of subrogation "could not be urged

successfully. . . . Good morals and important considerations of public policy forbid that conflagrations should be made profitable.").

n9 Courts resisting subrogation commonly assume that the insured has paid a premium to cover the entire loss insured, with no allowance for possible recovery by way of subrogation or reimbursement. That is an unwarranted assumption. But insurers litigating the permissibility of subrogation would be well advised to make a factual showing that potential subrogation/reimbursement recoveries have been properly accounted for in setting the premium.

In fact, past losses under similar policies are typically used to project future losses for which the premium must provide, and any subrogation/reimbursement recoveries for those past losses are treated as credits against those losses, so that the projections of future losses are automatically based on net losses after recoveries.

n10 See also A Michael Polinsky, *An Introduction to Law and Economics*, 53-55 (2d ed. 1989) (where one party to the transaction is risk averse (as most insureds are) and the other is risk-neutral (as insurers are), the risk is better allocated to the risk-neutral party).

n11 *Cutting v. Jerome Foods, Inc.*, 993 F.2d 1293, 1297-98 (7th Cir. 1993) (Posner, J.).

n12 See Jeffrey E. Thomas, *The New Appleman on Insurance Law*, Library Edition, §§ 5.06[1] (public policy limits the terms to which contracting parties may agree), 5.06[2][b] (public policy influences interpretation of insurance policies), 5.05[2] (policies construed to satisfy the reasonable expectations of insureds, at least if ambiguous) (2009); *Cutting v. Jerome Foods, Inc.*, 993 F.2d 1293, 1297 (7th Cir. 1993) (made-whole rule "exists only when the parties are silent. It is a gap filler.") (Posner, J.).

n13 See Johnny C. Parker, *The Made-Whole Doctrine: Unraveling the Enigma Wrapped in the Mystery of Insurance Subrogation*, 70 *Mo. L. Rev.* 723, 724-37 (2005) (discussing legal or equitable subrogation rule commonly applied by the courts). Indiana has a statute which reduces any subrogation lien or claim regarding personal injuries or death proportionately to any reduction of the tort claimant's recovery by comparative fault or uncollectability resulting from limited liability insurance or other causes. Ind. Code § 34-51-2-19. In effect, this mandates pro rata sharing of the recovery.

n14 E.g., Jeffrey A. Greenblatt, Comment, *Insurance and Subrogation: When the Pie Isn't Big Enough, Who Eats Last?*, 64 *U. Chi. L. Rev.* 1337, 1339-40 (1997) ("Subrogation finds its roots in suretyship"); *Amer.*

Contractors Indem. Co. v. Saladino, 9 Cal. Rptr. 3d 835, 839 (Cal. Ct. App. 2004) ("Payment of a principal's debt by a surety is the prototypical situation in which the equitable right to subrogation arises. "Subrogation is the right to recover from the *debtor-obligor*. A surety, e.g., pays the principal debtor's obligation to the creditor, and in equity is substituted for the creditor, or *subrogated* to his rights against the debtor."") (quoting 11 B.E. Witkin, Summary of California Law, Equity § 169, at 849 (9th ed. 1990) (emphasis by Witkin)).

n15 *Sapiano v. Williamsburg Nat'l Ins. Co.*, 33 Cal. Rptr. 2d 659, 660 (Cal. Ct. App. 1994).

n16 *Id.* at 661.

n17 *Id.* at 662.

n18 *Id.*, quoting *Samura v. Kaiser Found. Health Plan, Inc.*, 22 Cal. Rptr. 2d 20, 23 (Cal. Ct. App. 1993). These rules apply regardless whether the insurer is seeking subrogation or reimbursement. *Progressive West Ins. Co. v. Superior Ct.*, 37 Cal. Rptr 3d 434, 442 (Cal. Ct. App. 2005).

n19 *Progressive West Ins. Co.*, 37 Cal. Rptr 3d at 27-28.

n20 See Spencer L. Kimball & Don A. Davis, *The Extension of Insurance Subrogation*, 60 Mich. L. Rev. 841, 851 (1962).

n21 Johnny C. Parker, note 13 above, 70 Mo. L. Rev. at 730-31.

n22 *E.g.*, *Cunningham v. Metro. Life Ins. Co.*, 360 N.W.2d 33, 37-39 (Wis. 1985).

n23 *E.g.*, *Amer. Pioneer Life Ins. Co. v. Rogers*, 753 S.W.2d 530, 530-33 (Ark. 1988); *Schultz v. Gotlund*, 561 N.E.2d 652, 654 (Ill. 1990); *Milbank Ins. Co. v. Henry*, 441 N.W.2d 143, 145 (Neb. 1989); *Wolters v. Amer. Republic Ins. Co.*, 827 A.2d 197, 200-02 (N.H. 2003); *Perreira v. Rediger*, 778 A.2d 429, 437-38 (N.J. 2001);

Am. Med. Sec. v. Josephson, 15 P.3d 976, 978 (Okla. Civ. App. 2000); *Schumpert v. Time Ins. Co.*, 496 S.E.2d 653, 656-58 (S.C. Ct. App. 1998).

n24 *Perreira v. Rediger*, 778 A.2d at 438, quoting 3 John Appleman & Jean Appleman, *Insurance Law & Practice* § 1675, at 495-97 (1967).

n25 To be sure, determination of the amount of that an insurer should be able to recover can present complicated issues. But the point here is simply that some recovery ought to be authorized on appropriate facts, even if there is no subrogation provision in the policy.

n26 See, e.g., *Cain v. State Farm Mut. Auto. Ins. Co.*, 121 Cal. Rptr. 200, 207 (Cal. Ct. App. 1975).

n27 See, e.g., *State Farm Fire & Cas. Co. v. Knapp*, 484 P.2d 180, 185 (Ariz. 1971); *21st Century Ins. Co. v. Super. Ct.*, 98 Cal. Rptr. 3d 516, 518 (Cal. 2009); *Allstate Ins. Co. v. Reitler*, 628 P.2d 667, 670 (Mont. 1981). But see *Aetna Cas. & Sur. Co. v. Assocs. Transports, Inc.*, 512 P.2d 137, 142-43 (Okla. 1973) (even though personal injury claim is ordinarily nonassignable, where tortfeasor had knowledge of insurer's rights and settled with insured without providing for insurer's claim, insurer entitled to sue on claim for medical payments it had made).

n28 See, e.g., *Peller v. Liberty Mut. Fire Ins. Co.*, 34 Cal. Rptr. 41, 42 (Cal. Ct. App. 1963) (noting such questions but disposing of them on the ground that the legislature had codified the prohibition on assignment).

n29 E.g., *Progressive West Ins. Co. v. Superior Ct.*, 37 Cal. Rptr 3d 434, 442 (Cal. Ct. App. 2005).

n30 See cases collected in Annot., *Subrogation rights of insurer under medical payments provision of insurance policy*, 19 A.L.R.3d 1054, § 3 (1968, supplemented to Oct. 14, 2009).

n31 See, e.g., *Alyeska Pipeline Serv. Co. v. Wilderness Soc'y*, 421 U.S. 240, 245 (1973).

n32 *Means v. Montana Power Co.*, 625 P.2d 32, 37 (Mont. 1981).

n33 See *Trustees v. Greenough*, 105 U.S. 527, 532-33 (1881); *Central R.R. & Banking Co. v. Pettus*, 113 U.S. 116, 127 (1885); *Sprague v. Ticonic Nat'l Bank*, 307 U.S. 161, 163 (1939); John P. Dawson, *Lawyers and Involuntary Clients: Attorney Fees from Funds*, 87 Harv. L. Rev. 1597 (1974).

n34 Restatement (Third) of Restitution & Unjust Enrichment, § 30 (Tent. Dr. No. 3 2004).

n35 See Johnny C. Parker, *The Common Fund Doctrine: Coming of Age in the Law of Insurance Subrogation*, 31 Ind. L. Rev 313 (1998); Restatement, § 30, cmt. f.

n36 E.g. *Central Nat'l Ins. Group v. Hotte*, 213 So. 2d 235, 237 (Fla. Dist. Ct. App. 1975) (insurer "'may recover from the insured only the excess, which the insured has received from the wrongdoer causing the loss, remaining after the insured is fully compensated for his loss *and the cost and expense of the recovery thereof.*" (quoting 46 C.J.S. Insurance § 1209(b)); *Shawnee Fire Ins. Co. v. Cosgrove*, 121 P. 488, 489 (Kan. 1912); *Washtenaw Mut. Fire Ins. Co. v. Budd*, 175 N.W. 231, 232 (Mich. 1919) (dictum); *United Servs. Auto. Ass'n v. Hills*, 109 N.W.2d 174, 177-78 (Neb. 1961); *St. Paul Fire & Marine Ins. Co. v. W.P. Rose Supply Co.*, 198 S.E.2d 482, 485 (N.C. App. Ct. 1973); *Ortiz v. Great So. Fire & Cas. Ins. Co.*, 597 S.W.2d 342, 343 (Tex. 1980); *Propeck v. Farmers Mut. Ins. Ass'n*, 65 S.W.2d 390, 390 (Tex. Ct. Civ. App. 1933); *Smith, Inc. v. United States Fid. & Guar. Co.*, 949 P.2d 337, 345-46 (Utah 1997).

n37 *Foremost Life Ins. Co. v. Waters*, 337 N.W.2d 29, 32 (Mich. Ct. App. 1983); *Cataldi v. Methodist Hosp.*, 747 A.2d 1239, 1242 (Pa. Super. Ct. 2000).

n38 *CNA Ins. Cos. v. Johnson Galleries, Inc.*, 639 So. 2d 1355, 1359 (1994).

n39 *Oakley v. Fireman's Fund*, 470 N.W.2d 882, 831 (1991).

n40 *Skauge v. Mountain States Tel. & Tel.*, 565 P.2d 628, 632 (1977).

n41 *DeTienne Assocs. Ltd. Partnership v. Farmers Union Mut. Ins. Co.*, 879 P.2d 704, 709 (1994).

n42 *Youngblood v. Amer. States Ins. Co.*, 866 P.2d 203, 207 (1993) (made-whole requirement is a fundamental Montana public policy overriding a contractual choice of Oregon law, which would not have imposed that requirement).

n43 *Chong v. State Farm Mut. Auto. Ins. Co.*, 428 F. Supp. 2d 1136, 1145 (2006).

n44 *21st Century Ins. Co. v. Super. Ct.*, 98 Cal. Rptr. 3d 516, 527 (Cal. 2009).

n45 *Id.*

n46 *Id.*

n47 *Id.* at 528.

n48 *Id.*

n49 *Id.*

n50 *Id.*

n51 *Id.* at 529 (concurring op.).

n52 *Id.* at 532.

n53 *Id.* at 531.

n54 *Id.*

n55 *Id.* at 532.

n56 *Id.*

n57 *Id.* at 533 (concurring op.)

n58 *Id.* at 533-35.

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Sonnenschein Nath & Rosenthal on Insurance Subrogation and the Made-Whole Rule

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Sonnenschein Nath & Rosenthal on Insurance Subrogation and the Made-Whole Rule: When Does and Should It Apply Under State Law

By William Barker

October 30, 2009

SUMMARY: Common law often qualifies the right of an insurer to be subrogated to the insured's rights to recover from any responsible tortfeasor and/or be entitled to be reimbursed out of any recovery the insured might obtain from any tortfeasor by a requirement that the insured must be made whole before the insurer is entitled to any recovery. This Emerging Issues Analysis examines and evaluates these various rules applied under state insurance law.

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ARTICLE: Insurance policies commonly provide that, when benefits are paid for losses like damage to property or medical expenses, then the insurer is subrogated to the insured's rights to recover from any responsible tortfeasor and/or is entitled to be reimbursed out of any recovery the insured might obtain from any tortfeasor. Even without express provisions in the policy, the common law often would grant similar rights, but typically qualified by a requirement that the insured must be made whole before the insurer is entitled to any recovery. In *21st Century Insurance Co. v. Superior Court*, n1 the California Supreme Court (1) confirmed prior California precedent presumptively applying the "made-whole" requirement to a contractual subrogation/reimbursement provision and (2) decided that, in considering whether the insured has been made whole, one does not consider attorneys' fees the insured incurred to obtain any recovery. Rather, one utilizes the common-fund doctrine to charge a share of the attorneys' fees against the insurer's portion of the recovery.

While the second point was the major focus of the decision, there is a diversity of views among jurisdictions, on the application of the "made-whole" rule to contractual subrogation/reimbursement. This commentary examines and evaluates the various rules applied. A separate commentary will examine this issue as it affects employee benefit plans governed by the Employee Retirement Income Security Act ("ERISA"), where there is a different division of views. The role of attorneys' fees in the made-whole calculation will be examined in yet another commentary.

I. THE CASE

Silvia Quintana was insured by 21st Century, with coverage that included benefits for up to \$1000 in medical

payments resulting from any auto accident. That coverage provided that "[i]f we make any payment under this Part and the person insured .. recovers damages .., the person insured shall [Paragraph] 1. hold in trust for us the proceeds of the recovery; and [Paragraph] 2. reimburse us to the extent of our payment." n2

Quintana had an auto accident, was paid \$1000, and then settled her tort claim for \$6000, of which she was obliged to pay \$2106.50 in attorneys' fees and costs ("fees"). 21st Century then sought reimbursement. Quintana paid \$600, with the \$400 deduction representing an allocation of the fees she had incurred, an allocation accepted by 21st Century. She then filed a class action seeking to recover the payment, on the ground that no recovery could lawfully have been requested unless she had been made whole, which she said she had not been (because of the amounts she had paid for fees). n3 21st Century demurred to the complaint, the superior court overruled the demurrer, and court of appeal issued on writ of mandate directing the superior court to sustain the demurrer. The supreme court affirmed.

II. BACKGROUND: INSURANCE SUBROGATION AND THE MADE-WHOLE REQUIREMENT

A. The Made-Whole Requirement, the Principle of Indemnity, and the Collateral Source Rule

One of the doctrines of insurance law is the "principle of indemnity," "[t]he concept that insurance contracts shall confer a benefit no greater in value than the loss suffered by an insured." n4 As a leading treatise explains:

[I]t is now a generally accepted fundamental tenet of insurance law that opportunities for net gain to an insured through the receipt of insurance proceeds exceeding a loss should be regarded as inimical to the public interest. In other words, insurance arrangements are structured to provide funds to offset a loss, either wholly or partly, and the payments made by an insurer generally are limited to an amount that does not exceed what is required to restore the insured to a condition relatively equivalent to that which existed before the loss occurred. n5

The principle of indemnity coexists with the collateral source rule, whereby a tortfeasor is liable for all damages suffered by the injured party, whether or not those damages have been compensated by insurance or some other collateral source. n6 Allowing subrogation or reimbursement reconciles those two rules, by compensating the injured party's loss, but allowing the collateral source to recover any payments made that would exceed the net loss after the tort recovery. n7 Thus, the primary burden of compensating tortious injuries is placed on the tortfeasor, with collateral sources playing a secondary role, only to the extent necessary.

The principle of indemnity serves two purposes of current significance. First, by eliminating any profit from suffering an insured loss, it avoids creating any incentive to cause such losses (as by arson) and it minimizes the incentives to take less care to avoid such losses. Second, by limiting the net amount the insurer must pay and allowing the insurer to set premiums appropriate for that net payment level, it avoids the need to charge higher premiums that would create double-recovery windfalls for some insureds at the expense of those who have no opportunity for such a double recovery. Such double recoveries are regarded as a form of unjust enrichment: while the insured has paid a premium for compensation of losses, premiums should take account of the principle of indemnity and should not include the costs of providing a net recovery in excess of the loss. n8 Paying higher premiums for a chance at a double recovery would have some elements of a lottery; rational insureds would not want to participate in such a lottery, because charges for the insurer's expenses and profits would make any expected recovery less than the cost. n9

The Seventh Circuit has summarized the case for allowing subrogation or reimbursement rights to insurers (whether or not subject to a requirement that the insured be made whole):

In the usual case the insured incurs a medical expense for which he is promptly reimbursed by the insurance company (or equivalent), which then exercises its right of subrogation and goes off on what sometimes proves to be a wild goose chase after a possible tortfeasor to whom the expense can be shifted. The insured is out of the picture—well, not entirely, because he is entitled to any excess recovery by the insurance company. Subject to this qualification, of which more later, the risk of an uncertain recovery is shifted from the individual to a specialist in bearing risk and enforcing claims—the insurance company. The price of the insurance is thereby reduced (or, equivalently, the insured can

buy more insurance for the same price) because the insurance company acquires a contingent claim by virtue of the subrogation clause. Without subrogation, a part of the risk is shifted back to the insured. He pays more for the insurance because he retains, rather than (in effect) sells, a right to obtain through litigation a recovery that may actually exceed the actual loss that (after receiving the insurance proceeds) he suffered. This is because, by virtue of the collateral benefits rule, a tort plaintiff need not deduct from the judgment he receives in his tort suit compensation for the same loss which he may have obtained from another source, such as an insurance policy.

A legal right, for example a tort victim's right to sue his tortfeasor for damages, is like a lottery ticket. Its payoff is highly uncertain. Subrogation, consistent with the objective of insurance, transfers the lottery ticket from the individual policyholder to the collectivity of policyholders. The risk is spread, and by being spread eliminated or at least greatly reduced. Subrogation also eliminates the incentive to careless behavior created by the collateral benefits rule, which by enabling the insured victim of a tort to recover for the same loss from both the insurance company and the tortfeasor may (depending on the adequacy of tort damages) make the tort victim better off than he would have been had there been no accident. n10

A common-law rule providing insurers a right to subrogation or reimbursement, absent specific provision in the policy on that subject, both implements the public policy expressed in the principle of indemnity and fills a contractual gap by effectively implying contractual terms that probably correspond with what most buyers of insurance would want, if they were fully informed and asked to make a choice. n11 Such a rule is widely followed. n12

B. The Made-Whole Requirement in California Law

The law of subrogation derived from the law of suretyship n13 and, where the relevant contract was silent, California law effectively treated the subrogee as a surety for the debt owed by the tortfeasor to the insured/injured party: "The general rule is that an insurer that pays a portion of the debt owed to the insured is not entitled to subrogation for that portion of the debt until the debt is fully discharged... Until the creditor has been made whole for its loss, the subrogee may not enforce its claim based on the rights of subrogation." n14 The court assumed "that the parties *could*, explicitly, provide in their contract that the insurer has a priority, regardless whether the insured is first made whole." n15 But that could not be done by contract language providing

only in *general terms* that the rights to recover damages from another are "transferred to us." Although it substitutes plain language ("transferred") for legalistic jargon ("subrogated"), it is no more specific or explicit than language used in older policies stating that the insured "shall be subrogated" to the insured's rights against another. The clause does not *specifically* address the [priority] issue in this case. n16

The court contrasted that general language with more specific language that had been held sufficient in another case:

"" Health Plan .. shall be entitled to the payment, reimbursement, and subrogation as provided in section C(1) *regardless of whether the total amount of the recovery of the Member .. on account of the injury or illness is less than the actual loss suffered by the Member ...*"" n17

While language of that sort is generally enforceable, enforcement may be denied when the particular circumstances render enforcement unconscionable. n18

C. The Exception for "Personal Insurance"

The principle of indemnity presupposes a clearly defined economic loss, which can serve both as a measure of compensation and as a limit on any insurance recovery. Such a sharply defined loss is frequently absent in what is sometimes called "personal" insurance, that is, insurance on the person of the insured. Prototype examples are life

insurance, accidental dismemberment insurance, and some types of disability insurance which provide for payment of a specified sum on the happening of an insured event. n19 The principal of indemnity is not applied to policies of that sort. n20

While policies providing for indemnity against medical expenses do involve the sort of sharply defined loss that typically invokes the principle of indemnity, they are commonly treated as policies of "personal" insurance. n21 As a result, it is commonly held that an insurer under such a policy has no right of subrogation unless provided in the policy. n22 That result is said to be supported by the following reasoning:

"Subrogation rights are common under policies of property or casualty insurance, wherein the insured sustains a fixed financial loss, and the purpose is to place that loss ultimately on the wrongdoer. To permit the insured in such instances to recover from both the insurer and the wrongdoer would permit him to profit unduly thereby.

"In personal insurance contracts, however, the exact loss is never capable of ascertainment. Life and death, health, physical well being, and such matters are incapable of exact financial estimation. There are, accordingly, not the same reasons militating against a double recovery. The general rule is, therefore, that the insurer is not subrogated to the insured's rights or to the beneficiary's rights under contracts of personal insurance, at least in the absence of a policy provision so providing. Nor would a settlement by the insured with the wrongdoer bar his cause of action against the insurer. However, if a subrogation provision were expressly contained in such contracts, it probably would be enforced quite uniformly. Such a provision cannot be read into a policy by calling it an indemnity contract, however." n23

Analytically, this appears to be incorrect, as applied to coverage for medical payments. If the insured obtains a full tort recovery, by adjudication or settlement, the law considers that full compensation (putting aside for the moment any attorneys' fees and other expenses incurred in obtaining that recovery). So the recovery necessarily includes compensation for any medical expenses, and that is necessarily duplicative of the compensation provided by medical payments insurance, creating the sort of double recovery which the principle of indemnity seeks to bar and which a right of subrogation or reimbursement could prevent. n24 But the analytic error has few practical consequences, as current policies or benefit plans providing coverage for medical expenses almost always include subrogation or reimbursement provisions.

D. Implications of Tort Law Rules

A right to subrogation normally operates as a partial assignment by operation of law, entitling the subrogee to step into the shoes of the subrogor and sue the tortfeasor based on the subrogor's rights. Of course, the tortfeasor is entitled not to have the claim split between two lawsuits, but that problem can be avoided by having the insured and the insurer join in a single suit, each seeking recovery of its own portion of the claim. n25 More fundamentally, tort claims for personal injury are commonly held not assignable, a limit that would also preclude true subrogation. n26 One may question the rule against assignment, as applied to claims for medical expenses, n27 but even assuming that assignment is impermissible, the insurer should at least have a common-law right (absent a contrary policy provision) to reimbursement out of any recovery the insured may obtain, subject to the requirement that the insured be made whole, and equivalent contractual rights should be enforceable. n28 Contractual rights to reimbursement are usually enforced. n29

III. UNDER INSURANCE LAW, WHEN DOES A CONTRACTUAL PROVISION OVERRIDE THE "MADE-WHOLE" REQUIREMENT?

A. Survey of Rules Adopted by Various Courts

Courts have taken a variety of approaches to the ability of contractual terms to override the made-whole rule. Many jurisdictions hold that the requirement that the insured be made whole before the insurer is entitled to recover

cannot be overridden by any contrary contractual provision. n30

Others hold that contractual language can override the made-whole rule, though they differ on the standard to be applied in applying that rule. A few say that even general subrogation language, if unambiguous, will override equitable principles. n31 Like California, most jurisdictions that allow a contract to override the made-whole rule impose a heightened requirement of clarity and explicitness for contractual language to have that effect. n32 Some have not taken a position on whether special requirements of clarity and explicitness apply. n33

Courts requiring clear and explicit contractual language typically do not consider sufficient provisions stating only that the insurer will be subrogated (without addressing priority), n34 that the insurer shall be entitled to reimbursement of "duplicate" payments (when any tort recovery is insufficient to fully compensate the insured and is not allocated to particular damages), n35 that the insurer shall be entitled to reimbursement "to the extent of [its] payment." n36 Language that has been held sufficient specifically addresses the issue of priority. n37

B. The "Made-Whole" Requirement Should Be Modifiable by Contract

As already noted, n38 many jurisdictions hold that the requirement that the insured be made whole before the insurer can recover any of its payments is imposed by law and cannot be modified by contract. But they have not justified this rule, and it appears ill-advised.

There are good reasons to think that most insureds would prefer to pay a slightly higher premium for the greater protection provided by insurance with subrogation/reimbursement rights limited by the requirement that the insured first be made whole. That is an adequate basis to apply that requirement as what is sometimes called a "default rule," applicable whenever the contract does not provide otherwise. n39 But even if that is what most insureds would prefer, not all insureds would agree. Insurance buyers could reasonably choose to pay a lower premium for the narrow coverage that results from giving the insurer priority in any third-party recovery. There is no apparent reason for courts to deny insurers the right to sell such policies to any purchasers who wish to buy them.

In analyzing whether the made-whole requirement should be applied to an ERISA benefit plan, the Seventh Circuit found the choice to present a "close question," resolved in that case by the fact that the plan gave the administrator discretion to interpret the plan, requiring deference to the administrator's interpretation precisely because the question was close. n40 The beneficiary in that case had received \$90,000 in medical benefits from the plan, had recovered \$126,000 from uninsured motorist coverage and \$500,000 on a product liability claim, and estimated her total damages at \$1 million (meaning that she had not been fully compensated). The court explained why it could be sensible to allow a reimbursement claim even where the beneficiary had not been made whole:

A "make whole" rule does not enable the insured to gamble on double recovery, as he would be doing without subrogation. The rule comes into play only if without it the operation of the subrogation clause would, by making the insured in effect pay back the policy benefits with money he has received for another loss caused by the injury that gave rise to the policy claim, leave him with an uncompensated injury. That would be the consequence of subrogating Jerome Foods to Mrs. Cutting's tort claim to the extent of the plan's medical benefits; the uncompensated nonmedical costs that she incurred as a result of the accident would be \$ 90,000 greater if subrogation is permitted. One can see why many state courts have thought that the inclusion of a boilerplate subrogation clause was not intended to have this effect—the effect, practically speaking, of curtailing coverage. To put this differently, rejection of "make whole" makes subrogation a lot like assignment. If insurance contracts required the insured to assign any tort claim he might have to the insurer, the price of the insurance would be lower but *effective* coverage would also be lower. The insured would recover only the policy limits, and not his full damages, even in a case in which a judgment had been secured against the tortfeasor, and collected, for those damages.

These arguments need not be thought decisive in favor of the make-whole rule. It is true that rejecting make whole would bring subrogation closer to assignment, but that would not necessarily be a bad thing. Assignment, by shifting the

insured's tort rights to the insurance company, reduces the price of insurance and thus enables the insured to obtain more coverage, in effect trading an uncertain bundle of tort rights for a larger certain right, which is just the sort of trade that people seek through insurance. (The counterargument is that the make-whole rule is most likely to apply in a case of catastrophic loss, such as the present, where full insurance is rare.) It can also be argued against the make-whole rule that it is administratively more complex, requiring the medical insurer to calculate the insured's total medical and nonmedical loss, and therefore that it makes insurance (or its equivalent in this case) more expensive to the insured-and makes it more expensive to him for the additional reason that he will have to pay for the additional coverage that the rule in effect provides. And no one's demand for insurance is unlimited. The counterargument on the administrative-complexity front is that subrogation (which the make-whole rule would eliminate in cases such as the present) involves an agency problem because of the insured's entitlement to any excess recovery that the insurer-subrogee obtains. The insurer, having no (or very little) interest in making money for the insured, may fail to press hard for an excess recovery. To which it can be replied that the make-whole rule simply shifts the disincentive to press hard from the insurer to the insured. n41

For present purposes, it can be assumed (as almost all courts do) that most insured would prefer that subrogation/reimbursement rights be limited by a requirement that the insured be made whole, even at the cost of a higher premium. But precisely because some insureds could reasonably prefer the cheaper premium, courts ought not to forbid contract provisions overriding the made-whole requirement.

Insurance policy language is subject to administrative regulation in all states. n42 In some the language must be approved by the regulator before it can be used, while others allow use of language unless the regulator objects. n43 Regardless of the mechanics, the regulator typically has fairly broad authority to prevent use of forms that are considered inappropriate. n44 So, insurance regulators are more appropriate authorities than courts to decide whether insurers and insureds are to be prohibited from overriding the requirement that the insured be made whole. n45

C. It Is Reasonable for State Insurance Law to Require Clear and Explicit Language to Override the "Made-Whole" Requirement

The requirement that the insured be made-whole before any subrogation/reimbursement rights arise has most impact on large claims, which are most likely to exceed a tortfeasor's insurance limits or available assets. Yet it is precisely the larger losses that most insurance buyers seek to insure against. And the additional premium cost resulting from a requirement that the insured be made whole seems likely to be relatively modest in most cases. Those facts support the widely held view that most insureds would prefer that subrogation/reimbursement rights be so limited. That, in turn, supports adoption of that requirement as a "default rule" when the contract does not provide otherwise. n46

There is a counterargument that risk-averse insureds should prefer a rule giving the insurer priority to recover on the tort claim and use the premium savings to purchase higher limits of coverage, while taking the risk of incomplete recovery for losses over the higher limit. n47 This ignores the fact that the problem may not be the monetary limit of coverage, but the scope of the coverage. The insurance policy may cover medical expenses or lost income, but (unless it is uninsured or underinsured motorist coverage) is unlikely to cover other types of damages incurred in a personal injury. In that circumstance, increasing the amount of medical expense coverage (which may already be ample) provides no protection against other types of uncompensated loss. And where medical expenses are large, nonmedical losses are also likely to be large and the tortfeasor's insurance and assets are more likely to be inadequate, so that an insurer priority on recovery could leave the nonmedical losses entirely uncompensated. If that risk could be avoided at the cost of a small additional premium for coverage with subrogation subject to a made-whole requirement, it seems likely that most insureds would prefer that to an insurer-priority rule.

Another counterargument is that the risk of incomplete recovery should be placed on the party who has the greatest role in pursuing complete recovery. n48 But in most cases, the cause of incomplete recovery will not be inadequate vigor in pursuit of the tortfeasor, but rather the inadequacy of the tortfeasor's insurance and assets to compensate a large loss. Improving litigation incentives would do little to ameliorate the fundamental problem.

If the made-whole requirement is to be the default rule, that leaves the question of whether to impose special requirements of clarity and explicitness, as do the great majority of courts that allow contractual language to override the made-whole requirement. One reason for doing so is that the contract language should be read in light of the legal background: where the language appears to do little more than confirm the common-law default rule, it can be seen as ambiguous, even if a literal reading might arguably alter the default rule. n49 On that basis, special clarity is required to avoid ambiguity. Perhaps a better rationale would be a weak version of the rule that policies should be construed to effectuate the reasonable expectations of insureds. n50 The premise would be that the default rule reflects the reasonable expectations of insureds and that any insureds who read their policies should be given fair notice by clear language that a different rule will be applied. In this way, public policy would be used to influence interpretation, without limiting the contractual freedom of the parties. n51

The fact that requirements of explicit language are so prevalent and that insurers do not seem to use such language in very many state-regulated policies n52 suggests that insurers may not regard the issue as very important. Alternatively, they may fear regulatory hostility to clear language overriding the made-whole requirement. n53 And courts may appropriately take precautions against language with that effect escaping regulatory scrutiny: if the language is clear and explicit, it is less likely to be overlooked by form reviewers.

In sum, there are good reasons for insurance law to insist on clear and explicit language to override the requirement that the insured be made whole. And doing so imposes little burden on insurers who wish to override the requirement.

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n1 *21st Century Ins. Co. v. Super. Ct.*, 98 Cal. Rptr. 3d 516 (Cal. 2009).

n2 *Id.* at 519 & n.2.

n3 *Id.* at 519-20.

n4 Robert E. Keeton & Alan I. Widiss, *Insurance Law* § 3.1, at 135 (1988).

n5 *Id.*

n6 Restatement (Second) of Torts § 920A(2) ("Payments made to or benefits conferred on the injured party from other sources [than the tortfeasor or others acting on the tortfeasor's behalf] are not credited against the

tortfeasor's liability, although they cover all or a part of the harm for which the tortfeasor is liable.").

n7 John G. Fleming, *The Collateral Source Rule and Contract Damages*, 71 *Cal. L. Rev.* 56, 82 (1983) (recognizing that availability of subrogation "is widely considered the optimal solution for the whole problem of collateral benefits on the ground that it prevents both the defendant from taking an undeserved advantage of the benefit and the plaintiff from being overcompensated"); *see also Lake Erie & W.R. Co. v. Falk*, 56 *N.E.* 1020 (Ohio 1900) (The plaintiff's assertion that he was entitled to recover for his full loss against the defendant railroad and also retain the proceeds that his insurance carrier sought by way of subrogation "could not be urged successfully. . . . Good morals and important considerations of public policy forbid that conflagrations should be made profitable.").

n8 Courts resisting subrogation commonly assume that the insured has paid a premium to cover the entire loss insured, with no allowance for possible recovery by way of subrogation or reimbursement. That is an unwarranted assumption. But insurers litigating the permissibility of subrogation would be well advised to make a factual showing that potential subrogation/reimbursement recoveries have been properly accounted for in setting the premium.

In fact, past losses under similar policies are typically used to project future losses for which the premium must provide, and any subrogation/reimbursement recoveries for those past losses are treated as credits against those losses, so that the projections of future losses are automatically based on net losses after recoveries.

n9 *See also* A Michael Polinsky, *An Introduction to Law and Economics*, 53-55 (2d ed. 1989) (where one party to the transaction is risk averse (as most insureds are) and the other is risk-neutral (as insurers are), the risk is better allocated to the risk-neutral party).

n10 *Cutting v. Jerome Foods, Inc.*, 993 *F.2d* 1293, 1297-98 (7th Cir.) (Posner, J.), *cert. denied*, 510 *U.S.* 916 (1993).

n11 *See* Jeffrey E. Thomas, *New Appleman on Insurance Law Library Edition*, §§ 5.06[1] (public policy limits the terms to which contracting parties may agree), 5.06[2][b] (public policy influences interpretation of insurance policies), 5.05[2] (policies construed to satisfy the reasonable expectations of insureds, at least if ambiguous) (2009); *Cutting*, 993 *F.2d* at 1297 (made-whole rule "exists only when the parties are silent. It is a gap filler."). *See also* note 39, below.

n12 *See* Johnny C. Parker, *The Made-Whole Doctrine: Unraveling the Enigma Wrapped in the Mystery of Insurance Subrogation*, 70 *Mo. L. Rev.* 723, 724-37 (2005) (discussing legal or equitable subrogation rule

commonly applied by the courts). Indiana has a statute which reduces any subrogation lien or claim regarding personal injuries or death proportionately to any reduction of the tort claimant's recovery by comparative fault or uncollectability resulting from limited liability insurance or other causes. Ind. Code § 34-51-2-19. In effect, this mandates pro rata sharing of the recovery.

n13 *E.g.*, Jeffrey A. Greenblatt, Comment, *Insurance and Subrogation: When the Pie Isn't Big Enough, Who Eats Last?*, 64 *U. Chi. L. Rev.* 1337, 1339-40 (1997) ("Subrogation finds its roots in suretyship"); *Amer. Contractors Indem. Co. v. Saladino*, 9 *Cal. Rptr. 3d* 835, 839 (*Cal. Ct. App.* 2004) ("Payment of a principal's debt by a surety is the prototypical situation in which the equitable right to subrogation arises. 'Subrogation is the right to recover from the *debtor-obligor*. A surety, e.g., pays the principal debtor's obligation to the creditor, and in equity is substituted for the creditor, or *subrogated* to his rights against the debtor.'") (quoting 11 B.E. Witkin, Summary of California Law, Equity § 169, at 849 (9th Ed. 1990) (emphasis by Witkin)).

n14 *Sapiano v. Williamsburg Nat'l Ins. Co.*, 33 *Cal. Rptr. 2d* 659, 660 (*Cal. Ct. App.* 1994); *Saladino*, 9 *Cal. Rptr. 3d* at 843 ("where the surety is only liable for a portion of the obligation-the principal debtor is entitled to designate how the debtor's payments to the original creditor should be applied," relying on Cal. Civ. Code § 2822), 844 ("A surety has no right to compel the debtor's payment to be credited to the portion on which the surety is liable." (quoting H. Walter Croskey, Rex Heeseman, & Susan M. Popik, Cal. Prac. Guide: Insurance Litigation, 6:3633, at 61-95 (2003) (emphasis by the court omitted))).

n15 *Id.* at 661.

n16 *Id.* at 662.

n17 *Id.*, quoting *Samura v. Kaiser Found. Health Plan, Inc.*, 22 *Cal. Rptr. 2d* 20, 23 (*Cal. Ct. App.* 1993), *cert. denied*, 511 U.S. 1084 (1994). These rules apply regardless whether the insurer is seeking subrogation or reimbursement. *Progressive West Ins. Co. v. Superior Ct.*, 37 *Cal. Rptr. 3d* 434, 442 (*Cal. Ct. App.* 2005).

n18 *Samura*, 22 *Cal. Rptr. 2d* at 27-28.

n19 See Spencer L. Kimball & Don A. Davis, *The Extension of Insurance Subrogation*, 60 *Mich. L. Rev.* 841, 851 (1962).

n20 Johnny C. Parker, note 12 above, 70 Mo. L. Rev. at 730-31.

n21 *E.g.*, *Cunningham v. Metro. Life Ins. Co.*, 360 N.W.2d 33, 37-39 (Wis. 1985).

n22 *E.g.*, *Amer. Pioneer Life Ins. Co. v. Rogers*, 753 S.W.2d 530, 530-33 (Ark. 1988); *Schultz v. Gotlund*, 561 N.E.2d 652, 654 (Ill. 1990); *Milbank Ins. Co. v. Henry*, 441 N.W.2d 143, 145 (Neb. 1989); *Wolters v. Amer. Republic Ins. Co.*, 827 A.2d 197, 200-02 (N.H. 2003); *Perreira v. Rediger*, 778 A.2d 429, 437-38 (N.J. 2001); *Am. Med. Sec. v. Josephson*, 15 P.3d 976, 978 (Okla. Civ. App. 2000); *Schumpert v. Time Ins. Co.*, 496 S.E.2d 653, 656-58 (S.C. Ct. App. 1998).

n23 *Perreira v. Rediger*, 778 A.2d at 438, quoting 3 John Appleman & Jean Appleman, *Insurance Law & Practice* § 1675, at 495-97 (1967).

n24 To be sure, determination of the amount of that an insurer should be able to recover can present complicated issues. But the point here is simply that some recovery ought to be authorized on appropriate facts, even if there is no subrogation provision in the policy.

n25 *See, e.g.*, *Cain v. State Farm Mut. Auto. Ins. Co.*, 121 Cal. Rptr. 200, 207 (Cal. Ct. App. 1975).

n26 *See, e.g.*, *State Farm Fire & Cas. Co. v. Knapp*, 484 P.2d 180, 185 (Ariz. 1971); *21st Century Ins. Co. v. Super. Ct.*, 98 Cal. Rptr. 3d 516, 518 (Cal. 2009); *Allstate Ins. Co. v. Reitler*, 628 P.2d 667, 670 (Mont. 1981). But see *Aetna Cas. & Sur. Co. v. Assocs. Transports, Inc.*, 512 P.2d 137, 142-43 (Okla. 1973) (even though personal injury claims are ordinarily nonassignable, where tortfeasor had knowledge of insurer's rights and settled with insured without providing for insurer's claim, insurer entitled to sue on claim for medical payments it had made).

n27 *See, e.g.*, *Peller v. Liberty Mut. Fire Ins. Co.*, 34 Cal. Rptr. 41, 42 (Cal. Ct. App. 1963) (noting such questions but disposing of them on the ground that the legislature had codified the prohibition on assignment).

n28 *E.g., Progressive West Ins. Co. v. Superior Ct.*, 37 Cal. Rptr. 3d 434, 442 (Cal. Ct. App. 2005).

n29 See cases collected in Annot., *Subrogation rights of insurer under medical payments provision of insurance policy*, 19 A.L.R.3d 1054, § 3 (1968, supplemented to Oct. 14, 2009).

n30 A state-by-state examination of the cases is found in Johnny C. Parker, note 12 above, 70 Mo. L. Rev. at 738-773. Prof. Parker concludes that the made-whole requirement cannot be modified by contract in Arkansas, Colorado, Connecticut, Georgia, Iowa, Louisiana, Michigan, Mississippi, Montana, Nebraska, New York, North Carolina, Oklahoma, Pennsylvania, Tennessee, and Wisconsin. *Id.* at 774.

n31 *E.g., Capitol Indem. Corp. v. Strike Zone*, 646 N.E.2d 310, 311-12 (Ill. App. Ct. 1995) (provision that insured's rights transferred "to the extent of our payment" granted insurer priority); *Stancil v. Erie Ins. Co.*, 740 A.2d 46, 49 (Md. Ct. Spec. App. 1999) (right to subrogation on paying amount due under contract governed, regardless whether the insured had been made whole); *Westfield Ins. Co. v. Rowe*, 2001 SD 87, 14-15 (provision that, upon making payment, insurer "subrogated" to insured's right to recover from another and that the insured would hold any recovery in trust and reimburse insurer "to the extent of our payment" entitled insurer to reimbursement regardless of whether insured had been made whole); *Fortis Benefits v. Cantu*, 234 S.W.2d 642, 647, 649 (Tex. 2007) ("insurer "subrogated to all rights of recovery" and has a right to reimbursement "equal to the amount we have paid").

n32 *E.g., Int'l Underwriters/Brokers, Inc. v. Liao*, 548 So. 2d 163, 165 (Ala. 1989) ("equitable principles apply to all instances of subrogation *except when the contract explicitly provides otherwise*" (emphasis added); dictum, contract at issue not analyzed because not in the record), *overruled by Powell v. Blue Cross & Blue Shield*, 581 So. 2d 772, 777 (Ala. 1990), *reinstated by Ex parte State Farm Fire & Cas. Co.*, 764 So. 2d 543, 546 (Ala. 2000); *Capps v. Klebs*, 382 N.E.2d 947, 950 (Ind. Ct. App. 1978) (to permit subrogation before the insured has been made whole, the contract must be clear, unequivocal and so certain as to admit of no doubt on the question"); *Providence Wash. Ins. Co. v. Hogges*, 171 A.2d 120, 124 (N.J. Super. Ct. App. Div. 1961) (equitable principles apply "except as modified by specific provisions in the contract"; provision that insurer subrogated to "all of insured's rights of recovery" not specific as to priority). *But see Wolfe v. Alfa Mut. Ins. Co.*, 880 So. 2d 1163, 1167-69 (Ala. Ct. Civ. App. 2003) (ordinary subrogation language sufficient to override made-whole requirement).

n33 *E.g., Valora v. Pa. Employees Benefit Trust Fund*, 939 A.2d 312, 320-322 (Pa. 2007) (equitable principles apply to contractual subrogation unless contract provides to contrary; not reaching standard for language doing so).

n34 *Wine v. Globe Amer. Cas. Co.*, 917 S.W.2d 558, 564 (Ky. 1996); *Kanawha Valley Radiologists, Inc. v. One Valley Bank, N.A.*, 557 S.E.2d 277, 281-82 (W. Va. 2001).

n35 *Blue Cross/Blue Shield v. Flam*, 509 N.W.2d 393, 398 (Minn. Ct. App. 1993) (applying federal law under ERISA plan). In 1993, the relevant law under ERISA was not well developed, so the court's view of that law likely mirrored the rule it would have applied under state law.

n36 *Capps v. Klebs*, 382 N.E.2d at 950; *Willard v. Automobile Underwriters, Inc.*, 407 N.E.2d 1192, 1193 (Ind. Ct. App. 1980); *Westendorf v. Stasson*, 330 N.W.2d 699, 701-04 (1983) (language calling for reimbursement of the reasonable value of care or services provided "to the extent of compensation benefits or damages recoverable" construed to "make[] no effort to supersede the general rules of equity"); *N. Buckeye Educ. Council Group Health Benefits Plan v. Lawson*, 2004 Ohio 4886, 21-24; *Equity Fire & Cas. Co. v. Youngblood*, 927 P.2d 572, 573, 575-76 (Okla. 1996) (applying federal law under ERISA plan; subrogation "to the extent of the plan benefit payments" and requirement of reimbursement "to the extent of plan benefits paid" did not override requirement that insured be made whole); *Amer. Med. Security v. Josephson*, 2000 OK CIV APP 127, 15-16 (under state law, provision for "automatic lien" on any recovery did not override requirement that insured be made whole). See also *Kanawha Valley Radiologists, Inc.*, 557 S.E.2d at 282 (as applied to facts, subrogation language was ambiguous as to priority).

n37 *E.g.*, *Wine*, 917 S.W.2d at 564 (insured agreed to hold recovery in trust and reimburse the insurer for its payments, retaining any amount received in excess of insurer's payments); *Lawson*, 2004 Ohio 4886, 6 (plan beneficiary agreed to reimburse plan from any recovery "irrespective of whether any such settlement or judgment may or may not provide reimbursement to me for all illnesses, injuries or other damages"; plan subrogated to the extent of any benefit payments or the amount of recovery "whichever is less").

n38 See note 30, above, and accompanying text.

n39 See, e.g., Frank H. Easterbrook & Daniel R. Fischel, *The Economic Structure of Corporate Law*, 89 *Colum. L. Rev.* 1416, 1433 (1989) (courts should choose default terms "that the parties would have selected with full information and costless contracting"). There are arguments that courts should sometimes select "penalty" default rules, not on the basis of what the parties actually want, but for the purpose of providing incentives for one party to reveal information that will allow tailoring of the transaction in a more optimal manner. See, e.g., Ian Ayres & Robert Gertner, *Filling Gaps in Incomplete Contracts: An Economic Theory of Default Rules*, 99 *Yale L.J.* 87 (1989). But the latter arguments concern contracts whose terms are bargained between the parties, and have little relevance to the sort of adhesion contracts involved in the usual insurance policy or employee benefit plan.

n40 *Cutting v. Jerome Foods, Inc.*, 993 F.2d 1293, 1298-99 (7th Cir.) (Posner, J.), *cert. denied*, 510 U.S. 916 (1993).

n41 *Id.* at 1298.

n42 Jeffrey E. Thomas, New Appleman on Insurance Law, Library Edition, § 10.02 (2009) (chapter by Carrie E. Cope).

n43 Jeffrey E. Thomas, New Appleman on Insurance Law, Library Edition, § 10.02 (2009) (chapter by Carrie E. Cope) § 10.04.

n44 Jeffrey E. Thomas, New Appleman on Insurance Law, Library Edition, § 10.02 (2009) (chapter by Carrie E. Cope) §§ 10.02-10.05.

n45 The Utah Insurance Commissioner has announced an intent to disapprove policy forms that would override the made-whole requirement. Utah Ins. Dept Bulletin 96-9 (Frequent Problems Found in Filings: Disability Lines).

n46 *See also* note 39, above, and accompanying text.

n47 *See* Jeffrey A. Greenblatt, note 13 above, 64 *U. Chi. L. Rev.* at 1359.

n48 *Id.* at 1358.

n49 For a discussion of the rule that ambiguous insurance policy provisions are construed in favor of the insured, see Jeffrey E. Thomas, The New Appleman on Insurance Law Library Edition § 5.02 (2009).

n50 See Jeffrey E. Thomas, The New Appleman on Insurance Law Library Edition § 5.05 (2009).

n51 See Jeffrey E. Thomas, The New Appleman on Insurance Law Library Edition § 5.06[2][b] (public policy influences interpretation of insurance policies).

n52 Clear and express provisions overriding the requirement that the insured be made whole appear to be more common in ERISA benefit plans.

n53 See notes 42-45, above, and accompanying text.

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McCarter and English LLP on Tax Aspects in Forming a Captive Insurance Company

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McCarter and English LLP on Tax Considerations in Forming a Captive Insurance Company: The Deductibility of Premiums

By Gary Wilcox and Adam Budesheim

October 2, 2009

SUMMARY: The deductibility of premiums is a potential tax benefit in a corporation forming a captive insurer. The court has limited the deductibility of premiums to those situations in which the insurance issued by the captive is actual insurance, not just reinsurance. A key factor is whether the economic substance of the transaction resembles actual insurance. This Emerging Issues Analysis explores how this issue has been resolved in various instances.

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ARTICLE: Although captive insurance companies are often touted as a tax benefit to the parent corporation, a number of court rulings relating to the deductibility of premiums paid to a captive have undermined dramatically the potential tax benefits of the captive for the parent. The rules governing deductibility of premiums paid to a captive defy broad categorization because the inquiry is fact-intensive. The Internal Revenue Service ("IRS") and courts focus on whether the parent has purchased "real" insurance from its captive; premiums for "real" insurance are deductible, but premiums that resemble setting reserves for self-insurance are not. This article does not attempt to evaluate the other many benefits of a captive insurer, whether tax-related or otherwise. It looks, instead, to the criteria that must be satisfied before a corporation can take tax deductions for premiums paid to a captive.

The Availability of Tax Deductions for Insurance and Self-Insurance. Assessing the tax benefits of purchasing insurance from a captive insurer requires determining where the transaction falls on the spectrum of insurance, by which a business shifts risk of loss from itself onto an insurer in exchange for payment of a premium, and self-insurance, by which the business retains its risk of loss. The federal tax code considers premiums for the purchase of insurance to be tax deductible as "ordinary and necessary expenses paid or incurred during the taxable year in carrying on any trade or business" 26 U.S.C. § 162(a); 26 C.F.R. § 1.162-1(a). Conversely, it is well-established that money put aside by a business for funding self-insurance is not tax deductible. *See Clougherty Packing Co. v. Comm'r*, 811 F.2d 1297, 1300 (9th Cir. 1987) ("[A]mounts placed into self-insurance reserves are not [tax deductible]. Instead, the self-insuring taxpayer must wait until losses actually occur, at which time the reserve funds actually paid out may be expensed and deducted from gross income."). For a business to deduct legitimately the premiums paid to its captive insurer, the transaction between the business and its captive must resemble the purchase of actual insurance rather than

self-insurance.

The Definition of Captive Insurer. Neither the federal tax code nor any federal statute defines "captive insurer." Some, but not all states, however, have codified "captive insurer" in their statutes. For example, both New Jersey and Connecticut define captive insurer as: "an insurance company owned by another organization whose exclusive purpose is to insure risks of the parent organization and affiliated companies or, in the case of groups and associations, insurance organizations owned by the insureds whose exclusive purpose is to insure risks to member organizations or group members and their affiliates." *See, e.g.*, N.J. Stat. Ann. § 17:22D-1; Conn. Gen. Stat. § 38a-91(2).

The precise definition of a captive and the scope of its functions and limitations vary from state to state. However, because the analysis of whether premiums paid to captives are tax deductible focuses on the nature of the transaction between the parent and its captive, the varying definitions of captive insurers will have little to no impact on whether premiums are tax deductible.

The Economic Substance of the Transaction. When determining whether premiums are tax deductible, courts focus on the "economic substance" of the insurance transaction between the parent and the captive. *See Mobil Oil Corp. v. United States*, 8 Cl. Ct. 555, 556 (1985). Courts employ a three-part analysis, derived from *Helvering v. LeGierse*, 312 U.S. 531 (1941), to determine whether the economic substance of the transaction resembles actual insurance or self insurance. The courts look for the presence of: (1) an "insurance risk"; (2) risk shifting and risk distributing; and (3) "commonly accepted notions of insurance." *See Ocean Drilling & Exploration Co. v. United States*, 988 F.2d 1135, 1148 (Fed. Cir. 1993).

The requirement of an "insurance risk" does not receive much discussion in the cases, likely because it is generally present in the transaction between the parent and captive. The tax court has described insurance risk as requiring that the insurer face some "hazard" and that "[i]f no risk exists, then insurance cannot be present." *AMERCO, Inc. v. Comm'r*, 96 T.C. 18, 38-39 (1991), *aff'd*, 979 F.2d 162 (9th Cir. 1992). Primarily, the "insurance risk" requirement is intended to distinguish between actual hazards and investment risks. Insurance risk, from the perspective of the insured, is that either there will be a loss or there will not be a loss. There can be no profit for the insured from that risk. An investment risk is a speculative risk that can result in either profit or loss, based on the outcome of investments, underwriting activities, etc. *See AMERCO*, 979 F.2d at 167.

Risk shifting and risk distributing have received the most attention by the courts. Risk shifting "entails the transfer of the impact of a potential loss from the insured to the insurer." If the insured has shifted its risk to the insurer, then a loss by or a claim against the insured does not affect it because the loss is offset by the proceeds of an insurance payment. *Clougherty Packing*, 811 F.2d at 1300. The risk shifting analysis focuses on the individual contract between the insured and the insurer. *Humana Inc. v. Comm'r*, 881 F.2d 247, 251 (6th Cir. 1989).

Risk distribution involves shifting the risk insured to a group of individuals. *Humana*, 881 F.2d at 251. In other words, the insurer assumes many independent risks in return for many premiums. *Clougherty Packing*, 811 F.2d at 1300. This allows the insurer "to reduce the possibility that a single costly claim will exceed the amount taken in as a premium and set aside for the payment of such claims. . . . By assuming numerous relatively small, independent risks that occur randomly over time, the insurer smoothes out losses to match more close its receipt of premiums." *Id.*

In contrast to risk shifting, the focus of risk distributing "is broader and looks more to the insurer as to whether the risk insured against can be distributed over a larger group rather than the relationship between the insurer and any single insured." *Humana*, 881 F.2d at 251.

The third factor, commonly accepted notions of insurance, has not received much discussion in the case law. Courts tend to review the overall transaction to determine whether it resembles what is commonly understood as insurance. The Federal Circuit has noted the many factors it examines in assessing whether the transaction follows commonly accepted notions of insurance: the presence of a hazard; the transaction was understood by the parties to be

insurance; contracts were written and premiums were paid; unrelated parties reinsured the policies; premiums were based on commercial rates; claims are handled appropriately; claims are paid from the insurer's own funds; the policies were valid and binding; and adequate capitalization of the insurer. *Ocean Drilling & Exploration Co. v. United States*, 988 F.2d 1135, 1151 (Fed. Cir. 1993). The last factor, adequate capitalization or the lack thereof, has been discussed by several courts, though not necessarily in the context of "commonly accepted notions of insurance," in finding that the transaction was not true insurance. See, e.g., *Gulf Oil Corp. v. Comm'r*, 914 F.2d 396, 410 (3d Cir. 1990); *Carnation Co. v. Comm'r*, 640 F.2d 1010, 1012 (9th Cir. 1981). Furthermore, courts regularly find that when the parent indemnifies the captive for any losses it might suffer, there is no actual insurance. See, e.g., *Gulf Oil*, 914 F.2d at 410; *Stearns-Roger Corp. v. United States*, 774 F.2d 414, 415 (10th Cir. 1985).

Captives as Sham Corporations. The first step in determining whether premiums paid to a captive are tax deductible is to determine whether the captive was created "for a legitimate business purpose or whether the captive was in fact a sham corporation." *Malone & Hyde, Inc. v. Comm'r*, 62 F.3d 835, 840 (6th Cir. 1995). The classic example of a captive as a sham corporation is one which is an undercapitalized foreign corporation that is "propped-up by guarantees of the parent corporation." *Id.* Some foreign jurisdictions have minimal capitalization requirements for insurance companies, which allows a parent to form a captive with insufficient capitalization to pay any significant volume of claims. *Id.* at 841. If the parent supports its undercapitalized captive through an agreement to provide further capital as necessary, see *Carnation*, 640 F.2d at 1012, the creation of the captive may be considered a sham transaction and premiums paid to that captive are not tax deductible. *Malone & Hyde*, 62 F.3d at 841.

An undercapitalized captive may be considered a sham corporation even if the parent agrees to indemnify the captive rather than provide further capitalization. In *Malone & Hyde*, the parent issued hold harmless agreements on behalf of its captive due to the inability of the captive to pay claims with its minimal capitalization. *Id.* The Sixth Circuit considered the hold harmless agreements "weaknesses" of the captive which indicated the captive was a sham corporation. *Id.*

The Pure Parent-Captive Insurer Relationship. A pure captive insures the risks of only its parent and its parent's subsidiaries or affiliates. Premiums paid by the parent to its pure captive are not tax deductible for the parent because there is no shifting of the risk from the parent. When viewed from the perspective of the insured (i.e., the parent), any risks shifted to the subsidiary are, in actuality, retained by the parent. The parent pays a premium to the captive, and that premium is intended to meet the casualty losses of the parent. As the captive pays losses claimed against the policy, the captive essentially pays the parent back the premium. See *Stearns-Roger*, 774 F.2d at 416-17. Any losses paid by the captive insurer reduce the net worth of the captive by that amount. Because the parent owns the captive, the parent's net worth likewise is reduced by the same amount. See *Ocean Drilling*, 988 F.2d at 1146 (citing *Clougherty Packing*, 811 F.2d at 1305); *Kidde Indus., Inc. v. United States*, 40 Fed. Cl. 42, 57-58 (1997). The parent, therefore, still bears the entire risk. See *Mobil Oil Corp. v. United States*, 8 Cl. Ct. 555, 567-68 (1985). Because there has been no shifting of risk, there has been no insurance transaction; the "premiums" paid by the parent are viewed more as a loss reserve and are not tax deductible. See *Clougherty Packing*, 811 F.2d at 1307; *Humana*, 881 F.2d at 251.

Captives with Multiple Owners. Some captives are owned by more than one corporation, which alters significantly the tax treatment of premiums paid to this captive. When a captive is not owned by a single corporate parent, the fortunes of the captive do not have a direct bearing on the balance sheet of a single corporate owner. Two separate Revenue Rulings by the IRS advise that when a captive is owned by multiple unrelated corporations, none of which has a controlling interest in the captive, premiums paid for insurance provided by that captive are tax deductible, even though the captive provides insurance only to its several owners. See *Rev. Rul. 78-338*, 1978-2 C.B. 107; *Rev. Rul. 2002-91*, 2002-2 C.B. 991. Because the taxpayer and the other insureds-shareholders are not related companies (even if they are involved in the same industry), the risk of loss is shifted from an individual company and distributed among the multiple shareholders that comprise the insured group. *Rev. Rul. 78-338* at 4. However, the IRS also looks to whether the captive is functioning as a legitimate insurance company, that is, it is adequately capitalized, charges premiums using recognized actuarial techniques, issues insurance contracts, investigates and pays claims, and is taxed as an insurance company. *Rev. Rule 2002-91* at 8.

The principles espoused by the above cited Revenue Rulings have been applied by a federal district court in a situation involving a far more complex ownership structure of the captive than that discussed in the Revenue Rulings. In *Crawford Fitting Co. v. United States*, 606 F. Supp. 136 (N.D. Ohio 1985), a captive was formed to provide insurance to the plaintiff and other companies. The captive was owned by four different corporations and four individuals, each of which contributed to the capitalization of the captive. The interrelationship of the corporations and the individuals and their relationships to the plaintiff corporation was quite complex. *Id.* at 138. The plaintiff corporation, Crawford, did not have an ownership interest in the captive, but the sole shareholder of Crawford, Mr. Lennon, owned at least 50% interest in each of the four corporate shareholders of the captive with the remaining ownership interest in each of the four corporate shareholders belonging to relatives of Mr. Lennon. *Id.* at 137-38. Of the four individual shareholders, three were officers or employees of Crawford and the fourth was an attorney whose firm had long been retained by Crawford. *Id.* at 138. The captive wrote a single insurance policy that provided coverage for Crawford and numerous related companies, Mr. Lennon and some of his relatives, companies owned by Mr. Lennon and his relatives, and companies that did business with Crawford but were otherwise unrelated. *Id.* Crawford paid about one-quarter of the total premium for this policy with the remainder paid by the various other insureds. *Id.* at 139.

The court ruled that the premium paid by Crawford to the captive was tax deductible because Crawford, the shareholders of the captive, and the other insureds of the captive were not so "economically related" that there was no shifting of the risk from Crawford to the captive. *Id.* at 145. The court found it significant that although Crawford was wholly owned by the same individual that had at least a 50% ownership in each of the four corporate shareholders of the captive, Crawford was *not* the parent of the captive or the parent of the corporate shareholders of the captive. *Id.* at 145-46. Therefore the risk covered by the captive's policy was shifted from Crawford to the shareholders of the captive, none of which was Crawford. The court further found it inconsequential that the individual shareholders of the captive had an employment relationship with Crawford because the individual shareholders' relationships with Crawford would not be directly impacted by the gains or losses of the captive. *Id.* at 146. The relationships of the four individual shareholders to Crawford did not in any way diminish the shifting of the risk.

Premiums Paid by a Sister Subsidiary. Several cases have addressed the situation in which a pure captive issues insurance policies to both the parent and the parent's other subsidiaries. The separate corporate existence of the subsidiaries and the parent are not ignored for tax purposes. *See Malone & Hyde*, 62 F.3d at 839 (citing *Moline Props. v. Comm'r*, 319 U.S. 436 (1943)). Therefore, the insurance transaction, with respect to the deductibility of premiums paid by the subsidiaries, is examined from the perspective of the subsidiaries as the insureds, not from the perspective of the parent.

The seminal case addressing the sister subsidiary situation is *Humana, Inc. v. Commissioner*, 881 F.2d 247 (6th Cir. 1989). *See also Kidde Indus.*, 40 Fed. Cl. at 56. In *Humana* the parent corporation and its subsidiaries operated hospitals. The parent established a captive insurer from which it purchased insurance for itself and its subsidiaries, charging the subsidiaries premiums based on their relative share of the insured risk. Although the court ruled that premiums paid by the parent to the captive for the parent's own insurance were not deductible, the court held that premiums paid by the other subsidiaries to the captive were tax deductible. *Humana*, 881 F.2d at 257. The court arrived at its decision by analyzing whether the insurance issued to the subsidiaries involved risk shifting and risk distribution.

The *Humana* court examined the relationship between the subsidiaries and the captive; the relationship of the captive and the parent were not relevant because, under *Moline Properties*, each distinct corporate entity is treated individually for tax purposes. Looking at the insurance transaction from the perspective of the insureds, the court noted that the subsidiaries owned no stock in the captive, contributed no capital to the captive, and did not make any guarantees relating to the performance of the captive. *Id.* at 253. Thus, unlike the parent-captive relationship in which each loss paid by the captive causes an identical decrease in the net worth of the parent, when the captive pays a loss, the net worth of the subsidiary is not affected by that payment; the risk is fully shifted to the captive. *Id.* (This analysis appears to hold true even if the parent company purchased insurance from the captive to cover all the subsidiaries and then charged each of the subsidiaries for its relative share of the total premiums paid by the parent. *See Humana*, 881 F.2d at 248.)

The *Humana* court also addressed whether the transactions involved risk distribution. The court's analysis focused on the captive and whether the captive had the ability to distribute the risk of any individual subsidiary over a larger group than just the captive and the subsidiary. *Id.* at 256. The court found there was risk distribution because the captive insured several separate corporations, even though the corporations were all within the same affiliated group. Losses of a single subsidiary could be spread among the several distinct corporate entities that were all the subsidiaries. *Id.* at 257.

Under the *Humana* decision, the premiums paid by subsidiaries represented an actual shift of the risk from the subsidiaries to the captive and the captive was able to distribute losses among the many subsidiaries purchasing insurance from the captive. Thus, premiums paid by subsidiaries to a captive of the parent are deductible under 16 U.S.C. § 162 as necessary and reasonable business expenses.

Although *Humana* provides a valuable tax deduction for corporations, attempts to broaden the holding in *Humana* have not met with success. In *Kidde Industries*, the parent purchased insurance from unaffiliated insurers which then reinsured a portion of that risk with the parent's captive. Other subsidiaries of the parent were given the option of participating in the insurance program underwritten by the unaffiliated insurer and reinsured by the captive. *Kidde Indus.*, 40 Fed. Cl. at 45. The parent sought to expand the ruling of *Humana* by arguing that not only were the premiums paid by the subsidiaries tax deductible, but the premiums paid by the parent to purchase insurance for the divisions within the parent's own corporate structure were also deductible. *Id.* at 56. The court's analysis considered the perspective of each separate corporate entity when determining whether the premiums were deductible. *Id.* at 58. Following *Humana*, the court ruled that the premiums paid by the subsidiaries were tax deductible, because from their perspective, the insurance purchased from the captive by an individual subsidiary shifted risk away from that subsidiary into a pool with the risks of other entities in which that subsidiary did not have an ownership interest. *Id.* at 56. The court rejected the parent's argument that premiums paid to purchase insurance for the parent's own divisions were tax deductible. From the perspective of the parent, the insurance purchased by the parent did not shift the risk away from the parent; the risk was shifted into a pool with the risks of other entities wholly owned by the parent. *Id.* at 57-58.

Reinsurance and Captive Insurers. Reinsurance and captive insurers intersect in two possible ways: either the captive reinsures policies issued to the parent by an insurer unaffiliated with the parent, or the captive purchases reinsurance for the policies to the parent from an unaffiliated reinsurer. The former has been addressed in a number of cases, all of which hold premiums paid to an unaffiliated insurer that substantially reinsures its policies with the parent's captive are not tax deductible. While the latter situation has never been addressed directly by the courts, dicta in one case, as well as the three-part test for determining whether a transaction is insurance or self-insurance, strongly suggest that premiums paid to a captive insurer that substantially reinsures the policy the captive issued to its parent are tax deductible.

Several cases involving captive insurers have addressed the same basic factual pattern -- the parent company creates a captive insurer; the parent company then purchases insurance from an unaffiliated insurer; the unaffiliated insurer then cedes most of that risk to the captive. See *Malone & Hyde*, 62 F.3d at 836; *Carnation*, 640 F.2d at 1012; *Clougherty*, 811 F.2d at 1299; *Gulf Oil*, 914 F.2d at 410. In each of these cases, the courts disallowed as deductions that portion of the premium paid to the unaffiliated insurer that was subsequently ceded to the captive. Although payment of premiums to the unaffiliated insurer was a true shifting of risk, the unaffiliated insurer then shifted some of that risk to the captive. In effect, the parent was paying premiums to the captive, but through the medium of the unaffiliated insurer. All the risk the unaffiliated insurer shifted onto the captive was, in essence, being shifted back to the parent.

Several of the above-cited reinsurance cases have an additional element to support the courts' determinations that there was no risk shift. In *Carnation*, the parent formed a minimally capitalized captive to which the parent's unaffiliated insurer ceded a portion of the parent's risk. *Carnation*, 640 F.2d at 1012. Because the undercapitalization of the captive jeopardized the captive's ability to cover losses, the parent agreed, at the unaffiliated insurer's behest, to provide additional capital to the captive if requested by the captive. *Id.* Similarly, in both *Malone & Hyde* and *Gulf Oil*, the parent corporations formed captives which reinsured some of the parents' risks underwritten by unaffiliated insurers.

Malone & Hyde, 62 F.3d at 836; *Gulf Oil*, 914 F.2d at 410. The parents then issued hold-harmless agreements and guarantees to the unaffiliated insurers that the parent's would indemnify the insurers for any losses the captives failed to pay. *Malone & Hyde*, 62 F.3d at 836; *Gulf Oil*, 914 F.2d at 410. In all three cases, the courts ruled that agreements to capitalize or indemnify indicated there was no risk transfer and premiums paid to the unaffiliated insurer could not be deducted. *Malone & Hyde*, 62 F.3d at 842-43; *Gulf Oil*, 914 F.2d at 412; *Carnation*, 640 F.2d at 1013.

The reinsurance-captive situation that has received little attention is when the parent purchases insurance from the captive, but then the captive cedes that risk to an unaffiliated reinsurer. While it does not appear that any court has ruled on the issue directly, one federal court suggests that the IRS does not challenge such deductions. In *Crawford Fitting Co.*, the parent purchased a \$1.5 million policy from its captive. The captive retained \$100,000 of the risk and reinsured the balance with an unaffiliated insurer. *Crawford*, 606 F. Supp. at 139. The parent then sought to deduct the entire amount of the premium paid to the captive. The IRS disallowed a portion of the deduction, but only the portion based upon the \$100,000 of risk retained by the captive. *Id.* The Court noted, "It is undisputed that to the extent [the captive] reinsured the remainder of the risk, in the amount of \$1,400,000.00, with . . . an unrelated insurance company, [the parent] is entitled to a deduction for the insurance premium for that amount of coverage. This reinsurance arrangement neutralized the risk borne by [the captive] to the extent of that amount." It is undisputed that to the extent [the captive] reinsured the remainder of the risk, in the amount of \$1,400,000.00, with . . . an unrelated insurance company, [the parent] is entitled to a deduction for the insurance premium for that amount of coverage. This reinsurance arrangement neutralized the risk borne by [the captive] to the extent of that amount." *Id.* at 141.

This result is fully in accord with the cases discussed above because there is both risk shifting and risk distributing. Risk shifting is clearly present. The case law makes clear that the purchase of insurance by the parent directly from its captive is not true insurance because the risk is ultimately retained by the parent. When the captive cedes that risk to an unaffiliated reinsurer, the risk which had previously been retained by the parent is then shifted to an unaffiliated party. Because the risk is no longer retained by the parent directly or through its captive, a true risk transfer has occurred (at least to the extent of the ceded risk). Furthermore, it seems beyond dispute that the risk distribution will also occur since the reinsurer will, presumably, have many other clients across which to spread the risk.

Captive Insurers with Unrelated Business. Several courts have allowed a parent to deduct premiums paid to a captive when the captive writes a substantial amount of insurance covering unrelated entities. The courts have determined that the substantial unrelated business of the captive creates a pooling of risk with entities unaffiliated with the parent, thereby shifting the risk of the parent onto the general pool. The Seventh Circuit cited with approval the testimony of an expert witness that "insurance does not shift risk so much as the pooling transforms and diminishes risk." *Sears, Roebuck & Co. v. Comm'r*, 972 F.2d 858, 863 (7th Cir. 1992). The Ninth Circuit explained more fully: "[W]hen the pool consists of a substantial amount of dollars, and risk, from those outside the parent and its affiliates, there is a true shift of the risk, even though the parent could suffer somewhat if the captive made a payment on account of an insured's loss. In a real sense, the parent's risk has been placed with the captive and thence spread among all of those in the pool." *AMERCO*, 979 F.2d at 167. Because the captive pools the parent's risk with the risks of other unaffiliated insureds, the risk of the parent is no longer borne by the parent. It is, instead, borne by the entire pool of insureds that have purchased insurance from the captive.

The size of the pool can have an impact on whether there is a true risk shift. In *Gulf Oil*, the court held that the 2% of net premiums the captive received from parties unrelated to the parent was *de minimis* and did not create a sufficiently large pool to truly transfer risk. *Gulf Oil*, 914 F.2d at 412. Although the courts have not defined a specific percentage of unaffiliated business necessary to shift risks, the Ninth Circuit has held that unaffiliated business that makes up as little as 29% of the captive's total insurance business is enough for a true risk shift. *See Harper Group v. Comm'r*, 979 F.2d 1341, 1342 (9th Cir. 1992) (noting that the captive's unrelated business accounted for 29% to 33% of its total insurance business); *see also Ocean Drilling*, 988 F.2d at 1150 (noting that the captive's unrelated business accounted for 44% to 66% of its total insurance business); *AMERCO*, 979 F.2d at 164 (noting that the captive's unrelated business accounted for 52% to 74% of its total insurance business).

The caveat to this discussion of captives with unrelated business is that under the definition of a captive insurer in some states, the captive cannot have any unrelated business -- captives are limited, by definition, to issuing insurance to their parents and other affiliated companies. See N.J. Stat. Ann. § 17:22D-1. The Seventh Circuit has suggested the possibility that insurers with unrelated business are not captives, noting that a subsidiary insurer, of which 99.75% of its insurance business was unaffiliated, "put[the parent's] risks in a larger pool, performing one of the standard insurance functions in a way that a captive insurer does not." *Sears, Roebuck*, 972 F.2d at 863. The other courts, however, have classified as captives insurers with a substantial amount of unrelated business.

Conclusion. While the possibility of deducting premiums paid to captives can provide substantial tax benefits to parent corporations, the instances in which those premiums are deductible are fairly limited. The premiums can only be deducted when the captive insurer is not a sham and the parent can establish that purchasing insurance from the captive is a true risk shift and risk distribution.

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Sonnenschein Nath & Rosenthal On Emcasco Ins. Co. v. Nationwide Mut. Ins. Co.

2009 Emerging Issues 4376

Sonnenschein Nath & Rosenthal LLP On Illinois Emcasco Insurance Company v. Nationwide Mutual Insurance Company: Illinois Appellate Court Holds Insurer Communications With Its Coverage Counsel Privileged, Creates Appellate Split

By Daniel E. Feinberg

September 30, 2009

SUMMARY: Insurers and insureds in declaratory judgment actions pending in Illinois courts assume that attorney/client communications and work product are protected from discovery. In *Illinois Emcasco Ins. Co. v. Nationwide Mut. Ins. Co.*, 2009 Ill. App. LEXIS 760 (Ill. Ct. App. Aug. 6, 2009), the Appellate Court has rejected that communications between an insurer and its own separate coverage attorneys regarding insurance coverage issues is protected.

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ARTICLE: In *Illinois Emcasco Ins. Co. v. Nationwide Mut. Ins. Co.*, 2009 Ill. App. LEXIS 760 (Ill. Ct. App. Aug. 6, 2009), the Appellate Court of Illinois considered whether communications between an insurer and its own separate coverage counsel in a declaratory judgment action were protected by the attorney/client privilege. Disagreeing with another division of the Court, it held that they indeed are protected.

The Case

Illinois Emcasco sued Nationwide for contribution with respect to the payment of a verdict against a common insured. Nationwide counterclaimed, alleging that Illinois Emcasco was obligated to exhaust its coverage before Nationwide's coverage might be implicated. Nationwide also alleged that Illinois Emcasco acted in bad faith allegedly by steering liability toward their common insured, so it would not have to bear responsibility for all of the liability (had the liability properly been attributed to another of Illinois Emcasco's insureds). During discovery, Nationwide sought production of communications between Illinois Emcasco and its coverage counsel, which Illinois Emcasco refused to produce on attorney/client privilege grounds.

Nationwide filed a motion to compel, and the trial court granted that motion relying primarily on *Western States Insurance Co. v. O'Hara*, 357 Ill. App. 3d 509, 828 N.E.2d 842 (Ill. Ct. App. 2005), wherein another division of the Appellate Court had ruled that the common interest doctrine applied to defeat privilege claims with respect to

communications between an insurer and its own separate coverage counsel regarding settlement of an underlying claim. Illinois Emcasco appealed, and the Appellate Court reversed.

Waste Management

Determination of the privilege issue turned on interpretation of the Illinois Supreme Court's decision in *Waste Management, Inc. v. International Surplus Lines Ins. Co.*, 144 Ill. 2d 178, 579 N.E.2d 322 (Ill. 1991). In *Waste Management*, the insurers and insureds filed competing declaratory judgment actions with respect to the parties' respective rights and obligations under certain environmental impairment liability policies. After the actions were consolidated, the insurers sought production of the insureds' underlying defense counsels' files. The insureds objected, asserting that the files were protected by the attorney/client privilege and work product doctrine. The trial court ordered the insureds to produce certain of the files, and the Appellate Court affirmed in part and reversed in part, ruling that certain of the files should be produced subject to in camera inspection by the court. The Supreme Court concluded that none of the files were protected, making them discoverable, subject to in camera inspection.

The *Waste Management* Court first found that underlying defense counsel's services were "at issue" in the coverage case and thus discoverable because "it is the very conduct of defense counsel in the underlying litigation which is the basis of insurers' declaratory judgment action and [their] defense to insureds' declaratory judgment action." *Waste Management*, 144 Ill. 2d at 190-91, 579 N.E.2d at 327. Next, the Supreme Court held that the insurance policies' cooperation clauses mandated the files' production even though the underlying litigation had concluded. *Id.* at 192, 579 N.E.2d at 328 ("In light of the plain language of the cooperation clause in particular, and language in the policy as a whole, it cannot seriously be contended that insureds would not be required to disclose contents of any communications they had with defense counsel representing them on a claim for which insurers had the ultimate duty to satisfy"). Finally, the Court ruled that the common interest doctrine precluded application of any privilege or protection that otherwise might have applied:

On these facts, a less flexible application of the [common interest] doctrine effectively defeats the purpose and intent of the parties' agreement. Insureds and insurers share a special relationship; they are in privity of contract. In a limited sense, counsel for insureds did represent both insureds and insurers in both of the underlying litigations since insurers were ultimately liable for payment if the plaintiffs in the underlying action received either a favorable verdict or settlement. To deny discovery in this instance would be to disregard considerations of public policy which require encouragement of full disclosure by an insured to his insurer. [*Id.* at 194-95, 579 N.E.2d at 329.]

The Supreme Court, however, specified that its holding does **not** apply to communications or product relating to the insurance coverage dispute between the insurers and insureds:

We hold, only, that the attorney-client privilege and work product doctrine are not applicable to bar disclosure of defense counsel's files in either the Miller or Nunn litigations. The protections are, nonetheless, available to bar disclosure of any communications or materials generated in preparation for the present declaratory judgment action. [*Waste Management*, 144 Ill. 2d at 200-01, 579 N.E.2d at 331-32.]

Western States

In *Western States*, the Appellate Court applied *Waste Management* to insurer communications with coverage counsel. In that case, the insured was involved in an automobile accident that injured several people. The insured's liability insurer, *Western States*, exhausted its policy limits by settling one of multiple bodily injury claims; thereafter, the insureds were sued in a lawsuit filed by a different (non-settling) claimant injured in the accident. After retaining defense counsel to defend the insureds in the lawsuits under a reservation of rights, *Western States* filed a declaratory judgment action seeking a declaration that it had no duty to defend or indemnify with respect to that lawsuit because its policy limits had been exhausted by the previous settlement. The insureds filed a counterclaim, alleging breach of contract and bad faith failure to settle the current non-settled claims. During discovery, the insureds sought production

of Western States' settlement-related communications with its separate coverage counsel, asserting that the insurer's settlement with one of the claimants was "at issue," and that they had a "common interest" in attorney/client communications with respect thereto. Western States claimed that these materials were protected both by the attorney/client privilege and the work product doctrine.

The Appellate Court affirmed the trial court's mandate to produce the documents due to what it perceived as a parallel to the factual situation in *Waste Management*:

We find the common-interest doctrine applies. Like the insured and insurers in *Waste Management*, Western States and the O'Haras shared a common interest in settling or defeating the Lovelace claim. The Tressler firm, though not representing the O'Haras, was sought to give advice on settling this claim -- a claim in which the O'Haras, as the insureds, had an interest. Under *Waste Management*, both the insured and the insurer do not have to be privy to or involved in the communications with counsel for counsel to be acting in the interests of both. [*Western States*, 357 Ill. App. 3d at 538-39, 828 N.E.2d at 848-49.]

Justice Cook dissented:

The present case does not involve combined representation, disclosure from an attorney whom the insurer retained to defend a lawsuit for the insured but disclosure from the insurer's separate attorney. In fact, the O'Haras, during oral argument, suggested that Western States' communications with in-house general counsel would be equally discoverable with the discovery of the Tressler firm ordered here. [*Western States*, 357 Ill. App. 3d at 522, 828 N.E.2d at 852 (dissenting op.).]

Illinois Emcasco

After analyzing the *Waste Management* and *Western States* decisions, the Illinois Emcasco Court ruled that the Western State Court's extension of the common interest doctrine to communications between an insurer and its own separate coverage counsel conflicted with the Supreme Court's decision in *Waste Management*:

[T]he Illinois Supreme Court consistently distinguished between non-privileged communications regarding the underlying litigation, and privileged communications regarding the coverage issues that could arise in a subsequent declaratory judgment action. The *Waste Management* court preserved the privilege for coverage issues, despite the fact that discovery was directed at counsel directly throughout the underlying litigation. [Illinois Emcasco, 2009 Ill. App. LEXIS at * 14.]

Accordingly, Illinois Emcasco concluded that the attorney/client privilege protected the communications between Illinois Emcasco and its own separate coverage attorneys regarding insurance coverage issues. Additionally, pursuant to *Waste Management*, the Illinois Emcasco Court ordered the trial court to conduct an in camera review to resolve any disputes over which communications are privileged:

We would be equally mistaken to assume that coverage counsel never makes communications in the common interest of the insurer and insured. The Illinois Supreme Court resolved the issue by providing that the circuit court would conduct an in camera inspection of the documents sought and exclude from disclosure those entitled to protection. [Illinois Emcasco, 2009 Ill. App. LEXIS at * 15 (emphasis in original); citing *Waste Management*, 144 Ill. 2d at 200-01, 579 N.E.2d at 331-32.]

Implications

Illinois Emcasco decision is noteworthy because it recognized the protections that the Supreme Court of Illinois provided to attorney/client communications or attorney work product generated with respect to a pending insurance coverage action. It pointed out the conflict between *Western States* and *Waste Management*, and that *Western States* "mistakenly assumes that coverage counsel always acts for the mutual benefit of the insurer and the insured." Illinois

Emcasco, 2009 Ill. App. LEXIS at * 15. The Western States Court failed to understand the limitation that the *Waste Management* Court placed on its ruling, and somehow found it appropriate to extend the common interest doctrine to communications that an insurer had with its own separate coverage attorneys regarding insurance coverage issues, where there ordinarily is no common interest. Until now, Illinois circuit courts have been bound by Western States' interpretation of *Waste Management*. See *People v. Carpentar*, 228 Ill. 2d 250, 260, 888 N.E.2d 105, 111-12 (Ill. 2008) ("In Illinois, the decisions of an appellate court are binding precedent on all circuit courts regardless of locale; therefore, until the Supreme Court says otherwise, an applicable appellate court decision must be followed by the circuit courts").

As a result, Western States provided insurance litigants with means to try and discover their adversary's communications with their separate coverage counsel under the guise that separate coverage counsel somehow acts for the mutual benefit of the insurer and insured if the communication or product somehow relates to an underlying claim. Circuit courts are now free to follow Illinois Emcasco, and given its support by *Waste Management*, should do so. The Illinois Emcasco Court thus provided insurance litigants (especially insurers) with an additional basis for resisting adversary attempts to discover communications with coverage counsel that was retained to represent only one of the parties with respect to insurance coverage issues.

Moreover, Illinois Emcasco Court created an acknowledged conflict within the Illinois Appellate Court as to the discoverability of communications with or product generated by attorneys retained to represent one party to an insurance coverage dispute. Thus, it is quite plausible that the Supreme Court of Illinois will accept review to resolve that conflict. Should that happen, policyholders could well ask the Supreme Court to re-examine the *Waste Management* decision as a whole, in light of its failure to find acceptance in other jurisdictions. At a minimum, it would clarify the law on privilege for coverage counsel.

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McCarter and English LLP on Claims-Made-and-Reported Policies

2009 Emerging Issues 4190

McCarter and English LLP on Notice and Reporting Requirements in Claims-Made and Claims-Made-and-Reported Policies: A Potential Trap for Both Courts and Policyholders

By Anthony Bartell and Craig W. Davis

August 28, 2009

SUMMARY: Both "pure" claims-made and claims-made-and-reported policies require that, for coverage, a claim must be made against the insured during the policy period. Claims-made-and-reported policies further require that the claim also be reported to the insurer during the policy period. Whereas the notice-prejudice rule arguably does not apply to claims-made-and-reported policies, the rule should always be applied to pure claims-made policies.

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ARTICLE: INTRODUCTION. Many an unsuspecting liability policyholder has tendered to its insurer what, by all accounts, appears to be a legitimate coverage claim, only to have the insurer deny or reserve coverage because the policyholder allegedly gave notice of the claim too late. Indeed, a hair-trigger invocation of the "late notice" defense seems to constitute the standard operating procedure for insurers disclaiming or reserving rights in response to their insureds' coverage claims. Courts and legislatures throughout the country have responded to insurance companies' efforts to escape coverage on such formalistic grounds by establishing the "notice-prejudice" rule. Most states, by common-law rule or statute (or both), hold that an insurer can deny coverage based on late notice only by proving it suffered appreciable prejudice arising from the late notice. For most policyholders, therefore, an insurer's late notice defense constitutes little more than an empty threat.

Policyholders, however, must recognize a vitally important distinction when it comes to application of the notice-prejudice rule. Professional liability policies -- such as Directors and Officers ("D&O") policies, Errors and Omissions ("E&O") policies, and Employment Practices Liability Insurance ("EPLI") policies -- almost always apply on a claims-made basis or on a claims-made-and-reported basis. These "claims-made" policies differ, in several important respects, from typical "occurrence"-based policies. One difference concerns whether the notice-prejudice rule -- formulated with respect to occurrence-based policies -- applies equally to claims-made policies and to claims-made-and-reported policies.

The universe of claims-made policies encompasses two different types of coverage. Pure claims-made policies provide coverage for claims made against the insured during the policy term, as long as the insured gives notice to the

insurer as soon as practicable. The policy's notice provision, in short, mirrors that contained in an occurrence policy. The more restrictive claims-made-and-reported policy provides coverage for claims made against the insured during the policy period only if the insured provides notice of that claim to the insurer during the policy period.

The pure claims-made policy's notice requirements do not differ materially from those applicable to an occurrence policy. The notice-prejudice rule, therefore, always should apply to these policies. Claims-made-and-reported policies, however, provide coverage only for claims also reported to the insurer during the policy period. Arguable grounds exist, therefore, for exempting these policies from the notice-prejudice rule where the insured provides notice of the claim after the policy period. Many courts, unfortunately, fail to appreciate the distinction between the two categories of claims-made policies. This commentary will attempt to clarify this distinction for purposes of late notice and the notice-prejudice rule.

OCCURRENCE COVERAGE VS. CLAIMS-MADE COVERAGE. We first must distinguish between "occurrence"-based policies and policies that provide coverage on a "claims-made" basis. Simply put, coverage provided on an occurrence basis applies when a negligent act or omission (or some other covered event) gives rise to injury or damage during the policy period, regardless of when the policyholder receives a claim arising from such injury or damage. n1 Coverage, therefore, potentially exists for acts that occurred long (often years, sometimes decades) before the resulting claim against the insured. Insurers and insureds commonly refer to such coverage as "long-tail" because the insurer faces "a 'tail' that extends beyond the policy period itself." n2 The most well known "long-tail" claims involve property damage arising from environmental contamination and bodily injury arising from toxic substances such as asbestos. n3

Insurers compensate for the risk of long-tail claims by charging higher premiums for occurrence policies as compared to claims-made policies. n4 The insurer, however, still bears considerable risk because its premiums computed at underwriting might prove inadequate -- given, among other factors, inflationary pressures -- to cover claims asserted many years later. n5

A claims-made policy provides coverage for claims asserted against the insured during the policy period, "regardless of when the act or omission occurred." n6 A claims-made policy, therefore, involves no "long-tail" exposure because it establishes a definite cut-off date for coverage, *i.e.*, the last day of the policy period. n7 Claims-made policies provide coverage for claims asserted against the insured during the policy period, arising from injury and damage occurring before the policy period (normally limited by a retroactive date). n8

The lack of any "tail" exposure under claims-made, as opposed to occurrence, policies provides a distinct benefit to an insurer: "An underwriter who is secure in the fact that claims will not arise under the subject policy long after its termination or expiration can underwrite a risk and compute premiums with greater certainty. The insurer can establish his reserves without having to consider the possibilities of inflation beyond the policy period, upward-spiralling jury awards, or later changes in the definition and application of negligence." n9

"The core idea behind the move to claims made insurance policies was to *close the gap* between the time when the insurer *prices* the risk and the time when the insurer may incur an obligation to *pay on* that risk." n10

The class of claims-made policies contains an important division between pure claims-made policies and claims-made-and-reported policies. The case law, unfortunately, evidences much confusion relating to these different types of coverage because courts often fail to recognize the difference, sometimes with coverage-defeating results for the policyholder.

NOTICE IN GENERAL AND THE NOTICE-PREJUDICE RULE. The typical occurrence policy requires that the insured provide notice of an occurrence (or claim) to the insurer "as soon as practicable." "The giving of notice is only a condition of the policy, and in no manner is it an extension of coverage itself." n11 Courts and commentators agree the insurance industry drafted this notice requirement "to enable insurers to adequately investigate and respond to

claims." n12 The notice requirement ensures that an insurer's defense and investigation of a claim will not suffer because the "scent has grown cold," resulting in lost evidence and faded memories. n13 The notice requirement also allows insurers to estimate and set adequate reserves for a claim in a timely fashion. n14 "The object of all of these goals is to provide the insurer with an opportunity to protect its interests." n15

Given the insurer's interests protected by an occurrence policy's notice provision, late notice should not bar coverage if the untimely notice prejudices none of the protected interests. n16 Courts overwhelmingly have adopted this line of reasoning in imposing the notice-prejudice rule on insurers that invoke the late notice defense to escape otherwise covered claims. n17 These courts reason that "the requirement of notice in an occurrence policy is subsidiary to the event that invokes coverage, and the conditions related to giving notice should be liberally and practically construed." n18

Some jurisdictions require the policyholder to prove its late notice did not prejudice the insurer. n19 These courts generally maintain that because the insured bears responsibility for the late notice, it also should bear the burden of proof as a prerequisite to securing coverage. n20 Most jurisdictions, however, impose on the insurer the burden of proving it suffered appreciable prejudice from such notice. n21 These jurisdictions note the adhesive nature of insurance contracts and the principle that a merely technical and immaterial breach should not forfeit "the very thing paid for." n22 Forfeiture of coverage "would also disserve the public interest, for insurance is an instrument of a social policy that the victims of negligence be compensated." n23

A court observed, "This is not to belittle the need for notice of an [occurrence], but rather to put the subject in perspective. Thus viewed, it becomes unreasonable to read the [notice] provision unrealistically or to find that the carrier may forfeit the coverage, even though there is no likelihood that it was prejudiced by the breach. To do so would be unfair to insureds." n24

Some courts, however, have struggled with application of the notice-prejudice rule to claims-made policies and, particularly, to claims-made-and-reported policies.

APPLICATION OF THE NOTICE-PREJUDICE RULE TO CLAIMS-MADE POLICIES AND CLAIMS-MADE-AND-REPORTED POLICIES. Not all claims-made policies are created equal. The difference between pure claims-made coverage and claims-made-and-reported coverage bears particular significance with respect to notice requirements and the application of the notice-prejudice rule. A pure claims-made policy requires only that a claim against the insured be made during the policy period. n25 A claims-made-and-reported policy, by contrast, contains the added requirement that the policyholder report the claim to the insurance company during the policy period. n26

The key distinguishing feature of the claims-made-and-reported policy "gives the insurer administrative 'closure' " by allowing the insurer to close its books almost immediately after the policy period expires. n27 The reporting requirement also results in a lower premium for the policyholder. This lower premium, however, comes with a price; namely, the insured bears the risk of not timely reporting a claim to the insurer and, therefore, of losing coverage for a claim falling squarely within the policy. n28

Both claims-made and claims-made-and-reported policies normally contain a standard notice provision requiring notice to the insurer as soon as practicable. Where a claims-made-and-reported policy contains both a standard notice provision n29 and a reporting requirement, some courts have found the policy ambiguous as to its notice requirement. n30 Most courts, however, reconcile these provisions by finding the standard notice provision a policy condition independent of the insuring agreement, while finding the reporting requirement a part of the policy's coverage grant: "In the case of a notice provision, which is typically found in occurrence and claims-made policies and usually requires notice 'as soon as practicable,' the notification serves to facilitate the timely investigation of claims by bringing an event to the attention of the insurer and allows an inquiry 'before the scent of factual investigation grows cold.' In contrast, in the case of a reporting requirement, which is typically found only in a claims-made-and-reported policy, the prescribed

notification actually defines the scope of coverage provided by the policy, as the 'transmittal of notice of the claim to the insurance carrier' is the event that triggers coverage." n31

Another court has held that the "as soon as practicable" language of a claims-made-and-reported policy ".. is intended to preclude an insured, who has knowledge of a claim near the beginning of the policy period, from waiting many months until near the end of the policy period to notify the insurer of the existence of the claim, when such delay would cause prejudice to the insurer." n32

The reporting requirement of a claims-made-and-reported policy operates as a critical component of the policy's triggering mechanism. Courts, therefore, have proved reluctant, and often have declined, to apply the prejudice rule to a breach of the reporting requirement. Addressing a claims-made-and-reported policy (although referring to it simply as a "claims-made" policy), the New Jersey Supreme Court set forth the following basis for not applying the notice-prejudice rule to such policies: "[T]he event that invokes coverage under a [claims-made-and-reported] policy is transmittal of notice of the claim to the insurance carrier. In exchange for limiting coverage only to claims made during the policy period, the carrier provides the insured with retroactive coverage for errors and omissions that took place prior to the policy period. Thus, an extension of the notice period in a [claims-made-and-reported] policy constitutes an unbargained-for expansion of coverage, *gratis*, resulting in the insurance company's exposure to a risk substantially broader than that expressly insured against in the policy. Obviously, such an expansion in the coverage provided by [claims-made-and-reported] policies would significantly affect both the actuarial basis upon which premiums have been calculated and, consequently, the cost of [claims-made-and-reported] insurance. So material a modification in the terms of this form of insurance widely used to provide professional liability coverage both in this State and throughout the country would be inequitable and unjustified. The [notice-prejudice] doctrine .. [has] no application whatsoever to a [claims-made-and-reported] policy that fulfills the reasonable expectations of the insured with respect to the scope of coverage. n33

Several courts and commentators have questioned the emphasis some courts place on the location of the reporting requirement in a claims-made-and-reported insurance contract. n34 The *Root* court noted that "*just because* something is mentioned in an insuring clause does not *necessarily* mean that it goes to the scope of basic coverage provided by the insurance policy." n35 The court, instead, found the reporting requirement a condition precedent to coverage and, therefore, excusable under equitable doctrines. n36 The court found "the reporting condition in *Root's* policy here does *not* go to basic coverage but quacks, walks, looks and functions like a condition, not an element of the fundamental risk insured." n37 The court nevertheless rejected application of the notice-prejudice rule to a claims-made-and-reported policy because such application, in the court's opinion, would "convert the policy into a pure claims made policy, and therefore give the insured a better policy than he paid for." n38

Most courts reject application of the notice-prejudice rule to claims-made-and-reported policies because such application provides the insured with a better policy than that for which it bargained. This reasoning, however, cannot apply to a pure claims-made policy. A pure claims-made policy requires only that the policyholder receive a claim during the policy period, and that the insured provide notice of such claim "as soon as practicable." Application of the notice-prejudice rule does not expand coverage under a pure claims-made policy any more than it expands coverage under an occurrence policy.

The notice requirement in a pure claims-made policy serves exactly the same purposes as the notice requirement in an occurrence policy. The notice requirement, again, protects an insurer's interests in properly investigating a claim. Unless untimely notice prejudices the insurer's investigatory interests, it should not serve to forfeit coverage. While this reasoning appears straightforward enough, more than a few courts fail to grasp it.

COURT DECISIONS-THE GOOD, THE BAD, AND THE UGLY. Some courts sow confusion, and create bad law, by loosely employing the phrase "claims-made policy" and, more importantly, by failing to distinguish between a claims-made policy and a claims-made-and-reported policy. n39 At least one court found the notice-prejudice rule inapplicable to a pure claims-made policy under an analysis relevant only to a claims-made-and-reported policy. n40 In

Federal Insurance Co. v. CompUSA, Inc., n41 the court considered coverage under a pure claims-made policy sold by Federal Insurance Company. n42 The policy contained no reporting requirement, but only the standard notice provision requiring "written notice as soon as practicable." n43

The Federal policy inceptioned on December 16, 1998 and terminated on March 1, 2000. n44 In January 2000, the insured CompUSA received a complaint for breach of a joint venture agreement. n45 CompUSA answered the complaint in March 2000, but did not notify Federal of the claim, believing it frivolous. n46 In February 2001, a jury returned a verdict against CompUSA and its officer co-defendants for \$90 million, plus \$175 million in exemplary damages against one of the officers. n47 CompUSA, six days later, notified Federal of the claim. n48

Federal filed a declaratory judgment action against CompUSA and its officers, asserting no obligation to cover the insureds' losses because they failed to notify Federal of the claim "as soon as practicable" and because the untimely notice prejudiced Federal in investigating, defending and possibly settling the claim. n49 The court, however, never considered Federal's prejudice assertion, holding instead that "[b]ecause notice of a claim or potential claim defines coverage under a claims-made policy, we think the notice provisions of such a policy should be strictly construed." n50 The court's incorrect analysis led it to conclude Federal need prove no prejudice to escape coverage on late notice grounds. n51 The court, in effect, inserted a reporting requirement into a pure claims-made policy and converted the policy into a claims-made-and-reported policy. The court, in short, granted a decidedly unbargained for benefit to the insurer. n52

On the other end of the spectrum, some courts have applied the notice-prejudice rule to claims-made-and-reported policies. In *Village Escrow Co. v. National Union Fire Insurance Co.*, n53 the court applied the notice-prejudice rule to a policy that provided, as part of the insuring agreement, that the insurer would cover claims "first made against the insured and reported to the company during the policy period." n54 The underlying plaintiffs there filed an action against the insured (Village Escrow) during the policy period but failed to serve the insured until more than one year after the policy expired. n55 The insured then reported the claim to its insurer, who denied coverage based on late notice. n56

The court first noted it dealt with a particularly restrictive type of claims-made policy, which required that the claim against the insured, the reporting of the claim to the insurer, and the act or omission giving rise to the claim all occur during the one-year policy period. n57 The court then disregarded the commonly made distinction between a reporting requirement incorporated within a policy's insuring clause and a notice provision contained among a policy's conditions: "It would elevate form over substance to hold that a reporting requirement was subject to the 'notice-prejudice' rule if located in a separate clause of the insurance contract, but immune from that rule if placed in the same clause with other conditions defining the insurance company's liability under the policy." n58

The appeals court concluded that because placement of the notice requirement bears no relevance to its analysis, and because the late notice arose from no fault of the insured, the insurer could not escape coverage absent a showing of prejudice. n59 The court held "[t]he 'notice-prejudice' rule absolves insureds even when they are negligent or lazy. A fortiori, it absolves them when they are diligent but unaware of a secret claim." n60

Courts steering the middle course apply the notice-prejudice rule to pure claims-made policies but not to claims-made-and-reported policies. The policy in *Pension Trust Fund for Operating Engineers v. Federal Insurance Co.*, n61 provided coverage for "claims first made against the Insured during the Policy Period," and required that the insured, "as a condition precedent to [coverage], give the [insurer] notice as soon as practicable in writing of any claim made against it." n62 The court understood completely the difference between a pure claims-made policy and a claims-made-and-reported policy: n63 "The notice provision in a general claims made policy, as in an occurrence policy, often requires notice 'as soon as practicable.' This serves to 'facilitate the timely investigation of claims by bringing an event to the attention of the insurer and allows an inquiry 'before the scent of factual investigation grows cold.'" In contrast, in a claims-made-and-reported policy, notice is the event that actually triggers coverage. Because PTF's policy did not contain a reporting requirement, the notice prejudice rule applies." n64 The court remanded the

matter with instructions that the factfinder determine: (1) whether the insured provided untimely notice; and (2) if so, whether the insurer proved prejudice from the delay. n65

The Texas Supreme Court recently added another nuance to this issue in *Prodigy Communications Corp. v. Agricultural Excess & Surplus Insurance Co.* n66 The claims-made policy there required, "as a condition precedent" to coverage, that the insured "give notice of a claim to its insurer as soon as practicable . . . but in no event later than ninety (90) days after the expiration of the Policy Period or Discovery Period." n67 The insured gave notice of a claim more than one year after being served, and after expiration of the policy period, but within the defined reporting period. n68 The insurer argued, and the lower courts agreed, the insured could secure no coverage because it failed to provide notice "as soon as practicable." n69

The Texas Supreme Court reversed. Because of the definite notice period, the court treated the policy as a claims-made-and-reported policy. n70 The court then found the insured had reported the claim to the insurer within the policy's reporting period and, for that reason, concluded the insurer "was not denied the benefit of the claims-made[-and-reported] nature of its policy." n71 The court held that when the policyholder reports a claim to the insurer within the policy period or other defined reporting period, failure also to provide notice " 'as soon as practicable' will not defeat coverage in the absence of prejudice to the insurer." n72

Whereas other courts have treated pure claims-made policies as occurrence policies for purposes of the notice-prejudice rule, the *Prodigy* court has treated a claims-made-and-reported policy as an occurrence policy, for purposes of the notice-prejudice rule, when the insured satisfies the policy's reporting requirement. When an insured, under a claims-made-and-reported policy, reports a claim within the policy's time limits, the separate notice requirement will not result in a forfeiture of coverage unless the insurer proves appreciable prejudice resulting from the insured's failure to provide notice as soon as practicable. This common sense approach recognizes the distinction between the reporting requirement unique to claims-made-and-reported policies and the notice provision common to all claims-made and occurrence-based policies.

CONCLUSION. Courts have struggled with application of the notice-prejudice rule to the claims-made family of liability policies. The struggle ends when courts grasp the distinction between the general requirement that the insured provide notice of a claim "as soon as practicable" and the unique, coverage-restricting reporting requirement found only in claims-made-and-reported policies.

Return to Text

n1 See *DiLuglio v. New England Ins. Co.*, 959 F.2d 355, 358 (1st Cir. 1992); *Gulf Ins. Co. v. Dolan, Fertig & Curtis*, 433 So. 2d 512, 515 (Fla. 1983); *Hasbrouck v. St. Paul Fire & Marine Ins. Co.*, 511 N.W.2d 364, 366 (Iowa 1993); *Chas. T. Main v. Fireman's Fund Ins. Co.*, 551 N.E.2d 28, 29 (Mass. 1990); *Textron, Inc. v. Liberty Mut. Ins. Co.*, 639 A.2d 1358, 1361 n.2 (R.I. 1994).

n2 *Dolan, Fertig & Curtis*, 433 So. 2d at 515; *Hasbrouck*, 511 N.W.2d at 366-67.

n3 See *Root v. Am. Equity Specialty Ins. Co.*, 130 Cal. App. 4th 926, 945 (2005).

n4 *DiLuglio*, 959 F.2d at 358.

n5 *Root*, 130 Cal. App. 4th at 945; *Hasbrouck*, 511 N.W. at 367 (citing Note, *The "Claims Made" Dilemma in Professional Liability Insurance*, 22 U.C.L.A. L. Rev. 925, 928-29 (1975)).

n6 *Chas. T. Main*, 551 N.E.2d at 29.

n7 Many claims-made policies offer an extended reporting or "discovery" period, for an added premium, which provides coverage for claims asserted against the insured during a certain period (commonly 30, 60 or 90 days) after the expiration of the policy. See *Textron*, 639 A.2d at 1361 n.2.

n8 See *Hasbrouck*, 511 N.W.2d at 366.

n9 *Id.* (quoting Note, *The "Claims Made" Dilemma in Professional Liability Insurance*, 22 U.C.L.A. L. Rev. 925, 928 (1975) (alteration in intermediate source)).

n10 *Root*, 130 Cal. App. 4th at 944 (emphasis in original) (citing Bob Works, *Excusing Nonoccurrence of Insurance Policy Conditions in Order to Avoid Disproportionate Forfeiture: Claims-Made Formats as a Test Case*, 5 Conn. Ins. L.J. 505, 515 (1998-1999)).

n11 *Dolan, Fertig & Curtis*, 433 So. 2d at 515; see also *Esmailzadeh v. Johnson & Speakman*, 869 F.2d 422, 425 (8th Cir. 1989) ("[T]he requirement that the insured give prompt notice [is] merely one of the promises made by the parties to a bilateral contract.").

n12 *Dolan, Fertig & Curtis*, 433 So. 2d at 515; 1 Barry R. Ostrager & Thomas R. Newman, *Handbook on Insurance Coverage Disputes* § 4.02[a], at 135 (14th ed. 2008) (citing cases) (hereinafter, "*Ostrager & Newman*").

n13 See *Commercial Union Ins. Co. v. Int'l Flavors & Fragrances*, 822 F.2d 267, 271 (2d Cir. 1987); *Dalzell v. Northwestern Mut. Ins. Co.*, 32 Cal. Rptr. 125, 129 (Cal. App. Ct. 1963), cited in 1 *Ostrager & Newman* § 4.02[a], at 135.

n14 1 *Ostrager & Newman* § 4.02[a], at 136 (citing cases).

n15 *Id.*

n16 *Esmailzadeh*, 869 F.2d at 425 (stating that courts are "entirely justified in attaching no consequences to the insured's breach of the [notice provision in an occurrence policy], in circumstances where the breach caused no damage to the insurer").

n17 The most notable, and notorious, exception had been in New York, where the common-law rule remains that an insurer need not prove prejudice to prevail on a late notice defense. See *Argo Corp. v. Greater N.Y. Mut. Ins. Co.*, 827 N.E.2d 762, 765 (N.Y. 2005); *Unigard Sec. Ins. Co. v. N. River. Ins. Co.*, 594 N.E.2d 571, 573 (N.Y. 1992); *Sec. Mut. Ins. Co. v. Acker-Fitzsimmons Corp.*, 293 N.E.2d 76 (N.Y. 1972). However, New York's common-law rule has been abrogated by statute for policies incepting as of January 19, 2009. See N.Y. Ins. L. § 3420(a). Other jurisdictions adhering to some form of a no-prejudice rule include the District of Columbia (see *Greycoat Hanover F Street Ltd. P'ship v. Liberty Mut. Ins. Co.*, 657 A.2d 764 (D.C. Ct. App. 1995)), Idaho (see *Viani v. Aetna Ins. Co.*, 501 P.2d 706 (Idaho 1972), overruled in part on other grounds, *Sloviaczek v. Estate of Puckett*, 565 P.2d 564 (Idaho 1977)), Nevada (see *State Farm Mut. Auto. Ins. Co. v. Cassinelli*, 216 P.2d 606 (Nev. 1950)), and Virginia (see *State Farm Fire & Cas. Co. v. Walton*, 423 S.E.2d 188 (Va. 1992)). See generally 1 *Ostrager & Newman* § 4.04. Courts in these jurisdictions generally maintain that a policy's notice provision constitutes a condition precedent to coverage, and, as such, a breach thereof results in a forfeiture of the benefits of the agreement. See, e.g., *Greycoat Hanover F Street Ltd. P'ship*, 657 A.2d at 768; *Walton*, 423 S.E.2d at 192; *Acker-Fitzsimmons*, 293 N.E.2d at 78.

n18 *Zuckerman v. Nat'l Union Fire Ins. Co.*, 495 A.2d 395, 406 (N.J. 1985).

n19 See, e.g., *Grinnell Mut. Reinsurance Co. v. Jungling*, 654 N.W.2d 530, 541-42 (Iowa 2002); *Ferrando v. Auto-Owners Mut. Ins. Co.*, 781 N.E.2d 927 (Ohio 2002).

n20 See *Ferrando*, 781 N.E.2d at 936.

n21 See, e.g., *Nationwide Mut. Ins. Co. v. Starr*, 575 A.2d 1083 (Del. 1990); *Cooper v. Government Employees Ins. Co.*, 237 A.2d 870, 874 (N.J. 1968).

n22 See *Cooper*, 237 A.2d at 874; see also *Gazis v. Miller*, 892 A.2d 1277 (N.J. 2006) (applying *Cooper* principles to CGL occurrence-based policy).

n23 *Cooper*, 237 A.2d at 874.

n24 *Id.* (footnotes omitted).

n25 See *Pension Trust Fund for Operating Eng'rs v. Fed. Ins. Co.*, 307 F.3d 944, 955-56 (9th Cir. 2002); *Textron*, 639 A.2d at 1361 n.2. A typical claims-made policy provides that the insurer "shall pay on behalf of the Insured all sums . . . which the Insured shall become legally obligated to pay as damages as a result of Claims first made against the insured during the policy period." *United States v. A.C. Strip*, 868 F.2d 181, 188-89 (6th Cir. 1989) (typography altered).

n26 See *Pension Trust Fund for Operating Eng'rs*, 307 F.3d at 955-56; *Textron*, 639 A.2d at 1361 n.2; see also *Fed. Deposit Ins. Corp. v. St. Paul Fire & Marine Ins. Co.*, 993 F.2d 155, 158 (8th Cir. 1993) (discussing claims-made-and-reported policy, though referring to policy simply as "claims-made"). A typical claims-made-and-reported policy provides that the insurer "shall pay on behalf of the insured . . . all sums which the insured shall become legally obligated to pay as Damages as a result of Claims first made against the insured and reported to the Company during the Policy Period[.]" *A.C. Strip*, 868 F.2d at 185 (typography altered).

n27 *Root*, 130 Cal. App. 4th at 946.

n28 *Id.* This trade-off for a lower premium can become a huge problem when a policyholder receives a claim on the last day, or even during the last hours, of a policy period and, under such circumstances, finds it nearly impossible to timely report the claim to the insurer. Under such eleventh-hour circumstances, some courts apply equitable or contract principles to preserve coverage. See, e.g., *id.* at 948 (applying equitable principle that

condition of contract can be excused where it works a forfeiture when insured was not offered extended reporting period); *see also Cast Steel Prods., Inc. v. Admiral Ins. Co.*, 348 F.3d 1298 (11th Cir. 2003) (finding extended reporting period that applied when policy was cancelled or terminated ambiguous as applied to renewal of policy, and construing in favor of insured who reported claim within first hours of renewal policy, but hours after expiration of policy in effect when claim was first made against insured, and during which reporting of claim to insurer was required absent extended reporting period), *cert. denied*, 541 U.S. 1072 (2004). Other courts are less merciful. *See, e.g., Dolan, Fertig & Curtis*, 433 So. 2d at 516 (rejecting argument that public policy required contract be reformed to include extended reporting period when insured had opportunity to purchase such period but declined to do so). In *Catholic Medical Center v. Executive Risk Indemnity, Inc.*, 867 A.2d 453, 455 (N.H. 2005), the insured forwarded notice of several claims to its insurer by overnight delivery on the day the policy expired, but the insurer did not receive the notices until the day after policy expiration. The court, not faced with a situation in which the insured received notice of the claim at the last minute, and thus deferring that issue, construed the requirement that the insured "give notice" to mean that the insurer must actually receive notice within the policy period, and found no coverage. *Id.* at 458-59. Most claims-made carriers, for an added premium, will offer policyholders an extended reporting period to allow reports of such last minute claims. *See supra* note 7.

n29 A typical notice provision, found in the conditions section of the policy, reads: "As a condition precedent to the right of protection afforded by this insurance, the insured shall, as soon as practicable, give written notice of any Claim against the insured to the Company's agent or to the Company at [address]." *A.C. Strip*, 868 F.2d at 186 (emphasis omitted).

n30 The ambiguity argument has prevailed in cases involving "claims-made" policies that define a "claim" as being made on the date it is reported to the insurance company. *See St. Paul Fire & Marine Ins. Co. v. House*, 554 A.2d 404, 407-09 (Md. 1989); *accord Thoracic Cardiovascular Assocs., Ltd. v. St. Paul Fire & Marine Ins. Co.*, 891 P.2d 916, 924-26 (Ariz. Ct. App. 1994) (Contreras, J., dissenting). These policies differ in form from the typical claims-made-and-reported policies that include a reporting requirement as part of the coverage grant, *see House*, 554 A.2d at 408, but the two types of policies both provide coverage only for a claim made and reported during the policy period. *But cf. A.C. Strip*, 868 F.2d at 186 (holding notice and reporting provisions in same claims-made-and-reported policy did not render policy ambiguous).

Interestingly, New York regulations define a claims-made policy as a policy that "covers liability . . . [only when] the claim is first made during the policy period . . .," N.Y. Comp. Codes R. & Regs., tit.11, § 73.1(a), and further provide that "[a] claim will be deemed first made when the insurer receives written notice of [the] claim." *Id.* § 73.3(a). The New York regulations define a claim in terms of its *reporting* to the insurer; i.e., they subsume the reporting requirement into the definition of "claim" itself. No claim exists, therefore, until the insured reports it to the insurer. For that reason, New York prohibits authorized insurers in that State from issuing standard "claims-made-and-reported" policies, because such policies "impose[] additional reporting requirements not permitted under the statute." N.Y. Ins. Dep't, Office of General Counsel, *Opinion Re: Claims Made and Reported Policies* (July 31, 2003).

n31 *Textron*, 639 A.2d at 1364 (citations omitted).

n32 *A.C. Strip*, 868 F.2d at 186-87.

n33 *Zuckerman*, 495 A.2d at 406.

n34 *Root*, 130 Cal. App. 4th at 942 (quoting *Slater v. Lawyers' Mut. Ins. Co.*, 227 Cal. App. 3d 1415, 1429 (1991) (Johnson, J., dissenting)).

n35 *Id.* at 943.

n36 *Id.* at 943-48. Although the *Root* court found in favor of the insured, it did so by applying the equitable doctrine of excuse that causes a forfeiture, and not by imposing the notice-prejudice rule on a claims-made-and-reported policy.

n37 *Id.* at 943.

n38 *Id.* at 947.

n39 See, e.g., *Zuckerman*, 495 A.2d 395 (declining to apply prejudice rule to claims-made-and reported policy which the court consistently refers to as a "claims-made" policy); cf. *Gazis*, 892 A.2d at 1280 (clarifying that *Zuckerman* holding applies to claims-made-and-reported policy). See also *FDIC v. St. Paul*, 993 F.2d 155 (addressing and discussing claims-made-and reported policy but referring to policy throughout opinion as "claims-made" policy); *DiLuglio*, 959 F.2d 355 (referring to claims-made-and-reported policy as "claims-made" policy throughout opinion but holding that no prejudice was required based on reporting requirement); *Pizzini v. Am. Int'l Specialty Lines Ins. Co.*, 210 F. Supp. 2d 658 (E.D. Pa. 2002) (same); *City of Harrisburg v. Int'l Surplus Lines Ins. Co.*, 596 F. Supp. 954 (M.D. Pa. 1984) (same), *aff'd*, 770 F.2d 1067 (3d Cir. 1985); *Hasbrouck*, 511 N.W.2d 364 (same). Insurers often seize on such careless language, and the ambiguity it engenders, to expand a court's holding beyond the court's intent.

n40 *Federal Ins. Co. v. CompUSA, Inc.*, 239 F. Supp. 2d 612 (N.D. Tex. 2002).

n41 239 F. Supp. 2d 612 (N.D. Tex. 2002).

n42 See *id.* at 613, 615. The policy provided, in pertinent part, that the insurer "shall pay on behalf of each of the Insured Persons all Loss for which the Insured Person is not indemnified by the Insured Organization and which the Insured Person becomes legally obligated to pay on account of any Claim first made against him, individually or otherwise, during the Policy Period" *Id.* at 615.

n43 *Id.*

n44 *Id.* at 613.

n45 *Id.* at 614.

n46 *Id.*

n47 *Id.* Both CompUSA and its officers were insureds under the Federal policy. *Id.* at 613.

n48 *Id.* at 614.

n49 *Id.*

n50 *Id.* at 615.

n51 *Id.* at 617.

n52 The cases on which the *CompUSA* court relied amplify its confusion. None involve a pure claims-made policy. *FDIC v. Barnham*, 995 F.2d 600 (5th Cir. 1993), cited by *CompUSA*, 239 F. Supp. 2d at 616, involved a claims-made-and-reported policy (applying Louisiana law). The *CompUSA* court actually recognized that *Barnham* dealt with a different type of claims-made policy, but adopted *Barnham*'s reasoning nevertheless under purportedly "settled principles of Texas law." *Id.* The *CompUSA* court also relied on *Matador Petroleum Corp. v. St. Paul Surplus Lines Ins. Co.*, 174 F.3d 653 (5th Cir. 1999), which applied Texas law to a pollution endorsement in a commercial general liability policy that contained a 30-day reporting requirement. *Yancey v. Floyd West & Co.*, 755 S.W.2d 914 (Tex. Ct. App. 1988), cited by *CompUSA*, 239 F. Supp. at 617, involved a claims-made policy that defined covered "claims" as those reported to the insurer; in effect, a claims-made-and-reported policy. See *supra* note 30.

n53 248 Cal. Rptr. 687 (Cal. Ct. App. 1988), *op. withdrawn*, No. S006699, 1988 Cal. LEXIS 231 (Cal. Oct. 13, 1988) (previously published at 202 Cal. App. 3d 1309).

n54 *Id.* at 689 (italics removed).

n55 *Id.*

n56 *Id.*

n57 *Id.* at 690-91. The New Jersey Supreme Court has found such a restrictive policy unenforceable on public policy grounds. See *Sparks v. St. Paul Ins. Co.*, 495 A.2d 406, 414-16 (N.J. 1985), cited by *Village Escrow*, 248 Cal. Rptr. at 690-91.

n58 *Village Escrow*, 248 Cal. Rptr. at 692. This reasoning echoes that adopted by the California Court of Appeals in *Root*. The *Root* court, however, declined to apply the notice-prejudice rule, arguing it would convert a claims-made-and-reported policy into the less expensive pure claims-made policy. *Root*, 130 Cal. App. at 943-48. See *supra* note 38 and accompanying text. The *Root* court, instead, applied the equitable doctrine of excuse of a condition that works a forfeiture. *Id.*

n59 *Village Escrow*, 248 Cal. Rptr. at 694.

n60 *Id.* The court gave additional grounds for its holding. The cover page of the policy declared it to be a "claims made" policy, and not specifically a claims-made-and-reported policy, which made the very nature of the policy ambiguous. *Id.* at 694 n.4. See also *Lexington Ins. Co. v. Rugg & Knopp, Inc.*, 165 F.3d 1087 (7th Cir. 1999) (literally construing Wisconsin statute that applied notice-prejudice rule to "[e]very liability insurance policy" to apply to claims-made-and-reported policy); *Sherlock v. Perry*, 605 F. Supp. 1001 (E.D. Mich. 1985) (applying Michigan notice statute to claims-made-and-reported policy); *Stine v. Cont'l Cas. Co.*, 315 N.W.2d 887 (Mich. Ct. App. 1982) (same), *rev'd*, 349 N.W.2d 127 (Mich. 1984).

n61 307 F.3d 944 (9th Cir. 2002).

n62 *Id.* at 956.

n63 See *id.* at 955-57.

n64 *Id.* at 956-57 (citations omitted).

n65 *Id.* at 957. See also *Maynard v. Westport Ins. Co.*, 208 F. Supp. 2d 568, 574 (D. Md. 2002) (holding notice-prejudice statute did not apply to claims-made-and-reported policy at issue, and stating statute did apply to "true 'claims made' policies"), *aff'd*, 55 Fed. App'x 667 (4th Cir. 2003); *Hardwicke Recycling & Salvage, Inc. v. Acadia Ins. Co.*, 869 A.2d 82, 84, 96 (Vt. 2004) (holding notice-prejudice rule applied to commercial general liability policy that provided coverage for certain claims "*first made against any insured . . . during the policy period*").

n66 52 Tex. Sup. J. 475, No. 06-0598, 2009 Tex. LEXIS 111 (Tex. March 27, 2009). See Gregory H. Horowitz & Mark D. Villanueva, *The Lone Star State Takes the Lead on Notice Disputes Under Claims-Made Liability Policies by Requiring Carriers to Establish Prejudice*, __ Ins. Coverage L. Bull. __ (forthcoming).

n67 *Prodigy Communications*, 2009 Tex. LEXIS 111, at *2.

n68 *Id.* at *3-5.

n69 *Id.* at *2.

n70 *See id.* at *15.

n71 *Id.* at *17-23.

n72 *Id.* at *24-25. *See also Fin. Indus. Corp. v. XL Specialty Ins. Co.*, 285 S.W.3d 877 (Tex. 2009); cf. *A.C. Strip*, 868 F.2d at 186-87 (holding that notice "as soon as practicable" requirement "is intended to preclude an insured who has knowledge of a claim near the beginning of the policy period, from waiting many months until near the end of the policy period to notify the insurer of the existence of the claim, *when such delay would cause prejudice to the insurer*" (emphasis added)).

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McCarter & English LLP on Covering the Green Roof -- With Insurance

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McCarter & English LLP on Covering the Green Roof -- With Insurance

By J. Wylie Donald and Jocelyn Gabrynowicz Hill

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SUMMARY: The City of Toronto just enacted North America's first ordinance mandating the installation of a green roof on new construction commercial and industrial buildings greater than a certain square footage. Green roofs are sprouting in numerous other jurisdictions. A key question that must be answered is: how will they be insured? The answer may not be identical to the coverage response for a traditional roof.

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ARTICLE: INTRODUCTION. In the short story, *The Oranging of America*, Max Apple chronicles in a small way the presence of the Howard Johnson restaurants' trademark orange roofs. n1 Hard, impervious, anything-but-natural, these constructions have little in common beyond their fundamental purpose with the new color of roofs: green. "Green roofs" in turn are not classified by their color. Instead it is their attributes -- energy efficient, run-off reducing, pollutant absorbing, habitat creating, among others n2 -- that earn the green appellation.

Green roofs are becoming increasingly popular in light of the groundswell of interest in "green building" and sustainability. Many building owners, developers and investors are increasingly focused on participating in this trend (whether for principled or monetary reasons). Standards are developing such as those prepared by the American Society for Testing and Materials n3 and the U.S. Green Building Council ("USGBC"). One of the most significant is the USGBC's LEED Green Building Rating System. n4 Green roofs and other energy-efficient and low-resource-impact features can be part of the LEED system.

This commentary looks at green roofs from an insurance perspective. First, the commentary describes the nature of a green roof and catalogs potential problems that may occur with roofs generally and green roofs in particular. Next, the commentary considers the role of insurance in the context of traditional roof problems and extrapolates from those ideas to a discussion of how a claim concerning a green roof problem (including the effect of LEED standards) might be addressed.

WHAT IS A GREEN ROOF? Green roofs, also known as vegetative roofs, have evolved considerably from the sod and bluestem grass constructions common on the American prairie in the 19th century. n5 They have been

popularized recently in North America as part of the trend toward green building and sustainability. Indeed, Toronto just enacted the first municipal law mandating the construction of green roofs. n6

A green roof is more than a collection of planters located on a roof. Simply stated, a green roof is a construction of growing medium and plants added on top of a traditional, modified roofing system. n7 It includes:

- plants (limited in variety in some cases, in other cases diverse);
- a growing medium (not necessarily including soil);
- a fabric layer (to contain roots and the growing medium but permitting drainage of water);
- a drainage layer;
- a roofing membrane;
- insulation; and
- the roof structure (reinforced as necessary). n8

There are generally two types of green roofs: extensive and intensive. An extensive green roof is characterized by low weight and capital cost, minimal plant diversity, and reduced maintenance requirements and access. n9 The growing medium is generally less than six inches in depth. The roof micro-climate can be very dry and hot and the plant life, accordingly, must be low and hardy, such as species typically found in alpine, arid or semi-arid ecosystems. Maintenance visits are few for tasks such as inspections, application of fertilizer and limited weeding. n10

Intensive green roofs are the opposite. The depth of the growing medium is greater (up to two feet) and the roof costs substantially more. Because of the deeper soil depth, plant diversity can be greater, including trees and shrubs. n11 Maintenance is increased because the plants chosen require more tending (including watering and watering systems), but also because increased access (including visitors) puts more stress on the garden and the roof. n12

As may be obvious, a significant structural effect of green roofs derives from the soil depth and its accompanying weight when saturated with water. Extensive green roofs may have saturated media weight between 16 and 35 pounds per square foot; intensive roofs may be six times that. n13 Moreover, the additional loads from a green roof are located at the top of a building and may increase the design stresses that a building must support under earthquake and wind loads. These added stresses may require additional structural strength necessitating the use of steel or concrete or other strength components throughout the entire structure.

ROOF CLAIMS. That roofs can be problematic is not to be doubted. A case that catalogs many of the things that can go wrong arose in Delaware out of repairs to the roof of an anchor tenant at a shopping mall and subsequent leakage. In *Jardel Co., Inc. v. Lakewood Builders, Inc.*, n14 the Delaware Superior Court provided substantial detail on roof construction and the contracting, retention, supervision and technique that went into a repair, and the repair of the repair.

It should not be surprising that, as comprehensive and detailed as it is, the *Jardel* case does not catalog all the sources of problems that can arise with a roof and its repair. But it is a very good start. To distill it:

1. defective specifications;
2. unqualified contractors;
3. inadequate information regarding the design and condition of the roof;
4. negligent performance by the roofing contractor;
5. unavailability of materials;
6. resulting third-party damage;

7. defective conditions of the roof; and

8. weather delays. n15

All are in addition to the problems inherent in the passage of time with a properly constructed roof: leakage at joints, flashing, substrate, membrane, expansion joints, and penetrations.

When an extensive or intensive green roof is built there are several new systems that need to be combined on the roof, including structural support for the additional weight of plants, growing medium and water, watering systems, drainage systems, additional access and, of course, a living ecosystem of growing plants. Any of these can, for one reason or another, go wrong. But the potential problems go beyond that. Additional access provides more risks that something will be jarred loose, punctured, or deformed so that the watertight integrity of the roof is compromised. More significantly, the tons of dirt or other growing medium may obscure the condition of the roof potentially making punctured membranes, loose flashing or failed seals difficult to locate. This has the effect of allowing leakage to proceed longer before identification of the source and also increases the cost of repair. n16

COVERAGE FOR ROOFS. Regardless of the catalogue of potential new problems associated with green roofs, green roof coverage claims are likely to be analogous to traditional roof claims. In other words, we are likely to see an incremental shift in some regards, but not whole-scale change. Only time will tell whether this prediction is correct, as there have not yet been many claims associated with green buildings. Indeed, according to the insurance companies surveyed by Marsh in its 2008 report, there has only been one claim to date arising from a vegetative roof. The controversy involved a claim against a building's architect and structural engineer due to water infiltration into the building from the green roof. n17 That this is the first claim to have emerged is not surprising. Leaking is a common problem for all kinds of roofs, not to mention vegetative roofs, which incorporate water into the design.

The roof claim in the Marsh report likely involves claims of negligent design and construction under a commercial general liability ("CGL") policy or a professional liability/errors and omissions policy. Losses involving green roof problems may fall within the coverage provided by property policies as well. n18

Cause and Concurrent Causation. Disputes between policyholders and insurers over green roof problems will likely follow the current roof insurance claim patterns and policy analysis. For example, if an owner is seeking coverage for a leaking roof under a property policy, there are two main threshold questions: is there property damage, and, if so, was the property damage caused by a risk covered by the policy?

A typical property policy covers "direct physical loss of or damage to Covered Property caused by or resulting from any 'covered cause of loss.' " n19 The covered risks are either enumerated ("named peril" policies) or described as "all risk," by which the carrier covers all risks except those that are specifically excluded. n20

In a leaking roof case, it is pretty clear that there is "property damage" as the term is commonly understood and as it is defined in a typical policy. Thus, the inquiry tends to focus on whether there was a covered "cause" of loss. Oftentimes there may be more than one asserted cause leading to analysis of concurrent causation under the applicable policy.

The coverage grant in an insurance policy is always followed by various excluded causes of loss (often referred to as "excluded perils") and other specific exclusions. There are a number of standard exclusions which insurance companies are likely to raise which may be particularly pertinent to green roofs. In property policies, for example, there are typically exclusions for "wear and tear" and "deterioration," n21 as well as "defective design" or "defective construction." n22 Thus, an insurance company will argue that even though there is property damage, namely, the leaky roof and the damp, discolored or moldy building interior, there is no coverage because the leaky roof was caused by defective design, or faulty workmanship, or deterioration, which is excluded under the policy. Courts in such instances engage in a causation analysis.

To illustrate, despite an exclusion for "faulty workmanship" the court in *Driscoll v. Providence Mutual Fire Insurance Co.*, n23 found that the insureds' policy provided coverage where the damage to the roof in question was caused by a combination of both faulty workmanship, which was excluded, and by weight of ice and snow, which was not excluded. In that case, the policyholders discovered damage at one of their rental properties during an inspection in preparation for a new tenant, including outward-leaning outside walls, ceiling cracks, a two-inch drop in the roof, and other problems. The owners submitted a claim to their insurance company under their "all risk" policy. The insurance company denied the claim on the basis of its expert's opinion that the damage was caused by faulty roof design, a cause that was excluded from coverage under the terms of the insurance policy. The property owners hired their own engineer, who inspected the house and determined that faulty design had combined with the weight of snow from the prior winter to cause the property damage. n24

The owners had purchased an all risk policy, which broadly covered all risk of direct physical loss unless the loss was excluded. The weight of ice and snow was a covered cause of loss which was not excluded under the policy. n25 However, the policy also contained an exclusion for faulty work. Finally, the policy contained the following provision: "[w]e will not pay for loss or damage caused by or resulting from any of [the excluded causes of loss]. But if loss or damage by a 'covered cause of loss' results, we will pay for that resulting loss or damage." n26

The court found that both faulty design and the weight of snow and ice concurrently caused the damage. Because the damage was caused by both a covered and an excluded "cause of loss," the court found that the covered cause of loss trumped, and the faulty design exclusion did not bar coverage. n27

One can imagine similar concurrent causation issues arising around a green roof. For example, if the roof drains are inadequately sized and overwhelmed by torrential rains with resultant flooding of the green roof and structural damage to the roof because of the extra weight, can the property owner find coverage under his property policy, or must he seek recourse from his architect or builder under their malpractice policies? The answer undoubtedly will depend on the specific terms of the owner's policy and the specifics of the particular claim. What is not as idiosyncratic, however, is the need for the property owner to anticipate such problems and thoughtfully to address them so that the first time he is considering his insurance situation is not while the water is pouring in through the ceiling. Because many of the risks associated with green buildings and green roofs emanate from design-related services, we are likely to see concurrent causation as a repeated theme in the green build context.

"Green" Features May Go Beyond Aesthetics. Although in some instances green roof claims will follow the current roof insurance claim patterns and policy analysis, in light of the unique nature of the green roof, especially within the context of a LEED certified building, we may see some new twists on prior results. One old coverage battleground which may yield some new results is the question of what constitutes "property damage." Something a court considered as merely "aesthetic" -- and not property damage -- under the traditional rubric, may be transformed into something entirely different in the green building context.

For example, under the traditional rubric, if a builder installs the wrong colored shingles on a building, the carrier may assert there is no "property damage" -- the roof just does not look as it should. The result in *Down Under Masonry, Inc. v. Peerless Insurance Co.*, n28 illustrates this principle. In that case, a contractor building a new garage for a homeowner hired a subcontractor to install shingles on the roof of the garage. The subcontractor purchased and installed eastern grade B white cedar shingles instead of the western blue label red shingles that the contract required. The white shingles were different in color than the red shingles on the owners' nearby house, and were of inferior quality. n29 The owners sued the contractor, who in turn tendered the claim to its liability insurer. The contractor's insurance company denied coverage, refusing to defend or indemnify the contractor on the basis that there was no property damage. The court agreed with the insurance company, affirming the lower court's no-coverage ruling on the basis that no "physical injury" or "loss of use" occurred.

The policy in that case obligated the insurance company to pay those sums that the policyholder became legally obligated to pay as damages because of "property damage." The policy defined "property damage" as *physical injury to*

tangible property or the loss of use of tangible property that is not physically injured. n30

The subcontractor installed shingles that were of inferior quality and different in color from those specified in the original contract with the owners. "Nothing in the record, however, suggest[ed] that any physical defect existed in the shingle material used or in the manner in which the shingles were installed, or that the owners were unable to use their new garage as a result." n31 Accordingly, "[t]o find that the aesthetic impact on property value caused by the installation of inferior shingles equates to property damage would extend coverage beyond the contemplation of the parties." n32 The court thus declined to find coverage under the contractor's CGL policy for what the court viewed as aesthetic damage.

In the context of green buildings however, the color of a roofing material may be much more significant than mere aesthetics, and a court in the green-build context would likely reach a different result than the court in *Down Under Masonry*. According to LEED certification requirements, the color and grade of shingles has an impact on certification and the efficacy of the roof itself. For example, alternatives available under LEED to address the "heat island effect" permit a roof to be either a green roof, or covered with a material of Solar Reflective Index ("SRI") value of 29 or above for a steep-sloped roof, or 78 or above for a low-sloped roof. n33 The intent is to reduce the heat island effect by increasing the solar reflectivity of building materials. In general, lighter materials typically have a higher SRI than dark materials. Light materials reflect light, dark materials absorb light. Thus, the "wrong color shingles" would not be merely aesthetic, but would likely constitute property damage as the owner has lost the use of its roof to reflect sunlight. Two potential adverse consequences in this situation may be higher operational expenses due to higher heating loads on the building cooling system, as well as an impact on the building owner's ability to become LEED certified at a targeted level, due to the loss of LEED accreditation points from the use of nonconforming materials.

Improvements Required by Code. Attendant with the increasing public awareness of issues such as climate change, there has been a surge in demand for green buildings. The green building discourse has reached such a level that an increasing number of municipalities have enacted green building ordinances. As noted above, Toronto became the first city in North America to adopt an ordinance requiring green roofs on new construction buildings. But it is not alone in addressing the place of green buildings in the municipal skyline. A publication by the U.S. Green Building Council identifies 198 localities that have enacted LEED initiatives. n34 An interesting question arises where a covered peril damages a building without a green roof and missing other LEED features, but the local code requires rebuilding to include a green roof or otherwise incorporate green building attributes, including LEED certification. Would there be coverage for those improvements?

One of the often unanticipated consequences of any disaster is the cost of replacement of non-conforming structures with those that conform to code. Many policies contain exclusions for those costs. For example:

We will not pay for loss or damage caused directly or indirectly by any of the following: Such loss or damage is excluded regardless of any other cause or event that contributes concurrently or in any sequence to the loss. a. Ordinance or Law The enforcement of any ordinance or law: (1) Regulating the construction, use or repair of any property; .. n35

But by the same token, coverage extensions are available that put this coverage back in.

In the event of damage by a Covered Cause of Loss to a building that is Covered Property, we will pay the increased costs incurred to comply with enforcement of an ordinance or law in the course of repair, rebuilding or replacement of damage of that property, subject to the limitations stated ... n36

However, even in circumstances where an "ordinance or law" exclusion is not neutralized with an extension, policyholders may still prevail on coverage for increased code-required costs.

To predict how a court might deal with this replacement issue for a green roof, we can extrapolate from an analogous case, *Royal Cloud Nine, L.L.C. v. Lafayette Insurance Co.*, set in the Vieux Carre, the historic district of New Orleans. n37 During Hurricane Katrina, the historic Latrobe building was damaged by the storm. The building was on the National Register of Historic Places, and carried the Vieux Carre Commission's highest historical and architectural rating: "purple". The Vieux Carre Commission requires that the roofs of purple-rated structures be replaced with natural slate as opposed to materials of lesser quality. n38 The inspector hired by the insurance company prepared a roofing estimate for inferior slate valued at only a fraction of the price of the requisite natural slate. The policyholder filed suit against the insurance company seeking, among other things, the replacement cost of the roof using the natural slate.

Although it secured coverage at the trial level, on appeal the policyholder contended that the trial court erroneously failed to find the insurance company liable for the increased cost of replacing the roof with natural slate as required by the Vieux Carre Commission. The insurance company argued against the increased replacement cost on the basis that the ordinance or law exclusion in its policy precluded replacement cost coverage of the roof. n39

The insurance policy provided for the replacement costs in "the amount you actually spend that is necessary to repair or replace the lost or damaged property." n40 The court found that Hurricane Katrina caused the damage to the policyholder's roof, not the enforcement of the Vieux Carre Commission requirements and that replacement at the "purple" level was "necessary." Accordingly, the court awarded the policyholder an additional 62,400 to replace the roof with natural slate. n41

Green building ordinances often require that any new construction or renovation over a certain square footage must attain LEED certification or otherwise meet certain efficiency or sustainable attribute requirements. Toronto's new green roof ordinance, for example, requires that "[e]very building or building addition constructed after January 30, 2010 with a Gross Floor Area of 2,000 square metres or greater shall include a Green Roof." n42 If a Toronto building is destroyed by fire and the owner intends to rebuild, the owner is actually required by law to rebuild the structure to a more costly standard, much like the Latrobe building in *Royal Cloud Nine* was required to conform to specific, more expensive standards applicable to historic buildings. An insurance company is likely to assert arguments against code-required increased costs, similar to those asserted in *Royal Cloud Nine*. Even with a law and ordinance exclusion, however, the carrier may not prevail.

Weather, Seasons and the Period of Restoration. To this point, we have addressed only coverage issues with respect to "property." A significant feature of most property policies, however, is the provision of coverage for the interruption of the insured's business. While a green roof may be used by a business directly with its clients (e.g., a therapeutic garden at a hospital or the setting of a restaurant), a more substantial role is the place of the green roof in the overall characterization of the building as "green" or "sustainable" or "LEED certified." If the green roof is, for example, integral to the marketing of a building or the amount of rent that can be obtained or the approval of a certificate of occupancy, then the time for the restoration of the roof may be critical.

Analysis of the "period of restoration" was central to one of the decisions rendered in the World Trade Center insurance dispute over coverage for the September 11 terrorist attacks. In *SR International Business Insurance Co., Ltd. v. World Trade Center Properties LLC*, n43 the insured sought to recover lost rents for the *actual* period of time it took to rebuild the replacement structure for the World Trade Center, rather than a *theoretical* amount of time to rebuild. The insured's policy provided that its insurers would "pay for the actual loss of ... Rental Value sustained by the Insured due to the necessary 'suspension' of the Insured's 'operations' during the 'period of restoration.'" n44 In turn, however, the "period of restoration" was defined as beginning on "the date and time of direct physical loss or damage" and ending on "[t]he date when the property *should* be repaired, rebuilt or replaced with reasonable speed and similar quality." n45

The court concluded that the insured's "actual period to rebuild" argument would require the court to read "should be repaired" as "would be repaired." Unfortunately for the insured the court did not agree with the insured's parsing of the language:

That certain terms could apply to both an actual and a hypothetical period does not mean that they do when other text, and context, and authority, and logic, prove that they do not. n46

Accordingly, the court found that the period of restoration was the theoretical period, rather than the actual time it would take to restore the facility.

The central feature of a green roof is its vitality: by definition, it has a "living" biological component integral to its design. Accordingly, the time to restore a green roof may not be as simple as counting up the number of days required to lay down a membrane, install a drainage system, spread some soil and plant some cuttings or lay some sod. The weather and seasons may be entirely determinative of what can be done. And if the green roof's viability matters to the conducting of the insured's business, then ensuring coverage for the full required period of restoration is essential.

CONCLUSION. There are no doubt numerous other aspects of insurance coverage that will apply to green roofs; results will often turn on nuances in the applicable policy and will always depend on the particular facts in issue. Policyholders and their brokers and insurers need to approach the insurance of a green roof by recognizing that while many of the coverage questions and their answers will be similar to what has transpired with traditional roofs, only a thoughtful examination of coverage focused on the green roof will deliver the policy that provides the coverage required.

Return to Text

n1 Max Apple, *The Oranging of America, The Oranging of America and Other Stories* (New York: Grossman Publishers, 1976).

n2 See Larry Foxman, National League of Cities, *Greenroofs, A Municipal Action Guide* 3 (Dec. 2006).

n3 *E.g.*, American Society for Testing and Materials, ASTM E2397.05 -- Standard Practice for Determination of Dead Loads and Live Loads Associated with Green Roof Systems (2005).

n4 The Leadership in Energy and Environmental Design ("LEED") Green Building Rating System "accelerates global adoption of sustainable green building and development practices through the creation and implementation of universally understood and accepted tools and performance criteria." U.S. Green Building Council, What is LEED?, *available at* <http://www.usgbc.org/displaypage.aspx?CMsPageID=222>.

n5 Laura Ingalls Wilder, *On the Banks of Plum Creek* 45, 51 (HarperCollins Publishers, New York, 1953).

n6 See Press Release, Green Roofs for Healthy Cities, *Toronto City Council Adopts Mandatory Green Roof Requirements* (May 27, 2009).

n7 *E.g.*, City of Toronto, Municipal Code Ch. __, Requiring and Governing the Construction of Green Roofs ("Toronto Green Roof Ordinance"), art. I (May 27, 2009) ("GREEN ROOF: means an extension of an above Grade roof, built on top of a humanmade structure, that allows vegetation to grow in a growing medium and which is designed, constructed and maintained in accordance with the Toronto Green Roof Construction Standard.").

n8 Steven Peck and Monica Kuhn, Ontario Association of Architects, *Design Guidelines for Green Roofs* at 4-5, available at <http://www.cmhc.ca/en/inpr/bude/himu/coedar/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=70146>.

n9 *Id.* at 4.

n10 *Id.*

n11 *Id.* at 4-5.

n12 *Id.* at 5.

n13 *Id.* at 4-5.

n14 1987 *Del. Super. LEXIS 1154 (Del. Super. Ct. 1987)*.

n15 *Id.* at *2-*12.

n16 At the same time, according to the Marsh report, many agree that green design requirements can also mitigate risk. For example, one prerequisite for LEED certification is building commissioning, which can help identify and correct design errors before the building is operational. The systems included within scope of services for commissioning a LEED project are based on the owner's project requirements. In addition, the LEED certification process fosters a more collaborative, communicative working environment, which may reduce miscommunication and conflict. MARSH, THE GREEN BUILT ENVIRONMENT IN THE UNITED STATES, 2008 YEAR-END UPDATE OF THE STATE OF THE INSURANCE MARKET 3 (2009).

n17 *Id.*

n18 There are new insurance products specifically designed for green buildings.

n19 *E.g., Victory Peach Group, Inc. v. Greater New York Mut. Ins. Co.*, 707 A.2d 1383 (N.J. Super. Ct. App. Div. 1998).

n20 *Id.*

n21 *See, e.g., Ariston Airline & Catering Supply Co. Inc. v. Forbes*, 511 A.2d 1278 (N.J. Super. Ct. Law Div. 1986).

n22 *See, e.g., 242-44 East 77th St., LLC v. Greater N.Y. Mut. Ins. Co.*, 815 N.Y.S.2d 507, 509 (App. Div. 2006).

n23 867 N.E.2d 806 (Mass. App. Ct. 2007).

n24 *Id. at 807-08.*

n25 *Id. at 810.*

n26 *Id.*

n27 *Id. at 810-11.* This analysis is referred to as concurrent causation analysis.

n28 950 A.2d 1213 (Vt. 2008).

n29 *Id. at 1214.*

n30 *Id. at 1215-16.*

n31 *Id. at 1216.*

n32 *Id.*

n33 LEED 2009 For New Construction and Major Renovations, Sustainable Sites Credit 7.2, Heat Island Effect-Roof (U.S. Green Building Council, Inc., 2009), *available at* <http://www.usgbc.org/DisplayPage.aspx?CMSPageID=1970>.

n34 U.S. Green Building Council, LEED Initiatives in Governments and Schools (June 1, 2009), *available at* <http://www.usgbc.org/DisplayPage.aspx?CMSPageID=1852>.

n35 *E.g., Danzeisen v. Selective Ins. Co. of Am.*, 689 A.2d 798, 799-800 (N.J. Super. Ct. App. Div. 1997).

n36 *See e.g.*, SR Int'l Business Ins. Co., Ltd. v. World Trade Center Properties LLC, No. 01 Civ. 9291(HB), 2006 U.S. Dist. LEXIS 79326 at *13 (S.D.N.Y. Oct. 31, 2006).

n37 987 So. 2d 355 (La. Ct. App. 2008).

n38 *Id.* at 359.

n39 *Id.*

n40 *Id.*

n41 *Id.*

n42 Toronto Green Roof Ordinance, art. II, § __.A.

n43 No. 01 Civ.9291 (MBM), 2005 WL 827074 (S.D.N.Y. Feb. 15, 2005).

n44 *Id.* at *3 (internal quotations omitted).

n45 *Id.* (internal quotations omitted).

n46 *Id.* (emphasis added).

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Aylward on Allocating Indemnity Obligations in Long-Tail Environmental Claims

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Aylward on Allocating Indemnity Obligations in Long-Tail Environmental Claims: Boston Gas and the "Unavailability" Debate

By Michael Aylward

August 7, 2009

SUMMARY: The Massachusetts high court has ruled that long-tail claims should be allocated on a pure time on the risk basis whether or not insurance was unavailable to the policyholder for part of the time during which loss occurred. This enables insurers to argue around the country that pro rata allocation is appropriate in cases involving interstitial orphan shares and when insurance could not be acquired due to pollution and asbestos exclusions.

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ARTICLE: INTRODUCTION. Fifteen years after it opened the door to allocation disputes by rejecting a "manifestation-only" trigger in *Trustees of Tufts University v. Commercial Union Ins. Co.*,ⁿ¹ the Supreme Judicial Court ruled on July 24, 2009 in *Boston Gas Co. v. Century Indem. Co.*,ⁿ² that an insurer's indemnity obligation for long-tail claims must be determined in proportion to the insurer's policy period as a fraction of the overall duration of the claimed injury. Most importantly, the Supreme Judicial Court has rejected any exception to this general rule for periods of time for which insurance is claimed to be "unavailable."

While *Boston Gas* treads familiar ground in rejecting the insured's "all sums/joint and several liability" theory, it has forged an entirely new path in rejecting the policyholder's claim that years of "unavailable" insurance should be ignored in calculating allocation shares. Further, as will be discussed in this commentary, it appears from the breadth of the court's rejection of an "unavailability" exception that Massachusetts policyholders with long-tail environmental claims will henceforth be responsible not only for interstitial orphan shares (*i.e.* missing policies, exhausted years, insolvencies, etc.) but also for years since 1986, when most insurers added mandatory asbestos and absolute pollution exclusions to their policies.

THE BOSTON GAS DISPUTE. The *Boston Gas* case concerned a manufactured gas plant in Everett, Massachusetts that was operated between 1908 and 1969. Contamination was discovered in 1995 and has since resulted in extensive clean up activity and litigation among potentially responsible parties ("PRPs").

In 2001, Boston Gas brought suit against Century Indemnity Company, whose predecessor was alleged to have

issued a series of primary liability insurance policies to Boston Gas between 1951 and 1969. Each of the confirmed policies was written excess of a self-insured retention. In this case Boston Gas assigned its entire claim to a 1966-1969 policy, which unlike its predecessors, had an unusually large limit of coverage (\$17 million) subject to a self-insured retention ("SIR") of only \$100,000. Century Indemnity brought in as third-parties other insurers, all of whom settled with Boston Gas before trial.

Following a three-week jury trial in the U.S. District Court in Boston in 2005, Judge Rya Zobelⁿ³ awarded Boston Gas \$6.13 million, the total amount of damages found by the jury minus a single \$100,000 SIR, and declared that Century Indemnity would also be liable for any and all future clean up costs subject to its \$17 million limit.ⁿ⁴ Prior to trial, Judge Zobel had rejected Century Indemnity's request that the allocation issue be certified to the Massachusetts Supreme Judicial Court declaring, that the Appeals Court's opinions in *Rubenstein*ⁿ⁵ and *Chicago Bridge*ⁿ⁶ made clear to her that Massachusetts follows "the 'all sums,' joint-and-several allocation method."

On appeal, Century Indemnity's request for certification to the Supreme Judicial Court was not acted on by the First Circuit and the case proceeded to oral argument in early 2008. On June 10, 2008, the First Circuit issued a lengthy opinion,ⁿ⁷ reversing significant aspects of Judge Zobel's trial rulings but concluding (belatedly) that Massachusetts law was so uncertain on allocation issues that certification to the Supreme Judicial Court was, indeed, warranted.

The certified questions were accepted for review by the Supreme Judicial Court and heard on January 9, 2009. Despite the fact that the court ordinarily issues opinions within four months, its 130-day deadline came and went without an opinion, prompting questions with respect to whether a division had arisen within the court (a court where dissents are relatively rare) or whether the court could not come to terms with an issue with such enormous implications beyond the bare facts before it.

THE BOSTON GAS HOLDING. On the crucial threshold question of "joint and several versus pro rata," Justice Robert Cordy, writing for a unanimous court, concluded that "pro rata allocation of losses is consistent with, if not compelled by, the most reasonable construction of the policies at issue here." The court pointed to language in the definition of "occurrence" and the Territory clause as limiting coverage to property damage "during the policy period." The court declared that the use of "during the policy period" in the definition of "occurrence" was intended to limit the scope of the policy's "ultimate net loss" coverage, observing that:

This limitation makes sense: property damage during the policy period triggers the Century policies, which then respond by providing coverage for liability attributable to the amount of property damage occurring during the policy period.

Echoing a rhetorical question that Chief Justice Marshall had posed to counsel for Boston Gas during oral argument, Justice Cordy summed up the view of the court:

[W]e doubt that an objectively reasonable insured reading the relevant policy language would expect coverage for liability from property damage occurring outside the policy period. Read as a whole, neither Century policy expressly makes or implies a promise to pay one hundred per cent of Boston Gas's liability for multi-year pollution damage occurring decades before or after the policy period. No reasonable policyholder could have expected that a single one-year policy would cover all losses caused by toxic industrial wastes released into the environment over the course of several decades. Any reasonable insured purchasing a series of occurrence-based policies would have understood that each policy covered it only for property damage occurring during the policy year.

Having determined that pro rata should be the rule, the court turned to the second certified question, which asked it to determine exactly how pro allocation should work. As between an *Owens-Illinois*' "weighted shares" approach that takes policy limits into account and a pure "time on the risk" approach, that assigns an equal share to each share in which loss occurred, the court chose the latter. Further, in defining the period of "time on the risk," the court expressly declined to make an exception for years for which insurance was claimed to have been unavailable for such risks.

IS "UNAVAILABILITY" AN EXCEPTION TO PRO RATA ALLOCATION? With the addition of *Boston Gas*, eleven state supreme courts have now adopted "pro rata" allocationⁿ⁸ as contrasted with seven that have ruled for policyholders on the basis of either "all sums" or "joint and several" liability.ⁿ⁹ Even within these *pro rata* cases, however, a division has arisen with respect to whether and when policyholders should be responsible for orphan shares, particularly those relating to the years since 1985 when most insurers added mandatory asbestos and pollution exclusions to their commercial general liability ("CGL") policies.

Courts have, in fact, followed two very different paths in reaching the same *pro rata* result. The majority view, as exemplified by *Boston Gas*, does so by analyzing the terms of the subject insurance policies and, in particular, the significance of the policies' limitation of coverage to injuries "during the policy period." The other approach, pioneered by the New Jersey Supreme Court, concludes that the wording of the insurance contracts is, at best, inconclusive but nonetheless finds that *pro rata* allocation should be imposed for reasons of public policy, particularly the desirability of encouraging policyholders to buy insurance to transfer risk.

These two approaches differ most dramatically in the manner in which they address orphan shares. Under the insurance policy-based approach, an insurer pays for its "time on the risk" without regard to what other insurance the insured might or might not have purchased in other years. Under the public policy-based approach, loss is allocated in proportion to "risk." "Risk" is assigned in proportion to the total limits of coverage for each triggered year, including estimated limits for any year when the existence of actual policies cannot be confirmed. This approach omits consideration of any period of time when no insurance could have been purchased, as no public policy would be served by punishing an insured for failing to purchase insurance for risks that were uninsurable at the time.

The Owens-Illinois Holding. The "unavailability" doctrine finds its roots in *Owens-Illinois, Inc. v. United Ins. Co.*,ⁿ¹⁰ an asbestos case in which the New Jersey Supreme Court reversed an intermediate appellate ruling that the "all sums" language in the policies required each insurer to indemnify the insured in full, subject only to its policy limit. Although the New Jersey Supreme Court thus rejected the policyholder's claim that the "all sums" wording was dispositive of the allocation issue, it also rejected the insurers' argument that the policy language supported a "time on the risk" allocation. Having failed to find support in the wording of the policies for either side's position and refusing to accept the insured's position that the lack of clear policy wordings was itself a basis for maximizing coverage on the basis of ambiguity in the policies, the New Jersey Supreme Court struck out on a unique path of its own based purely on the public policy of devising an "efficient" means of allocating "resources":

The theory of insurance is that of transferring risk. Insurance companies accept risk from manufacturers and either retain the risk or spread the risk through reinsurance. Because insurance companies can spread cost through an industry and thus achieve cost efficiency, the law should, at a minimum, not abide disincentives to parties to acquire insurance when available to cover their risk. Spreading the risk is conventionally more efficient.ⁿ¹¹

Accordingly, the New Jersey Supreme Court found that insureds should be encouraged to transfer risk by purchasing insurance from third-party companies. Policyholders who chose not to "transfer risk" by purchasing insurance will be deemed to have "retained" that portion of the untransferred risk that they might otherwise have transferred to third parties.ⁿ¹² The court ruled that allocating loss in proportion to the risk transferred or contained "is more consistent with the economic realities of risk retention or risk transfer although later insurers might have to absorb a greater portion of the loss owing to the higher limits purchased in later years since the year-by-year increase in policy limits must have reflected an increasing awareness of the escalating nature of the risk sought to be transferred."ⁿ¹³ While declaring that it was reasonable to expect a policyholder to bear responsibility for shares in situations "where periods of no insurance reflect a decision by an actor to assume or retain a risk," the court distinguished "periods when coverage for a risk is not available."ⁿ¹⁴

The Stonewall Ins. Co. Holding. Whereas *Owens-Illinois* merely enunciated the possibility of an "unavailability" exception, this proposed exception was given concrete application a few months later in *Stonewall Ins. Co. v. Asbestos Claims Management Corp.*,ⁿ¹⁵ another asbestos case. The Second Circuit found that those courts that had endorsed

"pro-ratio to the insured" had only done so "to oblige a manufacturer to accept a proportionate share of a risk that it elected to assume, either by declining to purchase available insurance or purchasing what turned out to be an inefficient amount of insurance." n16 Based upon evidence that the adoption of an industry-wide endorsement excluding asbestos insurance made it impossible for asbestos manufacturers to transfer risk after 1985, the Second Circuit concluded that, in keeping with the economic "risk transfer" analysis that the New Jersey Supreme Court had enunciated in *Owens Illinois*, it would make little sense to punish a policyholder for failing to purchase insurance if it was impossible to acquire coverage for such risks at the time.

APPLICATION OF THE "UNAVAILABILITY" DOCTRINE. Although the "unavailability" exception has since gained little actual traction outside of New Jersey, it had the practical effect of deterring insurers from pursuing efforts to force policyholders to bear responsibility for post-1986 shares. As a result, most recent allocation case law has concerned the issue of whether the insured or its insurers will bear responsibility for "interstitial" orphan shares resulting from gaps during the period of time when most insureds have been able to confirm that they purchased CGL coverage.

While *Owens-Illinois* and *Stonewall* both concerned industry-wide absolute exclusions, policyholders have sought to rely on these cases to extend the "unavailability" doctrine to policies issued before 1986 on the theory that the adoption of the "sudden and accidental" exclusion had a similar effect on insurance markets. While these efforts have failed, to date, the resulting case law has clarified the applicable burdens of proof in "unavailability" cases.

The Olin Corp. Holding. One noteworthy ruling was issued by the Second Circuit in *Olin Corp. v. INA*, n17 which had the effect of constricting the scope of the "unavailability" exceptions to periods for which insurance was completely unavailable, as opposed to years where less comprehensive insurance was still available, albeit at a higher price. Olin had sought coverage for the cost of cleaning up a facility in North Carolina where it had manufactured fertilizer between 1950 and 1967, when the operation was sold to Kerr-McGee. Olin conceded that it was "self-insured" for a period in the 1950s but argued that it should not bear any responsibility for loss occurring after 1970, in light of the fact that New York law upholding the pollution exclusion made coverage unavailable to it under all policies issued after that date.

Following a preliminary ruling addressing these issues in July 1997, the parties presented evidence with respect to whether pollution insurance had been "available" to Olin after 1971 under a *Stonewall* standard. On December 30, 1997, Judge Griesa ruled that Olin must bear responsibility for the "orphan shares" resulting from INA's pollution exclusions. The court ruled that such exclusions were different from the situation in *Stonewall*, in which insurance for asbestos liability was wholly unavailable after a certain period of time, whereas Environmental Impairment Liability ("EIL") insurance coverage was available to Olin throughout the 1970s and 1980s.

On appeal, the Second Circuit found that nothing in its opinion in *Stonewall* suggested that "the relevant inquiry was limited to whether an insured was able to continue obtaining coverage for the particular risk in the same policy type, without an exclusion." n18 "If coverage under one type of policy becomes unavailable by exclusion, and the insurance customer can but does not buy the excluded coverage separately or in another policy type, it follows that the customer has opted to self-insure." n19 Whether or not Olin specifically elected not to purchase EIL insurance was irrelevant in the court's analysis. As with the district court, the Second Circuit concluded that it was sufficient to find that EIL coverage was available to companies like Olin in the marketplace and that it was not necessary to further prove that Olin subjectively elected to forego this coverage and to self-insure for such risks. The court therefore declared that the determination of "availability" would be undertaken on an objective basis. In calculating the amounts owed, the court declared that the denominator should be the overall period of injury whereas the numerator would be the insurer's years of coverage. INA was therefore declared to be liable for 13/28ths of the damages attributable to groundwater contamination and 2/35ths of the costs attributable to soil damage. The court ruled, however, that Olin could only recover the resulting sum insofar as it exceeded the \$100,000 deductible amount for each triggered year.

The Champion Dyeing & Finishing Co. Holding. Insurers fared less well in a recent New Jersey case construing

the application of the "unavailability" exception to periods of time when an insured had absolute pollution exclusions in its policies. In *Champion Dyeing & Finishing Co. v. Centennial Ins. Co.*,ⁿ²⁰ the Appellate Division ruled that although allocation would have been appropriate if insurers could prove that EIL coverage could have been purchased by a business of this sort in the year that its claims were received (1997), the evidence presented by the insurer had, in fact, not shown that coverage was available by then to small business with old leaking tanks. Even if "claims-made" EIL coverage was shown to have been available, the court ruled that it was error to use the insured's 1986-1997 CGL limits as a proxy measure of what the limits would have been under *Owens-Illinois* analysis since, under a "claims-made" policy, only one year's limits would apply.

The Wooddale Builders Holding. Whereas *Olin* restricted the scope of the "unavailability" exception, the exception gained unexpected traction in Minnesota in 2006 in a construction defect case, *Wooddale Builders, Inc. v. Maryland Cas. Co.*ⁿ²¹ *Wooddale* is curious because it represents the first time that "unavailability" has been recognized in a state where pro rata allocation had originally been approvedⁿ²² on a policy-based "time on the risk" basis approach. It is also the first case to apply "unavailability" in the context of construction defect claims.

Although the Minnesota Court of Appeals had ruled in a construction defect case that defense costs and indemnity should both be allocated based on "time on the risk" basis up until the date that the problems were remediated, the Minnesota Supreme Court declared on appeal that the end point for allocation should be the point in time when the insured received a notice of claim with respect to the property that was on the risk for that claim. Further, as the insured's later policies contained exclusions applying to water intrusion claims, the Minnesota Supreme Court also ruled the insured need not bear responsibility for any period of time for which insurance was unavailable for claims of this sort, so that the period of allocation ended as of the year in which the insured received a notice of claim or with the end of the last period of insurance coverage, whichever was earlier.

The Minnesota Supreme Court held that "strict application" of its *Northern States Power* "actual injury" rule was appropriate because any other result (1) would leave the policyholder uninsured with respect to damages allocated to the period between notice of the claim and the end of remediation and (2) would put a burden on insureds to prove not only that damage was the result of a single discrete occurrence, but during which particular policy period the occurrence took place, thus further increasing the costs of coverage litigation. The court rejected various insurers' argument that the allocation period should be co-extensive with the period of injury, thus extending up until the property damage from water intrusion in the homes had been fully remediated, despite the fact that *Wooddale* had apparently been unable to buy coverage for water intrusion exclusions after 2002. Also, in light of the "known loss" doctrine, the court ruled that coverage cannot be triggered under policies issued after the insured has received a claim, even if remediation is not yet complete. The court also ruled that if a policy is triggered, an entire policy year applies, even if the closing date or date of notice occurred midway through the policy.

WHAT IMPACT WILL BOSTON GAS HAVE ON THE "UNAVAILABILITY" DEBATE? Although *Boston Gas* is the eleventh state supreme court to rule for *pro rata* allocation,ⁿ²³ it is the first to do so while explicitly acknowledging the "unavailability" argument. Most prior cases did not address the issue of unavailability, either due to the reluctance of appellate courts to consider secondary allocation issues that might have uncertain implications for future disputes or because many of these cases have involved excess policies or policies written over large SIRs such that even a limited band of allocated years would moot any chance of the insurer's policies being triggered.ⁿ²⁴

Perhaps because *Boston Gas* was presented to the Massachusetts Supreme Judicial Court as a certified question, thus freeing the court to give a broad answer even with respect to subsidiary issues that were not actually implicated by the facts of the dispute between Boston Gas and Century Indemnity, or perhaps due to the court's desire to avoid having this issue rest on its doorstep for the next decade, Justice Cordy's analysis went far beyond the specific facts in the case and addressed a large number of the second and third tier issues that had been raised by the numerous *amici* in the case:

In its brief, *Boston Gas* did not take a position as to which method of pro rata allocation would be most appropriate, but it did suggest at oral argument that some limits should be placed on pro rata allocation, such as, that

there should be no allocation for uninsured years or where insurance could not be purchased. Some of the policyholder amici also suggest that it would be inappropriate to allocate to the policyholder for periods when coverage was unavailable. n25

Some courts have limited the policyholder's obligation to participate in the allocation to periods during which insurance was commercially "available." These courts have generally held that losses should not be allocated to a policyholder for periods during which the "policyholder was unable to obtain coverage in the market place for a particular risk and with respect to losses resulting from activities or products placed into commerce before such time as coverage became 'unavailable' due to pollution and asbestos exclusions." [Citation omitted.] We decline to adopt such an unavailability exception because to do so would contravene the limitation of coverage in the Century policies to liability attributable to property damage during the policy periods. As Century argues in its brief, the unavailability exception "effectively provides insurance where insurers made the calculated decision not to assume risk and not to accept premiums. In effect, because the policyholder could not buy insurance, it is treated as though it did by passing those uninsurable losses to insured periods." This would not be equitable to insurers if the insured purchased coverage for only a few years where there was protracted damage. n26

The force of the court's analysis in this regard is highlighted by Footnote 41, in which the court expressly distinguished *Owens-Illinois* and *Stonewall*, the leading cases in which courts have declined to extend allocation beyond 1986, and cited with approval rulings from Illinois and Wisconsin that have criticized the "unavailability" doctrine:

41 See, e.g., *Stonewall Ins. Co. v. Asbestos Claims Mgt. Corp.*, 73 F.3d 1178, 1203-1204 (2d Cir. 1995), modified, 85 F.3d 49, 51 (2d Cir. 1996) (adopting "proration-to-the-insured" for "years in which [the policyholder] elected not to purchase insurance or purchased insufficient insurance," but not for periods after 1985, when asbestos liability insurance became unavailable); *Owens-Illinois, Inc. v. United Ins. Co.*, 138 N.J. 437, 479, 650 A.2d 974 (1994) ("When periods of no insurance reflect a decision by an actor to assume or retain a risk, as opposed to periods when coverage for a risk is not available, to expect the risk-bearer to share in the allocation is reasonable"). But see, e.g., *Sybron Transition Corp. v. Security Ins.*, 258 F.3d 595, 599-600 (7th Cir. 2001) (rejecting *Stonewall's* distinction between periods when insurance was "available" or "unavailable" because "[t]he whole idea of a time-on-the-risk calculation is that any given insurer's share reflects the ratio of its coverage [and thus the premiums it collected] to the total risk"); *AAA Disposal Sys., Inc. v. Aetna Cas. & Sur. Co.*, 355 Ill. App. 3d 275, 287, 821 N.E.2d 1278, 290 Ill. Dec. 704 (2005) ("Because the policy periods contained in the . . . insurance policies do not include the years plaintiffs went uninsured, we fail to understand why [the insurer] should have to bear the costs from that period. . . . We understand that insurance coverage was not available for the period at issue, but intervenors cannot shift responsibility for the uninsured years to [the insurer]"). n27

Given the analytic basis on which these courts permitted allocation, it is far from surprising that the Massachusetts Supreme Judicial Court disagreed with their application of an "unavailability" exception. Thus, whereas the New Jersey Supreme Court concluded in *Owens-Illinois* that the wording of the policy did not help it in resolving the issue of allocation, the court's analysis in *Boston Gas* rests entirely on the wording of the policies and only relies on considerations of public policy to buttress its finding that pro rata allocation is required.

WHAT IS THE LONG-TERM SIGNIFICANCE OF *BOSTON GAS*? *Boston Gas* has significantly changed the shape of the playing field in Massachusetts and, in all likelihood, in the other states where these issues remain in dispute.

Up until now, most discussions concerning allocation in long-tail environmental claims stopped at 1986. While insurers might argue that insureds should bear responsibility for earlier gaps, few seriously sought to force insureds to accept coverage for the period after 1986 when most policies were amended to include "absolute" pollution exclusions or asbestos exclusions. This is no longer likely to be the case.

Not only does *Boston Gas* eliminate any distinction with respect to how different types of orphan shares should be treated, it expressly rejects any argument that insureds should not be responsible for that share of indemnity corresponding to years in which policies contain pollution or asbestos exclusions.

Boston Gas also eliminates the burden of proof obstacles that cases such as *Olin* and *Champion Dyeing* have erected that would require insurers to prove that during given periods of time the insured could have bought some kind of applicable insurance. As a result, issues of allocation can now be addressed on a much simpler factual record and resolved, where necessary, by summary judgment.

Despite being the eighteenth Supreme Court opinion on this issue, *Boston Gas* does not read like just any other allocation opinion. It is the author's opinion that the forthright and comprehensive manner in which Justice Cordy summed up the arguments that courts have considered up to this point will prove more than usually persuasive in future disputes.

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n1 *Trustees of Tufts University v. Commercial Union Ins. Co.*, 616 N.E.2d 68 (Mass. 1993).

n2 No. SJC 10246, 2009 Mass. LEXIS 419 (Mass. July 24, 2009).

n3 Coverage mavens will recall Judge Zobel as the author of the *Eagle Picher* "manifestation" opinion in *Eagle-Picher Indus., Inc. v. Liberty Mut. Ins. Co.*, 523 F. Supp. 110 (D. Mass. 1981).

n4 The proceedings are recounted in *Boston Gas Co. v. Century Indem. Co.*, 529 F.3d 8 (1st Cir. 2008). See also the commentary on the First Circuit's decision in this case, *Boston Gas Co. v. Century Indem. Co.*, 529 F.3d 8 (1st Cir. 2008), in Aylward, Michael F., *Boston Gas Co. v. Century Indemnity Co.*: New Developments in Massachusetts Allocation Disputes. LexisNexis Expert Commentary, 2008 *Emerging Issues* 2453.

n5 *Rubenstein v. Royal Ins. Co.*, 44 Mass. App. Ct. 842 (1998);

n6 *Chicago Bridge & Iron Co. v. Certain Underwriters at Lloyds*, 59 Mass. App. Ct. 646 (2003) (applying Illinois law).

n7 *Boston Gas Co. v. Century Indem. Co.*, 529 F.3d 8 (1st Cir. 2008).

n8 Insurers prevailed on this issue in *Public Service Co. of Colorado v. Wallis*, 986 P.2d 924, 940 (Colo. 1999); *Security Ins. Co. of Hartford v. Lumbermens Mut'l Cas. Co.*, 826 A.2d 107 (Conn. 2003); *Atchison, Topeka & Santa Fe Railway Co. v. Stonewall Ins. Co.*, 71 P.3d 1097 (Kan. 2003); *Aetna Cas. & Sur. Co. v. Commonwealth of Kentucky*, 179 S.W.3d 830, 842 (Ky. 2005); *Boston Gas Co. v. Century Indem. Co.*, No. SJC 10246, 2009 Mass. LEXIS 419 (Mass. July 24, 2009); *Northern States Power Co. v. Fid. & Cas. Co.*, 523 N.W.2d 657 (Minn. 1994); *EnergyNorth Natural Gas, Inc. v. Certain Underwriters at Lloyds*, 934 A.2d 517 (N.H. 2007); *Owens-Illinois, Inc. v. United Ins. Co.*, 650 A.2d 974 (N.J. 1994); *Consolidated Edison Co. of New York v. Allstate Ins. Co.*, 774 N.E.2d 687 (N.Y. 2002); *Sharon Steel Corp. v. Aetna Cas. & Sur. Co.*, 931 P.2d 127 (Utah 1997); *Towns v. Northern Security Ins. Co.*, 964 A.2d 1150 (Vt. 2008).

[9] Policyholders prevailed on this issue in *Aerojet-General Corp. v. Transport Indem. Co.*, 948 P.2d 909 (Cal. 1997); *Hercules, Inc. v. AIU Ins. Co.*, 784 A.2d 481 (Del. 2001); *Allstate Ins. Co. v. Dana Corp.*, 759 N.E.2d 1049 (Ind. 2001); *Aetna Cas. & Sur. Co. v. Goodyear Tire & Rubber Co.*, 769 N.E.2d 835 (Ohio 2002); *J.H. France Refractories Co. v. Allstate Ins. Co.*, 626 A.2d 502 (Pa. 1993); *B & L Trucking & Construction Co. v. Northern Ins. Co.*, 951 P.2d 250 (Wash. 1998); and *Plastics Engineering Co. v. Liberty Mut. Ins. Co.*, 759 N.W.2d 613 (Wis. 2009).

n10 650 A.2d 974 (N.J. 1994).

n11 650 A.2d at 992.

n12 650 A.2d at 991.

n13 650 A.2d at 993.

n14 650 A.2d at 995.

n15 73 F.3d 1178 (2d Cir. 1995).

n16 73 F.3d at 1204.

n17 221 F.3d 307 (2d Cir. 2000).

n18 221 F.3d at 326.

n19 221 F.3d at 326.

n20 810 A.2d 68 (N.J. Super. Ct. App. Div. 2002).

n21 722 N.W.2d 283 (Minn. 2006).

n22 *Northern States Power Co. v. Fidelity & Cas. Co.*, 523 N.W.2d 657 (Minn. 1994).

n23 Insurers prevailed on this issue in *Public Service Co. of Colorado v. Wallis*, 986 P.2d 924, 940 (Colo. 1999); *Security Ins. Co. of Hartford v. Lumbermens Mut'l Cas. Co.*, 826 A.2d 107 (Conn. 2003); *Atchison, Topeka & Santa Fe Railway Co. v. Stonewall Ins. Co.*, 71 P.3d 1097 (Kan. 2003); *Aetna Cas. & Sur. Co. v. Commonwealth of Kentucky*, 179 S.W.3d 830, 842 (Ky. 2005); *Boston Gas Co. v. Century Indem. Co.*, No. SJC 10246, 2009 Mass. LEXIS 419 (Mass. July 24, 2009); *Northern States Power Co. v. Fid. & Cas. Co.*, 523 N.W.2d 657 (Minn. 1994); *EnergyNorth Natural Gas, Inc. v. Certain Underwriters at Lloyds*, 934 A.2d 517 (N.H. 2007); *Owens-Illinois, Inc. v. United Ins. Co.*, 650 A.2d 974 (N.J. 1994); *Consolidated Edison Co. of New York v. Allstate Ins. Co.*, 774 N.E.2d 687 (N.Y. 2002); *Sharon Steel Corp. v. Aetna Cas. & Sur. Co.*, 931 P.2d 127 (Utah 1997); *Towns v. Northern Security Ins. Co.* 964 A.2d 1150 (Vt. 2008).

n24 See, e.g., *EnergyNorth Natural Gas, Inc. v. Certain Underwriters at Lloyd's*, 156 N.H. 333, 345 (2007); *Consolidated Edison Co. of New York v. Allstate Ins. Co.*, 774 N.E.2d 687 (N.Y. 2002). In *Consolidated Edison*, the New York Court of Appeals conceded that its ruling was not the "last word" with respect to questions such as whether allocation should be based on the total period of injury, the limits of available insurance coverage or the amount of injury in each year much less as to how allocation should apply to diverse factual circumstances, such as those involving self-insured periods, periods when the insured failed to purchase insurance, or periods for which insurance was unavailable for such losses.

n25 2009 Mass. LEXIS 419, at *70.

n26 2009 Mass. LEXIS 419, at *71-73.

n27 2009 Mass. LEXIS 419, at *74, n.41.

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Richmond on Insurance Intermediaries Narrow Duty to Advise

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Richmond on You Dont Say: Insurance Intermediaries Narrow Duty to Advise

By Douglas Richmond

August 4, 2009

SUMMARY: Clients regularly ask their insurance agents and brokers for advice on insurance issues, and that advice would seem to be part of an intermediary's role. In fact, insurance intermediaries generally have no duty to advise clients on insurance issues. Exceptions to that rule are quite narrow. This disconnect between desire and duty is a constant source of controversy.

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ARTICLE: INTRODUCTION. Many insureds purchase their insurance through agents and brokers. This is true for both personal lines and commercial policies. Unfortunately, prospective insureds may be uncertain about their insurance needs. They may not know how much insurance they should purchase or what coverages they should have. They may never consider reasons for selecting one insurer over another beyond the price of a given policy. Insofar as commercial insurance is concerned, insureds may be unaware of endorsements that are available to tailor coverage to fit their specific business needs. It is understandable that in many instances insured or prospective insureds who are uncertain about their insurance needs will seek advice from the agents or brokers with whom they deal. What are intermediaries' duties in such circumstances, if any?

CROSS REFERENCE: For a full discussion of the duties of agents and brokers, see Jeffrey E. Thomas, New Appleman on Insurance Law Library Edition, Chapter 2.

GENERAL PRINCIPLES. If an insured asks an intermediary about the coverage she is purchasing, the intermediary must answer her questions honestly. n1 As a general rule, however, agents and brokers have no duty to advise insureds about the adequacy or appropriateness of the insurance coverage they purchase, or about optional coverage that might be available, n2 although a few courts have held otherwise. n3 Similarly, intermediaries have no duty to advise insureds about the terms of other policies they hold. n4 An insurance agent or broker is not necessarily an insurance adviser. As New York's highest court reasoned in *Murphy v. Kuhn*: n5

Insurance agents or brokers are not personal financial counselors and risk managers, approaching guarantor status . . . Insureds are in a better position to know their personal assets and abilities to protect themselves more so than

general insurance agents or brokers, unless the latter are informed asked to advise and act. . . . Furthermore, permitting insureds to add such parties to the liability chain might well open flood gates to even more complicated and undesirable litigation. n6

In addition, imposing on intermediaries a general duty to advise insureds about coverage issues would remove from insureds the burden of caring for their own financial needs, and would allow insureds to effectively insure after losses merely by claiming that they would have bought additional or different coverage had it been offered. n7 Courts are especially troubled by the idea that insureds should be able after a loss to manufacture insurance coverage for which they never paid simply by alleging that agents or brokers did not advise them of their insurance needs. As a Missouri court explained:

This turns the entire theory of insurance on its ear as individuals, in theory, take an intellectual gamble when purchasing insurance as they weigh the expense of insurance versus the amount of coverage that they purchase. Allowing insureds to seek coverage, post-occurrence, allows them to completely circumvent this risk. n8

Failure-to-advise claims should be disfavored because they are speculative. n9 Although insureds are quick to assert with the benefit of hindsight that they would have acted differently had they enjoyed the benefit of an intermediary's advice, such allegations are the embodiment of speculation and conjecture.

In short, an intermediary satisfies her duty to the insured by placing the coverage the insured requests. n10 A customer's general request for insurance does not trigger a duty on an intermediary's part to recommend coverage for every possible scenario. n11 Once the agent or broker procures the specific coverage requested, she owes the insured no further duties. n12 An intermediary generally owes no continuing duties to an insured with respect to advice, guidance or insurance counseling.

These principles are especially true where the intermediary whose conduct is at issue is an agent rather than a broker. An insurance agent's duty is to sell the products offered by the company that employs him, or with which he has a captive or exclusive relationship. n13 An insurance agent has no duty to advise insureds about competing insurers' products or policies. n14 Indeed, a captive or exclusive agent has no duty even to tell an insured about his exclusive relationship with the insurer whose products he is selling. n15 When it comes to dealing with agents, any duty to shop the market, compare policies, evaluate optional coverage, etc., rests solely with the insured. n16

EXCEPTIONS TO THE GENERAL RULE. Like all general rules, the no-duty-to-advise rule has exceptions. For example, an intermediary may specifically agree to advise an insured on coverage issues. n17 This sort of arrangement is much more common in commercial and professional contexts than it is where personal insurance is involved. In some jurisdictions, an intermediary may be held to have a duty to advise where she has a continuing relationship with the insured and the insured specifically requests advice, n18 or where there is a course of dealing over an extended period of time which would put an objectively reasonable insurance [intermediary] on notice that his advice is being sought and relied upon. n19

It is certainly possible for an intermediary to voluntarily assume a duty to an insured. n20 Indeed, many brokers voluntarily advise clients on coverage issues, policy terms, alternative coverages, insurance program structure, etc., on the basis that doing so is a business necessity. They reason that they cannot become a trusted advisor to their clients unless they do these things and, absent such a relationship, they will be seen as mere vendors who can easily be replaced. Naturally, if an intermediary assumes a duty to advise an insured with respect to insurance needs, summarize policy terms, or analyze a client's insurance program, for example, she must do so in a non-negligent manner. n21 Brokers who voluntarily assume duties to insureds simply consider the risk of negligent performance of their assumed duties slight, and the benefits to be gained from the assumption of those duties substantial. This is purely a business decision.

Most importantly, the general rule does not apply if the intermediary and the insured share a special relationship.

n22 The existence of a special relationship between an agent or broker and an insured may be treated either as a question of fact or as a question of law, depending on the jurisdiction. n23 Either way, special relationships are not lightly created. The fact that an agent or broker does business with an insured over a number of years does not itself give rise to a special relationship, nor does an intermediary's advertisement of insurance checkups, offer of policy comparisons, or the like. n24 The fact that an agent or broker holds himself out as having special insurance expertise or knowledge, standing alone, is insufficient to create a special relationship. n25 Intermediaries' knowledge that their clients are nave or unsophisticated does not create a special relationship. n26

To be held to share a special relationship with an insured in some jurisdictions, an intermediary must (1) exercise broad discretion in serving the insured's needs; (2) counsel the insured about specialized insurance coverage; (3) hold himself out as a highly-skilled insurance expert coupled with the insured's reliance on his expertise; and (4) receive compensation beyond any ordinary commission for the advice or guidance provided. n27 In other jurisdictions a special relationship may be created where (1) the intermediary holds himself out as an insurance specialist and receives additional compensation for consulting and advice, or (2) there is a long-standing relationship, some type of interaction on the question of coverage, and the insured relied on the [intermediary's] expertise to the insured's detriment. n28 In still other jurisdictions, a special relationship may arise if an intermediary knows (1) that the insured is unsophisticated in insurance matters; (2) that the insured is relying on him to procure appropriate coverage; and (3) that the insured needs the coverage at issue. n29 Finally, in South Carolina, the special relationship rule is phrased in terms of an implied duty, and exists where (1) the intermediary receives compensation beyond a mere commission or fee for procuring coverage; (2) the insured makes a clear request for advice; or (3) there is a course of dealing over an extended period of time which would put an objectively reasonable agent or broker on notice that her advice was being sought and relied upon. n30

Regardless of the specific factors considered or test applied, an insured or applicant arguing for a special relationship bears the burden of proof on the issue. n31 Furthermore, the applicant or insured must demonstrate something more than a standard intermediary-consumer relationship. n32

DeHayes Group v. Pretzels, Inc., n33 illustrates the analysis of some of the key factors listed above. In *DeHayes*, the insured, Pretzels, sued its broker, DeHayes, after a fire consumed Pretzels' manufacturing facilities. The facts developed in the trial court revealed that DeHayes' responsibility was to procure appropriate insurance coverage to protect Pretzels against business and casualty risks. To get the best rates for its coverage, Pretzels asked insurers to bid on its insurance business every two years. Thus, every two years DeHayes and other brokers solicited bids from various insurers and presented those bids to Pretzels for its consideration. n34 DeHayes was compensated solely by commissions paid by Commercial Union, the insurer repeatedly selected by Pretzels throughout the 1990s; Pretzels paid DeHayes nothing. n35

DeHayes appealed the trial court's denial of its summary judgment motion on the lack of a duty owed to Pretzels to the Indiana Court of Appeals. The *DeHayes* court noted that a broker may be bound to do more for an insured than merely procure coverage if they share an intimate long-term relationship or other special circumstances exist. n36 In this case, the relationship between DeHayes and Pretzels began in 1986, some 11 years before the loss at issue. Pretzels did not rely exclusively on DeHayes, however, when it came time to solicit bids for insurance; other brokers also solicited quotes for Pretzels. The choice of a particular insurer from among the competing bidders was always made by Pretzels. As a result, there was no showing that DeHayes exercised broad discretion with respect to serving Pretzels' insurance needs. n37

There was no evidence that DeHayes ever counseled Pretzels about specialized insurance coverage. The most that DeHayes had ever done was to advise Pretzels to increase its coverage limits when it built additional buildings at its manufacturing facility. Such advice was insufficient to create a special relationship. Additionally, the insurance coverage requested by Pretzels with respect to its expanded facilities was standard property and casualty coverage rather than some type of coverage customized to meet Pretzels' particular needs. n38 Pretzels never claimed that DeHayes held itself out as a highly-skilled insurance expert. Beyond that, Pretzels always decided which policy it would buy.

n39

Finally, DeHayes was compensated solely through commissions paid by Commercial Union. Pretzels never directly compensated DeHayes for expert insurance advice.

The *DeHayes* court thus concluded that Pretzels failed to show the existence of a special relationship that would support the imposition of heightened duties on its insurance broker. The court remanded the case to the trial court to enter summary judgment for DeHayes. n40

If an intermediary is held to have a duty to advise an insured about coverage and does so, the insured's failure to follow that advice does not expose the agent or broker to liability. Once informed of optional available coverages, the need for additional or different coverage, or the like, the insured must specifically request the intermediary to procure the suggested coverage if the intermediary is to be held liable for its absence or insufficiency. n41

To be sure, insureds may be disconnected from their insurance needs. Many insureds do not stay abreast of developments and trends that potentially indicate needs for different or greater coverage. It does not follow, however, that agents or brokers are responsible for identifying such customers in order to advise them accordingly. n42 Insureds must be free to determine their own insurance requirements; they ought not have unwanted coverage foisted upon them. Agents and brokers should not be required to speculate about insureds' needs or become coverage detectives out of fear of liability. The question ultimately is one of fit between intermediary and insured. As a Maryland court explained:

In a sense, it is a matter of business judgment on the part of the broker or agent, and personal preference on the part of the customer, that determines whether a customer or agent pursues a laissez-faire style rather than a proactive, aggressive one. To be sure, some customers prefer the don't call me, I'll call you approach with regard to their insurance agents and brokers, believing that they can determine for themselves what they need, and that insurance brokers and agents are just out to sell policies or excessive coverages that are unnecessary. Many of these customers undoubtedly believe that they are able to decide the extent of risk that they can or should tolerate, and they know best what they can afford to pay in premiums. On the other hand, there are customers who undoubtedly want an insurance broker or agent who looks out for the customer's interests before a problem develops, and alerts a client to the kinds of insurance available for maximum protection, or who makes suggestions relating to appropriate coverage and adequacy of coverage. For many of the same reasons, some agents or brokers may consider it prudent business practice to adopt a proactive style, and volunteer information to an insured regarding additional types of coverage, the need for increased coverage, or to help the insured assess his or her particular insurance needs. In contrast, others may believe that they should only respond to a customer's particular request, without aggressively attempting to suggest alternatives. n43

If an intermediary and an insured are not a good fit because the insured needs the protection attending a special relationship and the intermediary is unwilling to accept the duties that inhere in such a relationship, that means only that the insured should look elsewhere for assistance with its insurance needs. It does not mean that the intermediary can be held liable for failing to advise the insured in the way the insured in hindsight would have wished. n44

Insureds sometimes argue that agents and brokers have a duty to advise them on coverage issues because they have requested adequate protection, full coverage, sufficient coverage, as good a policy as [they] can get, the best coverage or best policy available, and so on. n45 Because every insured wants these things, however, vague statements of this kind do not give rise to a duty to advise on an intermediary's part. n46 The *Trotter v. State Farm Mutual Automobile Insurance Co.* n47 court expressed the clear majority rule when it stated:

A request for full coverage, the best policy, or similar expressions does not place an insurance agent under a duty to determine the insured's full insurance needs, to advise the insured about coverage, or to use his discretion and expertise to determine what coverage the insured should purchase. n48

If an intermediary is found to have a duty to advise an insured about coverage, that duty has limits, and an intermediary who breaches her duty is not automatically liable for the damages alleged to result. With respect to the first

point, the scope of the intermediary's duty is defined by the nature of the insured's request for advice. n49 With respect to the second observation, an intermediary does not face liability unless the insured provides her with the information necessary to render the advice sought. n50

THE CLOSELY RELATED DUTY TO EXPLAIN. Closely related to an intermediary's duty to advise an applicant or insured about its insurance needs is an agent's or broker's duty to explain the coverage afforded by a policy. As is the case with respect to an intermediary's alleged duty to advise an insured about the adequacy, appropriateness, or availability of particular coverages, agents and brokers generally have no duty to explain specific policy terms to insureds. n51 Some of the same reasons that defeat a duty to advise apply equally in the duty to explain context. For example, the concern that insureds should not be allowed to obtain coverage after a loss merely by claiming that they did not know the true nature of their coverage is just as valid when the intermediary's alleged duty is one of explanation instead of advice. Additionally, imposing on agents and brokers a duty to explain policy terms to insureds arguably flies in the face of insureds' duty to examine their policies. Nonetheless, courts occasionally hold that a duty to explain exists. This is most often the case where renewal policies are involved. Even courts that are generally unwilling to recognize a duty to advise or explain by intermediaries may be willing to recognize one where a renewal policy differs from the prior policy. n52

CONCLUSION. Insureds routinely purchase their coverage through agents and brokers. As a general rule, insurance intermediaries' duties are confined to the procurement of the policies or coverages that their clients specifically request. Insurance agents and brokers are generally not considered to be insurance advisors or counselors. That said, the general rule that agents and brokers have no duty to advise their clients on insurance issues has several exceptions. Intermediaries may assume a duty to advise their clients on a variety of insurance issues, for example, and brokers are sometimes held to have a duty to advise their clients by virtue of a special relationship. The many cases on intermediaries' alleged duties to advise customers on insurance matters and to explain policy terms suggest a critical need for intermediaries, insureds, and the lawyers who advise them to better understand the related issues. With luck, this commentary is a small step in that direction.

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n1 *Buente v. Allstate Ins. Co.*, 422 F. Supp. 2d 690, 697-698 (S.D. Miss. 2006); *Youngblood v. Auto-Owners Ins. Co.*, 158 P.3d 1088, 1096 (Utah 2007).

n2 *Peter v. Schumacher Enters., Inc.*, 22 P.3d 481, 486 (Alaska 2001); *Scott-Huff Ins. Agency v. Sandusky*, 887 S.W.2d 516, 517 (Ark. 1994); *Roberts v. Assurance Co. of Am.*, 78 Cal. Rptr. 3d 361, 366-367 (Cal. Ct. App. 2008); *Ray v. Valley Forge Ins. Co.*, 92 Cal. Rptr. 2d 473, 479 (Cal. Ct. App. 1999); *Kaercher v. Sater*, 155 P.3d 437, 441 (Colo. Ct. App. 2006); *Sinex v. Wallis*, 611 A.2d 31, 33 (Del. Super. Ct. 1991); *Macabio v. TIG Ins. Co.*, 955 P.2d 100, 111-112 (Haw. 1998); *Indus. Enclosure Corp. v. Glenview Ins. Agency, Inc.*, 884 N.E.2d 202, 207 (Ill. App. Ct. 2008); *Marshall v. Donnelly*, 783 P.2d 1321, 1322 (Kan. Ct. App. 1989); *Mullins v. Commonwealth Life Ins. Co.*, 839 S.W.2d 245, 247 (Ky. 1992); *Szelenyi v. Morse, Payson & Noyes Ins.*, 594 A.2d 1092, 1094 (Me. 1991); *Sadler v. Loomis Co.*, 776 A.2d 25, 46 (Md. Ct. Spec. App. 2001); *Robinson v. Charles A. Flynn Ins. Agency*, 653 N.E.2d 207, 207-208 (Mass. App. Ct. 1995); *Pressey Enters., Inc. v. Barnett-France Ins. Agency*, 724 N.W.2d 503, 505 (Mich. Ct. App. 2006); *Clifton v. Allstate Ins. Co.*, 995 S.W.2d 38, 40 (Mo. Ct. App. 1999); *Manzella v. Gilbert-Magill Co.*, 965 S.W.2d 221, 225-229 (Mo. Ct. App.

1998); *Sintros v. Hamon*, 810 A.2d 553, 557 (N.H. 2002); *Murphy v. Kuhn*, 682 N.E.2d 972, 974 (N.Y. 1997); *Pinney v. State Farm Mut. Ins. Co.*, 552 S.E.2d 186, 191 (N.C. Ct. App. 2001); *Houck v. State Farm Fire & Cas. Ins. Co.*, 620 S.E.2d 326, 329 (S.C. 2005); *Booska v. Hubbard Ins. Agency, Inc.*, 627 A.2d 333, 334 (Vt. 1993); *Poluk v. J.N. Manson Agency, Inc.*, 653 N.W.2d 905, 909 (Wis. Ct. App. 2002); *Gordon v. Spectrum, Inc.*, 981 P.2d 488, 492 (Wyo. 1999).

n3 See, e.g., *Sw. Auto Painting & Body Repair, Inc. v. Binsfield*, 904 P.2d 1268, 1271-1272 (Ariz. Ct. App. 1995) (recognizing duty to advise); *Pinto v. N.J. Mfrs. Ins. Co.*, 874 A.2d 520, 527 (N.J. 2005) (imposing duty to advise in connection with business auto policies); *Lancos v. Silverman*, 946 A.2d 1073, 1078-1079 (N.J. Super. Ct. App. Div. 2008) (recognizing duty to advise owed by both agents and brokers); *Londo v. McLaughlin*, 587 A.2d 744, 748 (Pa. Super. Ct. 1991) (recognizing duty to advise).

n4 *Barnes v. Metro. Life Ins. Co.*, 612 S.W.2d 786, 788 (Mo. Ct. App. 1981).

n5 682 N.E.2d 972 (N.Y. 1997).

n6 *Id.* at 976 (citations omitted); see also *Kaercher v. Sater*, 155 P.3d 437, 441 (Colo. Ct. App. 2006); (Insurance agents are not personal financial counselors and risk managers, approaching guarantor status. . . .)

n7 *Nelson v. Davidson*, 456 N.W.2d 343, 367-347 (Wis. 1990).

n8 *Farmers Ins. Co. v. McCarthy*, 871 S.W.2d 82, 86 (Mo. Ct. App. 1994).

n9 *Pinney v. State Farm Mut. Ins. Co.*, 552 S.E.2d 186, 191 (N.C. Ct. App. 2001) (quoting *Phillips v. State Farm Mut. Auto. Ins. Co.*, 497 S.E.2d 325 (N.C. Ct. App. 1998)).

n10 *Peter v. Schumacher Enters., Inc.*, 22 P.3d 481, 486 (Alaska 2001).

n11 *Frost v. Mayville Tremaine, Inc.*, 750 N.Y.S.2d 398, 399 (N.Y. App. Div. 2002).

n12 *Blevins v. State Farm Fire & Cas. Co.*, 961 S.W.2d 946, 950 (Mo. Ct. App. 1998); *Weiss v. State Farm Fire & Cas. Co.*, 107 S.W.3d 503, 506 (Tenn. Ct. App. 2001); *Booska v. Hubbard Ins. Agency, Inc.*, 627 A.2d 333, 335 (Vt. 1993).

n13 *Weisblatt v. Minn. Mut. Life Ins. Co.*, 4 F. Supp. 2d 371, 382 (E.D. Pa. 1998); *Harts v. Farmers Ins. Exch.*, 597 N.W.2d 47, 50 (Mich. 1999).

n14 *Farmers Ins. Co. v. McCarthy*, 871 S.W.2d 82, 85-86 (Mo. Ct. App. 1994); *Dubreuil v. Allstate Ins. Co.*, 511 A.2d 300, 301-02 (R.I. 1986).

n15 *Wender v. Gilberg Agency, Inc.*, 757 N.Y.S.2d 286, 287 (N.Y. App. Div. 2003).

n16 *Weisblatt v. Minn. Mut. Life Ins. Co.*, 4 F. Supp. 2d 371, 382 (E.D. Pa. 1998).

n17 See *Marshall v. Donnelly*, 783 P.2d 1321, 1322 (Kan. Ct. App. 1989); *Pressey Enters., Inc. v. Barnett-France Ins. Agency*, 724 N.W.2d 503, 505 (Mich. Ct. App. 2006) (quoting *Harts v. Farmers Ins. Exch.*, 597 N.W.2d 47 (Mich. 1999)); *Houck v. State Farm Fire & Cas. Ins. Co.*, 620 S.E.2d 326, 329 (S.C. 2005); *Weiss v. State Farm Fire & Cas. Co.*, 107 S.W.3d 503, 506 (Tenn. Ct. App. 2001); *Avery v. Diedrich*, 734 N.W.2d 159, 165 (Wis. 2007).

n18 *Bentley v. N.C. Ins. Guar. Ass'n*, 418 S.E.2d 705, 712 (N.C. Ct. App. 1992).

n19 *Houck v. State Farm Fire & Cas. Ins. Co.*, 620 S.E.2d 326, 329 (S.C. 2005).

n20 *Peter v. Schumacher Enters., Inc.*, 22 P.3d 481, 486-487 (Alaska 2001); *Pressey Enters., Inc. v. Barnett-France Ins. Agency*, 724 N.W.2d 503, 505 (Mich. Ct. App. 2006) (quoting *Harts v. Farmers Ins. Exch.*,

597 N.W.2d 47 (Mich. 1999)).

n21 *Traina Enters., Inc. v. Cord & Wilburn, Inc. Ins. Agency*, 658 S.E.2d 460, 464 (Ga. Ct. App. 2008).

n22 See *Peter v. Schumacher Enters., Inc.*, 22 P.3d 481, 486 (Alaska 2001); *Buelow v. Madlock*, 206 S.W.3d 890, 893 (Ark. Ct. App. 2005); *Court View Centre, L.L.C. v. Witt*, 753 N.E.2d 75, 87 (Ind. Ct. App. 2001); *Sandbulte v. Farm Bureau Mut. Ins. Co.*, 343 N.W.2d 457, 464-465 (Iowa 1984); *Szelenyi v. Morse, Payson & Noyes Ins.*, 594 A.2d 1092, 1094 (Me. 1991); *Sadler v. Loomis Co.*, 776 A.2d 25, 46 (Md. Ct. Spec. App. 2001); *Harts v. Farmers Ins. Exch.*, 597 N.W.2d 47, 51-52 (Mich. 1999); *Beauty Craft Supply & Equip. Co. v. State Farm Fire & Cas. Ins. Co.*, 479 N.W.2d 99, 101-102 (Minn. Ct. App. 1992); *Sintros v. Hamon*, 810 A.2d 553, 556 (N.H. 2002); *Murphy v. Kuhn*, 682 N.E.2d 972, 974-975 (N.Y. 1997); *Lewis-Williamson v. Grange Mut. Ins. Co.*, 39 P.3d 947, 949-950 (Or. Ct. App. 2002); *AAS-DMP Mgmt., L.P. Liquidating Trust v. Acordia N.W., Inc.*, 63 P.3d 860, 863-864 (Wash. Ct. App. 2003); *Avery v. Diedrich*, 734 N.W.2d 159, 165 (Wis. 2007); *Gordon v. Spectrum, Inc.*, 981 P.2d 488, 492 (Wyo. 1999).

n23 Compare *Buelow v. Madlock*, 206 S.W.3d 890, 893 (Ark. Ct. App. 2005) (stating that the existence of a special relationship is a fact question) and *Sintros v. Hamon*, 810 A.2d 553, 557 (N.H. 2002); (same), with *Tackes v. Milwaukee Carpenters Dist. Council Health Fund*, 476 N.W.2d 311, 313 (Wis. Ct. App. 1991) (calling the existence of a special relationship a legal matter).

n24 See, e.g., *Sinex v. Wallis*, 611 A.2d 31, 33-34 (Del. Super. Ct. 1991) (However, an expanded duty of care is not created by an insured who deals with a particular agent over a period of years.); *Wyrick v. Hartfield*, 654 N.E.2d 913, 915 (Ind. Ct. App. 1995) (explaining that it is the nature of the relationship between an intermediary and an insured, not merely the length of that relationship, that triggers a duty to advise) (quoting *Parker v. State Farm Mut. Auto. Ins. Co.*, 630 N.E.2d 567, 569 (Ind. Ct. App. 1994)); *Graves v. State Farm Mut. Auto. Ins. Co.*, 821 So. 2d 769, 772-774 (La. Ct. App. 2002) (declining to hold agent liable where insureds were long-time customers of the agency and agent advertised family insurance checkups to which the insureds never responded).

n25 *Sewell v. Great N. Ins. Co.*, 535 F.3d 1166, 1171 (10th Cir. 2008) (discussing insured's claim of entrustment so as to create some sort of special or fiduciary relationship); *Kaercher v. Sater*, 155 P.3d 437, 442 (Colo. Ct. App. 2006).

n26 *AGA Fishing Group Ltd. v. Brown & Brown, Inc.*, 533 F.3d 20, 24 (1st Cir. 2008).

n27 *Court View Centre, L.L.C. v. Witt*, 753 N.E.2d 75, 87 (Ind. Ct. App. 2001) (quoting *Am. Family Mut. Ins. Co. v. Dye*, 634 N.E.2d 844, 847 (Ind. Ct. App. 1994)).

n28 *Lipscomb v. Farmers Ins. Co. of Wash.*, 174 P.3d 1182, 1186 (Wash. Ct. App. 2007) (footnote omitted).

n29 *Beauty Craft Supply & Equip. Co. v. State Farm Fire & Cas. Ins. Co.*, 479 N.W.2d 99, 101 (Minn. Ct. App. 1992);

n30 *Houck v. State Farm Fire & Cas. Ins. Co.*, 620 S.E.2d 326, 329 (S.C. 2005).

n31 *Billboards N' Motion, Inc. v. Saunders-Saunders & Assocs., Inc.*, 879 N.E.2d 1135, 1142 (Ind. Ct. App. 2008).

n32 *Sewell v. Great N. Ins. Co.*, 535 F.3d 1166, 1171 (10th Cir. 2008) (applying Colorado law); *Sintros v. Hamon*, 810 A.2d 553, 557 (N.H. 2002); *Murphy v. Kuhn*, 682 N.E.2d 972, 975 (N.Y. 1997); *Gordon v. Spectrum, Inc.*, 981 P.2d 488, 492 (Wyo. 1999).

n33 786 N.E.2d 779 (Ind. Ct. App. 2003).

n34 *DeHayes*, 786 N.E.2d at 780-781.

n35 *DeHayes*, 786 N.E.2d at 781.

n36 *DeHayes*, 786 N.E.2d at 782 (quoting cases).

n37 *DeHayes*, 786 N.E.2d at 783.

n38 *DeHayes*, 786 N.E.2d at 783.

n39 *DeHayes*, 786 N.E.2d at 783.

n40 *DeHayes*, 786 N.E.2d at 783.

n41 *See, e.g., Lancos v. Silverman*, 946 A.2d 1073, 1078-80 (N.J. Super. Ct. App. Div. 2008) (finding no liability where insured failed to procure recommended liability coverage).

n42 *Sadler v. Loomis Co.*, 776 A.2d 25, 46 (Md. Ct. Spec. App. 2001).

n43 *Sadler*, 776 A.2d at 46-47.

n44 *See Sadler*, 776 A.2d at 47.

n45 *See, e.g., Transp. Ins. Co. v. AARK Constr. Group, Ltd.*, 526 F. Supp. 2d 350, 360 (E.D.N.Y. 2007) (requesting full coverage); *Sinex v. Wallis*, 611 A.2d 31, 33 (Del. Super. Ct. 1991) (seeking sufficient coverage and best policy); *Sandbulte v. Farm Bureau Mut. Ins. Co.*, 343 N.W.2d 457, 465 (Iowa 1984) (wanting sufficient coverage); *Mullins v. Commw. Life Ins. Co.*, 839 S.W.2d 245, 246-247 (Ky. 1992) (involving request by insured for as good of a policy as [she] could get on liability and no-fault, everything [she] could get on it, because [she] couldn't afford full coverage); *Beauty Craft Supply & Equip. Co. v. State Farm Fire & Cas. Ins. Co.*, 479 N.W.2d 99, 101 (Minn. Ct. App. 1992) (requesting full coverage); *Banes v. Martin*, 965 S.W.2d 383, 385 (Mo. Ct. App. 1998) (involving request for full coverage); *DeWyngaert v. Bean Ins. Agency, Inc.*, 855 A.2d 1267, 1269 (N.H. 2004) (requesting full coverage); *Mueggenborg v. Ellis*, 55 P.3d 452, 454 (Okla. Ct. App. 2002) (involving request for adequate protection); *Small v. King*, 915 P.2d 1192, 1193-94 (Wyo. 1996) (requesting full coverage).

n46 *Transp. Ins. Co. v. AARK Constr. Group, Ltd.*, 526 F. Supp. 2d 350, 360 (E.D.N.Y. 2007) (applying

New York law); *Sinex v. Wallis*, 611 A.2d 31, 33 (Del. Super. Ct. 1991); *Sandbulte v. Farm Bureau Mut. Ins. Co.*, 343 N.W.2d 457, 465 (Iowa 1984); *Mullins v. Commw. Life Ins. Co.*, 839 S.W.2d 245, 249 (Ky. 1992); *Beauty Craft Supply & Equip. Co. v. State Farm Fire & Cas. Ins. Co.*, 479 N.W.2d 99, 101-102 (Minn. Ct. App. 1992); *Banes v. Martin*, 965 S.W.2d 383, 385 (Mo. Ct. App. 1998); *DeWyngaert v. Bean Ins. Agency, Inc.*, 855 A.2d 1267, 1270-1271 (N.H. 2004); *Mueggenborg v. Ellis*, 55 P.3d 452, 454 (Okla. Ct. App. 2002); *Small v. King*, 915 P.2d 1192, 1194 (Wyo. 1996). But see *Harts v. Farmers Ins. Exch.*, 597 N.W.2d 47, 52 n.11 (Mich. 1999) (suggesting that in certain circumstances an insured's request for full coverage might be ambiguous and accordingly trigger a duty to advise).

n47 377 S.E.2d 343 (S.C. Ct. App. 1988).

n48 Trotter, 377 S.E.2d at 347.

n49 *Empire Indus. Corp. v. Ins. Cos. of N. Am.*, 641 N.Y.S.2d 345, 345 (N.Y. App. Div. 1996); see also 43 Am. Jur. 2d Insurance § 162, at 205-206 (2003).

n50 See, e.g., *Nat'l Farmers Union Standard Ins. Co. v. Souris River Tel. Mut. Aid Coop.*, 75 F.3d 1268, 1273-1275 (8th Cir. 1996) (discussing Minnesota and North Dakota law); *Booska v. Hubbard Ins. Agency, Inc.*, 627 A.2d 333, 335-336 (Vt. 1993).

n51 *Aspen Specialty Ins. Co. v. Muniz Eng'g, Inc.*, 514 F. Supp. 2d 972, 983 (S.D. Tex. 2007) (discussing Texas law); *Wilmering v. Lexington Ins. Co.*, 678 S.W.2d 865, 872 (Mo. Ct. App. 1984) (noting further that this rule is particularly true where the insured does not ask for an explanation); *Pitts v. Jackson Nat'l Life Ins. Co.*, 574 S.E.2d 502, 509 (S.C. Ct. App. 2002) (holding that agent had no duty to explain differences between two life insurance policies offered by the same insurer); *Booska v. Hubbard Ins. Agency, Inc.*, 627 A.2d 333, 335 (Vt. 1993) (The agent's task is to be generally fair and truthful in explaining the nature of a policy, not to warn the insured about the impact of necessarily complex contract language on every eventuality.).

n52 See, e.g., *Wachovia Ins. Servs., Inc. v. Toomey*, 994 So. 2d 980, 982, 987 (Fla. 2008) (stating that broker had duty to explain where broker extended coverage but changed policy terms in the extension); *Haynes v. Edgerson*, 240 S.W.3d 189, 195-196 (Mo. Ct. App. 2007) (finding that intermediary has duty to advise where new policy differs from old policy); *Wynn v. Avemco Ins. Co.*, 963 P.2d 572, 574 (Okla. 1998) (stating that insurance agent has duty to explain where renewal policy differs from original policy).

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By Sherilyn Pastor and Alissa Pyrich

July 8, 2009

SUMMARY: The New Jersey Appellate Division recently held that Wakefern Food Corporation and its cooperative members have full coverage for food spoilage losses incurred as a result of the August 2003 Northeastern blackout. It rejects the insurers attempt to avoid coverage based on an exceedingly narrow and technical definition of "physical damage" favoring instead the plain meaning of the term.

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ARTICLE: The New Jersey Superior Court, Appellate Division, recently ruled in favor of Wakefern Food Corporation and affiliated supermarkets ("Wakefern") in connection with a dispute over their right to collect insurance coverage for food spoilage losses and loss of business incurred during the August 2003 Northeastern blackout. The insurer, Liberty Mutual Fire Insurance Company ("Liberty Mutual") had initially denied coverage claiming that the losses were not the result of "physical damage." In *Wakefern Food Corp., et al. v. Liberty Mutual Fire Ins. Co., Slip. Op., Docket No. A-2010-07T3 (N.J. Super. Ct. App. Div. Apr. 22, 2009)*, the Appellate Division held that the term "physical damage," not defined in the policy, should be given its plain meaning based on Wakefern's understanding of the protection it was purchasing, not some hyper-technical meaning based on the intricacies of electrical power transmission systems. Applying this common sense meaning, the Appellate Division found that Wakefern was entitled to collect insurance coverage from Liberty Mutual for the food spoilage losses and loss of business sustained during the blackout.

On August 14, 2003, problems with the interconnected North American electrical power generation and transmission system (colloquially known as the "electrical grid") caused a blackout over much of the northeastern United States and eastern Canada. During this four-day blackout, affected areas were completely without electrical power. Wakefern and the other plaintiff supermarkets sustained significant losses as the result of food spoilage and loss of business.

Wakefern sought coverage for the blackout losses from its insurer, Liberty Mutual. Wakefern had purchased from Liberty Mutual both a first-party all risk insurance policy and an additional "Services Away From Covered Location Coverage Extension." The "Services Away Extension" specifically provides coverage for losses resulting from interruptions in electrical power to Wakefern's supermarkets where the interruption is caused by "physical damage" to

certain electrical equipment and property located off of supermarket property. Wakefern's Director of Insurance certified that, in purchasing coverage from Liberty Mutual, Wakefern specifically wanted to have coverage for food spoilage and other losses that might result from the loss of power from utilities. He understood that by purchasing all-risk coverage and the "Services Away Extension," Wakefern had obtained and paid for such coverage.

Although there was no dispute that the food spoilage and other losses sustained during the blackout were the kinds of losses covered under Liberty Mutual's policy and the "Services Away Extension," Liberty Mutual nevertheless declined coverage. According to Liberty Mutual, the four-day August 2003 blackout was not caused by "physical damage" to electrical equipment, and thus any losses resulting from the blackout were not covered by its policy. Faced with Liberty Mutual's denial, Wakefern -- represented by McCarter & English, LLP partner Sherilyn Pastor, sued to enforce its right to coverage.

Neither Liberty Mutual's policy nor the "Services Away Extension" contained a definition of the key term "physical damage." Liberty Mutual advocated a highly technical definition of the term, relying on an expert to argue that the root cause of the blackout was not something wrong with the various components of the electrical grid but instead the proper functioning of protection systems designed to prevent surges and physical damage to the components of the grid. In support of its argument, Liberty Mutual relied on the Final Report of the task force investigating the blackout, which Liberty Mutual asserted attributed the blackout to four major causes, none of which involved the actual destruction of the various technical components of the electrical grid.

The trial court agreed with Liberty Mutual, but the Appellate Division did not. It began its analysis by invoking the general principle that, where the language of an insurance policy supports two reasonable meanings, courts will favor the meaning that affords coverage. Slip Op. at 18. Further, the Appellate Division acknowledged that New Jersey law for the interpretation of insurance contracts seeks to give effect to the reasonable expectations of the insured. In particular, policyholders "should not be subjected to technical encumbrances or hidden pitfalls and their policies should be construed liberally in their favor to the end that coverage is afforded 'to the full extent that any fair interpretation will allow.'" Slip Op. at 19, quoting *Kievit v. Loyal Protective Life Ins. Co.*, 34 N.J. 475, 482 (1961). Guided by these principles, the Appellate Division concluded that "the undefined term 'physical damage' was ambiguous and that the trial court construed the term too narrowly, in a manner favoring the insurer and inconsistent with the reasonable expectations of the insured." Slip Op. at 20.

The Appellate Division also conclude that the electrical grid was physically damaged within the meaning of Liberty Mutual's insurance because, "due to a physical incident or series of incidents, the grid and its component generators and transmission lines were physically incapable of performing their essential function of providing electricity." Slip Op. at 21. The Appellate Division found it significant that because of the interconnected nature of the systems, power could not be turned back on in several areas until individual pieces of damaged equipment were replaced. *Id.* The inability to perform the intended function due to some sort of physical, tangible or concrete change or effect in the system or its parts was, for the Appellate Division, a component of "physical damage." In a footnote, the court pointed out that it would have reached a different conclusion if the blackout had been the result of something other than the physical inability of the electrical grid to function (such as, for example, an order that power be shut off to conserve electricity).

In reaching its conclusions, the Appellate Division noted that neither Wakefern nor Liberty Mutual were electric utilities, operators or providers with detailed knowledge about the workings of the electrical grid and its components. n1[1] Slip Op., at 21-22. Thus, it made no sense to assign a highly technical definition to "physical damage." *Id.* at 22. Rather, the term had to be defined from the point of view of Wakefern, as a customer of electrical power who had purchased insurance to protect against the risk of losses from the loss of electrical power used to refrigerate products. *Id.* The Appellate Division concluded that, "[t]he average policyholder in plaintiffs' position would not be expected to understand the arcane functioning of the power grid or the narrowly-parsed definition of 'physical damage' which the insurer urges us to adopt." *Id.*

Because the term "physical damage" was not defined in Liberty Mutual's policy and was capable of more than one reasonable meaning, the Appellate Division followed the well-established law and construed the term in a way that favored coverage for Wakefern's losses. Slip Op. at 22-23. The Appellate Division rejected Liberty Mutual's argument that "physical damage" could only be the permanent ruin or destruction of the electrical grid or its components. Instead, the Appellate Division concluded that a temporary loss of function, after which the electrical grid went back on line, was sufficient to satisfy the requirements of the policy. Slip Op. at 26-27. The inherent nature of power losses -- for which Wakefern had actively sought out insurance coverage -- is necessarily temporary (as electricity will always be eventually restored). Adopting Liberty Mutual's requirement of permanent ruin or damage would have rendered the "Services Away Extension" purchased by Wakefern illusory and effectively useless. Since such a result would be at odds with the reasonable expectations of the policyholder (and indeed, with Wakefern's specific expectations), the Appellate Division could not accept Liberty Mutual's definition of "physical damage."

All in all, the Appellate Division's ruling in *Wakefern* reinforces the generally pro-policyholder stance of the New Jersey courts. Faced with a choice between a highly technical definition of a term and a more generalized and reasonable definition that comported with the policyholder's understanding of the coverage protections it purchased, the Appellate Division opted for the coverage-affording alternate meaning. For insurers, the *Wakefern* ruling serves as a reminder that, if their intention really is to exclude certain types of coverage, they must make that intention clear and explicit. Insurers cannot hope to rely on technical encumbrances or hidden pitfalls as their policies will be construed liberally in favor of coverage to the full extent that any fair interpretation so allows.

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n1 Following the same rationale, the Appellate Division noted the task force report's limited value in resolving the meaning of "physical damage" as used in Liberty Mutual's insurance policy. The report, while useful for its intended purpose of explaining on a technical level why the blackout occurred, was never intended for use in construing the meaning of insurance policies. Furthermore, as Wakefern noted, the report itself describes the physical damage that caused the blackout and extended its duration.

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About the Firm. McCarter & English's Coverage Group consists of over 40 attorneys providing legal assistance to corporate policyholders throughout the country and internationally.

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Sonnenschein Nath & Rosenthal, LLP on Boritz v. N.J. Manufacturers Ins. Co.

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Sonnenschein Nath & Rosenthal, LLP on Boritz v. New Jersey Manufacturers Insurance Co.: New Jersey Extends Insurer Duty To Inform re Coverage Limitations

By William T. Barker and Donna J. Vobornik

June 26, 2009

SUMMARY: Along with some other states, New Jersey has held that, in some circumstances, the duty of good faith and fair dealing requires an insurer to affirmatively inform an insured of the insured's rights under the policy. In *Boritz v. New Jersey Mfrs. Ins. Co.*, the intermediate court extended this duty to require that a permissive user be notified of a step-down provision reducing the underinsured motorist (UIM) coverage otherwise available.

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ARTICLE: Along with some other states, New Jersey has held that, in some circumstances, the duty of good faith and fair dealing requires an insurer to affirmatively inform an insured of the insured's rights under the policy. In *Boritz v. New Jersey Manufacturers Insurance Co.*,ⁿ¹ the intermediate court extended this duty to require that a permissive user be notified of a step-down provision *reducing* the underinsured motorist (UIM) coverage otherwise available. This commentary examines the significance of that decision in light of other cases on the duty to inform.

I. The Case

Boritz was injured in a traffic accident while a passenger in the Iacono car, which was rear-ended by Vinson's car. Vinson was insured by GEICO, which offered its \$15,000 limit in exchange for a release. New Jersey Manufacturers (NJM) insured the Iacono car, with a UIM limit of \$100,000 (but subject to a stepdown clause, reducing coverage for a nonnamed insured with his or her own UIM coverage to the limit provided by that coverage). Boritz herself had UIM coverage with a \$25,000 limit. ⁿ²

A UIM insurer typically has contractual subrogation rights against the tortfeasor responsible for injuries resulting in payment of UIM benefits. If the insured gives the tortfeasor a release, that would cut off the subrogation right. To protect the subrogation right, *Longworth v. Van Houten* ⁿ³ allows an insured to notify the UIM insurer of a proposed settlement with the tortfeasor, requesting consent to settle. If the UIM insurer wishes to prevent the settlement, it must pay the insured the amount offered in settlement. ⁿ⁴ Accordingly, Boritz notified NJM of the \$15,000 offer from GEICO, and it consented to the settlement. ⁿ⁵

NJM confirmed existence of UIM coverage for the Iacono car and the limit of \$100,000 per person, but it did not

mention the step-down provision, as it did not then know Boritz's own UIM limit. After reviewing documentation regarding the claim, NJM offered \$17,023 to settle the UIM claim. Boritz responded with a \$75,000 demand, which drew a \$32,023 counteroffer. NJM then received a copy of Boritz's declaration page, showing her UIM limit of \$25,000. It then invoked the step-down clause, which made the maximum recovery \$10,000 (Boritz's \$25,000 limit less the \$15,000 recovery from GEICO). Boritz then filed this declaratory judgment action, asserting that NJM was estopped from enforcing the step-down clause because it had confirmed the \$100,000 limit without disclosing the clause, and she had relied on that confirmation by accepting GEICO's offer. n6

The Law Division granted summary judgment to NJM, but the Appellate Division reversed, offering two rationales. First, a confirmation of coverage (or even a failure to timely disclaim) could be the basis for an estoppel if the insured detrimentally relied on that. Second, the duty of good faith is more than simply an obligation not to act in bad faith. According to the court, a request for consent under *Longworth* gives the insurer the opportunity to evaluate the settlement decision in light of all relevant factors, including its coverage limits. Because those limits are crucial to an insured's own settlement decision, the insurer ought to inform the insured if there are facts the insured needs to know. While NJM did not know Boritz's UIM limits when it gave consent to settle, it could have warned her of the step-down clause when it confirmed coverage. n7

II. Detrimental Reliance?

While this commentary focuses on the duty to inform, it is worth pointing out that *Boritz* seems to take the claim of detrimental reliance at face value, without describing any evidence supporting that claim. But whatever reliance an insured may have placed on an insurer's representations or omissions regarding UIM coverage would not be detrimental if there was no alternate course of action that at least might have yielded a greater total recovery by rejecting the tortfeasor's offer. Many tortfeasors are judgment proof. In fact, that is one reason why some people carry only the minimum limits necessary to satisfy the law. If the tortfeasor were (except for available insurance) unable to respond in damages, there could be no possible benefit in pursuing the claim once the tortfeasor's insurer offers its limits. And, even if the tortfeasor were not entirely judgment proof, that would make no difference if the available assets were too small to be worth the expense of litigating. In either event, accepting the settlement could not be detrimental, even if the insured was misled about the UIM limits. An insured asserting an estoppel should have the burden of proving that correct information on the UIM limit would have resulted in a different decision on settling for the tortfeasor's limits.

III. An Insurer's Duty To Inform

Some jurisdictions have held that an insurer's duty of good faith and fair dealing includes an affirmative duty, in some circumstances, to inform insureds about their rights under their insurance policies and what must be done to obtain benefits due. n8 New Jersey did this in *Bowler v. Fidelity & Casualty Co.*, n9 but *Boritz* (which did not even cite *Bowler*) represents an extension.

In *Bowler*, Fidelity issued a disability policy calling for payment of up to 200 weeks of specified disability payments so long as the insured was totally and continuously disabled. If the insured remained totally disabled at the end of that period, the policy called for payment of a lump sum equal to 600 weeks payments at the stated rate. Bowler, a buyer of ladies coats, suffered a severe fracture of the lower leg, requiring extended hospitalization. Osteomyelitis developed, causing chronic rotting away of the bone accompanied by continuing drainage of pus through an ulcer on the surface of the leg. Based upon reports from Bowler's doctor and periodic examination by its own doctor, Fidelity paid benefits for the first 199 weeks after the accident. n10

The 200 week period expired on December 2, 1957. In anticipation of this significant date, Fidelity sent Bowler additional claim forms in mid-November. Shortly afterward, he returned those forms asserting continuous and total disability to date. On November 25, 1957, Bowler's physician completed a report referring to his numerous prior reports, stating that Bowler was still under treatment and saying that the doctor could not predict how much longer Bowler would remain continuously and totally disabled. Bowler was reexamined by Fidelity's physician, Dr. Siegal, on

November 26, 1957. Dr. Siegal reported Bowler's lack of improvement since the accident and the continuing drainage and other problems with his leg. He then stated that Bowler was not totally disabled because he was capable of many kinds of work, but also noted that no one would hire him with his canes, his limp, and his foul-smelling leg. Without explanation, Fidelity failed to make either the 200th weekly payment or the lump sum payment of 600 weeks of indemnity. n11

More than six years later, Bowler sued for the unpaid benefits. The insurer raised the six-year statute of limitations as a defense, and the New Jersey Supreme Court held that it was estopped to claim the benefit of the statute. The court first reviewed the requirements of total and continuous disability, noting that courts found this requirement much less stringent than an untutored laymen (or doctor) might believe from a reading of the policy language. n12 Viewing the evidence available to the insurer in light of the proper standard, the court found that it was clear beyond all doubt that Bowler was entitled to the 200th weekly payment and that the company knew this. n13 Moreover, the court regarded the proof of Bowler's entitlement to the lump sum payment as practically conclusive." n14

The court regarded the insurer's conduct as shocking and unconscionable, precluding any right to rely on the statute of limitations. n15 It emphasized the insurer's duty of good faith and its special significance where the language expressing the extent of coverage may be deceptive to the ordinary layman." n16 It reasoned that:

When a loss occurs which because of its expertise the insurer knows or should know is within the coverage, and the dealings between the parties reasonably put the company on notice that the insured relies upon its integrity, fairness and honesty of purpose, and expects his right to payment to be considered, the obligation to deal with him takes on the highest burden of good faith. In situations where a layman might give the controlling language of the policy a more restrictive interpretation than the insurer knows the courts have given it and as a result the uninformed insured might be inclined to be quiescent about the disregard or non-payment of his claim and not to press it in timely fashion, the company cannot ignore its obligation. It cannot hide behind the insured's ignorance of the law; it cannot conceal its liability. In these circumstances it has the duty to speak and disclose, and to act in accordance with its contractual undertaking. The slightest evidence of deception or overreaching will bar reliance upon time limitations for prosecution of the claim. n17

Thus, the insurer was obliged to pay any amounts clearly due without waiting for any demand and, if it failed to do so, would be estopped from relying on the statute of limitations. The court went one step beyond requiring payment of benefits where the obligation to pay could not reasonably be disputed. It declared that:

if the insurer has factual information in its possession substantially supporting the policyholder's right to benefits, but it has a reasonable doubt as to whether the evidence is sufficient to require payment, the obligation to exercise good faith, upon which it knows or should know the insured is relying, cannot be satisfied by silence or inaction. It must notify the insured of its decision not to pay his claim. But mere naked rejection would not be sufficient. The giving of such notice should be accompanied by a full and fair statement of the reasons for its decision not to pay the benefits, and by a clear statement that if the insured wishes to enforce his claim it will be necessary for him to obtain the services of an attorney and institute a court action within the appropriate time. The appropriate time means the time remaining under the policy or the applicable statute of limitations within which the suit must be brought. Failure on the insurer's part to follow such a course, will bar reliance on the statute of limitations or a time restriction on court action expressed in the policy. n18

We have previously suggested that *Bowler* should not be read as broadly as this language might suggest:

Read broadly, the latter passage could suggest a duty to notify the claimant of many things, including the time period allowed for bringing suit, on every non-frivolous claim which an insurer declines to pay. But the New Jersey courts have not read it so. Indeed, there is hardly any caselaw citing *Bowler* for its statute of limitations holding and none relying on a failure of notice to preclude use of the statute of limitations. Thus, *Bowler* should be read to require notice only where the insurer has received evidence approximating a prima facie case of entitlement to benefits, and

perhaps, only where the insurer is on notice (because of policy language that a layman is likely to misunderstand or otherwise) that notice is necessary for the insured to exercise available rights, including the right to [contest denial of] the claim. n19

This language was quoted approvingly in *Azze v. Hanover Insurance Co.* n20 The issue there was tolling of the one-year suit limitation period in a property insurance policy. The New Jersey Supreme Court had held that such a limitation is tolled during the time between an insured's submission of a claim and the when the insurer gives formal notice that the claim has been denied. n21 *Azze* argued that a formal denial should have to include a warning about the limitation period, but the court disagreed, based in part on the quoted paragraph. n22 Because Hanover's denial of *Azze's* claim was not in bad faith, *Bowler* did not apply. n23 A federal district court has also concluded that *Bowler* does not apply unless the insurer is *clearly* required to pay or fails to notify the insured that the claim is being denied. n24

Because NJM was not denying Boritz's claim or withholding any benefits clearly due, *Bowler* would not apply, and *Boritz* represents an extension of a previously narrow duty. Unlike other cases in which bad faith has been found, NJM was not preferring its own interests to those of Boritz by failing to warn of the step-down clause. NJM had nothing to gain by leading Boritz to accept the settlement.

Moreover, *Boritz* rests, in part, on the dubious premise that a consent to settle is an acknowledgement of coverage. All a consent to settle actually says is that the insurer is waiving any subrogation right it might have. The most common reason is that the putative tortfeasor has too few noninsurance assets to make suit worthwhile, even if UIM benefits are paid. If UIM coverage is in doubt, that is another reason why any subrogation rights may have little value and can be relinquished. While there was an actual confirmation of coverage in *Boritz* itself, the court incorrectly treats a consent to settle as if it were such an acknowledgement.

IV. Conclusion

Courts in other states ought not to follow *Boritz*. If it is not reversed, New Jersey courts should read it narrowly, as they have consistently read *Bowler*.

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n1 *Boritz v. New Jersey Mfrs. Ins. Co.*, 968 A.2d 1223, 2009 N.J. Super. LEXIS 92 (N.J. Super. Ct. App. Div. 2009).

n2 *Boritz*, 2009 N.J. Super. LEXIS 92, at *1-4.

n3 *Longworth v. Van Houten*, 223 N.J. Super. 174 (N.J. Super. Ct. App. Div. 1988).

n4 *Id.* at 194-95.

n5 *Boritz*, 2009 N.J. Super. LEXIS 92, at *3-4.

n6 *Id.* at *4-5.

n7 *Id.* at *12-16.

n8 William T. Barker & Donna J. Vobornik, *The Scope of the Emerging Duty of First-Party Insurers To Inform Their Insureds of Rights Under the Policy*, 25 Tort & Ins. L. J. 749 (1990).

n9 *Bowler v. Fidelity & Casualty Co.*, 53 N.J. 313 (1969).

n10 *Id.* at 317-19.

n11 *Id.* at 319-20.

n12 *Id.* at 321-24.

n13 *Id.* at 325.

n14 *Id.* at 326.

n15 *Id.*

n16 *Id. at* 327.

n17 *Id. at* 327-28 (citations omitted).

n18 *Id. at* 328.

n19 William T. Barker & Donna J. Vobornik, *supra* note ___, 25 *Tort & Ins. L. J.* at 753.

n20 *Azze v. Hanover Ins. Co.*, 226 N.J. Super 630, 640 (App. Div. 2001).

n21 *Peloso v. Hartford Fire Ins. Co.*, 56 N.J. 514, 520 (1970).

n22 *Azze*, 226 N.J. Super at 639.

n23 *Id.*

n24 *Ali, Inc. v. Generali*, 954 F. Supp. 118, 121-22 (D.N.J. 1997). *Ali's* reading of *Bowler* and *Peloso* was followed in *Township of Hamilton v. Zurich American Insurance Co.*, 2006 U.S. Dist. LEXIS 67096, *10-11 (D.N.J. 2006).

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Reed Smith LLP on Thorpe Insulation

2009 Emerging Issues 3887

Reed Smith LLP on Thorpe Insulation: The Rising Use Of Course Of Performance Evidence To Interpret Insurance Policies In The Asbestos Context

By Douglas C. Rawles and Natasha Sung

June 26, 2009

SUMMARY: In California, course of performance evidence is one of several tools courts may use when resolving a dispute over the meaning of terms in contract disputes. But until last years decision in *Employers Reinsurance Company et al. v. Superior Court*, 161 Cal. App. 4th 906 (2008) (Thorpe Insulation), courts had not relied on course of performance evidence in disputes involving insurance contracts.

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ARTICLE: In California, course of performance evidence is one of several tools courts may use when resolving the intended meaning of disputed terms in a contract. But until recently, California courts have not utilized this tool in disputes involving insurance contracts, even when the parties to the dispute have a long history of interaction due to numerous similar claims being handled over many years. Instead, courts for the most part ignored course of performance evidence, n1 and on those few occasions when it was considered, courts referenced such evidence in dicta as further support for its findings. n2

Last year, however, the court in *Employers Reinsurance Company et al. v. Superior Court*, 161 Cal. App. 4th 906, 911 (2008) ("*Thorpe Insulation*"), held that "course of performance" evidence is relevant in the interpretation of insurance contracts, and may be used for that purpose. The court also held that course of evidence is only admissible when it relates to the contract of insurance in issue; the parties' performance pursuant to a claims handling agreement, for example, will not be admissible to prove the meaning of the insurance contract itself. *Thorpe Insulation* may well be a harbinger of things to come, as policyholders and insurers continue to battle over coverage for long-tail claims involving thousands of claimants.

The Opinion

In *Thorpe Insulation*, the policyholder, a distributor and installer of asbestos insulation products, had been sued in hundreds of asbestos-related bodily injury claims and had tendered such claims to its insurers for defense and indemnity since 1978. n3 Most of Thorpe's policies provided coverage for products/completed operations claims and operations

claims; the former were subject to aggregate policy limits, while the latter were not. n4

In 1984, Thorpe and ten of its primary insurers entered into a claims handling and settlement agreement that allocated the costs of defense and indemnification among the insurers ("1984 Agreement"). n5 In part, the 1984 Agreement stated that it was a compromise settlement of disputed claims, and that it "is not intended to nor shall it be construed as the admission of the existence of a policy or as a policy interpretation, and shall not be used in any Court or Arbitration to create, prove or interpret the obligations under general liability or other liability policies." n6 In 1998, seven of Thorpe's excess insurers entered into an interim claims handling agreement that also allocated the costs of defense and indemnification among the insurers ("1998 Agreement"). n7 When Thorpe's insurers paid claims, they reduced the aggregate limits of the policies, treating all claims as products claims. n8

In 2005, after its primary and excess policies were all nearly exhausted, Thorpe brought suit against its primary insurers claiming that at least some of the current and future asbestos claims against it should be treated as "operations" claims not subject to aggregate limits. n9 Thorpe claimed that the term "completed operations" was "indecipherably ambiguous," and sought a declaration that its insurers had the burden of establishing that each asbestos claim was a "products/completed operations" claim to be charged against policy limits. n10

The insurers argued that the parties had treated asbestos claims as "products/completed operations" claims for thirty years, that Thorpe had obtained millions of dollars in payments from excess insurers based on this treatment, n11 and asserted affirmative defenses of laches, waiver, estoppel and ratification based on the claims handling history. n12

In the policy interpretation phase of the case, Thorpe filed a motion for summary judgment on these four affirmative defenses, and filed a motion *in limine* to exclude evidence relating to the parties' thirty-year course of handling asbestos claims as evidence of the meaning of the term "completed operations" in the insurance policies. n13 Thorpe argued that course of performance evidence was not relevant in the interpretation of standard form contracts and should not be used in the interpretation of insurance contracts at all. n14 Thorpe also argued that much of the course of performance evidence the insurers sought to offer was the product of the 1984 and 1998 Agreements, which provided in their terms that they were not to be used for policy interpretation. n15 The trial court granted the motion *in limine*, and the insurers sought writ review. n16

Upon review, the appellate court rejected Thorpe's first argument, holding that course of performance evidence is "generally admissible in the context of interpretation of insurance policies, even standard form policies." n17 As to the second point, the court held that because the bulk of the parties' performance and the insurance payments received by the company were made pursuant to the 1984 and 1998 Agreements, not the insurance policies themselves, the trial court did not err in excluding that evidence. n18 Based on the record, the court concluded that the claims handling conduct was the product of the 1984 Agreement that resolved differences regarding the claims and represented "an agreement under which primary insurers would pay their policy limits and no more." n19 The court noted that the 1984 Agreement "expressly states that it is *not* a policy interpretation and shall *not* be used in any court to interpret the policies. It therefore cannot be considered to be evidence of the parties' interpretation of the policies. As the agreement cannot be considered for policy interpretation, we similarly conclude that conduct *pursuant* to the agreement cannot be considered for the purpose of policy interpretation." n20

In closing, the court held that evidence of the parties' course of performance prior to 1984 was not excluded by Thorpe's motion *in limine*. n21 Thorpe argued that pre-1984 evidence would not be admissible because the insurers would be unable to prove that Thorpe "*understood* that it was accepting performance in a way that interpreted the policies to have no non-products coverage for asbestos suits," as required by California statute. n22 The court found that while the insurers might be unable to meet this requirement, this argument was not a basis of Thorpe's motion *in limine*.

CONCLUSION

In *Thorpe Insulation*, California clarified two important points in the context of contract interpretation. First, when appropriate, course of performance evidence can be used to interpret standard form insurance contracts. Second, for the evidence to be considered in contract interpretation, the conduct to be considered must be the product of the contract to be interpreted. What is a bit unusual is that the insurers sought to offer course of performance evidence not to interpret a disputed term of any of contract of insurance, but to support affirmative defenses of waiver, laches, estoppel and ratification in the policy interpretation phase of the case. n23 Regardless, course of performance evidence will likely play a big part in asbestos coverage disputes and policy interpretation in the near future, and litigation regarding the admissibility of such evidence should be expected.

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n1 See, e.g., *London Market Insurers v. Super. Ct.*, 146 Cal. App. 4th 648, 653, 661-63 (2007) (where parties argued course of performance evidence supported their definition of "occurrence" in an asbestos coverage dispute, court relied solely on plain meaning analysis of the term and drafting history of insurance policy).

n2 See, e.g., *American Red Cross v. The Travelers Indemnity Co.*, 816 F. Supp. 755, 760 n.7 (D.C. 1993) (where defendant insurer claimed that HIV-contaminated blood claims fell under "products/completed operations" coverage subject to aggregate limits, court held plain meaning of "products" and "completed operations" did not include blood service, and supported its finding by referring to the parties' course of performance in a footnote).

n3 *Thorpe Insulation*, 161 Cal. App. 4th at 911-12.

n4 *Id.* at 911-912.

n5 *Id.* at 913.

n6 *Id.*

n7 *Id.* at 913-14.

n8 *Id. at 912.*

n9 *Id. at 912, 915.*

n10 *Id.*

n11 *Id. at 912.* The insurers pled affirmative defenses based on this argument, including laches, waiver, estoppel, and ratification. *Id.* Thorpe obtained summary adjudication of these defenses, a ruling not at issue before the court of appeal. *Id. at 912, 918*

n12 *Id. at 916.*

n13 *Id.*

n14 *Id.*

n15 *Id. at 916. Thorpe also argued that the insurer's interpretation of the policy was unreasonable.*

n16 *Id.*

n17 *Id. at 918.* The court noted that because insurance policies are contracts "to which the ordinary rules of contractual interpretation apply, it is apparent that the rules relating to course of performance as extrinsic evidence are equally applicable to insurance policy interpretation." *Id. at 921* (internal citations and quotation marks omitted)..

n18 *Id.* at 918, 924-25.

n19 *Id.* at 925.

n20 *Id.* (emphasis in original).

n21 *Id.* at 926.

n22 *Id.*, citing Cal. Com. Code § 1303 (course of performance evidence requires the party accepting the performance to do so "with knowledge of the nature of the performance").

n23 Last year, a court in New York found that a claims handling agreement and conduct supported a laches defense as applied to future asbestos bodily injury claims in "products/completed operations" or "operations" claim dispute. See *Continental Casualty Co. v. Employers Ins. Co. of Wausau*, 871 N.Y.S.2d 48, 51 (2008) ("Keasbey"). In *Keasbey*, insurers of a defunct asbestos insulation manufacturer and seller filed action seeking a declaration that they had no duty to indemnify the company for any pending asbestos claims against it because all such claims were "products/completed operations" claims subject to already-exhausted aggregate limits. *Id.* at 51-52. The court held the affirmative defense of laches barred the company and asbestos-injured claimants suing the company from arguing that such claims were not "products/completed operations" claims because, *inter alia*, the company, claimants, and insurers had all treated the claims "products/completed operations" claims in the past. *Id.* at 52. It is noteworthy that the insured accepted the excess insurers' contributing funds to a group of cases and "did not object to the cost-sharing agreement among excess carriers, which expressly treated the asbestos claims as products hazard claims subject to the aggregate limit." *Id.*

Although the evidence was not offered as "course of performance" evidence to interpret policy terms, the claims handling practices were admitted to support the laches defense directly. It will be interesting to see how course of performance evidence develops over the next several years in the wake of *Thorpe Insulation* and *Keasbey*.

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Richmond on the Sharp Points of the Eternal Triangle of Insurance Defense

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Richmond on the Sharp Points of the Eternal Triangle of Insurance Defense

By Douglas R. Richmond

June 22, 2009

SUMMARY: The Emerging Issues Analysis explores whether and to what extent conflicts of interest exist in various tripartite relationships involving the insurer, insured and insurance defense counsel and how they can be resolved. Recent pertinent court decisions are examined.

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ARTICLE: INTRODUCTION

The term eternal triangle refers to the tripartite relationship created when a liability insurer hires counsel to defend its insured when the insured is sued by a third party. The insurer, the insured, and insurance defense counsel form the points of this eternal triangle. Although much has been written about the tripartite relationship that characterizes insurance defense practice, and about ethical dilemmas in insurance litigation generally, the relationship between insurer, insured and insurance defense counsel is a recurring source of disputes. These disputes typically are connected to the conflicts of interest inherent in insurance defense practice. For present purposes, a conflict of interest between insurer and insured occurs if there is a significant risk that their common lawyer's representation of one will be materially limited by the lawyer's representation of the other, the lawyer's responsibilities to a third person, or the lawyer's personal interests.

THE ATTORNEY-CLIENT RELATIONSHIP

The eternal triangle's inherent conflicts of interest are attributable to the concept of dual representation, best known as the dual client doctrine. The dual client doctrine recognizes that insurance defense counsel represent both the insurer and the insured. As the court in *National Union Fire Ins. Co. v. Stites Professional Law Corp.*, 1 Cal. Rptr. 2d 570 (Cal. Ct. App. 1991), explained: As long as the interests of the insurer and the insured coincide, they are both clients of the defense attorney and the defense attorney's fiduciary duty runs to both the insurer and the insured. *Id.* at 575; see also *Kroll & Tract v. Paris & Paris*, 86 Cal. Rptr. 2d 78, 81 (Cal. Ct. App. 1999) (quoting *Stites*). Defense counsel therefore serve two masters in any given case. The problems created by the dual client doctrine rest on the premise that defense counsel cannot loyally represent the insured in a case in which the insured's and insurer's interests do *not* coincide.

Forced to choose between a repeat client and the insured, the reasoning goes, defense counsel will necessarily side with the insurer.

The dual client doctrine appears to represent the majority rule. See, e.g., *Home Indem. Co. v. Lane Powell Moss & Miller*, 43 F.3d 1322, 1331 (9th Cir. 1995) (interpreting Alaska law); *Nat'l Union Ins. Co. v. Dowd & Dowd*, 2 F. Supp. 2d 1013, 1017 (N.D. Ill. 1998) (interpreting Illinois law); *Mitchum v. Hudgens*, 533 So. 2d 194, 198 (Ala. 1988); *Gulf Ins. Co. v. Berger, Kahn, Shafon, Moss, Figler, Simon & Gladstone*, 93 Cal. Rptr. 2d 534, 542-44 (Cal. Ct. App. 2000); *Unigard Ins. Group v. O'Flaherty & Belgum*, 45 Cal. Rptr. 2d 565, 569 (Cal. Ct. App. 1995); *Pa. Ins. Guar. Ass'n v. Sikes*, 590 So. 2d 1051, 1052 (Fla. Dist. Ct. App. 1991); *Coscia v. Cunningham*, 299 S.E.2d 880, 881 (Ga. 1983); *Preferred Am. Ins. Co. v. Dulceak*, 706 N.E.2d 529, 533 (Ill. App. Ct. 1999); *Mobil Oil Corp. v. Md. Cas. Co.*, 681 N.E.2d 552, 561 (Ill. App. Ct. 1997); *Cincinnati Ins. Co. v. Wills*, 717 N.E.2d 151, 161 (Ind. 1999); *McCourt Co. v. FPC Props., Inc.*, 434 N.E.2d 1234, 1235 (Mass. 1982); *Moeller v. Am. Guarantee & Liab. Ins. Co.*, 707 So. 2d 1062, 1070 (Miss. 1996); *Nev. Yellow Cab Corp. v. Eighth Judicial Dist. Court*, 152 P.3d 737, 742 (Nev. 2007); *Lieberman v. Employers Ins.*, 419 A.2d 417, 423-25 (N.J. 1980); *Nationwide Mut. Fire Ins. Co. v. Bourlon*, 617 S.E.2d 40, 45-46 (N.C. Ct. App. 2005); *United States Fid. & Guar. Co. v. Pietrykowski*, No. E99-38 (Ohio Ct. App. Feb. 11, 2000); *Spratley v. State Farm Mut. Auto. Ins. Co.*, 78 P.3d 603, 607 (Utah 2003); *In re Illuzzi*, 616 A.2d 233, 236 (Vt. 1992); *Barry v. USAA*, 989 P.2d 1172, 1175 (Wash. Ct. App. 1999); see also *In re Allstate Ins. Co.*, 722 S.W.2d 947, 952 (Mo. 1987) (permitting dual representation). This has been the case for some while.

The recognition of an attorney-client relationship between insurers and defense counsel is not universal. Indeed, the minority position is substantial, with many jurisdictions holding that the insured is the defense lawyer's sole client. See, e.g., *Cont'l Cas. Co. v. Pullman, Comley, Bradley & Reeves*, 929 F.2d 103, 108 (2d Cir. 1991); *In re A.H. Robins Co.*, 880 F.2d 694, 751 (4th Cir. 1989); *Gen. Sec. Ins. Co. v. Jordan, Coyne & Savits, LLP*, 357 F. Supp. 2d 951, 957 (E.D. Va. 2005) (discussing Virginia law); *Essex Ins. Co. v. Tyler*, 309 F. Supp. 2d 1270, 1272 (D. Colo. 2004) (discussing Colorado law); *Gibbs v. Lappies*, 828 F. Supp. 6, 7 (D.N.H. 1993); *First Am. Carriers, Inc. v. Kroger Co.*, 787 S.W.2d 669, 671 (Ark. 1990); *Higgins v. Karp*, 687 A.2d 539, 543 (Conn. 1997); *Finley v. Home Ins. Co.*, 975 P.2d 1145, 1153 (Haw. 1998); *Kirschner v. Process Design Assocs., Inc.*, 592 N.W.2d 707, 711 (Mich. 1999); *In re Rules of Prof'l Conduct & Insurer Imposed Billing Rules & Procedures*, 2 P.3d 806, 814 (Mont. 2000); *Feliberty v. Damon*, 527 N.E.2d 261, 265 (N.Y. 1988); *Givens v. Mullikin*, 75 S.W.3d 383, 396 (Tenn. 2002); *Barefield v. DPIC Cos.*, 600 S.E.2d 256, 270 (W. Va. 2004). At least one state holds that in a case defended under a reservation of rights, the insurer's reservation trumps otherwise acceptable dual representation and transforms the insured into the defense lawyer's sole client. See *Mut. of Enumclaw Ins. Co. v. Dan Paulson Constr., Inc.*, 169 P.3d 1, 8 n.10 (Wash. 2007); see also *Vigilant Ins. Co. v. Behrenhausen*, 889 F. Supp. 1130, 1135 (W.D. Mo. 1995) (indicating that defense lawyer represents only insured, but perhaps not widely authoritative because district court was applying Missouri law in unusual case defended under reservation; Missouri law generally holds that an insurer defending under a reservation of rights loses the ability to control the insured's defense).

In fact, both the dual client and sole client models assume too much. As a general rule, whether a defense lawyer represents the insurer in addition to the insured—who is always a client—is a matter of contract. *Unauthorized Practice of Law Comm. v. Am. Home Assurance Co.*, 261 S.W.3d 24, 42 (Tex. 2008). Beyond that, the existence of an attorney-client relationship is a question of fact. Unless a jurisdiction has adopted the sole client model as a matter of law, an insurer and the attorney it hires to defend its insured can share an attorney-client relationship in any given case depending on their conduct and understanding.

Courts have begun recognizing the importance of fact-specific inquiry into the existence of an attorney-client relationship between a liability insurer and the lawyer it employs to defend an insured. See, e.g., *Swiss Reinsurance Am. Corp. v. Roetzel & Andress*, 837 N.E.2d 1215, 1220-21 (Ohio Ct. App. 2005). In *Paradigm Ins. Co. v. Langerman Law Offices*, 24 P.3d 593 (Ariz. 2001), for example, the Arizona Supreme Court embraced the general rule that the existence of an attorney-client relationship turns on whether (a) the would-be client has manifested to the lawyer its intent that the lawyer provide legal services for it; and (b) the lawyer manifests his or her consent to do so. The Minnesota Supreme Court supplemented the general rules concerning the creation of attorney-client relationships in *Pine Island Farmers*

Coop v. Erstad & Riemer, P.A., 649 N.W.2d 444 (Minn. 2002), to provide a bright-line rule to determine whether defense counsel represents the insurer as well as the insured. *Pine Island*, 649 N.W.2d at 451.

Under the *Pine Island* approach:

[I]n the absence of a conflict of interest between the insured and the insurer, the insurer can become a co-client of defense counsel based on contract or tort theory if two conditions are satisfied. First, defense counsel or another attorney must consult with the insured, explaining the implications of dual representation and the advantages and risks involved. . . . Second, after consultation, the insured must give its express consent to the dual representation.

Pine Island, 649 N.W.2d at 452 (citations omitted). Without this consultation and the insured's express consent, the insured is the defense lawyer's sole client.

Two final points must be made. First, defense lawyers who do not want an attorney-client relationship with an insurance company are free to structure their engagements so that the insured is their sole client. This can be accomplished in an engagement letter. A lawyer who accepts only the insured as a client significantly diminishes the likelihood of a conflict of interest. On the other side of the coin, an insurer that desires an attorney-client relationship with defense counsel is free to resist the lawyer's attempt to limit the engagement.

Second, some courts that recognize the dual client doctrine further hold that a defense attorney owes his or her primary allegiance to the insured. See, e.g., *Paradigm Ins. Co. v. Langerman Law Offices, P.A.*, 24 P.3d 593, 598 (Ariz. 2001); *Spratley v. State Farm Mut. Auto. Ins. Co.*, 78 P.3d 603, 607 (Utah 2003). This simply cannot be. A lawyer generally cannot favor one co-client over another absent the clients' informed consent; to do so would be the very embodiment of a conflict of interest. Co-clients have a right to expect that their common lawyer is equally loyal. Furthermore, this approach is unnecessary in light of general conflict of interest rules, which protect insureds in cases where their interests and those of their insurers are not aligned. Finally, the primary allegiance approach is insidious. It is insidious from the insurer's perspective because an insurer relying on a defense lawyer to protect its interests along with the insured's may be vulnerable on several fronts without knowing it. It is also insidious from the insured's standpoint, because if the concern that a lawyer hired by an insurer is bound to be influenced by economic self-interest to favor the insurer--even if subconsciously--is true, then an insured in a case presenting a conflict of interest should be defended by independent counsel owing it undivided loyalty rather than by a lawyer supposedly owing it primary allegiance.

Long story short, the dual client and sole client models generally represent default rules. Judgments about attorney-client relationships are best made on a case-by-case basis.

COMMON CONFLICTS OF INTEREST

Conflict of interest analysis is important to defense counsel and insurers alike. For defense counsel, obviously, conflict of interest allegations may expose them to professional discipline and to liability for malpractice or breach of fiduciary duty. An insurer that fails to recognize a conflict of interest may be estopped from raising coverage defenses or exposed to bad faith liability. Reservations of RightsIn theory, an insurer who decides to provide a defense for the insured under a reservation of rights presents a potential conflict of interest because the insurer may be more concerned with developing facts showing non-coverage than facts defeating liability. *State ex rel. Rimco, Inc. v. Dowd*, 858 S.W.2d 307, 308 (Mo. Ct. App. 1993). Defense counsel may be able to steer a case toward a coverage result favorable to the insurer. For example, a defense attorney might elicit deposition testimony supporting a defense against providing coverage.

Assuming that an insurer's reservation of rights creates a conflict of interest, how might the conflict be resolved or ameliorated? The most common approach is to appoint independent counsel to represent the insured at the insurer's expense.

Not every reservation of rights creates a conflict of interest requiring the insurer to provide its insured with independent counsel. Rather, an insurer is obligated to provide its insured with independent counsel at the insurer's expense only when the outcome of a coverage issue can be affected by the defense of the underlying action. *Rx.com Inc. v. Hartford Fire Ins. Co.*, 426 F. Supp. 2d 546, 559 (S.D. Tex. 2006) (applying Texas law); *James 3 Corp. v. Truck Ins. Exch.*, 111 Cal. Rptr. 2d 181, 186 (Cal. Ct. App. 2001); *Nisson v. Am. Home Assurance Co.*, 917 P.2d 488, 490 (Okla. Ct. App. 1996). Conversely, an insurer has no obligation to provide independent counsel for the insured when the manner in which the underlying action is defended cannot affect coverage. *Cybernet Ventures, Inc. v. Hartford Ins. Co. of the Midwest*, 168 Fed. App'x 850, 2006 U.S. App. LEXIS 4677 (9th Cir. Feb. 23, 2006) (citing California statute); *Armstrong Cleaners, Inc. v. Erie Ins. Exch.*, 364 F. Supp. 2d 797, 807 (S.D. Ind. 2005) (discussing Indiana law); *Dynamic Concepts, Inc. v. Truck Ins. Exch.*, 71 Cal. Rptr. 2d 882, 887 (Cal. Ct. App. 1998); *Golden Eagle Ins. Co. v. Foremost Ins. Co.*, 25 Cal. Rptr. 2d 242, 257 (Cal. Ct. App. 1993); *Blanchard v. State Farm Fire & Cas. Co.*, 2 Cal. Rptr. 2d 884, 887 (Cal. Ct. App. 1991). The inquiry here focuses not whether defense lawyers *intend* their actions to affect coverage, but simply whether they *could* influence coverage through their activities. *Gafcon, Inc. v. Ponsor & Assocs.*, 120 Cal. Rptr. 3d 392, 418-19 (Cal. Ct. App. 2002).

In what circumstances might defense counsel be able to affect coverage? The best example is a case in which the insurer is defending under a reservation of rights because the insured's conduct may have been intentional. *State Farm Fire & Cas. Co. v. Mabry*, 497 S.E.2d 844, 847 (Va. 1998). While both the insured and the insurer are interested in defeating the plaintiff's claims outright, if liability is found, their interests diverge in establishing the basis for that liability. *Long v. Century Indemnity Co.*, 78 Cal. Rptr. 3d 483, 491 (Cal. Ct. App. 2008). After all, if the insured can be shown to have intentionally injured the plaintiff, there was no occurrence, and the policy's intentional acts exclusion will additionally bar coverage. Accordingly, in such circumstances the insured may be entitled to a defense by independent counsel. See, e.g., *Aquino v. State Farm Ins. Cos.*, 793 A.2d 824, 830 (N.J. Super. Ct. App. Div. 2002); *State Farm Mut. Auto. Ins. Co. v. Van Dyke*, 668 N.Y.S.2d 821, 822-28 (N.Y. App. Div. 1998); see also *Britt v. Cambridge Mut. Fire Ins. Co.*, 717 S.W.2d 476, 481 (Tex. App. 1986) (stating that insured was entitled to independent counsel in wrongful death case where he had previously been convicted of murder in a separate criminal action).

Defense counsel also may be able to affect coverage in a mixed action, i.e., a case in which multiple claims are made against the insured but only some are covered. The archetypal mixed action is one in which some causes of action allege negligence and others intentional wrongs. The worry here is that a defense attorney can through discovery steer the case away from coverage, or might successfully move for summary judgment on covered claims and thus leave the insured defenseless on uncovered causes of action. Alternatively, a defense lawyer might insist on special interrogatories or special verdicts so that damages can be allocated between covered and uncovered claims. See *St. Paul Fire & Marine Ins. Co. v. Engelmann*, 639 N.W.2d 192, 201 (S.D. 2002) (indicating that lawyer doing this would breach duty to insured). Some courts therefore hold that a mixed action creates a conflict of interest entitling the insured to independent counsel. See, e.g., *Herbert A. Sullivan, Inc. v. Utica Mut. Ins. Co.*, 788 N.E.2d 522, 539 (Mass. 2003); *Moeller v. Am. Guarantee & Liab. Ins. Co.*, 707 So. 2d 1062, 1070-71 (Miss. 1996); *Aquino v. State Farm Ins. Cos.*, 793 A.2d 824, 830 (N.J. Super. Ct. App. Div. 2002). South Dakota would also seem to fall into this camp, although that is not entirely clear. See *Englemann*, 639 N.W.2d at 199-201.

In *Tank v. State Farm Fire & Casualty Co.*, 715 P.2d 1133 (Wash. 1986), the Supreme Court of Washington attempted to resolve the conflict posed by a reservation of rights defense by imposing an enhanced duty of good faith on the reserving insurer. *Id.* at 1137. Other states have followed Washington's lead. See, e.g., *Twin City Fire Ins. Co. v. Colonial Life & Accident Ins. Co.*, 839 So. 2d 614, 616 (Ala. 2002); *Finley v. Home Ins. Co.*, 975 P.2d 1145, 1156-57 (Haw. 1998). Insurers can demonstrate enhanced good faith by (1) thoroughly investigating the plaintiff's claim; (2) retaining competent defense counsel who, like the insurer, must understand that the insured is counsel's sole client; (3) fully informing the insured of all coverage issues and the progress of the case; and (4) refraining from any action that demonstrates a greater concern for the insurer's financial interests than for the insured's potential exposure. *Tank*, 715 P.2d at 1137; see also *Mut. of Enumclaw Ins. Co. v. Dan Paulson Constr., Inc.*, 169 P.3d 1, 8 n.10 (Wash. 2007) (discussing *Tank* standards and pointing out that a defense lawyer in this situation has insured as sole client). The *Tank*

standard and criteria effectively safeguard insureds' interests without impugning defense counsel's loyalty or integrity. *L & S Roofing Supply Co. v. St. Paul Fire & Marine Ins. Co.*, 521 So. 2d 1298, 1304 (Ala. 1987).

In summary, no conflict of interest necessarily exists in a reservation of rights defense. *Twin City Fire Ins. Co. v. Ben Arnold-Sunbelt Beverage Co. of S.C., LP*, 433 F.3d 365, 366, 372 (4th Cir. 2005) (discussing South Carolina law and collecting cases); *Trinity Universal Ins. Co. v. Stevens Forestry Serv., Inc.*, 335 F.3d 353, 356 (5th Cir. 2003) (applying Louisiana law); *Rx.com Inc. v. Hartford Fire Ins. Co.*, 426 F. Supp. 2d 546, 559 (S.D. Tex. 2006) (applying Texas law); *Tyson v. Equity Title & Escrow Co. of Memphis, LLC*, 282 F. Supp. 2d 829, 831-32 (W.D. Tenn. 2003); *MetLife Capital Corp. v. Water Quality Ins. Synd.*, 100 F. Supp. 90, 94 (D.P.R. 2000); *Delmonte v. State Farm Fire & Cas. Co.*, 975 P.2d 1159, 1174 (Haw. 1999); *Mut. Serv. Cas. Ins. Co. v. Luetmer*, 474 N.W.2d 365, 368-69 (Minn. Ct. App. 1991); *Twp. of Readington v. Gen. Star Ins. Co.*, 2006 WL 551404, at *4 (N.J. Super. Ct. App. Div. Mar. 3, 2006); *Nisson v. American Home Assurance Co.*, 917 P.2d 488, 490 (Okla. Ct. App. 1996); *Unauthorized Practice of Law Comm. v. Am. Home Assurance Co.*, 261 S.W.3d 24, 40 (Tex. 2008); *Johnson v. Cont'l Cas. Co.*, 788 P.2d 598, 600 (Wash. Ct. App. 1990). *But see Hartford Underwriters Ins. Co. v. Found. Health Servs., Inc.*, 524 F.3d 588, 592-93 (5th Cir. 2008) (discussing Mississippi law); *Hartford Cas. Ins. Co. v. A & M Assocs., Ltd.*, 200 F. Supp. 2d 84, 89-90 (D.R.I. 2002) (holding that insurer's reservation of rights creates conflict of interest entitling insured to independent counsel); *Great Divide Ins. Co. v. Carpenter ex rel. Reed*, 79 P.3d 599, 604 (Alaska 2003) (same); *First Jeffersonian Assocs. v. Ins. Co. of N. Am.*, 691 N.Y.S.2d 506, 506-07 (N.Y. App. Div. 1999) (same); *see also Twin City Fire Ins. Co. v. Ben Arnold-Sunbelt Beverage Co. of S.C., LP*, 433 F.3d 365, 370-71 (4th Cir. 2005) (collecting cases holding that a mere reservation of rights creates conflict of interest entitling insured to independent counsel). The same principle holds true when a defense is provided under a non-waiver agreement. On a daily basis defense lawyers hired by insurers are called upon to handle cases in which the insured's interests and those of the insurer do not fully coincide. The defense bar generally has shown no inability to zealously defend insureds (their clients) under such circumstances. The overwhelming majority of defense attorneys vigorously defend the insureds they represent without regard for insurers' coverage positions. Nevertheless, if defense counsel can affect coverage through the litigation of the third-party action, the insured may be entitled to independent counsel at the insurer's expense. *Great W. Cas. Co. v. Dekeyser Express, Inc.*, 475 F. Supp. 2d 772, 778-80 (C.D. Ill. 2006); *Cunniff v. Westfield, Inc.*, 829 F. Supp. 55, 57 (E.D.N.Y. 1993); *Am. Family Mut. Ins. Co. v. W.H. McNaughton Builders, Inc.*, 843 N.E.2d 492, 498 (Ill. App. Ct. 2006); *Am. Family Mut. Ins. Co. v. Blackburn*, 566 N.E.2d 889, 892 (Ill. App. Ct. 1991); *Roussos v. Allstate Ins. Co.*, 655 A.2d 40, 44 (Md. Ct. Spec. App. 1995); *Nisson v. American Home Assurance Co.*, 917 P.2d 488, 490 (Okla. Ct. App. 1996). If an insurer determines that an insured is entitled to independent counsel, it must so inform the insured, even if the insured has not demanded independent counsel. *Elacqua v. Physicians' Reciprocal Insurers*, 800 N.Y.S.2d 469, 473 (N.Y. App. Div. 2005).

Representation of Multiple Parties

The representation of multiple parties by a single lawyer or law firm routinely raises conflict of interest concerns. Different defendants may have adverse interests. *See, e.g., Murphy v. Nutmeg Ins. Co.*, 773 N.Y.S.2d 413, 415 (N.Y. App. Div. 2004) (finding that insurer was required to provide separate counsel for multiple insureds with potential contribution claims against each other). In construction circumstances, for example, a landowner is typically an additional insured under a general contractor's commercial general liability (CGL) policy. An attorney hired by the general contractor's CGL insurer to defend a premises liability action may be asked to defend the landowner, as well. The doctrine of comparative fault necessarily makes the landowner and general contractor potential adversaries, notwithstanding their common interest in defeating the plaintiff's claim. If an injured automobile passenger sues both the owner and the driver, the owner and driver may be adverse. It may be in the driver's best interest to argue that she is the owner's agent, while the owner may benefit by arguing that the driver was impermissibly operating the vehicle. *See, e.g., Murphy v. Urso*, 430 N.E.2d 1079, 1083-84 (Ill. 1981). *But see Allied Am. Ins. Co. v. Ayala*, 616 N.E.2d 1349, 1358 (Ill. App. Ct. 1993) (finding no conflict where permissive use acknowledged). In other cases, a driver and a passenger may be adverse. *See, e.g., Gustafson v. City of Seattle*, 941 P.2d 701 (Wash. Ct. App. 1997). Representing both a trucking company and its driver may pose a conflict of interest when there is a potential dispute as to whether the

driver was acting in the course and scope of his employment. Indeed, representing an organizational insured and its employee is often potentially troublesome because of course and scope issues. Co-defendants may have indemnification agreements or common law indemnity rights, essentially requiring defense counsel to assert cross-claims. In such circumstances, an insurer may be required to provide independent counsel. See *Atl. Mut. Ins. Co. v. Struve*, 621 N.Y.S.2d 5, 6 (N.Y. App. Div. 1994) (stating that insurer's retention of separate counsel fulfills its initial obligation to mutually adverse insureds) (quoting *Goldberg v. Am. Home Assurance Co.*, 439 N.Y.S.2d 2, 4 (N.Y. App. Div. 1981)).

The problems that can flow from multiple representation are illustrated by a recent bad faith case in a Pennsylvania federal court, *Jurinko v. Medical Protective Co.*, No. 03-CV-4053, 2006 U.S. Dist. LEXIS 13601 (E.D. Pa. Mar. 27, 2006), *aff'd in part, rev'd in part*, 305 Fed. App'x 13, 2008 U.S. App. LEXIS 26263 (3d Cir. Dec. 24, 2008). The insurer, Med Pro, appointed a single lawyer, Kilcoyne, to represent two doctors in a medical malpractice action. The doctors' interests were incompatible, since either could escape liability by pointing the finger at the other with respect to the alleged failure to diagnose the plaintiff's skin cancer. The Med Pro claims handler testified at trial that he knew that Kilcoyne had a conflict of interest and that the dual representation was unethical, but that he insisted on it to save [Med Pro] money. Based on this and other misconduct, the jury returned a verdict against Med Pro of just over \$7.9 million, including \$6.25 million in punitive damages. On appeal, the Third Circuit let the bad faith verdict stand, but reduced the punitive damage award to just under \$2 million on the basis that the original award was unconstitutionally excessive.

The insurer in *Wolpaw v. General Accident Ins. Co.*, 639 A.2d 338 (N.J. Super. Ct. App. Div. 1994), issued a \$50,000 homeowners policy to Saranne Frew. The policy also covered other members of Frew's household, including her sister Karanne Wolpaw, and Karanne's son, Heath. Heath Wolpaw blinded a playmate, Michael Heim, when he shot him with a BB gun. Heim and his parents sued Heath, his mother, his father Ivan, and Frew. General Accident hired a single law firm to represent all of the defendants except Ivan. The Heims also sued the BB gun manufacturer and the store that sold it, both of which had different insurers and defense counsel.

General Accident immediately paid its \$50,000 policy limits into court as a settlement offer. The Heims rejected the offer. A jury awarded the Heims \$502,000 after finding Michael Heim 50% at fault, Heath Wolpaw 20% at fault, and Ivan Wolpaw 30% at fault. Post-judgment interest brought the total judgment to \$709,964.20. Karanne Wolpaw then sued General Accident, alleging that the insurer's failure to provide separate counsel constituted a breach of contract.

The *Wolpaw* court noted the general rule that an insurer of codefendants whose interests conflict must retain independent counsel for each insured, or permit each insured to do so at the company's expense. That was clearly the case at bar.

The three insureds had the common interests of minimizing the amount of the Heims's judgment and maximizing the percentage of fault attributable to the other defendants. However, their interests in maximizing the percentage of the other insureds' fault and minimizing their own was clearly in conflict. For instance, it was in [Karanne Wolpaw's] interest to argue that she adequately had secured the rifle from Heath's unattended use and had carefully instructed him in its safe use, which he negligently disregarded; on the other hand, it was in Heath's interest to argue that [his mother] negligently failed to secure the rifle, and that he was not negligent in view of his mother's negligence and his youth.

[S]eparate attorneys representing . . . Heath [and his mother] might well have asserted cross-claims for contribution against the other's client. That was not done It was also in plaintiff's interest to assert a cross-claim against her sister and that she remain a codefendant to share the liability burden. Yet the single firm of attorneys, discharging its duty to her sister, not only did not file a cross-claim for contribution on plaintiff's behalf, but successfully moved to have Frew dismissed from the case.

Wolpaw, 639 A.2d at 340. The court termed the conflict of interest obvious, and concluded that the insurer breached its policy by virtue of its failure to provide independent counsel for its various insureds. The court then remanded the case so that damages attributable to the conflict could be apportioned in a separate trial.

The *Wolpaw* court reached the correct result. Defense counsel generally cannot represent co-insureds in a comparative fault case. While both insureds' interests may appear to be aligned, there is a substantial possibility--if not a probability--that one will eventually have to point the finger at the other. A defense attorney that attempts to avoid this problem by maintaining a unified defense at all costs may end up hurting both clients. Although co-insureds may knowingly consent to joint representation, thus solving defense counsel's ethical dilemma, there are cases in which defendants probably should not so consent. This is certainly true where potential damages exceed coverage, and where one insured's coverage may be challenged.

Defense Counsel's Activities Generate Information Suggesting a Possible Coverage Defense

The dual client doctrine poses serious communication and disclosure problems for defense attorneys. An appointed attorney who learns of information suggesting a possible coverage defense during the course of an insured's representation faces an obvious dilemma. If the attorney shares the information with the insurer, the insured will be prejudiced. With a potential loss of coverage comes exposure to personal liability. On the other hand, withholding the information prejudices the insurer, which may have to pay a judgment for which there is no coverage. Of course, it is the insurer that pays defense counsel's bills, and it is the insurer with which the attorney desires a continuing relationship. Regardless of whether defense counsel discovers the information or whether the insured shares confidential information, defense counsel are generally barred from sharing the information with the insurer.

The insurer in *Parsons v. Continental National American Group*, 550 P.2d 94 (Ariz. 1976), CNA, hired counsel to defend its insureds, the Smitheys, in connection with their son Michael's alleged assault on three neighbors. The plaintiffs made a settlement demand within policy limits which CNA rejected. The defense attorney CNA hired later obtained Michael Smithey's confidential file from the juvenile facility where he was incarcerated, and determined that his attack was knowing and deliberate. It therefore followed, the attorney told CNA, that the assault was intentional. *Id.* at 96. CNA then issued a reservation of rights letter, informing the Smitheys that their son's assault may have been intentional and that their policy specifically excluded liability for bodily injury caused by intentional acts. The case proceeded to trial and the court directed a \$50,000 verdict for the plaintiffs, which exceeded the Smitheys' \$25,000 policy limits. Judgment was entered in the verdict amount.

The plaintiffs garnished CNA, which responded by offering its \$25,000 policy limits. The plaintiffs declined CNA's offer. CNA successfully defended the garnishment action by asserting its intentional acts exclusion. The same attorney that represented the Smitheys at trial defended CNA in the garnishment action.

The plaintiffs contended on appeal that CNA was estopped to deny coverage and waived its intentional acts exclusion because it exploited defense counsel's fiduciary relationship with Michael Smithey. The *Parsons* court agreed, reasoning that public policy mandated this result. CNA was ultimately responsible for the entire amount of the judgment.

More offensive conduct was exposed in *Employers Casualty Co. v. Tilley*, 496 S.W.2d 552 (Tex. 1973). The *Tilley* insurer, Employers, filed a declaratory judgment action seeking a determination that its insured's late notice relieved it of its duty to defend a personal injury action.

Before filing the declaratory judgment action, Employers obtained a non-waiver agreement from Tilley and hired counsel to defend the personal injury action. Defense counsel knew of Employers' late notice contention and of the insured's related explanation. For nearly eighteen months, the defense attorney secretly developed evidence for Employers on the coverage question. The attorney took witness statements from five of the insured's employees to establish their knowledge of the accident and related communications with Tilley (contrary to Tilley's stated position); briefed the late notice question for Employers without informing Tilley; interviewed two independent witnesses at the insurer's request to establish late notice; and wrote numerous letters and had multiple conversations with Employers about developing its coverage defense, suggesting additional investigation, and offering legal advice. This conduct became the basis for the declaratory judgment action filed by separate counsel.

The Texas Supreme Court concluded that it would be untenable to permit the insurer to disclaim its defense obligation based on late notice. The question was not the validity of Employers' late notice defense, but whether it was improperly developed. Because Employers' conduct violated the guiding principles and public policy governing insurer-insured relations, it was estopped from denying its contractual duties.

The Insured Shares Confidential Information

A lawyer's obligation to maintain client confidences is fundamental to the attorney-client relationship. Confidentiality is necessary because it encourages clients to be candid with their lawyers and to trust them. Almost all states have adopted the American Bar Association's Model Rules of Professional Conduct in some form. Model Rule 1.6(a) provides in pertinent part that [a] lawyer shall not reveal information relating to representation of a client unless the client gives informed consent, the disclosure is impliedly authorized to carry out the representation, or certain other conditions are met.

A lawyer with multiple clients owes each an equal and undivided duty of confidentiality. Independent duties to multiple clients may become a problem in the insurance defense context, where a defense attorney must keep both the insurer and the insured informed about the status of the case. Outside counsel guidelines typically require defense attorneys to periodically report to the insurer, to timely report significant case developments, and to report after specified events, such as depositions. If the insured shares confidential information with the defense attorney, can the attorney pass on that information to the insurer? What if the company's guidelines mandate the communication of such information?

A defense attorney certainly cannot develop confidential information in the course of the insured's representation with the intent to benefit the insurer by perfecting a coverage defense. Unfortunately, few confidentiality issues are that clear. Two situations come immediately to mind: First, an insured shares with a defense attorney confidential information that affects coverage. For example, the insured may confide in the attorney that she intentionally caused the subject harm. Second, the insured shares with the defense attorney confidential information that does not affect coverage, but that likely affects the insurer's defense strategy or settlement decisions. Perhaps the insured abused drugs at relevant times, has a criminal record, or holds inflammatory personal views. In both situations the cooperation clause in the insured's policy arguably requires the insured to communicate the information to the insurer. In both situations the insurer's outside counsel guidelines apparently require the defense attorney to share the information with the insurer. In the latter situation, standard practice does the same.

Assuming a dual client relationship, the defense lawyer must determine whether the confidential information at issue is the kind that the insured might be required to communicate to the insurer under the duty to cooperate. The lawyer also must determine whether the information is such that the insurer would expect to receive in the course of the representation.

If the confidential information falls into either category, the lawyer must explain to the insured the lawyer's relationship with the insurer. The attorney must explain to the insured the significance of the information to the insurer, either as it relates to coverage or as it affects the defense. The attorney must explain to the insured the duty to cooperate and the effect his or her failure to cooperate may have on coverage or on the insurer's defense obligation. If the information relates to coverage, the lawyer may have to advise the insured to retain separate coverage counsel. In addition to needing immediate coverage advice, the insured will need separate counsel to defend any subsequent coverage action by the insurer.

Having fully informed the insured about all possibilities and all consequences of secrecy, the defense attorney may ask the insured for permission to share the information with the insurer. If the insured consents, the defense attorney may divulge the insured's confidences to the insurer. If the insured refuses to consent, the defense attorney must maintain the insured's confidentiality; the attorney cannot share the information with the insurer.

If the insured instructs the defense attorney to maintain confidentiality, the resulting conflict of interest mandates the attorney's withdrawal from the representation. The lawyer cannot continue to represent the insured. The lawyer cannot thereafter represent the insurer in a coverage dispute with the insured, nor can the attorney represent the insurer in a suit against the insured for the insured's breach of its duty to cooperate. The defense attorney's involvement in the case is over.

It does not matter whether the confidential information is detrimental to the insured because it affects coverage, or whether it simply affects the insurer's case evaluation or defense strategy, except as it relates to the lawyer's efforts to persuade the insured to authorize disclosure. If the information affects the insurer's case evaluation or defense strategy, but does not affect coverage, it should be easier for the defense attorney to persuade the insured to authorize disclosure of the information to the insurer. The insured should see the wisdom of cooperating with the insurer to defeat or minimize the third-party claim, even if the information to be revealed may be embarrassing or derogatory. The insured is unlikely to see any value in disclosing information suggesting a potential coverage defense to the insurer for obvious reasons. The insured's instruction to maintain confidentiality seals the defense lawyer's lips without regard for whether the information affects coverage.

Understandably, a lawyer may reveal a client's confidential information where it is impliedly authorized to carry out the representation. If coverage is established, a defense attorney is impliedly authorized to communicate to the insurer any information obtained from the insured to carry out the dual representation. Accepting that as true, isn't a defense attorney impliedly authorized to share the insured's confidences with the insurer if that information may shape defense strategy or cause the insurer to settle the case? The answer is yes. If the insured instructs the lawyer to maintain confidentiality, however, implied authority is irrelevant. The insured's specific instruction to keep quiet trumps the attorney's implied authority.

Punitive Damages Are Claimed

Plaintiffs regularly plead their entitlement to punitive damages whether justified or not. Depending on the jurisdiction, a plaintiff's punitive damage claim may create a conflict of interest for insurance defense counsel. *See, e.g., Mobil Oil Corp. v. Md. Cas. Co.*, 681 N.E.2d 552, 561-62 (Ill. App. Ct. 1997).

States are divided on the insurability of punitive damages. In states prohibiting the insurability of punitive damages, or where a policy explicitly precludes coverage for punitive damages, an insurer may be thought to have no interest in defending such claims. Insureds, on the other hand, are vitally interested in avoiding punitive damages. Hence defense counsel's alleged conflict of interest.

A California court considered whether the existence of a punitive damage claim creates a conflict of interest in *Foremost Ins. Co. v. Wilks*, 253 Cal. Rptr. 596 (Cal. Ct. App. 1989). California prohibits coverage for punitive damages as a matter of public policy. The *Wilks* court concluded that the plaintiff's punitive damage claim did not create a conflict of interest, because it was in the insurer's best interest to vigorously defend the underlying suit to avoid liability for compensatory damages. *Wilks*, 253 Cal. Rptr. at 602. Although evidence might be developed that the insured acted recklessly or maliciously, thus exposing her to punitive damages, the insurer would not benefit from pursuing such a theory. Ergo, there was no conflict of interest.

Wilks is well-reasoned. Aggravating circumstances or conduct giving rise to punitive damages simultaneously increase compensatory damage exposure. An insurer must therefore vigorously defend aggravated litigation to reduce its potential indemnity obligation to its insured. Accordingly, the mere existence of a punitive damage claim does not create a conflict of interest. A punitive damage claim might create a conflict of interest only if coupled with an allegation that the insured acted intentionally. In that case, however, it is the alleged intentional act that creates any conflict; the punitive damage claim is incidental. *See, e.g., Illinois Municipal League Risk Management Ass'n v. Seibert*, 585 N.E.2d 1130 (Ill. App. Ct. 1992).

There may be cases in which a plaintiff's compensatory damages are minimal, but the insured's conduct is so outrageous or reckless that it may be exposed to punitive damages. *See, e.g., Nandorf v. CNA Ins. Cos.*, 479 N.E.2d 988 (Ill. App. Ct. 1985) (seeking \$700,000 in punitive damages and \$5,000 in compensatory damages for false imprisonment). For example, a plaintiff might suffer relatively minor injuries in an automobile accident in which the insured driver was drunk, or an African-American shopper briefly detained by a store's security force because of her race might sue the store for false imprisonment. Here the defendant's insurer need not worry about minimizing compensatory damage exposure because it is already small. The potential for a punitive damage award is of no concern to the insurer because it is not obligated to indemnify the insured for punitive damages. It might therefore be argued that the insurer has no interest in zealously defending the insured, and that because of this conflict of interest the insured is entitled to independent counsel. *See Nandorf*, 479 N.E.2d at 992-94.

This argument misses the mark. While it is true that the insurer's provision of a robust defense is no longer guaranteed by its interest in defeating or mitigating compensatory damages, that does not mean that it has no incentive to protect the insured against punitive damages. To the contrary, an insurer that does not zealously defend its insured in this situation will almost certainly be exposed to bad faith liability. The threat of bad faith provides the insurer with all the incentive it needs to protect the insured by way of an aggressive defense. Accordingly, a defense lawyer hired by an insurer in such a case should face no conflict of interest.

Potential Damages Exceed Coverage

Cases in which potential damages exceed available insurance coverage may spawn conflicts of interest. Conflicts allegedly arise when a plaintiff offers to settle within policy limits. *See Lehto v. Allstate Ins. Co.*, 36 Cal. Rptr. 2d 814, 820 (Cal. Ct. App. 1994). As soon as a policy limits offer is made, the insured's interests and those of the insurer diverge. The insured wants the insurer to accept the offer in order to avoid excess liability and potential financial ruin. Such a settlement is not necessarily in the insurer's best interests. By going to trial, the insurer may escape liability altogether, or obtain a judgment lower than the plaintiff's settlement offer. The insurer might therefore be tempted to gamble with its insured's money. Precisely to avoid this problem, courts imply a duty on insurer's part to settle claims for their insureds' benefit. Defense counsel are frequently caught in the middle.

The court in *Allstate Insurance Co. v. Campbell*, 639 A.2d 652 (Md. 1994), concluded that potential excess liability, standing alone, does not create a conflict of interest requiring the insurer to surrender control of the defense and pay for the insured's independent counsel. The *Campbell* court acknowledged the potential conflict, but observed that the insured's and insurer's interests are in no way adverse to the extent that exists where coverage is an issue. The court concluded that any conflict was mitigated by the insured's ability to later pursue a bad faith claim should the insurer unreasonably refuse to accept a policy limits offer. Absent a separate conflict of interest necessitating the retention of independent counsel for the insured, the insurer retains the right to control the defense of a potential excess verdict case.

Campbell is a sound decision. Insurers must vigorously defend potential excess verdict cases to minimize their potential indemnity obligation up to policy limits, and to avoid bad faith liability. The latter factor provides special incentive. The mere possibility of an excess verdict does not create a conflict of interest depriving an insurer of the right to control the defense. *See Littlefield v. McGuffey*, 979 F.2d 101, 108 (7th Cir. 1992) (deciding case under Illinois law).

The fact that the insurer retains control of the defense in a potential excess verdict case does not relieve defense attorneys of certain ethical obligations, however. Generally speaking, defense counsel must make the insured aware that a potential conflict of interest exists, and advise the insured of its right to consult independent counsel regarding any excess liability. Defense counsel must also inform the insurer of any potential excess liability. Both parties can then take the steps necessary to protect their respective interests. Under no circumstances can defense counsel play settlement games. Failure to settle a policy limits case in the pursuit of some personal agenda exposes defense counsel to personal liability.

Conflicts Regarding Insureds' Affirmative Claims

An insurer defending its insured generally has no obligation to prosecute counterclaims or third-party claims that the insured may have either as a matter of contract or by virtue of its duty of good faith and fair dealing. *Ramsey v. Lee Builders, Inc.*, 95 P.3d 1033, 1040 (Kan. Ct. App. 2004); *Towne Realty, Inc. v. Zurich Ins. Co.*, 548 N.W.2d 64, 68-69 (Wis. 1996); *Shoshone First Bank v. Pac. Employers Ins. Co.*, 2 P.3d 510, 516-17 (Wyo. 2000). It is still possible, however, for insureds' affirmative claims to spawn disputes, as *Northern County Mutual Insurance Co. v. Davalos*, 140 S.W.3d 685 (Tex. 2004), illustrates.

Davalos was injured in an automobile accident in Dallas County, Texas. He resided in Matagorda County, Texas. He sued the driver of the other car in Matagorda County. The other driver and his wife then sued Davalos and a third party in Dallas County. Davalos turned over the Dallas County litigation to his lawyers in the Matagorda County case, who answered the suit and moved to transfer it to Matagorda County. The attorneys then notified Davalos's insurer, Northern, of the Dallas County suit. Northern responded to Davalos, telling him that it would defend him, that did not wish to hire his lawyers, that it opposed the motion to transfer the Dallas County case to Matagorda County, that it had retained another attorney to defend him in the Dallas County action, and warning him that his coverage might be jeopardized if his personal counsel did not abandon their motion to transfer venue and withdraw. Northern also told him that he was free to retain his personal counsel at his own expense to consult on the Dallas County case, and that Northern's chosen lawyer would cooperate with that lawyer as long as it did not jeopardize the defense. Northern legitimately believed Dallas County to be the proper venue for both actions arising out of the accident.

Davalos rejected Northern's defense, asserting that the company's offer was qualified and thus breached the duty to defend, and that Northern could not select defense counsel because its dispute over venue created a conflict of interest. Despite Davalos's resistance and the fact that Northern was never allowed to assume the defense, the Matagorda County action was transferred to Dallas County on another party's motion. Northern settled the claims against Davalos that had been asserted in the original Dallas County case, obtaining his full release at the company's sole expense. Meanwhile, Davalos sued Northern in Matagorda County, claiming that the insurer had breached its duty to defend the Dallas County action, and that Northern was guilty of bad faith and had violated the Texas Insurance Code.

Davalos's suit against Northern proceeded, with both the trial court and a lower appellate court concluding that Northern had breached its duty to defend and violated the Texas Insurance Code. Northern then sought review by the Texas Supreme Court. The supreme court granted review and reversed.

The supreme court rejected Davalos's claim that Northern had improperly conditioned his defense. An insurer's right to conduct the [insured's] defense includes the authority to select the attorney who will defend the claim and make other decisions that would normally be vested in the insured as the named party in the case. *Davalos*, 140 S.W.3d at 688. Not every disagreement between an insurer and an insured about the conduct of a defense is a conflict of interest; were that the case, the insured, not the insurer, could control the defense merely by disagreeing with the insurer's actions or strategy. Instead, an insured may rightfully refuse an inadequate defense and may also refuse any defense conditioned on an unreasonable, extra-contractual demand that threatens the insured's independent legal rights. *Davalos*, 140 S.W.3d at 689. For example, Northern could not have conditioned Davalos's defense on his promise to dismiss his Matagorda County action. Here, however, the disagreement centered on the proper venue for the defense of the third-party action, not Davalos's right to pursue his own remedy.

Northern never deprived Davalos of a defense. Choosing venue is a strategic decision entrusted to defense counsel. The choice of venue should ordinarily have no impact on the insured's legitimate interests under the policy. *Davalos*, 140 S.W.3d at 690. While Davalos had the right to reject Northern's offer of a defense because he did not want the case against him defended in Dallas County, he was not entitled to recover the costs of that defense. Northern's offer to defend the Dallas County action satisfied its contractual obligations.

The court likewise found that Northern did not violate the Texas Insurance Code. The company's disagreement

with Davalos over venue did not render its offer to defend him equivocal.

CONCLUSION

Conflicts of interest are an inevitable hazard in the eternal triangle. Insurance defense attorneys can best avoid conflicts by embracing the principle that their sole client is the insured they are hired to defend in any given case. They should reflect this position in their engagement or acknowledgment letters sent to insureds when accepting new matters. Thereafter, defense counsel's only reliable means of avoiding conflicts is to take the approach that their primary duty is to further the insured's best interests. Defense counsel must keep the insured fully informed of all settlement offers, and must keep the insured informed of all general case developments. This is especially true if the defense is being provided under a reservation of rights, or under a non-waiver agreement. Finally, defense counsel must appreciate the confidential relationship they share with the insureds they defend.

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Cirando on Insurance for the H1N1 Pandemic

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Cirando on Insurance for the H1N1 Pandemic

By Lisa M. Cirando

June 16, 2009

SUMMARY: This Emerging Issues Analysis identifies some of the special challenges faced by governments and businesses grappling with pandemic-related losses as they respond to the worst global economic crisis in generations. It analyzes three basic types of insurance coverage that may be available to those entities, and offers some helpful hints for pursuing pandemic-related insurance coverage claims.

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ARTICLE: INTRODUCTION

On Thursday June 11, 2009, the World Health Organization ("WHO") declared the first global influenza pandemic of the twenty-first century. The WHO's designation of a pandemic for a new strain of influenza A virus subtype H1N1 ("H1N1"), commonly referred to as swine flu, reflects the existence of ongoing community level outbreaks in over 70 countries worldwide. WHO's Director-General Dr. Margaret Chan has acknowledged that, "Further spread is considered inevitable." Past pandemics have reached at least a third of the global population.

Governments and businesses should carefully consider the potential for insurance coverage for their pandemic-related losses. This commentary presents a brief summary of the history and treatment of H1N1/swine flu and identifies some of the special challenges that will be faced by governments and businesses. This commentary also analyzes three broad types of insurance coverage that may be available to those entities grappling with the H1N1 pandemic: Property and Business Interruption (including Loss of Attraction); General Liability; and Directors and Officers Liability. Finally, some helpful hints for pursuing insurance coverage claims are offered.

HISTORY AND TREATMENT OF H1N1/SWINE FLU

The current pandemic is not the first time that humans have been infected with swine influenza. In 1976, a limited outbreak attributed to a different strain of the virus occurred among soldiers in Fort Dix, New Jersey. Until recently, the Centers for Disease Control and Prevention had received reports of approximately one human swine influenza virus infection every one to two years in the U.S., primarily among those persons with direct exposure to pigs. From December 2005 through February 2009, those numbers increased slightly, with approximately 12 reported cases of

human infection.

The numbers associated with the current pandemic have been steadily rising over the past few months, resisting early conclusions that the infection would not be widespread. Symptoms associated with H1N1 appear to be mild, with only roughly 150 deaths reported by the WHO since officials first discovered the virus in Mexico in March 2009. (In comparison, seasonal influenza kills about 500,000 a year worldwide). Reported cases of H1N1 now top out at nearly 30,000 worldwide, though experts believe that millions of people may have already been infected. Outbreaks have been most severe in Mexico and among Canada's indigenous populations, resulting in significant numbers being hospitalized.

When it comes to treatment, there are four different antiviral drugs licensed for use in the U.S., though the current H1N1 strain appears resistant to two of the four. A vaccine is expected to be ready for dissemination by October 2009, just in time for the start of the northern hemisphere's seasonal flu season.

GOVERNMENTS AND BUSINESSES GRAPPLE WITH THE PANDEMIC

A pandemic designation places increased pressure on all levels of government to take steps to contain the spread of H1N1, especially in the months before a vaccine is developed. In response to the initial outbreak, U.S. officials declared a public health emergency and the U.S. State Department warned citizens to avoid all nonessential travel to Mexico. In the U.S. and elsewhere, officials imposed quarantine measures such as school closures. Hong Kong instituted a quarantine at a hotel where Asia's first H1N1 case was traced, preventing 280 guests and employees from leaving the facility for a week.

Businesses have followed suit, taking extra precautions and assembling teams to develop and implement contingency plans in line with the Business Pandemic Influenza Planning Checklist posted by the U.S. Department of Health and Human Services at <http://www.pandemicflu.gov/plan/workplaceplanning/businesschecklist.html>. In fact, much of the actions taken by governments and businesses in the past few months had been developed in response to the avian flu and severe acute respiratory syndrome ("SARS") threats earlier this decade.

THE PANDEMIC PRESENTS SPECIAL CHALLENGES FOR GOVERNMENTS AND BUSINESSES DEALING WITH AN ECONOMY IN DISTRESS

The pandemic's likely effects-increased travel complications and declining productivity, coupled with escalating health care costs-present serious complicating factors for both governments and businesses as they respond to the worst global economic crisis in generations. In April 2009, the U.S. Congressional Budget Office estimated that a pandemic would reduce real (inflation-adjusted) gross domestic product by about one percent, or approximately US\$1.4 trillion. Experts have estimated that up to 30% of a company's employee base may be unable to work at some point in the pandemic, with potentially dire consequences for all businesses throughout the supply chain. In addition, governments and businesses may incur significant expenses, including the cost of sanitizing and decontaminating properties as well as the loss of income, either from property closures during decontamination or the resultant loss of customers due to the identification of the presence of H1N1.

Though international health authorities attempted to mitigate the effects on the economy by, for example, issuing recommendations against travel bans and other restrictions, some airlines canceled flights and waived change fees while cruise lines suspended port calls in Mexico. In addition, H1N1's link to pigs has led some countries to ban meat imports from Mexico and the U.S., even though it is not transmitted through the ingestion of pork, exacerbating a global slump in pork sales.

THREE TYPES OF INSURANCE FOR PANDEMIC-RELATED LOSSES

Governments and businesses may be able to recoup some of their pandemic-related losses under a variety of different insurance policies. The three most common types of insurance policies that may be implicated by the H1N1 pandemic include Property and Business Interruption (including Loss of Attraction); General Liability; and Directors

and Officers Liability.

Property Insurance Affords Coverage for Contaminated Properties

Property insurance protects against the risk of loss to the policyholder's buildings and building contents, such as equipment, furniture, computer hardware, etc. It may be written in one of two ways: All Risks or Listed Perils. All Risks policies provide coverage unless barred by a specific enumerated exclusion, whereas Listed Perils policies provide coverage for only certain defined risks (such as earthquakes, flooding, etc.).

Regarding All Risks coverage, certain property policies may contain disease or virus exclusions. To be enforceable, such exclusions must be narrowly tailored and written in clear and unmistakable language. In addition, exclusions are to be construed most strongly against an insurance company, with any ambiguities weighing in favor of coverage.

As to Listed Perils coverage, H1N1 is not likely to be a listed peril; however, some businesses may have purchased infectious disease coverage (which does not require physical damage to premises) in the wake of the SARS epidemic. Such additional coverages typically have significant limitations on the amounts available for loss, such as sublimits and high deductibles.

Loss or damage to property is a prerequisite to coverage under either All Risks or Listed Perils coverages. Significantly for businesses grappling with H1N1, contamination may constitute physical loss or damage. That is, the losses associated with the decontamination or destruction of insured property may be covered under first-party property insurance. Additionally, some first-party property policies include favorable language for policyholders that defines property damage to include the loss of use of insured property. In this way, a business may have property insurance to cover the loss of use of property made unavailable during times of quarantine or decontamination.

Business Interruption Insurance Compensates for Loss of Income

Property insurance policies also contain coverage for business interruption (or time element) losses that compensate policyholders for loss of business income in addition to the cost of repairs. Such coverage is typically triggered when a particular location becomes damaged and is not usable for an extended period of time. A typical insuring agreement states: "The Company will pay for actual loss sustained by the Insured resulting directly from the necessary interruption of the Insured's business caused by a peril covered hereunder." For example, the pandemic could lead to business interruption claims as a result of forced shut-downs or reduced access to a business' physical location, plant or warehouse.

The measure of the appropriate period of loss is often the subject of dispute. One definition is "the length of time that it should take to repair or replace damaged property." Policyholders may also have an extended period of indemnity that provides additional coverage beyond the initial period of loss. In addition, extra expense coverage for additional costs incurred because of the loss may be available. To gain these types of business insurance coverage, however, a policyholder must prove loss or damage to covered property.

Some businesses may have contingent business interruption coverage. Such coverage is triggered if an entity experiences pandemic-related losses as a result of a supplier's inability to deliver a product or service necessary to the policyholder's business. Other forms of business interruption insurance also recognize coverage where employees or customers are denied access because of a government decree, as in the case of Hong Kong's hotel quarantine.

Insurance companies may assert defenses to coverage, suggesting that the policyholder's loss is not due to H1N1 but instead a result of the economic crisis. Policyholders should consider retaining experts, such as forensic accountants, to assist with the determination of the extent of the loss.

Loss of Attraction: Special Coverage for Pandemic-Related Losses

In addition, some property insurance policies (especially those purchased by large hotel/hospitality-related businesses) may contain coverage for pandemic-related claims under loss of attraction provisions. Sample wording states: "This policy is extended to cover the actual loss sustained by the Insured resulting from cancellation of or inability to accept bookings for accommodation and/or a cessation or diminution of trade due to a loss of potential customers, as a direct result of: the occurrence at an insured location of murder, suicide, rape, attempted rape, armed robbery, and malicious activities, contagious and/or infectious disease, food or drink poisoning, vermin, pests or defective sanitation." To be covered, the policy typically requires that the loss exceed 24 hours. Some coverages specifically exclude loss "directly or indirectly arising out of, contributed to, or by resulting from SARS, Avian Flu, and/or atypical pneumonia, or fear of threat thereof."

General Liability Provides Defense and Indemnity Coverage Against Third-Party Claims

General liability (or comprehensive/commercial general liability) policies provide insurance for various types of claims brought by third parties alleging property damage, bodily injury, personal and advertising injury, as well as medical payments coverage. Some industries may be more susceptible to liability claims for pandemic-related losses than others. These include hospitality and food service industries, such as hotels, restaurants, cruise ships, resorts, tour companies, conference and event companies; common carriers such as airlines, trains, busses, taxi companies; and health care industries such as hospitals, elderly care homes, etc. Public institutions, such as prisons and detention centers, also may face pandemic-related claims.

Claimants asserting pandemic-related losses will look to hold entities accountable on the basis that they allegedly helped to spread H1N1 or failed to contain it. For example, employers experienced a wave of liability claims in 2003 for allegedly being unprepared for the SARS epidemic. There may be coverage for such claims, though causation may be a point of contention between insurance companies and policyholders. The determination of causation by the policyholder is fact-intensive, and it may be impossible for people who become ill to prove the precise moment and location of exposure; however, some cases may be easier to prove than others (*i.e.*, cruise ship v. supermarket).

The standard general liability insuring agreement provides both defense and indemnity coverages. Defense costs coverage is an important component and is available in addition to limits of liability. Where the allegations arguably fall within the coverage provided, the duty to defend terminates only when the limits are exhausted by payment of judgment or settlement. The definition of defense expenses may include expert and consultant expenses and site investigation costs, as well as attorneys' fees and costs.

Directors and Officers Liability Insurance Protects Against Loss for Wrongful Acts

Companies purchase directors and officers (D&O) liability insurance as the last line of defense for themselves and their directors and officers. In exchange for substantial premiums, D&O insurance companies promise to indemnify directors and officers for "Loss" that those individuals become legally obligated to pay due to "Wrongful Acts" committed in their capacity as directors and officers. "Wrongful Acts" may be defined to include negligent acts, errors or omissions, misstatements, or breach of duty committed by the directors or officers in the discharge of their duties and solely in their official capacity as such.

Though each policy is unique, D&O insurance policies typically provide three types of coverage:

- Side A or non-indemnifiable loss coverage, which protects directors and officers when the company is legally prohibited from indemnifying them or where the company is insolvent and cannot indemnify them;
- Side B or corporate reimbursement coverage, which pays the company back for amounts it expends to indemnify

directors and officers; and

- Entity coverage, which, when available, covers the company itself against securities fraud claims.

D&O insurance typically covers defense costs, settlements and judgments against directors and officers in securities fraud lawsuits and shareholder derivative actions. It also provides coverage for investigative and defense costs incurred by directors and officers and, sometimes, the corporation itself, with respect to Securities and Exchange Commission ("SEC"), regulatory and criminal investigations and proceedings.

Federal securities laws prohibit registered entities from making material misstatements or omissions of fact in their SEC filings, press releases and other public communications. With respect to the H1N1 pandemic, companies could violate the federal securities laws if they make false or misleading statements concerning-or if they fail to disclose entirely-the impact or lack of impact of a potential outbreak on their financial results. Securities class actions may be filed alleging nondisclosure or misstatement of risks. Shareholders of companies adversely affected by the H1N1 pandemic may claim that the conduct or decisions made by the company or its executives caused loss. Some allegations that may be made include not taking steps at the early stages of the outbreak to prevent exposure.

Public companies should consider the impact of the pandemic on their financial results. Certain industries, such as pharmaceuticals, may need to employ special accounting rules and SEC guidance for sales of their products. It is crucial that companies demonstrate corporate responsibility and accountability to their stakeholders through transparent actions and communications. Companies will need to assure their stakeholders that they can adequately respond to the pandemic from a humanitarian perspective and anticipate legal and public challenges.

CONCLUSION: HELPFUL HINTS FOR PURSUING INSURANCE CLAIMS

It is imperative that both governments and businesses acknowledge the potential that pandemic-related losses will trigger the protection afforded by several different types of insurance. Policyholders should gather and read all potentially relevant insurance policies and give timely notice of claims (or circumstances which may subsequently give rise to claims), as directed. Documents should be organized and well-maintained and experts, including legal counsel, should be retained early in the process, particularly for large claims. Relevant dates for filing proof of loss and lawsuits against the insurance company should be calculated as soon as possible. Time limits are strictly enforced under first-party property insurance; however, in most instances, time limits may be tolled by agreement.

Policyholders should be mindful of their duty to cooperate and keep insurance companies (including excess insurers) regularly updated and informed of decisions, especially any that involve large expenditures. Many policies require that policyholders seek insurance company consent to retain defense counsel or settle an action. Be assured that anything said to or shared with the insurance company may be used in its defense of the claim. If the claims-handling process should become adversarial, policyholders should remind the insurance companies that their duties of good faith and fair dealing continue even through coverage disputes and coverage litigation.

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Reed Smith LLP on Direct Mortgage Corp. v. National Union Fire Insurance Co.

2009 Emerging Issues 3610

Reed Smith LLP on Direct Mortgage Corp. v. National Union Fire Insurance Co.: Fidelity Bond Coverage for Insureds Liability to Third Parties

By Mark S. Hersh and Yisroel I. Hiller

May 8, 2009

SUMMARY: Insured financial institutions often seek fidelity coverage, but fidelity insurers deny requests for coverage on grounds that this type of loss fails to satisfy the requirements of the standard fidelity agreement. This article analyzes *Direct Mortgage Corporation v. National Union Fire Insurance Co.*, and provides insureds with arguments to assist them in obtaining fidelity coverage for loss resulting from employee misconduct to third parties.

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ARTICLE: I. Introduction

In the wake of the current financial crisis, insured financial institutions should be more aware than ever of potentially available sources of reimbursement for losses they suffer at the hands of their employees. Financial institutions commonly purchase fidelity coverage to protect themselves against losses resulting from employee dishonesty, and are often able to access such coverage for reimbursement of loss they suffer when employees defraud the company or misappropriate funds from the company's own accounts. But to what extent will a fidelity bond cover losses insureds incur arising from their liability for employee misconduct against third-parties?

In *Direct Mortgage Corporation v. National Union Fire Insurance Co.*, 2008 U.S. Dist. Lexis 60695 (August 8, 2008), the court analyzed this issue and noted a split of authority between courts limiting coverage to "direct" losses, and courts permitting coverage for any losses "proximately caused." The *Direct Mortgage* court sided with the decisions holding that a fidelity bond will cover only "direct" losses, concluding that it "is not intended to be a liability policy." It found that third party liability was covered only in limited circumstances, namely when the third party's property was being held by the insured in a bailment or trust situation.

This article analyzes the scope of fidelity coverage available to insureds for losses they incur in connection with liability to third parties, with particular emphasis on rejoinders to the two most common arguments carriers raise when denying fidelity coverage for such losses: (1) that these losses do not constitute "direct loss" under the bond (as the *Direct Mortgage* court found); and (2) that in causing losses to third parties, the defalcating employee lacked the

requisite intent to cause a loss to the insured institution (an issued raised but not reached in *Direct Mortgage*). n1

II. Analysis

A. The "Direct Loss" Requirement

When insureds seek coverage under fidelity bonds for loss incurred as a result of their liability to third parties ("third party loss"), carriers often assert that such liability is not "direct loss," citing to the language of the insuring agreement providing that only "Loss *resulting directly from*" employee dishonesty is covered. Some courts agree and reject coverage for third party loss on grounds that such loss results directly from third party claims, rather than from employee dishonesty. The *Direct Mortgage* case is one such decision.

However, as the *Direct Mortgage* court noted, there is case law to the contrary. Some courts have found third party liability to be covered under fidelity bonds as long as the loss (the payment to the third party) was caused by the employee's dishonesty:

The loss covered by an employee's fidelity bond is not necessarily limited to loss directly resulting from the employee's act, such as embezzlement. To the contrary, it may include liability on the part of the insured resulting from the application of the principles of vicarious liability. In other words, a bond insuring against loss sustained by reason of dishonesty, fraud, embezzlement, and so forth, covers losses imposed by the creation of liability to third persons. To illustrate, it has been held that a loss may be suffered by the insured through being required to make good on an obligation to a third person created by the fraud of its employee perpetrated on such third person.

Rafoth v. Nat'l Union Fire Ins. Co. (In re Baker & Getty Fin. Servs.), 93 B.R. 559, 564-65 (Bankr. N.D. Ohio 1988) (citations omitted). As noted in *Direct Mortgage*, some courts have applied a "proximate cause" standard in assessing whether liability to a third party is covered under the bond, i.e., there is coverage if the loss was proximately caused by the employee dishonesty. See *Auto Lenders Acceptance Corp. v. Gentilini Ford, Inc.*, 854 A.2d 378, 386 (N.J. 2004) (and cases cited therein) ("[T]he majority of federal courts that have addressed the question have concluded that the term 'direct loss' or its equivalent does, in fact, call for the application of a proximate cause standard").

Other courts hold that losses covered by fidelity bonds include losses directly resulting from liability of the insured under vicarious liability principles. See, e.g., *Rafoth v. Nat'l Union Fire Ins. Co. (In re Baker & Getty Fin. Servs.)*, 93 B.R. 559, 564-65 (Bankr. N.D. Ohio 1988) (citations omitted); *Ins. Co. of N. Am. v. Gibalco, Inc.*, 847 F.2d 530, 533 (9th Cir. 1988).

B. The "Intent" Requirement

The fidelity bond insuring agreement generally limits coverage to dishonest or fraudulent acts: "committed by the Employee with the intent: (a) to cause the Insured to sustain [a] loss; and (b) to obtain financial benefit for the Employee or another person or entity." Bond, INSURING AGREEMENTS, FIDELITY, (A). Carriers often rely on this language in denying coverage for third party loss, asserting that third party loss does not satisfy the "intent requirement" because when an employee engages in misconduct against third parties the employee intends to cause a loss to those third parties, rather than to the Insured. n2

While there is adequate case law to support this position, there appear to be a number of different approaches to the intent requirement in the case law. See generally *Resolution Trust Corp. v. Fid. & Dep. Co. of Md.*, 205 F.3d 615, 638-640 (3d Cir. 2000) (discussing the split in authority). Some courts have held that the intent requirement in a fidelity bond requires the specific intent or purpose to harm the insured. See, e.g., *Gen. Analytics Corp. v. CNA Ins. Cos.*, 86 F.3d 51 (4th Cir. 1996) (bond required specific intent to accomplish a purpose, akin to the intent required under criminal law). Under this approach, it is unlikely an insured would be able to establish that an employee's awareness that his misconduct toward third parties constitutes intent to cause loss to the insured. However, other courts have held that the intent requirement does not require that the dishonest employee must "actively wish for or desire" to cause

the loss to his or her employer. Rather, an intent to cause loss to the insured can be established if the employee acted with "substantial certainty" that its employer would suffer the loss. *See, e.g., Peoples Bank & Trust Co. of Madison County v. Aetna Cas. & Sur. Co.*, 113 F.3d 629, 635 (6th Cir. 1997). n3

Because "intent" is typically left undefined in the Bond, the insured should note that undefined terms in insurance policies are given their ordinary meanings, and where the meaning of words is uncertain or capable of several reasonable interpretations, resolve the doubts in favor of the policyholder. *See, e.g., Woods v. Nationwide Mut. Ins. Co.*, 246 S.E2d 773, 777 (N.C. 1978). n4 Accordingly, insureds should argue that the intent requirement has been satisfied when an employee causes losses to third parties for which the insured will face vicarious liability, because in doing so, the employee effectively intended (*i.e.*, acted with the knowledge that his conduct would) to cause the insured a loss. After all, a natural consequence of committing dishonest or fraudulent acts while consciously holding oneself out as an agent is potential vicarious liability of the principal to the victims. *See* Restatement (Second) of Agency § 261.

C. Other Relevant Policy Language

Two other common fidelity bond provisions also support the insured's argument that third party liability should be covered. Most Bonds require the insured to give notice to the carrier of any legal proceeding brought against the insured asserting claims for loss "which, if established, would constitute a collectible loss under this bond." Bond, GENERAL AGREEMENTS, NOTICE OF LEGAL PROCEEDINGS AGAINST INSURED -- ELECTION TO DEFEND, E. In connection with this notice requirement, most bonds provide that the insurer has discretion to assume the defense of the underlying proceeding, including third party claims asserted against the insured. The clear import of these provisions is that third party claims for loss caused to third parties may be covered under the Bond. However, some courts have rejected this argument. *See, e.g., Aetna Cas. & Sur. Co. v. Kidder, Peabody & Co., Inc.*, 676 N.Y.S.2d 559, 564 (App. Div. 1998).

Additionally, the Bond typically will exclude from coverage "damages of any type for which the Insured is legally liable, *except compensatory damages*, but not multiples thereof, arising directly from a loss covered under this bond." Bond, Exclusions § 2(u) (emphasis added). The carveback in this exclusion for "compensatory damages" clearly implies that the bond is intended to cover compensatory damages the insured pays to third parties in connection with its liability to those third parties. Some courts, however, have rejected this argument. *See Direct Mortgage*.

III. Conclusion

In sum, the *Direct Mortgage* decision is the latest in a line of cases severely limiting fidelity bond coverage for third party loss. However, as that decision acknowledged, there is a split of authority on this issue. Insured financial institutions seeking fidelity coverage for third party loss have reasonable arguments at their disposal to rebut the defenses to coverage for such loss commonly raised by fidelity carriers. These arguments can be an effective tool in negotiating a settlement of the coverage dispute or in persuading the carriers to contribute to a settlement of the underlying claim brought against the insured, and also serve as viable support for the insured's coverage position should a coverage dispute between the insured and its carrier escalate into litigation or other forms of dispute resolution.

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n1 This article analyzes potential coverage for third party claims under the standardized fidelity insuring agreement language utilized by the 1986 edition of a Standard Form No. 24 Financial Institution Bond. *See* The Financial Institution Bond, Standard Form No. 24 (revised to April 1986), reprinted in STANDARD FORMS OF THE SURETY ASSOCIATION OF AMERICA (hereinafter, the "Bond").

n2 Many of the cases discuss the intent requirement in connection with policies requiring that the employee have "manifest intent" to cause loss to the insured. Bonds occasionally omit the term "manifest" from the intent requirement. Insureds may assert that the omission of the word "manifest" from the intent requirement lessens the burden on the insured to produce evidence demonstrating the employee had specific intent to cause a loss to the insured. *See Resolution Trust Corp. v. Fid. & Dep. Co. of Md.*, 205 F.3d 615, 642 (3d Cir. 2000) (holding "manifest" in the term "manifest intent" must be given meaning)).

n3 Some courts appear to merge the two approaches by requiring specific intent to harm the insured but permitting proof of recklessness to satisfy this standard. As the Third Circuit has stated, "proof of an employee's recklessness, or an employee's knowledge that a result was substantially certain to occur from the conduct, are objective indicia-manifestations-of the employee's specific purpose or intent." *Resolution Trust Corp.*, 205 F.3d at 641-42; *see also FDIC v. Nat'l Union Fire Ins. Co.*, 205 F.3d 66, 74 (2d Cir. 2000) (holding similarly).

n4 However, some courts have held that this usual rule of policy construction does not apply to financial institution bonds, on the grounds that they are negotiated by the banking industry. *See, e.g., Sharp v. FSLIC*, 858 F.2d 1042 (5th Cir. 1988).

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Sonnenschein Nath & Rosenthal, LLP on Trout v. Nationwide Mutual Insurance Co.

2009 Emerging Issues 3589

Sonnenschein Nath & Rosenthal, LLP on Trout v. Nationwide Mutual Insurance Co.: An Inconclusive Decision on a New Bad Faith Set-Up

By William Barker and Gauri Chopra

May 4, 2009

SUMMARY: Trout v. Nationwide Mutual Insurance Co. is an unreported decision reporting on a new approach to setting up a liability insurer for bad faith, and leaves open the possibility that the approach might be allowed to work. This commentary examines the new approach, offers an argument that it should not work, and considers how insurers might handle claims where this approach is tried.

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ARTICLE: *Trout v. Nationwide Mutual Insurance Co.* n1 is an unreported decision reversing a summary judgment because (as everyone agreed) the district court applied the wrong standard and (as the court held) the error was not harmless. But the case reports on a new approach to setting up a liability insurer for bad faith, and leaves open the possibility that the approach might be allowed to work. This commentary examines the new approach, offers an argument that it should not work, and considers how insurers might handle claims where this approach is tried.

I. The Case

Trout was a passenger in a car owned by Budnikov's father, Raysh, and driven by Kreyche, with Budnikov's permission. Both Kreyche and Budnikov had been drinking. The car hit a tree and Trout was severely injured in December, 2002. Kreyche was insured by Nationwide, with a per person limit of \$100,000 and the car was insured by American Express, with a per person limit of \$25,000. American Express assumed the defense.

In January, 2004, Trout's lawyer asked Kreyche's lawyer if Kreyche's insurer would offer its limits (also saying that he was not agreeing to accept the limits). He set a short deadline for response, but extended that once. Defense counsel responded by offering Nationwide's \$100,000 limit, with conditions, and reporting that American Express had also offered its limit, later adding that there was no other insurance available. Trout rejected Nationwide's conditional offer, made no counteroffer, went to trial, and was awarded \$640,000 plus costs. Kreyche was also criminally prosecuted and subjected to a \$170,138 restitution judgment in favor of Kaiser Permanente, which provided hospital and medical care to Trout for her injuries.

Kreyche assigned his right to Trout, who sued Nationwide for failure to settle, and Nationwide removed the case to federal court. Trout claimed that at least some of Nationwide's conditions were unreasonable, and had an expert witness who supported that claim. Among Nationwide's contentions was that it never had an opportunity to settle within limits, because Trout never made a demand within limits. The district court granted summary judgment to Nationwide.

Under Colorado law, as elsewhere, different standards apply to so-called third-party bad faith (failure to settle to prevent excess exposure) and first-party bad faith (improper failure to compensate the insured's own losses). As the Tenth Circuit explained:

"In the third-party context, an insured's claim is based on general principles of negligence and requires proof that the insurer acted 'unreasonably under the circumstances.'" By contrast, first-party claims require an additional element: "[i]n a first-party claim, . . . the insured must prove both that the insurer acted 'unreasonably under the circumstances' and that 'the insurer either knowingly or recklessly disregarded the validity of the insured's claim.'" n2

The district court mistakenly applied the first-party standard and found that Trout had shown neither unreasonable conduct nor reckless disregard. n3 Everyone agreed that this was error, and the issue was whether it was harmless. Stated differently, review of a decision on summary judgment is *de novo*, n4 so the appellate court can affirm the grant, if correct, even if the reasons given below were wrong. But the Tenth Circuit concluded (without explaining its analysis) that the expert evidence created an issue of material fact. n5

II. Analysis of the Bad Faith Claim

The Tenth Circuit's explanation of the difference between the third-party and first-party standards might indicate that the use of the first-party standard was harmless, because the district court found no unreasonable conduct. However, even though Colorado law seems confused on the point, reasonable conduct means two different things under the two standards. n6 In the first-party context, Colorado emphasizes the need to accord an insurer "wide latitude in its ability to investigate claims and to resist false or unfounded efforts to obtain funds not available under the contract of insurance." n7 Accordingly, establishing bad faith requires proof of "the absence of a reasonable basis for denying benefits of the policy and the defendant's knowledge or reckless disregard of the lack of a reasonable basis for denying the claim." n8 The insurer may challenge any claim that is "fairly debatable." n9 In contrast, the third-party context involves a quasi-fiduciary obligation to protect the insured from the third-party claim, and this obligation differs from a first-party insurer's obligation to pay benefits. n10 Many courts hold that this requires the insurer to consider a settlement demand as if it alone would be liable for any judgment. n11 Thus, even a reasonable hope of a defense verdict does not necessarily justify refusal to settle, if the potential damages are very large. So, one cannot assume that reasonable conduct under the first-party standard would also satisfy the third-party standard.

But the district court in *Trout* had relied on an independent ground that, if correct, should have sufficed to sustain the judgment. It reasoned that Nationwide could not be liable for failure to settle unless it had received an offer to do so, and Trout had never offered. n12 Some courts agree that an offer by the plaintiff is required, n13 some do not. n14 Colorado has not spoken to this issue, but the Tenth Circuit could have done so if the issue was adequately presented by the parties.

I have argued that an offer by the plaintiff (usually referred to as a "demand") should be required. n15 In summary, the argument is that the duty of good faith is imposed to provide the insurer with proper incentives in considering settlement opportunities. But the imposition of that duty has created incentives for manipulation by plaintiffs, who try to remove the policy limits without ever actually taking the risk of being limited to that amount.

A party that would prefer a breach of the duty to settle over performance of that duty would rather not make demands because the demand might be accepted and eliminate any possible recovery above limits. Such a party would prefer to wait for an offer, perhaps "signaling" supposed receptiveness. If the offer never comes, it can later be argued that a reasonable insurer would have made one and the injured party can then testify that it would have been accepted. If

an offer below limits is rejected, there is still an ability to claim that a higher offer, still within limits, would have been accepted. Yet the injured party (who may not have decided what would be acceptable), retains the ability to reject any offer that is made.

In order to avoid later disputes about whether a within-limits offer would have been accepted and to limit abuse by plaintiffs, I argue that the plaintiff should be required to make a demand that the insurer fails to accept before any bad faith claim can arise. If that were the law of Colorado, there would have been no need for a remand in *Trout*. Without checking the briefs, it is impossible to know whether this possibility was adequately presented and, in any event, the opinion is not precedential.

What makes the approach taken by Trout novel is that she essentially ignored Nationwide's effort to settle. Usually, bad faith actions not based on rejected demands have relied on the failure of the insurer to make an offer. Once an offer has been made, there has typically been either a demand for more money (if the offer were less than limits) or for removal of objectionable conditions, giving the insurer at least one opportunity to improve its offer. Trout simply rejected the offer and went to trial. Even if a court holds that an insurer has an obligation to explore settlement, it would be a considerable extension of that principle to say that the insurer must make the best possible offer as the opening of negotiations.

Such a rule would be particularly inappropriate on the facts in *Trout*. Nationwide's conditions were primarily, if not exclusively an effort to protect its insureds -- not itself. Those conditions were as follows:

- a release of Trout's claims against Kreyche, Budnikova and their respective parents;
- Trout's agreement to defend, hold harmless, and indemnify Kreyche, Budnikova and their respective parents in any action brought by a third party;
- Trout's warrant that she had not assigned any portion of her claim to anyone other than Kaiser Permanente and agreement to release and hold harmless Kreyche, his parents and Nationwide from any sums awarded for restitution in the State Action;
- dismissal of the State Action with prejudice;
- waiver of subrogation rights by Kaiser Permanente, Trout's medical insurance provider; and
- waiver of subrogation by any underinsured motorist insurance carrier.

Nationwide was attempting to buy peace for all of its insureds by offering its entire limits. It would have been remiss in not making some attempt to do so, unless it had the insureds' informed consent to leave them exposed to further suits-suits against which Nationwide would probably have had no obligation to defend once its limits were exhausted. Moreover, Nationwide may have had a legal obligation to demand some of those conditions. State law sometimes gives hospitals and other medical providers liens on their patients' tort claims, which must be satisfied before any payment can be safely made to the patient. When this occurs, the insurer is both obligated and entitled to resolve any lien claim as part of any settlement. n16 Colorado law may or may not provide for a lien, but it probably grants the medical provider at least a subrogation claim, a claim that apparently exceeded the policy limits.

In any event, looking at the matter from the perspective of Nationwide's insureds (including Kreyche, whose bad faith claim Trout is prosecuting) it is difficult to see how an effort to protect the insureds was a breach of duty to those same insureds.

III. Lessons for Insurers

The court does not tell us what the letter offering Nationwide's limits said about the conditions. But it might have helped if Nationwide made explicit what should have been obvious on the face of the conditions: that Nationwide was trying to perform its duty to protect its insureds against exposure in excess of limits by offering those limits in return for elimination of all exposure. The letter might have continued by saying that any proposed settlement that did not

eliminate all exposure would require consultation with the insureds, while offering to initiate such consultations if necessary. A letter of that sort might have made a bad faith claim less attractive and led to global settlement negotiations. And it would likely help with any bad faith jury.

IV. Conclusion

When plaintiffs' are faced with inadequate insurance, their lawyers are often creative in trying to find ways to reach beyond the limits. It remains to be seen how Trout's effort will ultimately fare, though the analysis above suggests that it should fail. In the interim, insurers should prepare for others who may try similar approaches.

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n1 *Trout v. Nationwide Mut. Ins. Co.*, 2009 U.S. App. LEXIS 6298 (10th Cir. Mar. 12, 2009).

n2 *Id.* at *13 (citations omitted).

n3 *Id.* at *10-11.

n4 *Id.* at *11.

n5 *Id.* at *17.

n6 *But see Farmers Grp., Inc. v. Trimble*, 691 P.2d 1138, 1142 (Colo. 1984) (suggesting that the question, under either standard, is "'would a reasonable insurer under the circumstances have denied or delayed payment of the claim'").

n7 *Travelers Insurance Co. v. Savio*, 706 P.2d 1258, 1274 (Colo. 1985).

n8 *Id.* at 1275.

n9 *Id.*

n10 *Id.* at 1274.

n11 *Crisci v. Security Ins. Co.*, 66 Cal. 2d 425, 429 (1967), relied on in *Farmers Grp., Inc. v. Trimble*, 691 P.2d 1138, 1141 (Colo. 1984)

n12 *Trout*, 2009 U.S. App. LEXIS 6298, at *7-8.

n13 *E.g., Amer. Physicians Ins. Exch. v. Garcia*, 876 S.W.2d 842, 851 (Tex. 1994).

n14 *Hartford Cas. Ins. Co. v. New Hampshire Ins. Co.*, 417 Mass. 115, 122 (1994) (insurer must explore settlement if failure to do so unreasonable).

n15 William T. Barker, H. Robert Powell, & Michael S. Truesdale, *Too Many Claimants, Too Little Money: The Missed Opportunity of Trinity Universal Insurance Co. v. Bleeker*, 14 *Bad Faith L. Rep.* 123 (1998).

n16 *Trinity Universal Insurance Co. v. Bleeker*, 966 S.W.2d 489 (1998).

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About the Law Firm. Sonnenschein Nath & Rosenthal, LLP, regularly handles high-risk and complex matters for financial and insurance industry clients. Staffed with seasoned litigators and former insurance regulators, Sonnenschein lawyers are relentless advocates for its clients interests. For more than 70 years, Sonnenschein has partnered with insurance companies to understand their business and legal needs. Recent confirmation of Sonnenschein's outstanding insurance industry qualifications came in *Chambers USA: Americas Leading Lawyers for Business*. The 2007 edition identifies Sonnenschein as one of the top firms in the country representing insurers on their most complex matters. The Chambers description speaks for itself: This powerhouse litigation firm is known for its sophisticated and thorough work in insurance and its ability to pull together a sterling set of resources. The firm fields a wide range of specialists, which it can use to staff complex cases. Its recent track record ranges from involvement in the WTC litigation to Hurricane Katrina-related issues. Matters are handled by a number of offices at any one time and practitioners are said to work tirelessly and creatively to help manage disputes and create briefings that are strong and impressive. Key areas of interest are bankruptcy and insolvency in insurance companies, class actions and catastrophic loss in both appeals and litigation. The firm also has strength in personal lines insurance and in regulatory proceedings. When products are attacked, when lawsuits go national, when regulators join the fray, when reputations are on the line, leading businesses turn to Sonnenschein.

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The Limits of Insurance Coverage to Compensate Victims of a Swine Flu Pandemic

2009 Emerging Issues 3572

Reed Smith LLP on the Limits of Insurance Coverage to Compensate Victims of a Swine Flu Pandemic

By James Davis, Richard Lewis and Noel Paul

April 30, 2009

SUMMARY: This commentary proposes a worst-case scenario for a Swine Flu pandemic, and discusses why insurance cannot be relied upon to meet the needs of many victims, or protect myriad parties from liability or loss.

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ARTICLE: As the Swine Flu outbreak spreads across the United States and the world, political and business leaders are focused on prevention and bolstering public health. Most experts agree, however, that an increase in incidence of infection and death are inevitable. "We expect to see more cases, more hospitalizations, and, unfortunately, we are likely to see more deaths from the outbreak," said Health and Human Services Secretary Kathleen Sebelius. n1

One lesson of recent catastrophes in the US, however, is that leaders must also focus on planning for the aftermath of disaster, even as they work to lessen its impact. Many leaders already are considering the legal implications of their prevention efforts, and ways in which victims and their families will seek compensation. n2 Many will look to insurance for answers. This article proposes a worst-case scenario for a Swine Flu pandemic, and discusses why insurance cannot be relied upon to meet the needs of many victims, or protect myriad parties from liability or loss.

A SWINE-FLU PANDEMIC: WORST-CASE SCENARIO

The world is shrinking. International commerce and travel is widespread. People and products can move from one side of the world to the other in a single day. Thus, what likely would have remained an isolated outbreak in one part of the world a century ago could very likely impact the rest of the world today. Swine-flu infections already have been reported in Mexico, the United States, Canada, the United Kingdom, Austria, New Zealand, and other countries. n3 Indeed, France has asked the European Union to ban all flights to and from Mexico, and Cuba and Argentina already have done so. n4

As horrible as 9/11 and Katrina were, they directly impacted only a relatively small number of people on a regional basis. Within this context, our institutions have performed poorly, but have managed the disasters with some degree of order. A global catastrophe will test our institutions -- particularly the insurance industry -- to a dramatic degree.

Consider the cost of a global pandemic. The World Bank has estimated that each year of a pandemic could cost the US economy \$100-\$200 billion, and the global economy \$800 billion. n5 Many businesses and individuals will look to their insurance to provide a safety net amid these losses. Many will come up empty handed.

Consider this scenario: The spread of Swine Flu across the United States begins to accelerate, and authorities quickly estimate that, without immediate action, the nation could be subject to at least a "medium-level" flu pandemic causing to up to 200,000 deaths.

There is enough vaccination for only 2 percent of the population, and it has already been purchased by some major corporations and city and state governments. These groups begin inoculating as many as they can, but several corporations choose to immunize key employees who they believe are essential to managing the crisis.

As the number of those diagnosed increases, companies begin instructing employees in best practices to avoid contracting or spreading the flu. Some businesses send home non-essential employees with the promise that they will continue to be paid.

After a few days it becomes clear that the outbreak will surpass initial estimates, and that as many as 2 million people could be infected. Businesses close en masse. Others require key employees to continue to report to work, or attempt to establish telecommuting networks so they are able to work from home.

Thousands of businesses begin to inquire with their insurer regarding business interruption coverage. Most insurers deny coverage, however, citing the lack of "direct physical damage" in the office place. They also argue that Swine Flu qualifies as "environmental pollution" under the policy's absolute pollution exclusion. Insurers argue that they have been inundated with coverage requests under health and life policies, and request state and federal funds to subsidize their losses.

After several weeks, hundreds of thousands are hospitalized and even more are quarantined after contracting the virus. Many seek workers' compensation coverage, but are told that they lack sufficient evidence that their injury arose out of and in the course of their employment. One result: hundreds of thousands of lawsuits begin flooding the courts.

Plaintiffs seek possible negligent parties, and hordes of plaintiffs' attorneys help them in their cause. Victims sue their employers for negligently failing to prevent the virus's spread to the workplace, for providing inadequate medical advice, and for requiring that they continue to work.

"Non-essential" and blue-collar employees bring suit against their employers for failing to provide the same level of protection given key, white-collar employees. Even those who received vaccinations bring suit, arguing that the vaccination failed to work. Lacking anyone else to provide them compensation, families of deceased bring suit against the very medical care first-responders who sought to aid them from the start.

Thousands of suits move forward in state and federal court across hundreds of jurisdictions. While some jurisdictions allow consolidation of plaintiffs' claims, others will only hear individual complaints. An absence of common fact among plaintiffs scuttles efforts to form class actions. Lawyers on both sides, meanwhile, wrangle over procedural issues and substantive choice of law.

Although millions of victims are able to prove that they contracted the flu, many face a daunting task in establishing causation. They will have to retain perhaps dozens of scientific experts as witnesses. While some courts issue rulings advantageous to plaintiffs, other jurisdictions hold very differently, creating a patchwork of confusing precedent across the country. As the litigation moves forward, many plaintiffs lose touch with their cases, and the effort to secure justice largely becomes the matter of plaintiffs' attorneys and corporate defense firms. Administrative costs and legal fees begin to skyrocket.

COVERAGE ISSUES

Policyholders seeking coverage under various lines of insurance for damages and losses resulting from Swine Flu will necessarily contend with myriad practical considerations, and face a series of legal hurdles imposed by insurance companies.

Workers Compensation Coverage

Employees sent home under quarantine may not receive coverage if they are not actually infected. Even employees that are infected may struggle receiving coverage if they cannot show that their infection "arose out of" and was contracted "in the course of" their employment. Moreover, US workers compensation laws are a state-by-state patchwork. Whether a claim stemming from Swine Flu is covered would depend on whether the specific state restricts the range of occupational diseases that are covered. In California, for example, a disease that is not incident to a particular kind of occupation generally would not be covered under the state's workers compensation law. n6

Health & Life Insurance Coverage

A pandemic on the scale of the above scenario could threaten the financial solvency of the life insurance industry. According to the Insurance Information Institute, a moderate influenza pandemic could cost life insurers \$15 billion; a severe pandemic on the scale of the influenza outbreak of 1918, which affected 25-30 percent of the US population, could cost up to \$155 billion. n7 Given the poor financial health of many insurers resulting from the recession, claims for coverage for Swine Flu could tip health and life insurers over the breaking point. In this circumstance, these insurers are likely to deny many claims for coverage, or at least delay payment for many months or years. Indeed, the impact of a pandemic on the industry's own work force undoubtedly would significantly hinder the processing, evaluation, and payment of claims.

Professional Liability Coverage

As discussed above, employers face a host of liability issues relative to their management of their employees in the workplace, particularly with respect to compelling employees to either come to work or stay home, and providing a safe working environment. A claim rooted in an employer's discrimination against a certain type of employee, such as a non-essential employee, may be excluded from coverage. Insurance companies also likely would argue that an employer's decision with respect to its management of employees was "expected or intended", and that related damages are excluded from coverage.

General Liability Coverage

Institutions employing first responders, primarily paramedics and other medical personnel, likely would be vulnerable to suits for bodily injury. State and city public health departments, employers, and pharmaceutical companies also could face legal action if the main anti-viral drugs are unsuccessful or cause side effects. The two main anti-viral drugs, Tamiflu and Relenza, primarily have been tested in laboratories and may not be successful in each instance. n8 Insurers likely would argue that bodily injury resulting, for example, from ineffective anti-viral drugs was "expected or intended", because all of these parties knew that the drugs were not entirely effective or without adverse side-effects.

Claims brought against individuals for failing to take necessary precautions to prevent the spread of the flu, despite awareness of their own symptoms, might arise as well. A common provision in homeowners' coverage, however, excludes coverage for liability for transmission of a communicable disease by the insured. n9 Thus, individuals and families that are not judgment proof from the start may protection against a basic liability claim.

Institutions sued for exposing their workers, invitees, licensees, and other parties might be denied coverage based on the standard pollution exclusion in general liability policies. Even some specialized environmental pollution policies contain exclusions for liability resulting from "naturally occurring substances" or "microbial matter". n10

First-Party Property

Property Damage. Many businesses likely would try to recover under a first-party policy for costs to remediate a building infused with the Swine Flu virus. Whether a policyholder can bring a successful claim would depend upon whether the presence -- or suspected presence -- of Swine Flu virus in a building constitutes physical loss or damage to the building. Under existing law, it likely does: courts generally accept that property somehow rendered unfit for its intended use by some event or condition -- such as contamination -- has suffered "physical loss or damage."

Many businesses also might tender coverage for damage to property, and associated lost business, when labor unrest damages the policyholder's property. Lacking a specific exclusion for damages resulting from labor unrest, coverage should exist. If the strikers cause physical loss or damage to property, the value of that property, and the amount of lost income, can be recovered under most first-party forms. Note that many forms reference strikers, but only exclude an increase in Business Income loss due to strikers, and may not exclude loss caused by damage wrought by strikers.

Lost Income. Businesses likely would turn to their first-party property insurance to recover lost income. Policyholders should have coverage for lost Business Income -- expected profit, and continuing unavoidable expenses such as insurance premiums or payroll of crucial employees -- during the period needed to remediate their property. The critical issue for Business Income is establishing that there has been physical loss or damage. Note that the policyholder need not own the property affected by Swine Flu, as long as that property is used in its operations, nor must it make a claim for the remediation (e.g., if the remediation cost is within the deductible or the remediation is paid for by the landlord).

Questions may arise when costs are associated with a building mistakenly suspected to contain the Swine Flu virus. Policyholders should, however, be entitled to recover in this circumstance, on the ground that a building suspected as being contaminated is unfit for its intended use and thus has suffered physical loss or damage.

Policyholders also might be able to trigger coverage for lost income when orders of a civil authority restrict access to the policyholder's business in relation to an outbreak of Swine Flu. Civil or military authorities may impose restrictions on access to buildings or areas believed to harbor the Swine Flu virus, pending elimination of the contamination. Policyholders may have purchased coverage for this exact circumstance, under Civil or Military Authority clauses providing as follows:

We will pay for the actual loss of Business Income you sustain and necessary Extra Expense caused by action of civil authority that prohibits access to the described premises due to direct physical loss of, or damage to, property other than at the described premises, caused by or resulting from a Covered Cause of Loss.

In recent years, insurance companies, facing a spate of Civil Authority claims stemming from the attacks on the WTC and the 2005 Hurricanes, have reacted aggressively, atomizing the standard Civil Authority promise and requiring a policyholder to make a number of showings to secure coverage. In cases stemming from alleged Swine Flu contamination, carriers will require the policyholder not only to establish that the presence, or believed presence, of the virus in a building constitutes "physical loss or damage," but also that: (1) the sole motivation for the order was such existing property damage, not fear of additional property damage or bodily injury; and (2) the order made it impossible for anyone -- not simply more difficult for customers -- to access the property.

CONCLUSION

Authorities and leaders around the world currently are attempting to prevent the spread of the Swine Flu virus. The lesson of past catastrophes, however, is that these same leaders must simultaneously plan for the aftermath of a possible pandemic. Many political and business leaders -- and individuals -- will depend on the insurance industry to provide a backstop to what could be massive human losses and financial disruption. Many will return without assistance. Each type of insurance likely to be relied upon -- workers compensation, health and life, professional liability, general liability, and first-party property -- presents significant obstacles for policyholders. Thus, leaders and policymakers

should begin now to consider alternative means of compensating victims and providing a measure of legal protection to liable parties, many of whom likely will be at the front lines in attempting to prevent the spread of the virus.

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n1 Thomas H. Maugh II, *Swine Flue cases rise to 91 in U.S. with one death*, Los Angeles Times, April 30, 2009.

n2 *Swine Flu measures could be legal minefield, experts warn*, Personnel Today, April 29, 2009.

n3 Thomas H. Maugh II, *Swine Flue cases rise to 91 in U.S. with one death*, Los Angeles Times, April 30, 2009.

n4 *Id.*

n5 Michael Bradford, *Potential avian flu pandemic raises insurance questions*, Business Insurance, January 2, 2006.

n6 Lawrence S. Greengrass and William C. Kolb, *Avian Flu: Assessing the Risk, Part 1*, riskVue, November 2006.

n7 Steven Weisbart, *Pandemic: Can The Life Insurance Industry Survive The Avian Flu*, January 17, 2006 (updated November 1, 2006).

n8 *Id.*

n9 Lawrence S. Greengrass and William C. Kolb, *Avian Flu: Assessing the Risk, Part 2*, riskVue, November

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n10 Robert C. Meder and Frank Scott, *Avian Flu and the Property/Casualty Industry*, Insurance Journal, May 22, 2006.

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Sonnenschein Nath & Rosenthal on R.C. Wegman Construction v. Admiral Insurance

2009 Emerging Issues 3539

Sonnenschein Nath & Rosenthal, LLP on R.C. Wegman Construction Co. v. Admiral Insurance Co.: When Must An Insured Be Warned About Excess Exposure and Who Must Do It?

By William Barker and Geoffrey Repo

April 20, 2009

SUMMARY: R.C. Wegman Construction Co. was named an additional insured under its contractor's policy with Admiral. Wegman's claim exceeded Admiral's \$1 million limit. Wegman was not notified until a few days before trial and immediately put its excess carrier on notice, but coverage was denied due to late notice. Wegman sued Admiral. An Illinois federal court dismissed Wegman's claim, finding that Admiral had breached no duty to notify.

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ARTICLE: R.C. Wegman Construction Co. ("Wegman"), a construction manager, was sued for injuries suffered by Brian Budrick ("Budrick"), an employee of Standard-Hayes Boiler & Tank, LLC ("Standard"), one of the contractors working at the site. Standard's policy with Admiral Insurance Co. ("Admiral") named Wegman as an additional insured and Admiral defended. While Budrick's claim exceeded Admiral's \$1 million limit, Wegman claims not to have been told this until a few days before trial. It immediately put its excess carrier on notice, but coverage was denied because the notice came too late. Wegman sued Admiral for not informing it sooner. In *R.C. Wegman Construction Co v. Admiral Insurance Co.*, n1 an Illinois federal court dismissed Wegman's claim, finding that Admiral had breached no duty to notify. This commentary examines that decision and the exposures it may signal for insurance defense counsel.

I. The Case

Budrick sued in 2003, claiming a 2001 injury. According to Wegman, Admiral learned at Budrick's deposition in May 2005 that there was a realistic chance of an award exceeding its policy limits. In April 2007, Budrick demanded \$6 million to settle. Admiral never told Wegman either of these things, so Wegman never notified its excess carrier. The verdict was \$2,039,059.10. n2

Wegman urged that Admiral's duty of good faith required Admiral to inform it of the excess exposure. The court concluded that Illinois recognizes a duty of good faith in managing the defense and settlement negotiations, which can be breached by failure to settle within limits or by picking an unduly risky defense strategy. But Wegman did not allege any breaches of that sort. n3

Wegman argued that failure to notify the insured of possible excess exposure creates risks similar to refusing a within-limits settlement, so the duty of good faith should require such notice. But Wegman did not claim that Admiral could have done anything to prevent the excess judgment. Wegman claimed only that, with notice, it might have retained independent counsel and could have notified its excess insurer. That claim was "too attenuated to fit the [Illinois] courts' circumscribed application of the duty of good faith." n4

Moreover, the court found that "the duty of the insure[r] to consider the interest of the insured at least equal to its own is rooted in the possibility that a conflict of interest [regarding settlement] may arise where the insured is a defendant in a suit in which potential recovery may exceed policy limits." n5 But here, no conflict arose because there were no within-limits demands and the only demand was clearly excessive, so there was no reasonable prospect that Wegman might have wanted to accept that (and Wegman did not allege that it would have been interested in doing so). n6

The court further observed that Wegman had not cited any authority supporting a duty of the *insurer* to tell the insured what had occurred at a deposition or in anything other than settlement negotiations (which a single unreasonable demand did not constitute). *Defense counsel* might have such a duty, but defense counsel were not sued and an Illinois insurer is not vicariously liable for defense counsel's errors. n7 Moreover, the very fact that the insurer had provided counsel who presumably did have a duty to keep Wegman informed counseled against imposing any duty to inform on the insurer itself. n8

II. Implications

In light of Illinois practice, it is likely that Budrick's complaint did not state an *ad damnum*. But even if it had, that would not necessarily have been taken seriously, as such amounts are frequently exaggerated.

Unless Wegman told Admiral or defense counsel that it had excess insurance, they would not have known that Wegman needed to be advised of excess exposure, in the absence of settlement negotiations that might provide an opportunity to avoid or limit that exposure. But defense counsel might have been obligated to inquire about possible excess insurance, unless they had defined the scope of their representation to exclude that subject.

It has been held that whether defense counsel are obliged to provide advice on possible insurance coverage depends on whether that topic is part of the scope of representation, which is typically a question of fact. n9 Accordingly, defense counsel who wish to avoid obligations relating to insurance coverage should make that clear to the insured and confirm that limitation in writing.

But even if Wegman's defense counsel had limited their engagement that way, they would still have been obliged to "keep [Wegman] reasonably informed about the status of the matter." n10 The Model Rules indicate that "the lawyer should fulfill reasonable client expectations for information." n11 Ideally, the lawyer should consult with the insured to determine what sorts of information the insured desires. Without direction from the insured, it would be prudent to provide the information that would normally be provided to an uninsured client with a similar matter.

III. Conclusion

Defense counsel appointed by insurers can minimize their exposure to risks related to other insurance that the insured may have by appropriately limiting the scope of their engagement and assuring that the limitation is documented. But they also need to consult with the insured about what information the insured will want as the case progresses and to be sure they fulfill their duty to "keep the [insured] client reasonably informed about the status of the matter."

n1 *R.C. Wegman Constr. Co v. Admiral Ins. Co.*, No. 08 C 6479, 2009 U.S. Dist. LEXIS 22546 (N.D. Ill. Mar. 20, 2009).

n2 *Id.* at *3-5.

n3 *Id.* at *6-9.

n4 *Id.* at *10.

n5 *Id.* at *10-11.

n6 *Id.* at *11-12.

n7 *Id.* at *13-14 n.3, relying on *Brocato v. Prairie State Farmers Ins. Ass'n*, 166 Ill. App. 3d 986, 990-91 (4th Dist. 1988).

n8 *Id.* at *14-15.

n9 *Shaya B. Pacific, LLC v. Wilson, Elser, Moskowitz, Edelman & Dicker, LLP*, 38 A.D.3d 34 (2006). Richard Milone and Justin Lavelle provided a commentary on that case, which may be accessed on Lexis.

n10 Ill. R. Prof. Cond. 1.4(a). A similar requirement is contained in the ABA Model Rules of Professional Conduct and is part of the law in every other state.

n11 ABA Model Rules of Professional Conduct, Rule 1.4, cmt. 5 (2008).

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ABOUT THE LAW FIRM. Sonnenschein Nath & Rosenthal, LLP, regularly handles high-risk and complex matters for financial and insurance industry clients. Staffed with seasoned litigators and former insurance regulators, Sonnenschein lawyers are relentless advocates for its clients' interests.

For more than 70 years, Sonnenschein has partnered with insurance companies to understand their business and legal needs. Recent confirmation of Sonnenschein's outstanding insurance industry qualifications came in *Chambers USA: America's Leading Lawyers for Business*. The 2007 edition identifies Sonnenschein as one of the top firms in the country representing insurers on their most complex matters. The Chambers description speaks for itself:

This powerhouse litigation firm is known for its 'sophisticated and thorough' work in insurance and its ability to pull together a sterling set of resources. The firm fields a wide range of specialists, which it can use to staff complex cases. Its recent track record ranges from involvement in the WTC litigation to Hurricane Katrina-related issues. Matters are handled by a number of offices at any one time and practitioners are said to 'work tirelessly and creatively to help manage disputes' and 'create briefings that are strong and impressive.' Key areas of interest are bankruptcy and insolvency in insurance companies, class actions and catastrophic loss in both appeals and litigation. The firm also has strength in personal lines insurance and in regulatory proceedings.

When products are attacked, when lawsuits go national, when regulators join the fray, when reputations are on the line, leading businesses turn to Sonnenschein.

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Reed Smith LLP on The Madoff Losses: How Will You Recover?

2009 Emerging Issues 3482

Reed Smith LLP on The Madoff Losses: How Will You Recover?

By Matthew Schlesinger and Jan Larson

March 24, 2009

SUMMARY: In the wake of the Bernard Madoff fallout, this commentary identifies and examines potential sources of recovery-including the full extent of insurance coverage available to cover defense costs, direct losses and possible settlements and judgments-as well as provides practical guidelines for investors and entities facing exposure.

PDF LINK: [Click Here for Enhanced PDF of Commentary](#)

ARTICLE: Numerous entities, including financial institutions, hedge funds, accounting firms, investment advisors, charities, and individual investors, are caught in the fallout of Bernard Madoffs unprecedented investment fraud scheme. The estimated losses to investors from Madoffs self-described ponzi scheme are anywhere between \$24 billion and \$65 billion. Lawsuits pending against Madoff include both criminal and civil suits brought by the Securities and Exchange Commission (SEC), class actions brought by individual investors, and a civil suit brought by the Securities Investor Protection Corporation (SIPC), a securities-industry group formed by Congress to assist investors of failed brokerage firms in recovering their losses. These suits contain allegations of securities fraud, professional malpractice, breach of fiduciary duty, and gross negligence.

Litigation has also spread to other feeder fund entities such as financial institutions, hedge funds, accounting firms, and other investment advisors involved in the auditing and vetting of Madoff investments. Such funds facing suits include Tremont Group Holdings, Inc. and Fairfield Greenwich Group. The causes of action against feeder funds range from breach of contract to professional malpractice to fraud. Given the extent of the losses and with litigation swirling, it is critical that investors and entities understand all potential sources of recovery, including the full extent of insurance coverage available to cover defense costs, direct losses and possible settlements and judgments.

Securities Investor Protection Corporation ("SIPC")

For those who invested directly with Madoff, SIPC provides one potential avenue of recovery. Under the Securities Investor Protection Act (SIPA), SIPC is granted the power to either act as trustee or work with an independent court-appointed trustee to assist customers of a failed brokerage firm in recovering registered, non-negotiable securities such as stocks or bonds. On December 15, 2008, SIPC applied for liquidation of Bernard L. Madoff Investment Securities (BLMIS). The U.S. District Court for the Southern District of New York (the Court) granted the application for liquidation and appointed Irving Picard as the trustee to oversee the liquidation.

SIPC does not permit recovery for commodity futures contracts, investment contracts (such as limited partnerships), or fixed annuity contracts that are not registered with the SEC. An individual investors recovery through SIPC is capped at \$500,000, which includes a maximum of \$100,000 on claims for cash losses. As of December 2007, SIPC reportedly had around \$1.5 billion to cover potential claims.

In January 2008, over 8,000 claims forms were mailed to known-investors of BLMIS, and made available to unknown investors on the trustees website (<http://www.madofftrustee.com>). The original deadlines for investors to file claims against BLMIS with the trustee were March 4, 2009 for investors hoping to recover securities in kind, and July 2, 2009 for all others. On February 20, 2009, the trustee clarified that both filing deadlines will be considered timely, with no recovery advantage associated with either date.

It appears that the trustee plans to pursue recovery from several sources. As of the end of December 2008, the trustee reported that it had recovered at least \$29 million of Madoffs personal assets that could be used to reimburse investors. In addition, the trustee could potentially undertake clawbacks of funds that individual clients previously invested with Madoff but redeemed prior to the discovery of the securities fraud. It is estimated that such a clawback could reach back as far as six years before the December 2008 discovery. The exact time frame and extent, however, will be determined by the Court and the trustee, based on the federal Bankruptcy Code, the New York Debtor and Creditor Law, and other applicable case law.

Those individuals and entities that invested directly with Madoff particularly those who previously cashed-out must decide by July 2, 2009 whether to file a claim with the trustee under SIPC, and by doing so, subject themselves to the jurisdiction of the S.D.N.Y. in any clawback proceeding and, thus, the absence of the right to a trial by jury.

Insurance Coverage

Insurance coverage should provide another critical avenue of recovery for investors that experienced financial loss, as well as a source of protection for feeder fund entities at-risk in suits involving the investment of investors money in Madoff. Individual investors could potentially draw upon homeowners and possibly other first party property policies, while feeder funds facing claims or lawsuits may look to their errors and omissions (E&O) and directors and officers (D&O) liability policies, as well as possibly to fidelity bonds, for relief.

The insurance industry faces an estimated \$1 to \$6 billion in potential liability and losses connected to the Madoff investment fraud. It is predicted that the sheer scale of the Madoff losses could affect the dynamics of the insurance market going forward, both as to the availability and cost of insurance coverage. Regardless of whether they are individual investors or at-risk entities, policyholders will have to aggressively pursue their insurance claims, and even litigate, to ensure they receive the benefits of the coverage they purchased. The wording and terms of policies insurers issued can vary widely, so it is critical that investors and entities review their policies carefully in the context of the particular losses and/or suits they are litigating or facing.

First Party Property Policies and Homeowners Policies. Homeowners policies often provide coverage for the loss of theft of an individuals personal property and belongings. Specifically, many of these policies offer coverage for the loss of cash, stocks, bonds, and securities. One example of such policy language reads:

This policy covers you against all risks of direct physical loss or damage to your house, contents, or other permanent structures unless an exclusion applies.

The limit shown for each of the following categories is the maximum we will pay for a covered loss to that type of contents. money, bank notes negotiable papers, securities, accounts .

Often, though, the limits are fairly low and will vary according to the individual policy. On the other hand, the

individual policyholder should be the only claimant under the policy and will not have to compete with other investors for the same pot of money.

E&O Liability, D&O Liability, and Fidelity Bond Coverage. E&O (or professional services) coverage is insurance to cover the defense costs and any liability costs resulting from a third party suit against an entity in which it is alleged that the entity somehow failed in the performance of the professional services they provide (i.e. managing investment portfolios). A typical E&O coverage clause reads:

The Company shall pay loss on behalf of the Insureds resulting from any claim first made against such Insureds and reported to the Company in writing during the policy period, or any extended reporting period, for wrongful acts committed by the Insureds solely in the performance of, or failure to perform, insured services.

D&O coverage protects an entity's directors and officers and sometimes the entity itself against costs arising out of third party suits alleging breaches of fiduciary duty, misrepresentation, failure to disclose, or other wrongful acts in their capacity as directors and officers. A standard D&O coverage clause reads:

This policy shall pay the Loss of each and every Director, Officer or Employee of the Company arising from a Claim first made against such Insureds during the Policy Period or the Discovery Period (if applicable) and reported to the Insurer pursuant to the terms of this policy for any actual or alleged Wrongful Act in their respective capacities as Directors, Officers or Employees of the Company except when and to the extent that the Company has indemnified such Insureds. The Insurer shall, in accordance with and subject to Clause 8, advance Defense Costs of such Claim prior to its final disposition.

Fidelity bond coverage reimburses an entity for losses, among other things, due to intentional employee theft, fraud, or dishonesty, including breaches of due diligence requirements, where the employee acts for his own benefit and not for that of the company. A typical fidelity bond coverage clause reads:

[This bond] covers: (A) Loss resulting directly from dishonest or fraudulent acts committed by an Employee acting alone or in collusion with others. Such dishonest or fraudulent acts must be committed by the Employee with the manifest intent: (a) to cause the Insured to sustain such loss; and (b) to obtain financial benefit for the Employee or another person or entity.

Particular attention should be paid to the definition of key terms such as claim or professional services in these types of policies. Some policies define claim broadly to include any demand against the insured seeking monetary damages, while other policies define claim narrowly to exclude regulatory proceedings brought against the insured. As for the term, professional services, some policies define it generically as applying to any services related to the entity's business, while other policies specifically define only limited types of services that fall within coverage. Insurers may attempt to construe aggressively the scope of these and other terms to support a coverage denial.

These types of liability policies also contain multiple coverage exclusions insurers may attempt to utilize in support of coverage denials, including:

- . So-called conduct exclusions that preclude coverage for losses resulting from fraud, dishonesty, or the gaining of illegal profits. These exclusions should apply only if there has been a final adjudication or finding in fact that the alleged conduct was fraudulent or criminal;

- . Prior Acts exclusions that preclude coverage where the alleged wrongful acts occurred prior to a specified date;

- . Investment Banking exclusions that preclude coverage for losses arising out of services performed by the insured that relate to investment banking as defined by the policy (typically as a consultant, adviser or specialist providing economic or investment advice relating to the valuation of any assets or business entity, any aspect of mergers, acquisitions, leveraged buyouts, tender offers, securities offerings, restructurings, recapitalizations, divestitures, or other

forms of investment banking);

- . Late Trading/Market Timing/Selective Disclosure exclusions that preclude coverage following the actual or alleged late trading or market timing of shares of any investment company, or the actual or alleged selective disclosure of portfolio holdings of an investment company.

In addition, some insurers may seek to rescind policies altogether asserting some misrepresentation or fraudulent statement in the insurance application regarding the entity's management or knowledge of Madoff's scheme.

Recommended Action

The discovery of Madoff's investment fraud scheme has resulted in a swift tide of legal action and time is of the essence for those seeking either recovery or protection. Investors and entities with any potential losses or exposure should seek the expert advice of counsel in order to navigate these complex waters.

- . Understand the nature of the non-insurance recovery options available to you, including their advantages, disadvantages, risks, limits of recovery, and critical deadlines.

- . Review your insurance policies and understand the nature of the coverage you purchased. Did you purchase first party property, homeowners, E&O liability, D&O liability, or fidelity bond coverage? If so, what are the terms, limits, and exclusions? How are they likely to be applied?

- . Know when to provide notice of a claim to your insurance company. Many policies require notice be provided within a relatively short amount of time and, in any event, no later than a specified date (the end of the policy period or a certain number of days thereafter). In addition, even funds not yet the target of litigation may want to provide notice of circumstances to park claims under this year's policies before insurers add Madoff exclusions at the next renewal.

- . Understand how and what to communicate with your insurers in litigating a claim. Does the policy allow you to ask the insurer to assume the defense of a claim or must you retain your own counsel? If you must retain your own counsel, must you select counsel from a designated list and/or seek consent from the insurer? What information about the defense and costs must you provide to the insurer on an ongoing basis throughout the litigation?

- . Remember that claims submitted by policyholders to insurers are often met by reservation of rights letters or even coverage denials. If you understand your rights, you may not need to take no for an answer.

With the assistance of experienced counsel, the investors and entities facing potential exposure in the wake of the Madoff investment fraud will be in the best possible position, whether their goal is maximum recoveries or protection against future suits.

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McCarter English LLP on New York Insurance Department Opinion No. 08-10-07

2009 Emerging Issues 3462

McCarter English LLP on New York Insurance Department Opinion No. 08-10-07: An Insurers Duty to Defend Under A Directors And Officers Insurance Policy

By Steven Weisman and Cynthia Morrison

March 19, 2009

SUMMARY: The New York State Insurance Department recently rejected an insurance carriers proposed policy language for a directors and officers liability insurance policy (D&O Policy) that placed the duty to defend on the insured. Placing the duty to defend on the carrier may reduce disputes between carriers and their insureds concerning the timing of payments and reimbursement of defense costs.

PDF LINK: [Click Here for Enhanced PDF of Commentary](#)

ARTICLE: The Office of General Counsel for the New York State Insurance Department (Department) issued Opinion No. 08-10-07 (the Opinion) rejecting an insurance carriers proposed policy language for a directors and officers liability insurance policy (D&O Policy) that placed the duty to defend on the insured. 2008 NY Insurance GC Opinions LEXIS 230 (NY Insurance GC Opinions 2008). It, therefore, appears that carriers, admitted in New York, must issue D&O Policies to New York insureds that include a duty to defend their insureds.

This is a departure from D&O Policies that require only payments of all loss that the insured is legally obligated to pay, which typically includes defense costs. The timing of such payment usually is a critical issue for insureds and sometimes results in litigation between an insured and its carrier. Some courts hold that a carrier is obligated to pay defense costs as they are incurred, ⁿ¹ while other courts hold that, if a D&O Policy provides only a duty to indemnify, then a carrier is not obligated to pay defense costs until resolution of the underlying litigation. ⁿ² In both cases, the insurer may be released from paying any defense costs if it is finally determined that the loss incurred is not covered under the policy. Because, however, the duty to defend is broader than the duty to indemnify, carriers likely will have to pay defense costs as long as the claim may be covered by the D&O Policy.

The Opinion

A carrier sought Department approval of a D&O Policy that included the following provisions:

A. It shall be the duty of the Insureds and not the duty of the Insurer to defend Claims . The insurer shall have the right and shall be given the opportunity to effectively associate with the Insureds in the investigation, defense and settlement of any Claim that appears reasonably likely to be covered in whole or in part hereunder.

B. The Insureds shall not settle any Claim, select any defense counsel, incur any Costs, Charges and Expenses, admit or assume any liability, stipulate to any judgment or otherwise assume any contractual obligation without the Insurers prior written consent, which shall not be unreasonably withheld. The Insurer shall not be liable for any settlement, Costs, Charges and Expenses, assumed obligation, admission or stipulated judgment to which it has not consented or for which the Insureds are not legally obligated. The Insureds shall not knowingly take any action which increases the Insurers exposure for Loss under this Policy. Notwithstanding any of the foregoing, if all Insureds are able to fully and finally dispose of, with prejudice, all Claims that are subject to one Retention for an amount not exceeding any applicable Retention, including Costs, Charges and Expenses, then the Insurers consent shall not be required for such disposition.

See 2008 NY Insurance GC Opinions LEXIS 230 (NY Insurance GC Opinions 2008) at pp. 1-2.

The Department concluded that requiring the insured to defend to the carriers satisfaction or to obtain all of the required approvals from the carrier resulting in the carrier trying to disclaim coverage for an otherwise covered claim, would run contrary to Insurance Law § 3420, which establishes that the insurer be directly responsible for paying claims on behalf of the insured. 2008 NY Insurance GC Opinions LEXIS 230 (NY Insurance GC Opinions 2008) at p. 3. The proposed Policy also runs contrary to New York Insurance Regulation 107, which requires the carrier to bear the duty to defend and provide a proper defense regardless of cost, because it limits the availability of coverage for defense costs. See 2008 NY Insurance GC Opinions LEXIS 230 (NY Insurance GC Opinions 2008) at p. 4 (citing 11 NYCCR §§ 71.1-71.2). Accordingly, by placing the duty on the insured, the proposed Policy inappropriately conditions defense cost coverage on the insured taking charge of the defense. See 2008 NY Insurance GC Opinions LEXIS 230 (NY Insurance GC Opinions 2008) at p. 5.

The Department also considered the carriers assertion that imposing the duty to defend on the carriers will negatively impact an insureds ability to control its defense of a covered underlying liability claim. The Department observed that a D&O Policy may be in keeping with Regulation 107 where the insured has an option to assume control over a defense provided that the carrier maintains the ultimate duty. n3 See 2008 NY Insurance GC Opinions LEXIS 230 (NY Insurance GC Opinions 2008) at p. 6. The proposed D&O Policy, moreover, significantly limits any real control an insured would have over the litigation because the insured is not permitted to handle any substantive aspect of the defense without the carriers consent. See 2008 NY Insurance GC Opinions LEXIS 230 (NY Insurance GC Opinions 2008) at p. 6.

The Insureds shall not settle any Claim, select any defense counsel, incur any Costs, Charges and Expenses, admit or assume any liability, stipulate to any judgment or otherwise assume any contractual obligation without the Insurers prior written consent, which shall not be unreasonably withheld. The Insurer shall not be liable for any settlement, Costs, Charges and Expenses, assumed obligation, admission or stipulated judgment to which it has not consented or for which the Insureds are not legally obligated. The Insureds shall not knowingly take any action which increases the Insurers exposure for Loss under this Policy.

See 2008 NY Insurance GC Opinions LEXIS 230 (NY Insurance GC Opinions 2008) at pp. 1-2. Accordingly, the Department concluded that the proposed D&O Policy would not give an insured any greater ability to control its defense than if the Department imposes the duty to defend on the carrier.

Potential Economic Implications

Requiring the carrier to defend the insured against claims that may implicate coverage under a D&O Policy may provide insureds with greater economic certainty without eroding an insureds control of its defense.

First, the duty to defend is broader than the duty to indemnify. See, e.g., *Ruder & Finn v. Seaboard Sur. Co.*, 439 N.Y.S.2d 858 (N.Y. 1981). The duty of an insurer to defend its insured arises whenever the allegations within the four corners of the underlying complaint potentially give rise to a covered claim, or where the insurer has actual knowledge

of facts establishing a reasonable possibility of coverage. *Frontier Insulation Contrs., Inc. v. Merchants Mut. Ins. Co.*, 91 N.Y.2d 169, 175, 690 N.E.2d 866, 667 N.Y.S.2d 982 (1997). D&O carriers, therefore, likely will be obligated to provide a defense, including payment of defense costs as they are incurred.

Second, the Department further determined that "the cost allocation provision of the proposed D&O Policy affords less defense costs coverage to the insured than a policy under which the insurer bears the duty to defend" and is inconsistent with Regulation 107, which "does not authorize allocation of defense costs." See 2008 NY Insurance GC Opinions LEXIS 230 (NY Insurance GC Opinions 2008) at p. 5. Accordingly, insureds likely will not have to incur underlying defense costs in cases that include allegations in the complaint that potentially give rise to a covered claim. The Department's decision also likely will reduce the volume of insurance coverage actions filed solely to resolve disputes over the timing of payment of defense costs and the reimbursement of advanced defense costs if the ultimate loss is not insured under the D&O Policy.

* * *

Conclusion

It remains to be seen whether any carrier will seek approval of an alternative policy form that does not require the carrier to provide a defense to its insureds. Presently, however, it appears that the Department requires carriers to include a duty to defend provision in its D&O Policies. It also remains to be seen whether courts, applying New York law to determine a carrier's defense obligation under a D&O Policy, will rely on the Department's interpretation of New York Insurance Law and New York Insurance Regulation 107.

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n1 *McGuinniss v. Employers Reinsurance Corp.*, 648 F.Supp. 1263 (S.D.N.Y. 1986) (the policy contained both a provision requiring the insurer to pay loss and a provision giving the insurer an option to pay expenses as incurred provided the policyholder agreed to repay the insurer if no liability is established). See also *Little v. MGIC Indemnity Corp.*, 836 F.2d 789 (3d Cir. 1987) (finding the policy provision ambiguous and, therefore, the policy must be construed against the insurer requiring defense costs to be paid as incurred); *American Cas. Co. v. Bank of Montana System*, 675 F.Supp. 538, 543-44 (D.Minn. 1987).

n2 *In re Kanai Corp.*, 136 B.R. 59 (S.D.N.Y. 1992) (the policy contained only the provision requiring an insurer to pay loss). See also *Bank of Commerce and Trust Co. v. National Union Fire Ins. Co.*, 651 F.Supp. 474, 476 (N.D.Okla. 1986) (the policy contained both the loss and options provision); *Enzweiler v. Fidelity & Deposit Co.*, 1986 WL 20444 (E.D.Ky. May 13, 1986).

n3 Defense counsel hired by an insurer under a duty to defend policy, in fact, has an ethical duty to the insured as its client even though the insurer has the duty to defend and, therefore, pay defense costs. *Feliberty v. Damon*, 527 N.E.2d 261, 265 (N.Y. 1988) (The insurer is precluded from interference with counsel's independent professional judgments in the conduct of the litigation on behalf of its client.).

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Sonnenschein Nath & Rosenthal LLP on Addison Insurance Co. v. Fay

2009 Emerging Issues 3457

Sonnenschein Nath & Rosenthal LLP on Addison Insurance Co. v. Fay: The Supreme Court of Illinois Adopts the "Time and Space" Test for Purposes of Determining the "Number of Occurrences"

By Daniel Feinberg

March 18, 2009

SUMMARY: The Addison Ins. Co. v. Fay decision is noteworthy because the Supreme Court of Illinois expanded on the "cause test" adopted in *Nicor, Inc. v. Assoc. Electric & Gas Ins. Services, Ltd.*, unanimously holding that the deaths of two boys constituted two separate occurrences because the insurer presented insufficient evidence from which it could be ascertained that the deaths "were so closely linked in time and space as to be considered one event."

PDF LINK: [Click Here for Enhanced PDF of Commentary](#)

ARTICLE: In *Addison Ins. Co. v. Fay*, 2009 Ill. LEXIS 176 (Ill. Jan. 23, 2009), the Supreme Court of Illinois considered whether the deaths of two boys constituted a single occurrence or two separate occurrences under the terms of a liability insurance policy defining occurrence as an accident, including continuous or repeated exposure to substantially the same general harmful conditions. The two boys were killed by a quick condition in an excavation pit on the policyholders property, which (like quicksand) involves a cushion of water that prevents the soil from supporting a load of weight, which can result in that load sinking and becoming trapped. The boys bodies were found in close proximity to one another. Investigators concluded that one of the boys became trapped in the pit when trying to jump across it, and that the other boy became trapped trying to help free the first one. However, the investigators could not conclude how much time elapsed between the two entrapments, nor could they confirm that the boys were together when they first became trapped.

The boys families sued the policyholder, and Addison (the policyholders liability insurer) agreed to settle the suit for an amount equal to the policy limits. A dispute ensued as to whether the \$1,000,000 per occurrence limit or \$2,000,000 aggregate limit (for two separate occurrences) applied. Addison thus filed a declaratory judgment action to resolve that issue. The trial court ruled that the boys deaths resulted from two separate occurrences, finding that the evidence was sufficient to show that the causes of death were different and that the circumstances immediately prior to the deaths were different. Relying on the Supreme Courts decision in *Nicor, Inc. v. Assoc. Electric & Gas Ins. Services, Ltd.*, 223 Ill. 2d 407, 860 N.E.2d 280 (Ill. 2006), and a New Jersey appellate decision, n1 the Appellate Court reversed, ruling that the boys deaths were so closely linked in time and space as to be considered by a reasonable person as one occurrence. The boys families appealed to the Supreme Court of Illinois.

The Supreme Court began its analysis by discussing its prior decision in *Nicor* in which it adopted the cause test

for determining the number of occurrences. Under the cause test, the number of occurrences is determined by referring to the cause or causes of the damage. *Addison Ins. Co.*, 2009 Ill LEXIS 176, at *13. In addition, where each asserted loss is the result of a separate and intervening human act, whether negligent or intentional, or each act increased the insureds exposure to liability, Illinois law will deem each such loss to have arisen from a separate occurrence. 2009 Ill LEXIS 176, at *14. However, the *Nicor* Court went on to state: By contrast, where the damages for which coverage is sought resulted from the manufacture and sale of defective products or a fraudulent sales scheme, the loss will be found to have emanated from a single cause and there will be but one occurrence for purposes of the applicable policies. *Nicor*, 860 N.E.2d at 294. Applying these principles in *Nicor*, the Supreme Court found that mercury spilled from gas meters resulted from intervening acts of negligence by the employees that replaced the individual gas meters and thus, that each mercury spill was a separate occurrence. *Nicor*, 860 N.E.2d at 295-96.

Addison argued that, under *Nicor*, the boys deaths were caused by one occurrence -- the policyholders sole negligent act of failing to properly secure and control his property. The Court distinguished *Nicor* (and other Illinois cases), n2 finding that those cases applied only in instances involving affirmative acts of negligence as opposed to an ongoing negligent omission:

[A]pplying *Nicor* in the way Addison suggests leads to an unreasonable interpretation of Parrishs insurance policy. Focusing on the sole negligent omission of failing to secure the property would allow two injuries, days or even weeks apart, to be considered one occurrence If several injuries suffered over the course of several weeks could be bundled into a single occurrence, the likelihood that damages would exceed a per-occurrence limit is significant, as demonstrated by the damages in the instant case. Purchasers of insurance such as Parrish would be left unprotected by their insurance policy, and liable for any amount above the per-occurrence limit. In accepting a per-occurrence limit, Parrish could not have intended to expose himself to greater liability by allowing multiple injuries, sustained over an open-ended time period, to be subject to a single, per-occurrence limit.

Addison Ins. Co., 2009 Ill LEXIS 176, at *16-17.

The Supreme Court held that some limiting principle must be applied in situations where a continuous negligent omission results in insurable injuries. *Addison Ins. Co.*, 2009 Ill LEXIS 176, at *17. The Court thus adopted the time and space test as the means of limitation, following a New Jersey appellate court in *Doria v. Ins. Co. of North America*, 210 N.J. Super. 67, 509 A.2d 220 (N.J. Super. Ct. App. Div. 1986). n3 *Addison Ins. Co.*, 2009 Ill LEXIS 176, at *21 (Where negligence is the result of an ongoing omission rather than separate affirmative acts, a time and space test effectively limits what would otherwise potentially be a limitless bundling of injuries into a single occurrence). Under that test, if cause and result are simultaneous or so closely linked in time and space as to be considered by the average person as one event, then the injuries will be deemed to be the result of one occurrence. *Addison Ins. Co.*, 2009 Ill LEXIS 176, at *19-20; citing *Doria*, 509 A.2d at 224. Applying the time and space test, the Supreme Court held that Addison failed to sustain its burden of proving that the deaths were so closely linked in time such that they could be considered one event:

[A]lthough we conclude that the appellate court properly analyzed the facts under a time and space test, we cannot accept the courts opinion that the facts conclusively demonstrate that the injuries to Hodgins and Carr constitute only a single occurrence The record presented both to the trial court and the appellate court reflects the fact that what can be known about the events of April 30, 1997, is far outstripped by what cannot be known From the evidence presented at trial, we can infer that the boys did not become trapped simultaneously. We can also infer that Hodgins became trapped after Carr, in an attempt to free Carr from the sand. Beyond these basic facts and inferences, there is little evidence to support Addisons claim that the injuries suffered by these two boys were the result of a single occurrence. The police investigators could not determine how closely in time the boys became trapped. They suggested it could have been seconds or minutes apart, but acknowledged that there was no way to know. Nor could the medical experts give a time of death with certainty, or indicate how closely in time the two boys had died. Any opinions on these issues of timing would be inappropriately speculative. The substantial uncertainty on this issue persuades us that Addison cannot meet its burden of proving that the two boys injuries were so closely linked in time and space as to be considered one event. Because Addison cannot meet its burden, we hold that the injuries to Carr and Hodgins constitute

two occurrences.

Addison Ins. Co., 2009 Ill LEXIS 176, at *21-23. n4

The *Addison* decision is noteworthy because the Supreme Court expanded on the cause test previously adopted in *Nicor*, finding that some limiting principle must be applied in situations where a continuous negligent omission results in insurable injuries. The Court implemented the time and space test as that means of limitation. Under that test, courts will treat injuries or damage as the result of one occurrence if cause and result are simultaneous or so closely linked in time and space as to be considered by the average person as one event. Thus, some might argue that the *Addison* decision creates uncertainty as to the direction of Illinois law on the number of occurrences issue, particularly in the context of progressive injury claims. The time and space test focuses on the temporal and spatial connection between the injuries at issue; progressive injury cases, such as asbestos products injury claims, typically involve separate injuries to many different claimants over long periods of time from products or substances at numerous different sites. It is thus arguable that the injuries in such cases are not closely linked in time and space. However, in *Nicor*, the Supreme Court found that where the damages for which coverage is sought resulted from the manufacture and sale of defective products or a fraudulent sales scheme, the loss will be found to have emanated from a single cause and there will be but one occurrence for purposes of the applicable policies. *Addison* did not address this aspect of the *Nicor* decision, or the Appellate Courts similar ruling in *United States Gypsum Co. v. Admiral Ins. Co.*, 268 Ill. App. 3d 598, 643 N.E.2d 1226 (Ill. Ct. App. 1994) (ruling that the manufacture and sale of asbestos constitutes a single occurrence). Accordingly, *Addison* did not overrule *Nicor* or *U.S. Gypsum*, both which can be relied upon to support a single occurrence position in progressive injury cases.

In addition, the *Addison* Court limited the time and space test to situations where a continuous negligent omission results in insurable injuries. Many progressive injury cases do not involve negligent omissions, but instead, involve affirmative acts. See, e.g., *Outboard Marine Corp. v. Liberty Mut. Ins. Co.*, 283 Ill. App. 3d 630, 642, 670 N.E.2d 740, 748 (Ill. Ct. App. 1996) (ruling that contamination from the insureds manufacturing activities amounted to a single continuous occurrence); *U.S. Gypsum*, 643 N.E.2d at 1259. Hence, it also can be argued that the time and space test is inapplicable in progressive injury cases.

Another important implication of *Addison* is the Courts allocation of the burden of proving the number of occurrences on the insurer and not the policyholder. An argument can be made that it would have been reasonable for a trier of fact to infer that the boys were together at the time they were killed and, therefore, that their deaths were closely linked in time and space. Indeed, the New Jersey Supreme Court reached that result in *Doria*, which the *Addison* Court found to be a factually analogous case. Nonetheless, the *Addison* Court held that the timing of the boys deaths was too uncertain to establish a time and space connection and thus, a single occurrence. *Addison* thus appears to be the product of compelling facts, and the Supreme Courts analysis of the inferences arising from the evidence may well have been influenced by its desire to maximize insurance coverage for the decedents families.

In all events, while some might argue that *Addison* creates uncertainty in Illinois number of occurrence jurisprudence, the fact that the Supreme Court distinguished *Nicor* based on omissions versus affirmative acts indicates that the Court has not strayed from its cause test in progressive injury cases involving defective products or fraudulent schemes.

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n1 *Doria v. Ins. Co. of North America*, 210 N.J. Super. 67, 509 A.2d 220 (N.J. Super. Ct. App. Div. 1986).

n2 [2] See *Mason v. Home Ins. Co. of Illinois*, 177 Ill. App. 3d 454, 532 N.E.2d 526 (3rd Dist. 1988) (each act of serving contaminated food to a customer over a three-day period was a separate occurrence); *Illinois National Ins. Co. v. Szczepkowitz*, 185 Ill. App. 3d 1091, 542 N.E.2d 90 (1st Dist. 1989) (two separate car accidents constituted two separate occurrences); *Village of Camp Point v. Continental Cas. Co.*, 219 Ill. App. 3d 86, 578 N.E.2d 1363 (4th Dist. 1991) (each individual instance of erroneous legal advice constituted a separate occurrence); *Illinois Central R.R. Co. v. Acc. & Cas. Co. of Winterthur*, 317 Ill. App. 3d 737, 739 N.E.2d 1049 (1st Dist. 2000) (separate occurrence resulted each time an executive exercised hiring authority in a discriminatory manner).

n3 In *Doria*, two brothers sustained injuries when accessing a negligently maintained swimming pool. See *Addison Ins. Co.*, 2009 Ill LEXIS 176, at *19-20 (discussing the *Doria* case). The *Doria* court ruled that there was one occurrence, because the injuries resulted from a single cause -- the property owners negligent maintenance of the pool area. *Addison Ins. Co.*, 2009 Ill LEXIS 176, at *20. The *Doria* court held further that the temporal and spatial connection between the injuries was sufficient to conclude that the average person would have considered it one event. *Addison Ins. Co.*, 2009 Ill LEXIS 176, at *20.

n4 In light of the uncertainty regarding the sequence and timing of events, the Court refused to consider the policyholders argument that the second boys attempt to rescue the other constituted a separate and intervening act which increased the insureds liability and thus, a separate occurrence (under the *Nicor* standard). *Addison Ins. Co.*, 2009 Ill LEXIS 176, at *23.

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About the firm. Sonnenschein Nath & Rosenthal, LLP, regularly handles high-risk and complex matters for financial and insurance industry clients. Staffed with seasoned litigators and former insurance regulators, Sonnenschein lawyers are relentless advocates for its clients interests.

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Current Developments in State and Federal Regulation of Swaps and Derivatives

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Gkonos and Cawley on Current Developments in State and Federal Regulation of Swaps and Derivatives

By James S. Gkonos and Mark C. Cawley

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SUMMARY: Recent pronouncements from the New York Insurance Department and the Missouri Insurance Department have concluded that some credit derivatives are "insurance" and are to be regulated as such. This commentary explores recent proposals to exert regulatory authority over the largely unregulated credit default swap market by the New York Insurance Department and the federal government.

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ARTICLE: Introduction

Credit derivatives have become synonymous with the recent credit crisis and the attendant collapse of prominent Wall Street institutions. Recent pronouncements from the New York Insurance Department and the Missouri Insurance Department have concluded that some of these products are insurance and are to be regulated as such. This commentary explores these and other recent proposals to exert regulatory authority over the largely unregulated credit default swap market by the New York Insurance Department and the federal government.

Credit Derivatives and the Roots of the Financial Crisis of 2008

The financial meltdown that began in August, 2008 and that has plunged the U.S. and the world into recession is directly traceable to the intersection of the U.S. housing market bubble and innovative financial products known generally as collateralized debt obligations (CDOs) and credit default swaps (CDSs). The housing bubble began in the late 1990s as housing prices began to spike upward deviating from historical rates of increase. The rapid increase in home prices was supported in part by mortgage lending to so-called subprime borrowers who either had less than perfect credit or who had good credit but borrowed more than their income and assets might otherwise allow. Subprime lending, in turn, was made increasingly possible by the use of innovative--and risky--mortgage products like adjustable rate mortgages and by the advent of the mortgage backed security (MBS), a form of CDO.

CDOs are constructed from a portfolio of fixed-income assets divided into different tranches of debt. The most senior tranches are rated AAA because they are paid first. The junior tranches contain progressively lower-rated debt and offer higher interest rates to compensate for the added default risk. Many investors used leverage to buy more CDOs than they could purchase with existing capital alone--thereby increasing their potential losses if the CDOs

defaulted.

MBSs consist of bundles of mortgages sold by the loan originator--a bank or mortgage company--to an investment bank that securitizes the loans. The investment bank issues shares of the MBS to investors who receive principal and interest payments from the cash flow generated by the underlying monthly mortgage payments. An MBS typically is divided into different tranches depending upon the risk associated with the underlying mortgages. Tranches comprised of mortgages with relatively little risk of default are rated AAA and investors in the AAA tranche receive less interest than investors in higher-risk AA or BBB tranches.

CDO (and MBS) buyers often purchased credit default swaps (CDSs) as a hedge or protection to guard against the risk of default. CDSs are private financial contracts under which a protection buyer pays a periodic fee (often expressed in basis points) to a protection seller in return for a contingent payment by the protection seller upon the happening of a credit event to a company, equity or transaction (a reference entity or security.) The definitions of credit event, the obligations of the counterparties, and the mechanism used to determine the payment upon the credit event are flexible and determined by negotiation between the counterparties and set forth in a standardized agreement called an ISDA Master Agreement, published by the International Swaps and Derivatives Association, Inc. Standardized terms are set forth in the ISDA Master Agreement with any alterations or amendments contained in additional documents referred to as schedules or confirmations. A credit event may include a number of adverse financial events such as a failure to make a payment, default, or bankruptcy. It may also include a credit downgrade of the underlying reference entity or its guarantor. Frequently, CDS contracts require the protection seller to post collateral if the value of the reference entity declines or if the creditworthiness of the protection seller declines. Collateral may be in the form of letters of credit or guarantees issued by insurance companies.

As home prices increased throughout the late 1990s through 2006, the cycle of subprime lending and subsequent securitization continued unabated. Interest rates, however, began to increase in 2007 and adjustable rate mortgage payments--as well as mortgage defaults--increased in tandem. Concomitantly, property values began to decline. Investors in MBSs and CDOs saw their stream of interest payments diminish significantly as increased mortgage payments exceeded the ability of mortgagees to pay and home values dropped below the principal mortgage amounts. As more and more mortgages went into default, CDS credit-event triggers required payment to CDO buyers by their CDS counterparties.

According to ISDA, the volume of CDSs have doubled every year since 2001, reaching \$55 trillion as of June 30, 2008. n1 Protection sellers viewed CDSs as highly profitable, low-risk protection in which the risk of having to pay on any one default was historically low and the risk of having to pay on multiple defaults at the same time was virtually nonexistent. The protections provided by CDSs were viewed by protection buyers in many ways like insurance, since it protected them substantially against losses stemming from, for example, the failure of cash flows from an MBS to pay the required principal and interest payments. There are, however, three important differences between CDSs and traditional insurance.

The first difference has to do with the nature of the risks being insured by CDSs. Premiums for automobile, homeowners, and life insurance policies are calculated to cover the cost of actuarially measurable risks. Moreover, the occurrence of one insurable event generally does not make the occurrence of another more likely. One house burning down does not increase the likelihood of another house burning down in another part of town. With CDSs, however, the underlying risks are not always understood or easily measured--particularly when the risk is mortgage debt several layers removed from the insured CDO tranche. Moreover, unlike traditional insurance, the risk of a credit event can increase the likelihood of the happening of another credit event. Mortgage defaults are a case in point. The rise in interest rates caused all adjustable rate mortgages to rise, which increased the likelihood that all affected homeowners would default.

Second, unlike insurance, speculators used CDSs to bet on the likelihood of credit events happening to particular reference entities, even when the speculators had no stake in the reference entities or transactions. A speculator might,

for example, enter into a CDS with a counterparty whereby the protection seller would pay the speculator if a reference entity suffered a credit downgrade. The speculator, however, would not own the bonds of the reference entity or have any other ownership interest in it. The swap would simply amount to a blatant gamble on the reference entity's credit rating. If the credit event occurred, a protection seller would have to pay even though the protection buyer has no insurable interest in the reference entity. In such cases, protection buyers--unlike purchasers of automobile or homeowners insurance--have no incentive to minimize their losses. To the contrary, speculative protection buyers have every incentive to maximize their losses.

The third difference between CDSs and insurance is that the CDS market is entirely unregulated. Protection sellers are not required to abide by regulatory controls applicable to insurance companies. Thus, they are not required to keep adequate--or, indeed, any--reserves for loss payments. The insurance industry, on the other hand, is a highly regulated industry.

Although banks and hedge funds treated CDSs as highly profitable insurance policies, they ultimately failed to appreciate the full extent of the risks associated with CDSs. As mortgage defaults increased, protection sellers were forced to post mounting losses as the CDO or MBS failed to generate sufficient cash flow to make the required periodic payments. Further, protection sellers were vulnerable to collateral calls as their losses mounted and their creditworthiness declined. Collateral calls required protection sellers to sell assets to generate cash. As the losses mounted and collateral calls increased, asset sales increased--driving down asset prices and leading to a death spiral for weaker protection sellers and placing even the strongest counterparties under financial stress. Consequently, entities like AIG and Lehman Brothers were required to post billions in collateral due to the amount of losses and their declining financial condition.

Credit Derivative Regulation Past and Present

Despite their central role in the current financial crisis, CDSs are crucial to the smooth functioning of the capital markets. When used for non-speculative purposes, they provide a legitimate means of hedging risks. ⁿ² They free up capital for further lending by enabling banks to reduce their exposure to particular industry segments and by allowing them to manage capital requirements imposed by federal or state regulations. By freeing up more capital for banks to lend, CDSs increase the amount of capital available to borrowers. Many analysts believed that the cost of protection of a given company was a much more accurate assessment of the creditworthiness of a company than its rating. Unlike credit ratings, which are based on snapshots of corporate financial data, an efficient CDS market arguably provides real-time monitoring of the creditworthiness of companies covered by that market.

Given their centrality to the smooth functioning of the capital markets and the grave risk for abuse, why have CDSs gone unregulated? The absence of federal and state regulation is, at first glance, surprising. After all, insurance is heavily regulated by the states and many aspects of securities and commodities trading are regulated by the Securities Exchange Commission (SEC) and the Commodity Futures Trading Commission (CFTC). Part of the answer lies in the fact that speculative CDSs--where the protection buyer is simply using the CDS to bet on a credit event happening--developed in a gap of both federal and state law.

At the federal level, this gap was initially fueled by uncertainty within the federal government as to what these products were and who was to regulate them. In 1998, a dispute erupted between the CFTC, the SEC, the Treasury Department, and the Federal Reserve. The CFTC sought to initiate regulation of swaps and derivatives. In response, the SEC, Treasury and Federal Reserve issued a joint statement citing grave concerns that the CFTC action would cast a shadow of regulatory uncertainty over an otherwise thriving market. ⁿ³ Also in response to the CFTC's proposed action, Treasury sponsored a bill, ultimately passed by Congress, that placed a six-month moratorium on CFTC action relating to the swaps and derivatives market. ⁿ⁴

Shortly thereafter, in 1999, the head of the CFTC quit. Thereafter, the Presidents Working Group, made up of the heads of the SEC, Treasury, Federal Reserve and the new CFTC chairman, issued a report recommending no CFTC

regulation on the grounds that such regulation would otherwise perpetuate legal uncertainty or impose unnecessary regulatory burdens and constraints upon the development of these markets in the United States. n5

In 2000, President Clinton signed the Commodities Futures Modernization Act of 2000 (CFMA), which pre-empted the regulation of swaps and derivatives from state and local laws and exempted such transactions from CFTC regulation. n6 The CFMA also provided for a self-regulated industry clearinghouse, but with federal oversight of risk management procedures. No industry action was taken with regard to this provision. As a result, no federal regulatory body had any jurisdiction over swaps and derivative transactions.

Nor did state regulatory agencies seek to regulate these types of transactions. State law had traditionally focused more on prohibiting fraud and gambling than in attempting to provide comprehensive regulation of these complex business instruments. In the regulation of insurance, concerns regarding speculation and fraud prompted legislatures and courts to require buyers of insurance to have an insurable interest in the underlying insured loss. n7 Otherwise, insureds were merely speculating and gambling on the happening of an insurable event.

State regulation of securities shared similar concerns. Early state statutes prohibited various types of speculation on securities, such as stock jobbing, which entailed speculation on price movements of securities not owned by the speculator. n8 State law also prohibited fake or fraudulent exchanges, called bucket shops. n9

While state laws did not try to regulate the underlying swap or CDS transactions, some states beginning in 1987, began to regulate insurance products that guaranteed the obligations of parties to purely financial transactions. New York was the first to comprehensively regulate such guarantees. The New York Financial Guaranty Law created a new class of insurance called financial guaranty insurance that could only be issued by specially created insurers, monolines, whose sole line of business was to issue financial guarantees. n10 Other states, such as California, Connecticut and Florida enacted similar legislation or promulgated similar regulations. n11 Nothing in these statutes prohibited insurers from guaranteeing swaps, CDOs and other derivatives.

In 2000, the same year that Congress passed the CFMA, the New York Insurance Department was asked whether credit default swaps in which the protection buyer had no interest in the underlying transaction was an insurance policy. The Insurance Department issued an opinion that concluded that such swaps were not insurance policies because the protection buyer had no interest (an insurable interest) in the underlying transaction. n12 The Department did not address whether credit default swaps in which the protection seller had an interest constituted insurance. As Eric Dinallo, Superintendent of the New York Insurance Department succinctly put it: In sum, in 2000 as a society we chose not to regulate credit default swaps. n13

Recent Regulatory Shifts

Following the collapse of Lehman Brothers, the near-collapse of AIG as a result of their exposure to CDSs, and the financial distress of the majority of monoline insurers, the New York Insurance Department decided to revisit the issue of the regulation of these financial products. In a September 22, 2008 Circular Letter, the New York Department of Insurance announced that, beginning in January, 2009, it would regulate covered CDSs, which it defined as CDSs where the protection buyer holds, or reasonably expects to hold, a material interest in the reference entity or obligation. n14 Consistent with its role as insurance regulator, New York intended to provide an appropriate way for those with an insurable interest to protect themselves and [the Department will] ensure that whoever sells them that protection is solvent. n15

The Department clearly viewed what it termed naked or speculative swaps, where the protection buyer has no interest in the underlying reference entity, as a form of gambling. n16 As Superintendent Dinallo stated before the House Agriculture Committee in October, 2008:

We engaged in the ultimate moral hazard no one owned the downside of their underwriting decisions, because the banks passed it to Wall Street, that securitized it; then investors bought it in the form of CDOs; and then they took out

CDSs. And nowhere in the chain did anyone say, you must own that risk. n17

Notwithstanding this abhorrence of the product, the Department concluded that these naked swaps were not insurance and could not be regulated by the State. n18 The Circular Letter, itself, did not provide any other details about the new regulations of covered swaps.

The Circular Letter also set forth Best Practices, which impose restrictions on financial guaranty insurance companies. n19 In addition to increased capital and surplus requirements, some of the more significant Best Practices include the following restrictions.

. *Concentrations of Risk.* The New York Insurance Law limits a financial guaranty company's exposure with respect to a single entity to ten percent of the financial guaranty company's aggregate surplus and contingency reserves. In determining risk concentrations when asset-backed securities are at issue, the Department had previously only evaluated such risks in reference to the issuer of the security, without consideration to the underlying transactions. The Department concluded that financial guaranty companies must evaluate the ten percent limitation not only as to the exposure associated with the issuer of the debt, but also as it relates to the initial lender and servicer of each category of the underlying obligation (such as consumer debt obligations or obligations secured by residential real estate).

. *Restrictions on Insurance for Collateralized Debt Obligations of Asset-Backed Securities.* Financial guaranty companies may no longer insure so-called CDO squares--pools of asset-backed securities that are comprised or include portions of other pools of such securities, except in very limited circumstances. The Department regards CDO squares as inherently riskier and unpredictable than an [asset-backed security] that is no more than one layer removed from the underlying debts or obligations.

. *Limits on Insurance of CDSs.* The Department also will prohibit financial guaranty companies from issuing policies on collateralized debt obligations or credit default swaps in which the policy guarantees an underlying swap agreement that triggers or accelerates liability based on changes in the credit quality or solvency of the financial guaranty company.

Circular Letter 19 prompted considerable attention not only because the vast majority of CDS activity occurs in New York and the majority of financial guaranty companies are domiciled there, but also because these new Best Practices caused a sea change in the way monoline insurers are regulated and may carry on their business in the future. The changes to the ten percent rule requiring the monolines to aggregate risk by issuer, lender and servicer, respectively, vastly change the prior practice of focusing solely on the issuer.

Further, the prohibition against guaranteeing transactions in which the monoline's credit rating can be a trigger for the posting of collateral may negate the entire purpose and utility behind the use of financial guarantee companies. Usually monolines are used to wrap a transaction that has a credit rating lower than that of the monoline, so that the transaction will get the benefit of the monoline's higher credit rating. The financial rating for the transaction affects pricing, and availability of protection buyers or sellers. In many instances, protection buyers seek to use the swap to obtain protection from a known risk, such as volatile foreign exchange or interest rates. An integral part of that protection comes from the credit rating of the protection seller, from which the protection buyer determines the likelihood that the protection it is purchasing will pay in the event of a loss or other credit event. The sole purpose of the monoline is to enhance the transaction's rating in order to improve the pricing and attractiveness to protection buyers. If the monoline's credit rating drives the transaction, but the monoline cannot participate if a drop in its credit rating creates a credit event, then protection buyers will be unlikely to buy swaps backed by monoline guarantees, because of the lack of any remedy if the monoline's credit rating (and also that of the transaction) drops. Taken to its logical conclusion, the end result is that monolines will be used very infrequently to guarantee swap and other derivative transactions because protection buyers will find little comfort in their participation.

The Department's Circular Letter raised--but failed to answer--many questions about the scope and effect of the

Departments intent to regulate covered CDSs as insurance. Before the Department could provide clarification, however, Superintendent Dinallo announced on November 20, 2008 in testimony before the U.S. House of Representatives Committee on Agriculture that the Department would indefinitely table its plan to regulate CDSs in light of federal efforts to develop a comprehensive CDS regulatory scheme. n20 That same day, the Department issued a Supplement to Circular 19 confirming that it would delay its plans to regulate CDSs but making clear that this delay did not affect implementation of Circular 19s Best Practices to financial guaranty companies. n21

In late January, the National Conference of (State) Insurance Legislators (NCOIL) received presentations by various representatives of interested parties relating to the regulation of swaps and derivatives and expressed the view that states should play a significant role in the regulation of these types of transactions. Concurrently, the Missouri Department of Insurance, Financial Institutions and Professional Regulation (the Missouri Department) also weighed in on the regulation of CDSs as insurance. On November 19, 2008, it issued Insurance Bulletin 08-12, which states that certain covered CDSs will be considered insurance for purposes of Missouri insurance law. n22 The Bulletin provides that, [a] CDS may be referred to as covered where the protection buyer has a present legal interest in the reference entity or reference obligation that is the subject of the credit event of the CDS. n23 Because the issuance of a covered CDS constitutes an insurance transaction, the issuer of a covered CDS must obtain a certificate of authority from the Missouri Department. n24

Significantly, however, the Missouri Department stated in the same Bulletin that covered CDSs represent only a small segment of the larger CDS market and that a segmented approach to CDS regulation was not desirable. n25 Accordingly, like the New York Insurance Department, the Missouri Department stated that it would exercise discretion in enforcement of the insurance laws in regard to covered credit default swaps, in order to allow an opportunity for the enactment of comprehensive federal regulation. n26 Further, the Missouri Department explained that, [i]f a comprehensive federal regulatory scheme regarding credit default swaps, including covered credit default swaps is adopted prior to January 1, 2009, or appears significantly likely to be adopted soon after that date, the director may defer or suspend any or all department enforcement actions. n27 As of this writing in late February 2009, the Missouri Department has not suspended enforcement of the Bulletin, and it remains in effect.

Federal Efforts to Regulate CDSs

Just as the effects on insurers and financial institutions caused the New York and Missouri Insurance Departments and state legislators to re-evaluate their stance on swaps and derivatives, these events also have spurred activity at the federal level. The New York Insurance Departments decision to table its regulation of CDSs was spurred at least in part by efforts of the Presidents Working Group (PWG) to cooperate in developing a comprehensive regulatory scheme for CDS regulation. The chairs of the CFTC, the Federal Reserve, and the SEC along with the Treasury Secretary comprise the PWG. On November 14, 2008, the PWG announced that its top near-term OTC [over-the-counter] derivatives priority is to oversee the successful implementation of central counterparty services for CDSs. n28 A central counterparty places itself between the existing counterparties to a CDS. Although it does not become a party to the CDS, it bears the credit risk of both counterparties by agreeing to make required payments due by a particular counterparty. To minimize risk, the central counterparty typically might require counterparties to meet its own criteria for capitalization and creditworthiness. It also would require participants in the clearinghouse to contribute funds over and above posted collateral to cover the central counterparty in the event of default. The PWGs announcement also included a Memorandum of Understanding pursuant to which the CFTC, the Federal Reserve, and the SEC agreed to cooperate in the regulation of centralized counterparties.

In its November, 2008 announcement, the PWG stated that it hoped to grant approval to at least one clearinghouse before year end. It met that deadline when the CFTC approved the Chicago Mercantile Exchange as a clearinghouse for certain CDSs. Under the Memorandum of Understanding, the CFTC consulted with the Federal Reserve and SEC in reviewing the Chicago Mercantile Exchanges application. NYSE Euronext Inc. also has received SEC approval to begin clearing CDSs.

In late January, the House Agriculture Committee circulated a discussion draft of a bill entitled the Derivatives Markets Transparency and Accountability Act of 2009 (DMTA). The discussion draft proposed, among others, detailed reporting of positions of market participants and disaggregation of market data to provide more transparency to commodities and other capital markets trading, including swaps and derivatives, consideration of trading limits on commodities and on over-the-counter (OTC) agreements that could disrupt market liquidity or cause severe market disturbance, and required all future OTC transactions to be settled and cleared through a CFTC-regulated designated clearing organization. Of particular note, Section 16 of the discussion draft would have amended the Commodity Futures Exchange Act by adding the following provision:

LIMITATION ON ELIGIBILITY TO PURCHASE A CREDIT DEFAULT SWAP.--It shall be unlawful for any person to enter into a credit default swap unless the person would experience financial loss if an event that is the subject of the credit default swap occurs.

The provision paralleled the view of the New York Insurance Department that such naked swaps were nothing more than gambles on a company's or transaction's success and proposed to make it unlawful to enter into a naked CDS. The bill also proposed to amend the Commodity Futures Exchange Act by adding the following definition of credit default swap:

The term credit default swap means a contract which insures a party to the contract against the risk that an entity may experience a loss of value as a result of an event specified in the contract, such as a default or credit downgrade.

The definition provision also exempted such transactions from regulation by the SEC. By defining a CDS as a contract that insures a party against a risk of loss, the bill proposed to vest regulation of transactions which insure against a risk of loss of value with the CFTC. The definition does not exclude financial guaranty insurance policies.

On February 3-4, 2009, the House Agriculture Committee held hearings on the proposed draft of the DMTA. Not surprisingly, these provisions provoked a strong reaction from various constituencies interested in swaps and derivatives. Robert Pickel, CEO of ISDA, argued that significant regulation of the swaps and derivative market was unnecessary and that the OTC markets had continued to operate smoothly when other markets had experienced significant dislocation. He argued that the limitation on eligibility to purchase provision would effectively eliminate the CDS business in the United States by making it impossible for sellers of protection to hedge their own risks. n29 Pickel also opined that the provision, by requiring parties to a CDS to show a loss, would essentially turn naked CDSs into insurance contracts that would be subject to state insurance regulations. n30 He added that these consequences would drive the CDS business overseas, limit access to credit derivatives in the U.S., and create disincentives to lending necessary to restart the economy. n31

John M. Damgard, President of the Futures Industry Association, also testified that Section 16 of the draft bills was anti-competitive and anti-innovation. n32 He stated that Section 16 appears to ban so-called naked credit default swaps in OTC dealer markets (where all CDS transactions now occur), while allowing them on exchange markets (where today none occurs). n33 Like Pickel, Damgard believed that prohibiting naked CDSs would remove important liquidity from our credit markets and could operate to make credit itself more expensive for those in struggling businesses that now thirst for credit. n34 Damgard urged the Committee to focus on improving the derivative clearing provisions of Section 13 of the bill, rather than banning liquidity providers from the CDS market n35

New York Assemblyman Joseph Morelle also weighed in on Section 16 of the draft bill on behalf of the NCOIL. n36 Although Morelle agreed that covered CDSs were insurance, he contended that the states were better suited to regulate covered CDSs as insurance than the federal government. n37 He further suggested that the definition of covered CDS should be broadened to include not only those CDSs where the protection buyer has an interest in the underlying asset, but also where the protection buyer is using the CDS for legitimate hedging purposes. n38 According to Morelle, although CDSs used for purely hedging purposes may not contain as direct an exposure to the underlying reference entity as purely covered CDSs, an insurable interest [nonetheless] exists which can be identified through

GAAP accounting which requires that CDS be listed as used for hedging or speculative purposes. n39 In Morelles own words, [t]he point of demarcation, then, is not so much one of clothed v. naked swaps, but rather speculative v. hedged. n40

Following the hearings on the discussion draft, a revised HR 977 was referred on February 11, 2009 to the Committee on Agriculture and to the House Committee on Financial Services. The referred bill was, in most respects, the same as the discussion draft except for two significant changes. First, the language prohibiting entering into naked CDSs was stricken from the revised bill. Rather than ban such transactions outright, the bill was amended to permit the CFTC to summarily suspend trading of CDSs if the public interest and the protection of investors so require. n41 Moreover, such action by the CFTC to suspend trading will not take effect until the CFTC notifies the President of its decision and the President does not disapprove. n42 The bill as passed also grants to the CFTC the right to bring criminal prosecutions under the Commodity Exchange Act if the Attorney General has declined to do so. n43 The definition of credit default swap did not change from that stated in the discussion draft.

The Future of CDS Regulation

Some regulation of CDSs is unquestionably needed. The recent credit crisis has demonstrated with frightening clarity the dangers inherent in CDSs, the geometric growth of risk and loss through their use, and the potential for a financial meltdown when financial institutions lack sufficient resources to meet their counterparty obligations. History has proven Warren Buffets 2002 prophetic characterization of swaps and derivatives as financial weapons of mass destruction. n44

What form and the extent of such regulation is a much more difficult question to answer and a subject of great debate now and in the future. Proponents of state regulation argue that state regulation of insurance companies has helped the vast majority of insurance companies weather the current financial crisis. Conversely, they argue that the exclusion of state regulation by the CFMA, and the failure of any federal agency to regulate the products was a failure of colossal magnitude, and has contributed to the substantial weakening of the banking system. Proponents of federal regulation point to the need to have comprehensive regulation of the capital markets, commodity traders and financial institutions, which, they argue, cannot be provided by the states. Finally, the companies and associations representative of the capital market participants argue that the issue behind the financial crisis is not attributable to swaps and derivatives, but instead lies with the over-investment in subprime loans and the greed of financial institutions and investment banks in packaging these loans for general investor consumption. This is clearly a debate that will continue for quite some time.

The DMTA is the opening salvo from Congress on this issue. It is short on both the what and the how components of CFTC regulation. Critical definitions are left to the rulemaking authority of the CFTC with little guidance. How reporting would be provided, when previously none had existed is yet to be determined. Moreover, crucial issues of what will be reported received no consideration whatsoever. Will reporting of trades be done based on the notional amounts involved or the actual value of the risk? If the risk is to be valued on a mark-to-market basis, how and when will that occur? Moreover, seeking presidential affirmation (or more precisely, lack of rejection) for an order limiting trading in credit default swaps seems practically and politically awkward.

Further, and perhaps more importantly, the inclusion of credit default swaps that insurance departments have declared as insurance products may bring into sharp focus the current debate on federal versus state regulation of insurance and the continuing efficacy of the McCarran-Ferguson Act. This debate has been a raging stalemate for years and is likely to engender stiff resistance from the states.

State regulation is no panacea either. The proposed regulations of certain kinds of CDSs as insurance by the New York Insurance Department were problematic on many levels. Its proposal to exert regulatory authority over covered

CDSs was based on whether the protection buyer had a material interest in the reference entity. That distinction appears to be rooted in Section 1101 of the New York Insurance Law, which defines an insurance contract as:

Any agreement or other transaction whereby one party . . . is obligated to confer a benefit of pecuniary value upon another party . . . dependent upon the happening of a fortuitous event in which the insured or beneficiary has, or is expected to have at the time of such happening, a material interest which will be adversely affected by the happening of such event.

Section 1101, however, does not define material interest, and little other guidance exists as New York courts have not grappled with the question in the context of capital markets transactions. Is 100% ownership of the reference obligation a material interest? What if the protection buyer holds only a minority stake in the reference obligation or in a small number of reference entities out of a larger portfolio of reference entities? What if the protection buyer itself holds no interest in the reference entity, but the buyer is a subsidiary of a holding company that does? Will the holding company's interest be attributed to the subsidiary?

All of these issues also raise a more fundamental question: how will a protection seller learn about the holdings and expectations of a protection buyer? After all, any regulatory penalties will almost certainly fall on protection sellers for selling credit default swaps without the necessary license from the Department. Will the burden be on the protection seller to find out the extent of its counterpart's interest in the reference entity, or will the protection buyer have a duty to disclose such interests? Moreover, the state regulation as currently proposed admittedly only reaches a part of the market. Even the NCOIL suggested inclusion of properly hedged risks as insurance has the same issues.

Splitting the CDS market into insured and uninsured segments also would likely reduce liquidity by dividing trading volume into separate pools. Reduced trading volume also could lead to higher costs for purchasing credit default protection, which would make CDS less attractive as hedging instruments. Also unknown is the effect of the differential tax treatment for insurance and derivatives. For all these reasons, the New York Insurance Department's proposed regulation of the covered CDS would lead to considerable confusion and uncertainty in the market. This could cause CDS market participants to shift the situs of transactions to other jurisdictions.

Finally, while the states have achieved substantial uniformity through the National Association of Insurance Commissioners, there are a number of issues for which there is a disparity in treatment by the states. One of those areas of disparity is the treatment of financial guaranty insurance. Many states have no statutory or regulatory framework for financial guarantees and it is considered part of surety. Under the laws of those states, multiline property and casualty companies could issue financial guarantees on an unfettered and unregulated basis. Other states, such as New York, California and Florida, have comprehensive statutory and regulatory frameworks that prevent or limit multiline insurers from issuing financial guarantees and that impose stringent capital and underwriting requirements on those monoline companies that are licensed to issue such guarantees. The question remains whether state regulation could achieve the required and necessary uniformity that regulation of swaps and derivatives would likely entail.

It is too early to tell how these various state and federal attempts at regulation will ultimately play out. There does appear to be a collective will to have some form of regulation, but a number of constituencies have vastly competing views as to the form and extent of such regulation. A truly comprehensive solution would entail seamless federal and state regulation, since these products appear to be both insurance and financial instruments. Such regulation would be attractive to insurance and capital markets participants, since it would likely yield less confusion and therefore greater confidence in the operation of the marketplace. Yet to date, the states and federal government have yet to cooperate in the insurance arena in any smooth and seamless fashion. One thing is certain there will be lots more debate, molding and crafting of these and any other regulatory structures before a final regulatory program is enacted and enforced.

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n1 See Nicholas Varchaver & Katie Brenner, *The \$55 Trillion Question*, *Fortune*, Oct. 13, 2008.

n2 Steven L. Schwarcz, *The Universal Language of International Securitization*, 12 *DUKE J. COMP. & INT'L L.* 285, 300 n.68 (2002) (Indeed, there is ongoing controversy as to whether derivative products can be abused, particularly where investors borrow on leverage to purchase derivative products for speculation. In a non-leveraged context, however, the use of derivatives to hedge currency (or interest rate) risks in cross-border transactions is not only prudent but essential for minimizing the risk to investors.).

n3 Anthony Faiola, Ellen Nakashima & Jill Drew, *What Went Wrong*, *Washington Post*, Oct. 15, 2008, at A1.

n4 *Id.*

n5 *Id.*

n6 Pub. L. 106-554, 114 *Stat.* 2763. The primary substantive provisions of the act are codified at 7 *U.S.C.S.* § 27a- 27f. The exclusion of CFTC jurisdiction is codified at 7 *U.S.C.S.* § 27a-27e while the preemption of state law is codified at 7 *U.S.C.S.* § 27f (2008). See also 7 *U.S.C.S.* § 2(c)-(h) (excluding OTC swap, derivative and other similar contracts from application of the Commodities Futures Act).

n7 See, e.g., N.Y. Ins. Law § 3401; Couch on Ins. Law 3d § 41:1 (2005) (Today it is universally held, either by force of statute or on public policy grounds, that insurable interest is necessary to the validity of a policy, no matter what the subject matter.).

n8 See, e.g., Stock Jobbing Act, 1 N.Y. Rev. Stat. 710, tit. 19, art. 2 § 6.

n9 See, e.g., N.Y. Gen. Bus. Law § 351.

n10 *See, e.g.*, N.Y. Ins. Law §§ 901 et seq.

n11 *See, e.g.*, Cal. Ins. Code § 12102(b); Conn. Gen. Stat. Ann. § 38c-92a(1)(A); Fla. Stat. § 627.973.

n12 Opinion Letter, Office of the Gen. Counsel, New York Ins. Dept (June 16, 2000). *See also, e.g.*, *Gen. Elec. Co. v. Metals Res. Group Ltd.*, 741 N.Y.S.2d 218, 219-20 (N.Y. App. Div. 2002) (Contrary to defendant's argument, the parties' contract was not an illegal contract to gamble, but rather a legitimate commodity swap agreement exempt from the strictures of the Commodities Exchange Act); *see also Korea Life Ins. Co. v. Morgan Guar. Trust Co. of N.Y.*, 269 F. Supp. 2d 424, 442 (S.D.N.Y. 2003) (Although I have characterized KLI's swap agreements as bets and speculations on currency fluctuations, the transactions were in the form of forward contracts, swaps and derivatives. Derivatives transactions, forward contracts and swap agreements in currencies and commodities are not considered illegal gambles, and do not violate New York's gambling statute.).

n13 Testimony of Superintendent Eric DiNallo, Hearing Before the House Committee on Agriculture to Review the Role of Credit Derivatives in the U.S. Economy, at 5 (Nov. 20, 2008).

n14 New York Ins. Dept, Circular Letter No. 19, at 7 (Sept. 22, 2008).

n15 Press Release, *Governor Paterson Announces Plan to Limit Harm to Markets from Damaging Speculation*, State of New York, Executive Chamber, at 1 (Sept. 22, 2008).

n16 *Id.* at 2.

n17 *The Role of Financial Derivatives in the Current Financial Crisis*: Hearing before the Senate Agriculture Committee, 110 Cong. 3 (Oct. 14, 2008) (Opening Statement of Eric Dinallo, Superintendent of the New York Insurance Department.)

n18 Press Release, *Governor Paterson Announces Plan to Limit Harm to Markets from Damaging Speculation*, State of New York, Executive Chamber, at 2 (Sept. 22, 2008).

n19 New York Ins. Dept, Circular Letter No. 19, at 7 (Sept. 22, 2008).

n20 Testimony of Eric Dinallo to the U.S. House of Representatives Comm. On Agriculture, at 3 (Nov. 20, 2008).

n21 N.Y. Ins. Dept, First Supplement to Circular Letter No. 19 (Nov. 20, 2008).

n22 Missouri Dept of Ins., Financial Institutions and Professional Regulation, Insurance Bulletin 08-12 (available at <http://insurance.mo.gov/laws/bulletin/index.htm>).

n23 *Id.*

n24 *Id.*

n25 *Id.*

n26 *Id.*

n27 *Id.*

n28 Press Release, *PWG Announces Initiatives to Strengthen OTC Derivatives Oversight and Infrastructure* (Nov. 14, 2008) (available at <http://www.ustreas.gov/press/releases/hp1272.htm>).

n29 Testimony of Robert Pickel, Chief Executive Officer, Intl Swaps & Derivatives Assoc. Before the Comm. on Agric. U.S. House of Representatives, at 4 (Feb. 4, 2009) (available at <http://agriculture.house.gov/testimony/111/h020409/pickle.doc>).

n30 *Id.*

n31 *Id.*

n32 Prepared Testimony of John M. Damgard, President, Futures Indus. Assoc., Hearing on the Derivatives Markets Transparency and Accountability Act of 2009 Before the U.S. House Comm. on Agric. (Feb. 3, 2009) (available at <http://agriculture.house.gov/testimony/111/h020309/damgard.doc>).

n33 *Id.*

n34 *Id.*

n35 *Id.*

n36 Testimony of Joseph D. Morelle, Natl Conference of Ins. Legislators (NCOIL), Before The House Comm. on Agric. (Feb. 4, 2009) (available at <http://agriculture.house.gov/testimony/111/20409/morelle.pdf>).

n37 *Id.* at 7.

n38 *Id.* at 7-8.

n39 *Id.* at 8.

n40 *Id.*

n41 H.R. 977, 111th Cong. § 16(a) (1st Sess. Feb. 12, 2009).

n42 *Id.*

n43 *Id.* at § 17.

n44 Berkshire Hathaway, Inc., Annual Report, at 15 (2002).

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McCarter & English LLP on Admiral Ins. Co. v. Debber

2009 Emerging Issues 3371

McCarter & English, LLP on Admiral Ins. Co. v. Debber: Ninth Circuit Affirms Rescission of EPLI Policy Based on Misrepresentations in Policy Application

By Brian Osias and Mark Villanueva

February 19, 2009

SUMMARY: Employment Practices Liability Insurance (EPLI) is a somewhat new form of liability insurance that covers employers for certain claims made by its employees. In an unpublished decision, the Ninth Circuit Court of Appeals recently affirmed a lower courts holding that an insurer was entitled to rescind consecutive EPLI policies where it was determined that the insured misrepresented its claims history in the policy application.

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ARTICLE: Overview

Employment Practices Liability Insurance (EPLI) is a somewhat new form of liability insurance that covers employers for certain claims made by its employees. EPLI ostensibly provides protection against a host of different employee lawsuits, including discrimination, wrongful termination, sexual harassment, failure to employ or promote, and other employment-related allegations. EPLI coverage is sometimes packaged with Directors and Officers coverage and/or Errors and Omissions coverage, and often is written on similar forms.

According to insurers, the cost of EPLI policies depends on a variety of underwriting considerations, including the insureds business, the number of employees, and other risk factors, such as whether the insured has faced prior employment-related claims. EPLI carriers purportedly seek to become familiar with a potential policyholders business by requiring the completion of a very detailed policy application. If an EPLI policy is issued based on an application that fails to disclose material information, the insurer may attempt to rescind the policy, regardless of whether the omission in the application was intentional.

Background of Admiral Ins. Co. v. Debber

In an unpublished decision, the Ninth Circuit Court of Appeals recently affirmed a lower courts holding that an insurer was entitled to rescind consecutive EPLI policies where it was determined that the insured misrepresented its claims history in the policy application. *Admiral Ins. Co. v. Debber*, 2008 U.S. App. LEXIS 20898 (9th Cir. Cal. Sept. 26, 2008).

A. The 2002 Policy

In November 2002, Admiral Insurance Company (Admiral) priced an EPLI policy for Data Control Corporation (DCC). About three weeks later, DCC's broker asked Admirals underwriting agent, Monitor Liability Managers (Monitor), to bind EPLI coverage for DCC. Monitor issued a binder for an EPLI policy to DCC, which stated that Admirals review of a completed application was a condition precedent to coverage.

On February 11, 2003, Dale Debber (Debber), Chief Executive Officer of DCC, and Lorna Martin (Martin), DCC's Chief Technical Officer, completed and signed a policy application (the 2002 Application) for the December 13, 2002 to December 13, 2003 policy. The 2002 Application asked whether [i]n the last 5 years . . . any current or former Employee or third party made any Claim or otherwise alleged discrimination, harassment, wrongful discharge and/or Wrongful Employment Act(s) against [DCC] or its directors, officers, or Employees. Claim, as defined in the application, was not limited to the filing of a lawsuit or similar complaint with the EEOC or similar state or local agency, but also included a written demand or a threat by any current or former Employee seeking relief in connection with an employment related dispute or grievance. In response to the question, DCC answered no.

Another question in the 2002 Application asked: [d]uring the last 5 years, has [DCC] or any of its directors, officers or Employees thereof known of, or been involved in any lawsuit, charges, inquiries, investigations, grievances, or other administrative hearings or proceedings before a number of government agencies or any U.S. District or state court? Again, DCC responded no to this question.

Martin contended that DCC's broker instructed her to follow a prior renewal application for a different insurer to complete the Admiral application. The prior renewal application did not list any claims or lawsuits against DCC, as DCC previously disclosed to the other insurer the details of prior claims and lawsuits in the original application for coverage. Specifically, DCC disclosed to its other insurer that Debber had been sued in three prior actions, captioned *Jenise Whittle, et al. v. Dale Debber*, Case No. 58835, filed September 22, 1997; *John Atkinson, et al. v. Dale Debber, et al.*, Case No. 60533, filed August 6, 1998; and *Barbara Hunyada v. J. Dale Debber, et al.*, Case No. 60534, filed August 6, 1998. The *Hunyada* and *Atkinson* actions were pending within five years of DCC's completion of the 2002 Application.

After receiving the completed 2002 Application, on September 3, 2003, Admiral issued an EPLI Policy to DCC for policy period December 13, 2002 to December 13, 2003 (the 2002 Policy).

B. The 2003 Renewal

In December 2003, Monitor issued a binder for the renewal of the 2002 Policy, which stated that a condition precedent to coverage was Monitors [r]eceipt, review and underwriting acceptance of [a] properly completed, signed and currently dated EPLI renewal application (the Renewal Application). Debber and Martin completed the Renewal Application on behalf of DCC, and submitted the signed application on December 22, 2003.

As with the 2002 Application, the Renewal Application queried whether within the last five years, DCC had been involved in any lawsuit, charges, inquiries, investigations, grievances or other administrative hearings or proceedings before various agencies or any U.S. District or state court. Again, DCC representatives Debber and Martin responded no to the inquiry.

Martin contended that she relied on DCC's broker when filling out the Renewal Application. Specifically, Martin attested that because the prior claims against Debber were filed more than five years prior to the Renewal Application, the broker advised that they did not need to be disclosed.

On January 27, 2004, Admiral issued an EPLI policy to DCC for the policy period December 13, 2003 to December 13, 2004 (the 2003 Policy).

C. The Altman Action

On May 11, 2004, Vickie Altman and her husband (the Altmans) filed a complaint in the Nevada County Superior Court against DCC, Debber, and Martin. Among other things, the Altmans alleged claims of sexual harassment and retaliation in violation of California's Fair Employment and Housing Act and Title VII. In particular, the Altmans alleged that Debber and [DCC] have defended at least three sexual harassment and retaliation lawsuits in Nevada County since 1996 and that the complaints for these lawsuits contain strikingly similar allegations to those experienced and set forth by the Altmans.

D. Tender of Altman Complaint to Admiral

On May 24, 2004, DCC tendered the Altman complaint for defense and indemnity. Admiral agreed to defend the Altman action under the 2003 Policy, subject to a full reservation of rights. Admiral specifically reserved the right to file an action for a judicial determination that [Admiral] is entitled to rescind the Policy and that the Policy is void *ab initio* and provides no coverage whatsoever to any person or entity.

The Altman action was removed to the United States District Court for the Eastern District of California on June 2, 2004. On August 23, 2004, the Altman defendants motion to compel arbitration was granted and the federal action was dismissed. On August 11, 2005, counsel for the Altman defendants -- with Monitors consent -- served the Altmans with an offer of judgment. The Altmans accepted the offer and obtained an arbitration award in the amount of the offer. On September 26, 2005, Admiral issued a payment to the Altmans, subject to a reservation of rights to rescind the Admiral EPLI policies and to seek recovery of the payment from DCC, Debber and Martin.

E. The Rescission Action

On February 22, 2005, Admiral sought to rescind the 2002 and 2003 Policies in an action against Debber, Martin, and DCC. *Admiral Ins. Co. v. Debber*, 442 F. Supp. 2d 958 (E.D. Cal. 2006). Counsel for Admiral subsequently tendered a check to DCC, which represented a return of the premiums paid by DCC for the EPLI policies.

In opposition to Admirals summary judgment motion, DCC argued that the 2002 Application was irrelevant because the Altman claim was tendered against the 2003 Policy. DCC further argued that because the prior lawsuits were filed outside the five year window set forth in the 2003 Application, it had no obligation to disclose the earlier lawsuits. The Court rejected these arguments, and found that the 2002 Policy would not have been issued had the prior lawsuits been disclosed in the 2002 Application. The District Court held that [t]o allow an insured to conceal two sexual harassment and retaliation lawsuits clearly filed within five years of the original application and then claim upon renewal of the policy that those suits are outside the five year period is, understandably, unsupported in law. *Id.* at 968.

Further, the Court rejected DCC's argument that the questions in the policy applications contemplated only new lawsuits first made in the prior five years. The Court held that the application requested information relating to DCC's knowledge or involvement in lawsuits in the last five years, and was not limited to claims first made within that timeframe. The Court also held that DCC's reliance on advice from its insurance broker was not a defense to rescission. The Court noted that even an unintentional non-disclosure is sufficient to support rescission of an insurance contract, if the non-disclosed information was material to the contract. *Id.* at 967.

The District Court also held that Admirals issuance of a conditional binder prior to review of a completed policy application did not show lack of reliance on the application in issuing the policy. The Court noted the distinction between a binder and a policy, and found that the policy was not issued until after the 2002 Policy Application was completed. The District Court also rejected DCC's argument that rescission of the contract was improper because Admiral did not verify the truth of DCC's claims and loss history.

Finally, the Court denied DCC's cross motion for summary judgment on the basis of laches. DCC argued that Admiral unreasonably delayed seeking rescission of the EPLI policies, causing DCC substantial prejudice. The Court

held, however, that nine months was not an unreasonable amount of time for Admiral to investigate and act upon information supporting rescission.

F. The Ninth Circuits Decision

The Ninth Circuit Court of Appeals affirmed the District Courts ruling, and held that Admiral was entitled to rescind the EPLI Policies *ab initio*. The Appellate Court recognized that [u]nder California law, a material misrepresentation or concealment in an insurance application, whether intentional or unintentional, entitles the insurer to rescind the insurance policy *ab initio*. *Admiral Ins. Co. v. Debber*, 2008 U.S. App. LEXIS 20898 at *1 (9th Cir. Cal. Sept. 26, 2008) (quoting *West Coast Life Ins. Co. v. Ward*, 33 Cal. Rptr. 3d 319, 323 (Ct. App. 2005)). The Circuit Court found that the information omitted from the applications was material, and affirmed the District Courts ruling that the insurer was entitled to rescind both the 2002 and 2003 Policies.

Comment

EPLI carriers generally require potential policyholders to complete detailed applications that are supposedly intended to reveal the applicants knowledge of any prior or pending employment-related claims. An insureds misrepresentations about its claims history generally may provide a basis for rescission. As confirmed by the Ninth Circuit Court of Appeals, even an unintentional failure to disclose material information may justify rescission. Insureds may therefore wish to take an expansive and/or over-inclusive view in determining what information to disclose in connection with completing their EPLI applications to avoid rescission of their policies. Indeed, the *Debber* decision underscores the importance for the insured to be scrupulously accurate in the policy application to avoid potential post-claim rescission issues. Although materiality is a key consideration in determining whether a claim of rescission is justified, *Debber* instructs that insurers and at least some courts will take a broad view of what is material. The *Debber* Court appears to suggest that facts related to loss history in particular will often meet the threshold of materiality.

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Ernst & Young 2009 Insurance Outlook--US Property/Casualty

2009 Emerging Issues 3357

Ernst & Young 2009 Insurance Outlook--US Property/Casualty

By Ernst & Young

February 8, 2009

SUMMARY: Ernst & Young presents its 2009 outlook for the U.S. property and casualty insurance industry.

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ARTICLE: Overview

The US property and casualty (P/C) industry is emerging from the turmoil in financial markets with significant isolated damages, but so far no serious general impairment. The outlook for 2009 includes greater risks from continuing volatility in investment and underwriting performance, what looks to be a more active merger and acquisition (M&A) market, and the prospects of market defining regulatory changes. Looking ahead, this may be the beginning of a transitional if not transformational environment for the industry. It is a time when challenges in the competitive landscape can become opportunities for the efficient and well-prepared. In this context, we have identified seven key actions:

1. Redirect focus on premium pricing
2. Monitor claims inflation risk
3. Prepare for changes in regulatory oversight
4. Prepare for changes in accounting requirements
5. Address effective expense control
6. Rethink risk modeling
7. Watch for new M&A activity

Redirect focus on premium pricing

Because of the recent financial crisis, compounded by a return to normal or above-average catastrophe loss levels, price reductions are likely over for the foreseeable future. After a four-year period where technical and market pricing diverged, 2009 appears to be reversing the trend. This does not necessarily mean a return to a hard market, but it does signal a change in the dynamics of competition in the marketplace. In most P&C business segments, pricing levels have been soft for the past four years. During that period, rate decreases were offset by an increase in insured exposures, resulting in virtually flat premiums. This changed with a softening of the economy in 2007. Still, profitability held up well, as loss levels declined in 2006 and 2007 in large part due to fewer catastrophe losses, loss reserve releases, and favorable casualty loss frequency experience. In spite of the ongoing rate competition, returns on capital reached record levels in 2007.

In 2008 catastrophes, pricing and the financial market crisis contributed to stress in the industry. Insured catastrophes totaled over \$50 billion and reduced loss reserve releases contributed to an overall deterioration of 7 points in the combined ratio. Although it is unlikely that this level of catastrophe losses alone will significantly change overall market pricing, the current crisis in financial markets is exerting upward pressure on pricing. As a result, US P&C policyholder surplus has fallen because of (i) financial guarantee insurance losses, (ii) other than temporary impairment (OTTI) of investment grade bonds and preferred stock, and (iii) substantial decreases in values of equity holdings. Surplus may drop by 10% or more by the end of 2008.

Early indications of pricing negotiations give strong support to at least a firming of the market in most lines. Insurer and reinsurer concerns over loss volatility and potential for mega-losses in highly developed catastrophe-prone locations should contribute to price stabilization. Additionally, losses in directors and officers (D&O) and errors and omissions (E&O) products will certainly result in significant price increases in those market segments. These factors will give rise to additional scrutiny by both rating agencies and regulators. Surplus preservation, particularly against catastrophic events, remains a critical cycle survival strategy.

Monitor claims inflation risk

The environment for P&C insurers through 2009 is likely to continue a volatile pattern that drives claims costs. In spite of the deepening recession and the rising concern of deflation, longer term, the industry must account for the massive deficit spending undertaken by the federal government. Insurers exposure to inflationary risk in many instances is fundamentally different from the factors that drive inflation in the broader economy: medical costs, construction costs and tort issues continue to account for the lions share of the industrys inflation trend. Although severity and frequency trends have benefited from the positive effects of broad tort reform in the last decade, these effects are starting to erode. The most significant factor in the broader economy will be the long-term impact of the federal bailout and economic stimulus packages that have already added to government deficits.

Through most of 2008, inflation spiked upward: since the financial crisis, the commodities futures for construction inputs have fallen and retail prices have followed. In an inflationary environment, P&C insurers as third-party payers or in adversarial claims settlement positions are in a poor negotiating position relative to larger purchasers of commodities or services. Medical cost is the broadest element in inflation, and it impacts product lines such as personal and commercial automobile, general liability, workers compensation, commercial multi-peril, and medical malpractice insurance. Over the past five years, medical care costs and hospital services have outpaced general inflation by 20%, making it difficult to predict the direction or magnitude of medical cost inflation.

Prepare for changes in regulatory oversight

Will 2009 be the year that federal regulation gets a firm foothold in the insurance industry? Recent market events, including the federal involvement in banking, have added a sense of urgency to these discussions. Momentum for change in the insurance regulatory structure is building, and the near-term uncertainty about the outcome presents challenges for the industry.

It is almost certain that the P&C industry will face increased regulation as an outcome of the current crisis in the financial services industry. Regulation is likely to be more intrusive, encompassing more continuous monitoring of activities and financial performance, perhaps with higher standards of solvency over the longer term (even though there may be some loosening of standards to help life insurers out of the current crisis).

The form of federal supervision favored in the Treasurys 2008 report, *Blueprint for a Modernized Financial Regulatory Structure*, is the optional federal charter (OFC) -- allowing insurance organizations the opportunity to choose the form of regulatory oversight that they find most appropriate. At this stage, it appears OFC is giving way to increased likelihood that federal regulation will be applied to all insurance and financial services sectors to some degree.

While the case for federal oversight is more apparent in the life industry, where geography matters little in product design or consumer preferences, the P&C industrys geographic variations present a formidable hurdle for centralization. Solvency protection and the workings of guaranty funds vary dramatically among the states. Differing levels of catastrophe exposure are a divisive factor that separates their interests. Consumer protection in automobile and housing repair, variations in litigation trends driven by the influences of state courts and legislation, and business sector concentrations all differ considerably by state. In 2007 and 2008, there are no clear indications that solvency or failure of regulation has been a systemic problem in the P&C arena, as it has in other insurance sectors and in financial services. Some form of compromise legislation may apply to P&C companies: maintaining rate and consumer protection regulation at the state level, but developing federal mechanisms to monitor solvency and provide an alternative to guaranty funds.

In the existing state-based insurance regulatory framework, the current guaranty fund structure is not designed to respond to events like the recent crisis. It handles specific failures of an individual entity, but not systemic failures that might broadly imperil the industry. States are hampered in addressing system-wide events because the process lacks the principle of a lead regulator and the dollar cost is too high. While state regulation is structured to act by seizing a company when a situation forces the equivalence of bankruptcy, it is limited in the capability and tools to head off systemic problems before they cause collapse. Furthermore, state ratings agencies currently act as shadow regulators, and while they may be able to influence behavior more proactively, they need to address a current lack of consistency and transparency.

Federal regulation could alter the competitive landscape of the P&C insurance industry. Opportunities to accelerate geographic expansion through both organic and acquisition channels will develop for those prepared to exploit the changes. Value will likely be created by those who can quickly adopt and defend strong regional and super-regional market presence.

Prepare for changes in accounting requirements

Accounting issues will be critical in 2009 and beyond as companies prepare to adopt a new financial reporting platform. With the Securities and Exchange Commissions 2008 pronouncements regarding the convergence of US generally accepted accounting principles (GAAP) with International Financial Reporting Standards (IFRS), companies are beginning to prepare for the anticipated change to a market-consistent framework. Implementing principles-based and market-consistent accounting challenges nearly every established system and operational facet of an insurance company. Under such a system, income statements and balance sheets become more volatile as assets and liabilities are increasingly subject to market valuations.

IFRS 4 Phase II and Solvency II have planned European Union implementation dates of 2012. Until then, US companies need to build the infrastructure to accommodate not only the existing IFRS framework but also the added challenges these changing rules and regulations present. This involves a huge operational undertaking, even in the best of times, but the financial crisis and recession have increased the pressures. As companies plan for the upcoming changes, the definition of the market-consistent framework may undergo changes as the impact of the financial crisis, and the role played by mark-to-market accounting of thinly-traded instruments, is better understood. The International Accounting Standards Board has allowed companies in certain circumstances to reclassify some financial instruments out of the trading category and into the loan category, which is carried on a cost basis, to help resolve the credit crisis, while reaffirming the need for transparency in asset valuations.

Thus, companies need to prepare for an uncertain roll-out of these requirements. This can increase the risks associated with some longer-term strategic decisions, where changing accounting or related tax regimes may alter the nominal value of the decision. Management must keep up with their peers in adopting systems and information capabilities to respond to these changes as they unfold.

Address effective expense control

For most of this decade, expense ratios have been rising steadily. For the P&C industry overall, underwriting, acquisition and general expense ratios as a percentage of premium are expected to reach 27.5% in 2008; this is higher than in any year since 1999. More significantly, underwriting, acquisition and general expense dollars were up 52% in those nine years. While premiums and claims grow in tandem, expenses should see benefits of size and economies of scale and so far, this has not happened. The pace of cost increase indicates that real inefficiencies are accumulating and are not simply a function of slowing premiums.

Long-term reversal of expense growth requires an emphasis on effective service outcomes in three critical operating areas: underwriting costs (including policy administration), acquisition expense (primarily, fees to brokers and agents), and claims-adjustment expense. Expense cutting cannot be haphazard or it may create more problems than it solves. Offshore and onshore outsourcing are expense-control options to reduce operating costs, especially those related to routine submissions and policy administration. However, outsourcing core functions carries risks associated with the long-term stability of the service providers. Regardless of the risks, successful outsourcing is a long-term solution that requires a broad view in terms of training, effectiveness of communication, and quality control.

Distribution is another area of expense control where efficiencies can be achieved through alternative marketing channels, including online quotation and policy delivery. While improvements have been made in personal lines, the complexity of policy applications continues to slow the process on the commercial side. Compounding this issue is the rather low confidence that corporate buyers and agents/brokers often feel in using new forms of electronic commerce. However, this should change as a new generation of users become more comfortable with electronic interchange and become more included in risk-management purchasing and decision-making positions.

Many of the largest P&C insurers undertook cost-reduction initiatives during the second half of 2008. However, a longer-term, sustainable approach to insurance spending must be applied to make a real difference.

Rethink risk modeling

In the year ahead, P&C insurers will need to incorporate risk-management lessons learned, particularly lessons learned in 2008, into their risk-management processes. Insurers will go beyond refreshing models, to focus on expanding information used for risk analysis and to better understand the realities of new and continually volatile financial-market conditions.

Risk models may provide insight into the proper application of information or into the additional information that is needed, but they should only play a part in the overall risk-management process. When it comes to modeling priorities, line managers and corporate functions will have increasing responsibility to ensure that lessons learned are incorporated into models. Adjustments may be needed in order to improve the modeling of changing economic and capital-markets conditions. On the asset side, modelers will pursue more complex credit-ratings transition matrices, correlations between asset classes and sectors, the importance of maintaining liquidity under stress scenarios, and methods of projecting both the deterioration and recovery of assets over time. Outputs from models and scenario tests will also need to be examined critically against real-world experience with an increased respect for extreme scenarios and worst-case hypotheticals.

Models may also continue to provide insight to managers, and are an opportunity to illustrate effects to third party audiences in characteristics such as unexpected correlations, rates of decay or deterioration, and aggregation risks. But the effort to improve models will fall flat without supervision by managers who are accountable and who are knowledgeable about real-world trends and influences.

Watch for new M&A activity

The financial crisis has created a unique confluence of events resulting in an unprecedented landscape for insurance mergers and acquisitions. The government bailout of one of the worlds largest financial institutions has placed its most prized assets on the auction block. Additionally, other insurers are looking to focus on core businesses and shed nonstrategic lines of business in order to free up capital and streamline operations. The total insurance properties currently available for sale exceeds the M&A activity of the last several years combined.

Concurrently, potential buyers are capital-constrained. Insurers are holding on to any excess capital to protect against further deterioration in investment markets, and private equity investors are challenged to find an appetite in the credit markets for large-scale acquisitions. Transactions will wait until acquisition-minded insurers are more assured of having adequate capital, and until private equity investors are once again able to access the debt market. Given current equity valuations, the use of stock is not generally available as currency to fund transactions. A few companies will emerge from the current situation with strong balance sheets and will use a portion of capital to fund an acquisition, but they are likely to wait until the depth of the current economic downturn, and its impact on operating performance, is better understood.

If current economic conditions persist, two additional factors will come into play that will drive down current sales prices for insurance properties. First, pressures from debt holders, regulators and rating agencies will force organizations to sell at prices below current valuations. Second, the performance of insurance units on the sales block will deteriorate over time as morale and employee performance suffer with the uncertainty of a sale. Depending on the speed and pace of economic recovery, 2009 may be one of the more significant years in the insurance M&A market.

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Reed Smith LLP on Insurance Coverage for Violations of Statutory Privacy Rights

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Reed Smith LLP on Insurance Coverage for Violations of Statutory Privacy Rights

By Timothy Law and Toki Rehder

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SUMMARY: In this commentary, Reed Smith LLPs Timothy Law and Toki Rehder advocate that given that insurance policies definitions of personal and advertising injury explicitly include the publication or making known of material that violates a persons right of privacy, insurers should cover damages imposed under privacy statutes.

PDF LINK: [Click Here for Enhanced PDF of Commentary](#)

ARTICLE: Introduction: In 1890, Samuel Warren and Louis Brandeis wrote a seminal article for the Harvard Law Review on the Right to Privacy. n1 In advocating for expanded privacy rights, they explained that [p]olitical, social, and economic changes entail the recognition of new rights, and the common law, in its eternal youth, grows to meet the new demands of society. n2 Noting the technological advances of the day, such as instantaneous photographs and numerous mechanical devices [that] threaten to make good the prediction that what is whispered in the closet shall be proclaimed from the house-tops, those scholars presciently recognized that with new technology comes novel threats to the right to be let alone. n3

In todays world, the increased use of computers to process, store, and retrieve personal financial information, coupled with the aggressive use of technology for marketing purposes, are creating pervasive threats to privacy. Instead of the expansion of the common law advocated by Warren and Brandeis, the response has come from Congress, which has enacted numerous statutes to protect the privacy rights of consumers and businesses. Such laws include the Telephone Consumer Protection Act (TCPA), n4 the Fair Debt Collection Practices Act (FDCPA), n5 the Fair Credit Reporting Act (FCRA), n6 the Electronic Communications Privacy Act (ECPA), n7 the Right to Financial Privacy Act (RFPA), n8 the Cable Communications Privacy Act, n9 the Video Privacy Protection Act (VPPA), n10 the CAN-SPAM Act of 2003, n11 the Employee Polygraph Protection Act (EPPA), n12 the Drivers Privacy Protection Act, n13 the Gramm-Leach-Bliley Financial Modernization Act of 1999, n14 Health Insurance Portability and Accountability Act of 1996 (HIPAA), n15 and the Fair and Accurate Credit Transactions Act of 2003 (FACTA). n16 This commentary discusses common issues that arise when policyholders seek insurance coverage for lawsuits alleging violations of privacy laws.

Various Insurance Policies Protect Against Liability for Privacy Violations: Different types of insurance policies may provide coverage for violations of statutory privacy rights. The most ubiquitous commercial insurance coverage is the Commercial or Comprehensive General Liability (CGL) insurance policy. Typically written on a standard form,

most typically the one drafted the Insurance Services Office, CGL policies generally include Coverage A and Coverage B. Coverage A covers Bodily Injury and Property Damage Liability while Coverage B extends to Personal and Advertising Injury Liability. While violations of privacy statutes may result in bodily injury or property damage, alleged violations of privacy statutes are more often analyzed under Coverage B, which usually defines Personal and Advertising Injury to include: [o]ral or written publication, in any manner, of material that violates a persons right of privacy (the Publication Language). Other standard-form CGL policies define Personal and Advertising Injury to include making known to any person or organization covered material that violates a persons right to privacy (the Making Known Language).

Other types of insurance policies may provide coverage for privacy claims. Directors and officers (D&O) liability insurance may provide coverage not only for individual directors and officers, but also for the entity (although entity coverage is often limited to securities claims). Within the wide-ranging wrongful acts covered by D&O insurance may be employment practices such as employment-related libel, slander, humiliation, defamation, or invasion of privacy. Furthermore, if the claim of a violation of a privacy statute is made by an employee, Employment Practices Liability (EPL) coverage, or in rare instances the employers liability coverage in a workers compensation policy, can potentially provide coverage. n17 In addition to CGL, D&O and EPL insurance, many corporations purchase insurance policies covering professional errors and omissions (E&O) or technology-based risks. D&O, EPL, and E&O insurance policies are usually sold on a claims-made basis, requiring the claim to be made during the policy period and to be based on a wrongful act, which is often broadly defined. Coverage for TCPA Claims Heralds Coverage for Claims Under All Privacy Statutes: As it pertains to insurance coverage, the most litigated privacy statute has been the Telephone Consumer Protection Act, or TCPA, which protects peoples privacy from unwanted calls and faxes. n18 The TCPA makes it unlawful, subject to limited exceptions, to use any telephone facsimile machine, computer, or other device to send, to a telephone facsimile machine, an unsolicited advertisement. n19 The term unsolicited advertisement is defined as any material advertising the commercial availability or quality of any property, goods, or services which is transmitted to any person without that persons prior express invitation or permission, in writing or otherwise. n20 Courts can award damages equal to actual monetary losses, statutory damages of up to \$500 per fax, or triple damages of \$1,500 if the infringement is intentional. n21 The total damages sought in TCPA cases are often large because the faxes are typically sent to thousands of recipients.

In seeking coverage from their CGL insurance companies, some policyholders have argued that alleged violations of the TCPA are covered under Coverage A, in that the fax recipient suffers a loss of use of their fax machine and a small amount of ink, paper and toner whenever a fax is received. The loss of use of property, even if it is not physically damaged, normally falls within the insurance policys definition of property damage, so there is a strong basis for this argument. n22 It is more common, however, for coverage to be analyzed under Coverage B for alleged violations of the right of privacy. This logically follows from Congress express purpose in enacting the TCPA, which was to protect the privacy interests of residential telephone subscribers by placing restrictions on unsolicited, automated telephone calls to the home and to facilitate interstate commerce by restricting certain uses of facsimile ([f]ax) machines and automatic dialers. n23

The Right of Privacy Includes Seclusion and Secrecy: Illinois has been the central battleground for TCPA insurance coverage disputes. The main debate has been whether Coverage B covered violations of all types of invasion of privacy, or only those relating to violations of the right of secrecy. At least with regard to the Publication Language, this battle was won by policyholders, and lost by insurance companies, when the Illinois Supreme Court decided *Valley Forge Ins. Co. v. Swiderski Electronics, Inc.* n24

The court held that: [t]he receipt of an unsolicited fax advertisement implicates a persons right of privacy insofar as it violates a persons seclusion, and such a violation is one of the injuries that a TCPA fax-ad claim is intended to vindicate. n25 The Illinois Supreme Court found it unproblematic that the Complaint contained no mention of the right to privacy because a violation of privacy in the sense of a violation of seclusion is implicit in a TCPA fax-ad claim. n26 Referring to dictionary definitions, the court confirmed that right of privacy connotes both an interest in seclusion and

an interest in the secrecy of personal information. n27 Accordingly, the Illinois Supreme Court ruled that the policy language material that violates a persons right of privacy can reasonably be understood to refer to material that violates a persons seclusion, including unsolicited fax advertisements. n28 In the two years preceding the *Swiderski* opinion, many courts had reached the same opinion, finding coverage for TCPA claims under Coverage B. n29

The few cases that have found no coverage under the Publication Language followed *American States Ins. Co. v. Capital Associates of Jackson Co. Inc.*, n30 which ruled that the insurance policy was intended only to cover violations of the privacy right of secrecy, not seclusion. n31 In *Swiderski*, the Illinois Supreme Court specifically rejected *American States*, which had attempted to predict Illinois law. n32 Because the Seventh Circuit in *American States* incorrectly predicted the course of Illinois law, the *American States* decision and its progeny now lack precedential value. n33 Following *Swiderski*, a majority rule and a clear trend has been established favoring coverage for TCPA claims. n34

Generally, when courts have found no coverage for TCPA claims, they have relied not only on the now-discredited *American States* decision, but also on the Making Known Language, which some courts consider distinguishable from the Publication Language at issue in *Swiderski*. n35 The leading court to draw this distinction is the Court of Appeals for the Fourth Circuit in *Resource Bankshares*. n36 In that case, the Fourth Circuit focused on the term making known to rule that the policy was intended to provide coverage only for injury arising from the violation of the right of privacy by unwarranted disclosure, i.e., a violation of a right of secrecy, rather than from the violation of the right of privacy by unwanted intrusion, i.e., a violation of a right of seclusion.

Subsequent precedent involving Resource Bank calls into question the Fourth Circuits decision in *Resource Bankshares*. In addition to seeking coverage from St. Paul under its general liability insurance policy, which was the subject of the Fourth Circuits decision in *Resource Bankshares*, Resource Bank sued its directors and officers liability insurance company, Progressive Casualty Insurance Company, which had sold an Entity Errors and Omissions Endorsement. n37 The Progressive policy *excluded* coverage for loss in connection with any claim for invasion of privacy, presumably because it would be covered by CGL insurance. Attempting to use to its benefit the parsing of seclusion and secrecy that the Fourth Circuit had previously endorsed, Resource Bank urged that the exclusion addressed only the right of secrecy. The federal district court found that the plain meaning of invasion of privacy encompassed both the seclusional and secrecy variants of the right of privacy, so those claims were excluded.

Given that the right to privacy includes both the rights of seclusion and secrecy, the right of privacy should not be parsed, holding one to be covered and the other not. Indeed, the right of privacy protects many things, often not so easily labeled as a right of seclusion or secrecy. The term right of privacy appears in thousands of cases with factual scenarios so variable as to defy easy categorization. n38 The Harvard Law Review article by Warren and Brandeis makes no distinction between seclusion and secrecy, and instead indicates that they are intertwined in the right to be let alone. n39 Indeed, the authors stated that the right to privacy is like the right not to be assaulted, beaten, imprisoned, maliciously prosecuted or defamed. n40 Interestingly, the other offenses typically covered as a personal or advertising injury include (1) false arrest, detention or imprisonment; (2) malicious prosecution; (3) the wrongful eviction from, wrongful entry into, or the invasion of the right of private occupancy; (4) the publication of material that slanders or libels a person or organization or disparages its goods; and (5) use or infringement of anothers copyright, trade dress, or slogan in your advertisement.

Harassing calls by debtors that violate the FDCPA or other debt collection statutes are clear intrusions upon privacy, similar to the intrusion of unwanted faxes, and are covered. n41 Some privacy statutes are focused on the right of secrecy, such as those statutes that protect patient and credit card information, making the secrecy/seclusion debate moot. For example, the FCRA prevents the unwarranted disclosure of financial information; thus, the right of secrecy is plainly implicated. Indeed, the FCRA is an excellent example of how secrecy and seclusion are intertwined. In a typical FCRA case, n42 a consumer will complain that a company improperly accessed his or her credit information and then improperly used that information for marketing purposes, implicating both secrecy and seclusion interests.

Insurance policies draw no distinction between the right of secrecy and the right of seclusion or any other rights which are protected by the right of privacy, like the right to control one's own body, likeness, and image. ⁿ⁴³ In our modern times, legislators are responding to invasions of privacy by creating firm rules and liability for violating those rules. When businesses unintentionally violate those rules, thereby creating liability to third parties, those businesses should have access to the insurance they purchased to provide recompense to the victims.

The Privacy Violation Need Not Relate to the Content of the Material: Insurance companies also argue that the privacy violation must be caused by the *content* of the material published or made known, not simply by the manner of publication. Using this argument in TCPA cases, insurance companies sometimes argue that because an unwanted fax does not publish or make known private facts, there is no coverage. This distinction, however, is not supported by the language of the insurance policy. The word material or covered material means the thing itself (the fax), not just the content of the thing (the words or images on the fax). When the word material or covered material is defined in the insurance policy, this is made explicit.

Even when undefined by the insurance policy, this meaning is implicit in the use of the term covered material or material in another personal or advertising injury offense, the one relating to libel and slander, which usually reads, libel or slander in or with covered material. The libel or slander must be in material or covered material, such as a fax, a telephone call, a newspaper, or an email. When someone is alleged to have violated the privacy rights protected by the TCPA by sending, transmitting, publishing, or otherwise making known the facsimile advertisement (i.e., the material) in a prohibited manner, there should be coverage under a CGL policy. **Damages Imposed by Statute Are Covered:** While it would seem non-controversial that damages imposed by statute are damages within the meaning of an insurance policy, one federal court recently disagreed in the context of a FACTA claim. ⁿ⁴⁴ Congress provides statutory damages to compensate victims when their actual damages are nominal or difficult to prove. ⁿ⁴⁵ Indeed, many privacy statutes provide for statutory damages because the actual damages might be difficult to prove or quantify. For example, in a TCPA case, what are adequate damages for the annoyance of receiving an unwanted fax? In a FACTA case, what are adequate damages for exposing your credit card information in a manner that could lead to identity theft?

In enacting privacy statutes, Congress typically establishes liability for failing to protect private information or for overly aggressive advertising techniques that violates our right to be let alone, then imposes statutory damages (often called civil damages in the privacy statutes) to compensate the victim in a civil action. It would be a clear misinterpretation of the federal statutes to rule that Congress imposes statutory damages because the victim is not injured by a violation of the privacy protected by those statutes. ⁿ⁴⁶ Rather, the statutes are enacted and statutory damages provided because Congress recognizes that, in a whole host of ways, invasions of privacy cause harm.

Allegations of Intentional or Willful Violations of Privacy Statutes Will Not Preclude Coverage:

CGL policies contain exclusions that potentially may be implicated in privacy cases, including those exclusions addressing (1) knowing violations of the rights of another; (2) statements that are published with knowing falsity of their contents; and (3) intentional violations of penal statutes. Usually, those exclusions are *not* implicated because there are allegations of negligence, willfulness, recklessness, and carelessness in addition to any allegations of knowing or intentional statutory violations. ⁿ⁴⁷ Moreover, privacy statutes are not penal statutes. ⁿ⁴⁸

The FCRA provides a private right of action against businesses that misuse consumer credit reports. A negligent violation entitles a consumer to actual damages, ⁿ⁴⁹ while a willful violation entitles the consumer to actual, statutory, and even punitive damages. ⁿ⁵⁰ The United States Supreme Court recently held that the willful standard of the statute reaches both knowing and reckless violations of the FCRA, so a knowing or intentional violation is not established by a willful violation ruling. ⁿ⁵¹

Specific Exclusions May Eliminate Some Coverage for Certain Privacy-Based Statutes: The insurance industry has responded to the spate of TCPA and privacy claims and the resulting coverage disputes not by clarifying their insurance

policies to ensure unambiguous coverage, but instead by issuing new exclusions. ISO form exclusion CG00 67 03 05 and AAIS form exclusion GL 0225 10 05 are examples. Those exclusions are typically focused on the TCPA and the CAN SPAM Act of 2003, with many other privacy statutes remaining covered. If an exclusion identifies only specific statutes, then only liability under those particular statutes would be excluded.

When insurance companies do not utilize explicit language to exclude TCPA liabilities, especially when such language is available in the marketplace, there should be no question that the intent of the parties was to cover that liability. If the insurance company could have used more specific language, but chose not to do so, it should not benefit from any lack of clarity in its insurance policy.

Conclusion: The purpose of insurance is to insure. n52 Coverage provisions are therefore construed broadly, exclusions narrowly, with all ambiguities resolved in favor of coverage. CGL insurance is intended to cover damages for which the policyholder is legally obligated to pay (whether obligated in tort, through contract, or by statute) for bodily injury, property damage, and personal and advertising liability. Given that insurance policies definitions of personal and advertising injury explicitly include the publication or making known of material that violates a persons right of privacy, insurance companies should cover damages imposed under privacy statutes.

[Return to Text](#)

n1 Samuel D. Warren and Louis D. Brandeis, *The Right to Privacy*, 4 *Harv. L. Rev.* 193 (1890).

n2 *Id.* at 193.

n3 *Id.* at 195.

n4 47 *U.S.C.* § 227 (allowing a private right of action for unsolicited facsimile advertisements, certain automated telephone calls, and other unwanted telephone solicitations).

n5 15 *U.S.C.* § 1692, et seq. The FDCPA regulates the steps that a debt collector can take to learn the debtors location, communicate with the debtor, and communicate with third parties about the debt. The FDCPA also prohibits harassment or abuse, as well as false or misleading representations. The purpose of the statute is to eliminate abusive debt collection practices by debt collectors, which contributes to invasions of individual privacy. 15 *U.S.C.* § 1692.

n6 *See 15 U.S.C. § 1681*, et seq. The FCRA was enacted in 1970, in part, to insure that consumer reporting agencies exercise their grave responsibilities with fairness, impartiality, and a respect for the consumers right to privacy. *15 U.S.C. § 1681(a)(4)*. The FCRA, among other provisions, prohibits the release of consumer reports for purposes not authorized by the Act. *Pietras v. Sentry Ins. Co.*, No. 06 C 3576, 2007 U.S. Dist. LEXIS 16015, at *6 (N.D. Ill. March 6, 2007).

n7 *18 U.S.C. § 2510*, et seq. (authorizing civil damages for any person whose wire, oral or electronic communication is intercepted, disclosed, or intentionally used in violation of the ECPA).

n8 *12 U.S.C. § 3401*, et seq. (providing civil damages for unauthorized disclosure of financial records by a financial institution to federal government).

n9 *47 U.S.C. § 551* (allowing damages for collection, use, and disclosure of personally identifiable information by cable operators).

n10 *18 U.S.C. § 2710* (authorizing civil damages for the wrongful disclosure of video tape rental or sale records).

n11 *15 U.S.C. § 7701*, et seq. (establishing national standards for the sending of commercial email to be enforced by the Federal Trade Commission).

n12 *29 U.S.C. § 2001*, et seq. (allowing civil action for misuse of polygraphs in employment and for improper disclosure of information acquired from a polygraph test).

n13 *18 U.S.C. § 2721*, et seq. (allowing civil damages from anyone who knowingly and improperly obtains, discloses, or uses personal information from a motor vehicle record).

n14 *15 U.S.C. § 6801*, et seq. (providing obligations on financial institutions to respect the privacy of its customers).

n15 42 U.S.C. § 1320d et seq. While there is no private right of action under HIPAA, it is being considered by courts in assessing state privacy claims. See *Bagent v. Blessing Care Corp.*, 244 Ill. 2d 154 (2007) (privacy violations from phlebotomist allegedly revealing in a social setting that the patient was pregnant); *Acosta v. Byrum*, 638 S.E.2d 246 (N.C. Ct. App. 2006) (claims of invasion of privacy and infliction of emotional distress against a psychiatrist and office manager who allegedly improperly accessed and disseminated the patients health information). Administrative proceedings for damages for violations of HIPAA may be covered if not specifically excluded.

n16 On or about December 4, 2003, the FACTA was enacted as part of amendments to the FCRA, 15 U.S.C. § 1681, et seq. Among other things, FACTA required the truncation of credit card and debit card numbers to avoid printing more than the last 5 digits of the card number or the expiration date upon any receipt provided to the cardholder at the point of the sale or transaction. 15 U.S.C. § 1681c(g).

n17 Different types of insurance policies are written to be complementary and what is specifically included in one policy may be specifically excluded in another. Thus, the personal and advertising injury coverage provided in the CGL policy is often excluded from other policies.

n18 47 U.S.C. § 227.

n19 47 U.S.C. § 227(b)(1)(C).

n20 47 U.S.C. § 227(a)(5).

n21 47 U.S.C. § 227 (c)(5).

n22 See *Park Univ. Enters., Inc. v. American Cas. Co. of Reading, Pa.*, 442 F.3d 1239, 1244-1247 (10th Cir. 2006).

n23 47 U.S.C. § 227(b)(2)(B)(ii)(I).

n24 *Valley Forge Ins. Co. v. Swiderski Electronics, Inc.*, 860 N.E.2d 307 (Ill. 2006).

n25 *Id.* at 315.

n26 *Id.* at 316.

n27 *Id.* at 317.

n28 *Id.*

n29 See, e.g., *Park Univ. Enters., Inc. v. American Cas. Co. of Reading, Pa.*, 442 F.3d 1239, 1249 (10th Cir. 2006); *Universal Underwriters Ins. Co. v. Lou Fusz Auto. Network, Inc.*, 401 F.3d 876 (8th Cir. 2005); *Hooters of Augusta, Inc. v. American Global Ins. Co.*, 272 F. Supp. 2d 1365 (S.D. Ga. 2003), *affd*, 157 Fed. Appx. 201 (11th Cir. 2005); *Western Rim Inv. Advisors, Inc. v. Gulf Ins. Co.*, 269 F. Supp. 2d 836 (N.D. Tex. 2003), *affd*, 96 Fed. Appx. 960 (5th Cir. 2004); *American Home Assurance Co. v McLeod USA, Inc.*, 475 F. Supp. 2d 766 (N.D. Ill. 2007); *Auto-Owners Ins. Co. v. Websolv Computing, Inc.*, No. 06 C 2092, 2007 U.S. Dist. LEXIS 65339 (N.D. Ill. Aug. 31, 2007); *Nutmeg Ins. Co. v. Employers Ins. Co. of Wassau*, No. Civ. A. 3:04-CV-1762B, 2006 U.S. Dist. LEXIS 7246 (N.D. Tex. Feb. 24, 2006).

n30 392 F.3d 939 (7th Cir. 2004).

n31 See *Ace Rent-a-Car, Inc. v. Empire Fire & Marine Ins. Co.*, 580 F. Supp.2d 678 (N.D. Ill. 2008) (relying on *American States* and *Watts*); *Penzer v. Transportation Ins. Co.*, 509 F. Supp. 2d 1278 (S.D. Fla. 2007); (relying on *American States* and distinguishable Florida state appellate precedent relating to sexual touching); *Erie Ins. Exch. v. Kevin T. Watts, Inc.*, No. 1:05-cv-867-JDT-TAB, 2006 U.S. Dist. LEXIS 91762 (S.D. Ind. Dec.19, 2006) (unreported decision relying on *American States* and failing to cite other precedent); *St. Paul Fire & Marine Ins. Co. v. Brunswick Corp.*, 405 F. Supp. 2d 890, 895 (N.D. Ill. 2005) (relying on *American States*). After reviewing and rejecting much of the District Courts decision in *Penzer*, the Eleventh Circuit certified to the Florida Supreme Court the question of whether the Publication Language covers TCPA claims. *Penzer v. Transportation Ins. Co.*, 545 F.3d 1303, 1307 n.3 (11th Cir. 2008) (calling *American States* significantly undermined by *Swiderski*).

n32 *Valley Forge Ins. Co. v. Swiderski Electronics, Inc.*, 860 N.E.2d 307, 320 (Ill. 2006).

n33 As the United States Supreme Court has noted, any effort to resolve a question of state law could be nothing more than a prediction, a prediction that might tomorrow be proved wrong by the courts of [the state], which alone have the power to render an authoritative interpretation. *The Vessel M/V Tungus v. Skovaard*, 358 U.S. 588, 595 (1959).

n34 See *Penzer v. Transportation Ins. Co.*, 545 F.3d 1303 (11th Cir. 2008) (collecting cases); see also *Scheutz v. State Farm Fire & Cas. Co.*, 890 N.E.2d 374 (Ohio Ct. Com. Pl. 2007).

n35 See *Resource Bankshares Corp. v. St. Paul Mercury Ins. Co.*, 407 F.3d 631 (4th Cir.), cert. denied, 126 S. Ct. 568 (2005); *Melrose Hotel Co. v. St. Paul Fire & Marine Ins. Co.*, 432 F. Supp. 2d 488, 500-501 (E.D. Pa. 2006); *ACS Systems, Inc. v. St. Paul Mercury Ins. Co.*, 147 Cal. App.4th 137, 148 (2007). See also *Penzer v. Transportation Ins. Co.*, 545 F.3d 1303, 1307 n.3 (11th Cir. 2008) (certifying TCPA case to Florida Supreme Court, noting that many of the cases where coverage was denied involve the Making Known Language).

n36 *Resource Bankshares Corp. v. St. Paul Mercury Ins. Co.*, 407 F.3d 631 (4th Cir.), cert. denied, 126 S. Ct. 568 (2005).

n37 See *Resource Bank v. Progressive Cas. Ins. Co.*, 503 F. Supp. 2d 789, 791 (E.D. Va. 2007).

n38 See, e.g., *National Archives & Records Admin. v. Favish*, 541 U.S. 157 (2003) (discussing the right of privacy in relation to a family's control over the body and death images of a deceased relative, including interference with the character or memory of the deceased); *Lawrence v. Texas*, 539 U.S. 558 (2003) (discussing the right of privacy in relation to governmental intrusion into private matters and places, particularly homosexual activity in the privacy of the home).

n39 Samuel D. Warren and Louis D. Brandeis, *The Right to Privacy*, 4 Harv. L. Rev. 193, 205 (1890) (But if privacy is once recognized as a right entitled to legal protection, the interposition of the courts cannot depend on the nature of the injuries resulting.)

n40 *Id.*

n41 See *St. Paul Fire & Marine Ins. Co. v. Green Tree Financial Corp.*, 249 F.3d 389 (5th Cir. 2001); *Collection Bureau of Orlando, Inc. v. Continental Cas. Co.*, 342 So. 2d 1019 (Fla. Dist. Ct. App. 1977). Debt collectors will often have specialized policies that specifically cover violations of the FDCPA and similar state statutes. See *Foster v. D.B.S. Collection Agency*, 2008 U.S. Dist. LEXIS 22264 (S.D. Ohio March 20, 2008).

n42 See *Zurich Amer. Ins. Co v. Fieldstone Mortgage Co.*, 2007 U.S. DIST LEXIS 81570 (D. Md. Oct. 26, 2007).

n43 The Restatement (Second) of Torts identifies four non-exclusive ways in which privacy can be invaded: (1) unreasonable intrusion upon the seclusion of another; (2) appropriation of the others name or likeness; (3) unreasonable publicity given to the others private life; and (4) publicity that unreasonably places the other in a false light before the public. Restatement (Second) of Torts, § 652A(2).

n44 *Whole Enchilada, Inc. v. Travelers Property Casualty Co. of Am.*, 2008 U.S. Dist. LEXIS 77186 (W.D. Pa. Sept. 28, 2008).

n45 See *Murray v. GMAC Mortgage Corp.*, 434 F.3d 948, 951, 952-953 (7th Cir. 2006) (noting that Congress enacts laws like the FCRA (of which FACTA is a part) and provides for modest statutory damages where the consumers loss is small and difficult to quantify); *Planned Parenthood of Columbia/Willamette Inc. v. American Coalition of Life Activists*, 422 F.3d 949, 963 n.7 (9th Cir. 2005), cert. denied, 547 U.S. 1111 (2006) (Statutory damages are meant to compensate victims when actual loss is hard to prove.); *Turner v. Beneficial Corp.*, 242 F.3d 1023, 1038 (11th Cir. 2001) (noting that Congress provided for statutory damages in TILA because, in many cases, actual damages are extremely difficult to prove).

n46 The District Court in *Whole Enchilada* so erred. The court distinguished statutory damages from damages generally, holding that [s]tatutory damages are generally awarded in place of actual damages, where no actual injury is alleged. *Whole Enchilada, Inc. v. Travelers Property Casualty Co. of Am.*, 2008 U.S. Dist. LEXIS 77186, at *67 (W.D. Pa. Sept. 28, 2008). [I]n order for coverage to be found, the underlying Complaint must allege that the damages sought are compensation for injury Here . . . the Complaint alleged only *potential* harm, therefore, no damage is alleged that would subject Travelers to coverage under the terms of its policies. *Id.* at *67-68. Further, [t]he purpose of statutory damages is to require a FACTA defendant to pay for willful violations . . . , not to compensate the claimants for any actual monetary or physical loss. Said damages are akin to punitive in nature. *Id.* at *69. The District Court misconstrued the purpose of statutory damages, as well as the

nature of the harm. Congress has definitively found that consumers are harmed when FACTA is violated because their private credit card information is published on a receipt. While a receipt may be handed only to the consumer, Congress has recognized that receipts easily find their way into the hands of those who would commit identify theft. It is not for the Courts to second-guess Congress's determination that the publishing of certain credit information on a receipt causes harm regardless of whether a particular receipt finds its way to a criminal.

n47 See *American Family Mut. Ins. Co. v. C.M.A. Mortgage, Inc.*, No. 06-10444, 2008 U.S. Dist. LEXIS 30233 (S.D. Ind. March 31, 2008).

n48 *Penzer*, 545 F.3d at 1310; *Hooters of Augusta, Inc. v. American Global Ins. Co.*, 272 F. Supp. 2d 1365, 1375-1376 (S.D. Ga. 2003), *affd*, 157 Fed. Appx. 201 (11th Cir. 2005); *Western Rim Inv. Advisors, Inc. v. Gulf Ins. Co.*, 269 F. Supp. 2d 836, 848-849 (N.D. Tex. 2003).

n49 15 U.S.C. § 1681o(a).

n50 15 U.S.C. § 1681n(a).

n51 See, e.g., *Safeco Ins. Co v. Burr*, 551 U.S. 47 (2007) (willfully fails as the Fair Credit Reporting Act includes careless or reckless behavior).

n52 13 John Alan Appleman & Jean Appleman, *Insurance Law and Practice* § 7403 (With respect to the rule of liberal construction, the courts have kept in mind that the primary purpose of insurance is to insure or to provide for indemnity, and have so construed insurance contracts as not to defeat the dominant purpose by technical rules of interpretation.)

ABOUT THE AUTHOR(S):

Tim Law is a partner at Reed Smith and has been representing policyholders exclusively in insurance recovery disputes for over 10 years, gaining wide-ranging experience in that field. He has advised and represented corporate policyholders facing potential liability for claims under privacy-related statutes, including the TCPA and FACTA. Recently, Tim has been actively pursuing recovery under mortgage-related insurance products for some of the nation's leading mortgage lenders. He is also one of the nation's leading attorneys representing policyholders in premium disputes and insurance company insolvencies.

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Bullivant Houser Bailey P.C. on Pollution Exclusions After MacKinnon

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Bullivant Houser Bailey P.C. on Pollution Exclusions: Alive and Well After MacKinnon

By Samuel Ruby

January 22, 2009

SUMMARY: In *MacKinnon v. Truck Ins. Exchange*, the California Supreme Court adopted a relatively narrow interpretation of what is "pollution" within the meaning of an insurance policy exclusion. In this commentary, Bullivant Houser Baileys Samuel H. Ruby revisits *MacKinnon*, examines its progeny in California, and reviews how it has been received in other jurisdictions.

PDF LINK: [Click Here for Enhanced PDF of Commentary](#)

ARTICLE: Overview

In *MacKinnon v. Truck Ins. Exchange*,ⁿ¹ the California Supreme Court adopted a relatively narrow interpretation of what is pollution within the meaning of an insurance policy exclusion. At the time, some thought that *MacKinnon* had so narrowed the scope of the exclusion that it would apply only to claims for massive environmental disasters involving the most nefarious chemicals. Years later, however, *MacKinnon* has proven to have had no such impact. Despite *MacKinnon*, California courts have continued to apply the pollution exclusion to a range of circumstances, and outside of California, *MacKinnon* has had no discernable influence. *MacKinnon v. Truck*: Or, When Is a Pollutant Not a Pollutant? *MacKinnon*, an apartment building owner, hired a pest control company to eradicate yellow jackets at the building. The company treated the building with pesticides on several occasions. When one of the tenants died, her parents brought a wrongful death action in which they blamed the pesticides for her death. *MacKinnon* tendered his defense to *Truck*, his commercial general liability carrier.

Truck initially accepted the tender under a reservation of rights but later withdrew its defense after concluding that the policy's pollution exclusion applied. The exclusion provided that *Truck* would not cover bodily injury or property damage resulting from the actual, alleged, or threatened discharge, dispersal, release or escape of pollutants . . . at or from the insured location. The policy defined pollution and pollutants as mean[ing] any solid, liquid, gaseous or thermal irritant or contaminant, including smoke, vapor, soot, fumes, acids, alkalis, chemicals and waste materials.

After *Truck* withdrew its defense, *MacKinnon* hired new counsel and settled with the plaintiffs for \$10,000. *MacKinnon* then brought suit against *Truck*, alleging breach of the duty to defend, breach of the duty to indemnify, and breach of the implied covenant of good faith and fair dealing. A trial court found the pollution exclusion to be clear, unambiguous, and applicable to the wrongful death claim. Accordingly, the trial court granted summary judgment for

Truck.

MacKinnon appealed, but the California Court of Appeal affirmed. Like the trial court, the appellate court rejected MacKinnon's argument that the exclusion should not be read literally to apply to any dispersal of any irritant or contaminant. Undeterred, MacKinnon petitioned the California Supreme Court for review. The court granted review and reversed the trial court and the Court of Appeal.

Surveying the legal landscape, the Supreme Court found other jurisdictions that had considered the issue roughly divided into two camps. ⁿ² One camp, the Supreme Court observed, maintains that the exclusion applies only to traditional environmental pollution into the air, water, and soil, but generally not to all injuries involving the negligent use or handling of toxic substances that occur in the normal course of business. ⁿ³ The other camp, the Supreme Court commented, maintains that the clause applies equally to negligence involving toxic substances and traditional environmental pollution. ⁿ⁴

After identifying the split of authority in other jurisdictions, the Supreme Court discussed the historical background of the pollution exclusion. ⁿ⁵ Borrowing heavily from the analysis in *American States Ins. Co. v. Koloms*, ⁿ⁶ the Supreme Court traced the exclusion's origin to unsuccessful attempts to limit coverage through the definition of occurrence, amendments to the Clean Air Act that ushered in a new era of environmental litigation, and the environmental disasters of Times Beach, Love Canal and Torrey Canyon. ⁿ⁷ Reviewing the evolution of the exclusion from the original (and so-called qualified) version to the modern (so-called absolute) version, the Supreme Court embraced a view that the exclusion has been intended primarily to exclude traditional environmental pollution rather than all injuries from toxic substances. ⁿ⁸

After discussing the exclusion's history, the Supreme Court identified that history as one of the primary arguments for a narrow interpretation. ⁿ⁹ A second reason to reject a broad interpretation, the Supreme Court gleaned from cases in jurisdictions in the first camp, is that interpreting pollutant as literally any contaminant or irritant would bring virtually [any] substance or chemical in existence within the exclusion. ⁿ¹⁰ A third argument for restricting the exclusion, the Supreme Court observed, is that the phrase discharge, dispersal, release or escape may imply expulsion over a considerable area rather than a localized toxic accident occurring in the vicinity of intended use. ⁿ¹¹

The Supreme Court acknowledged that not all courts had found those arguments persuasive. Discussing the counter-arguments adopted by jurisdictions in the second camp, the court observed that some courts--finding the exclusion to be unambiguous--had not found it necessary or appropriate to divine its scope from its drafting history. Such courts, respecting the literal meaning of the broad definition of pollutant recited in the policy, had declined to employ popular connotations of the term pollution (or the phrase discharge, dispersal, release or escape) in order to constrain the policy definition.

Yet after briefly recognizing the second camp's viewpoints, the Supreme Court pitched its tent squarely in the first camp. The pollution exclusion, the court unanimously held, does not plainly and clearly exclude ordinary acts of negligence involving toxic chemicals such as pesticides. ⁿ¹² Rather, the court held, the scope of the exclusion is limited to injuries arising out of events commonly thought of as pollution, i.e., environmental pollution. ⁿ¹³ In short, the court superimposed what it perceived to be the common understanding of the term pollutant over the definition provided in the policy.

Applying its interpretation of the exclusion to the claim against MacKinnon, the court concluded that it was far from clear that the injuries arising from the normal, though negligent, residential application of pesticides would be commonly thought of as pollution. ⁿ¹⁴ While not ruling out that pesticides may be pollutants under some circumstances, the court found it unlikely that a reasonable policyholder would think of the act of spraying pesticides under these circumstances as an act of pollution. ⁿ¹⁵ Resolving the doubt in favor of coverage, the court reversed Trucks' summary judgment. ⁿ¹⁶

Children of *MacKinnon*: Subsequent California CasesThe *MacKinnon* court acknowledged that terms such as commonly thought of as pollution, or environmental pollution, are not paragons of precision, and further clarification may be required. n17 Some expected that in the wake of *MacKinnon*, the pollution exclusion would be applied only to cases involving massive environmental damage caused by release, over a wide geographic area, of the more infamous industrial products and byproducts. However, that expectation has not been vindicated. In all of the four pollution exclusion decisions published since *MacKinnon*, the lower California appellate courts have applied the exclusion under lesser circumstances.

The first case, *Garamendi v. Golden Eagle Ins. Co.*, n18 involved claims brought by two groups of sandblasting workers for silica-related injuries and damages. The sandblasters alleged that throughout their employment, they had been injured through the defendants sale of silica-containing products, the use of defective respiratory equipment, and the use of sandblasting equipment. One of the defendants tendered its defense to Golden Eagle. Citing a Total Pollution Exclusion Endorsement, among other reasons, Golden Eagle denied coverage.

The insured argued that silica should not be considered a pollutant because it was not one of the enumerated examples in the policy (smoke, vapor, soot, etc.). Rejecting that argument, the court noted that the examples were just that--examples--and that silica fell within the *definition* of pollutant as any solid . . . irritant or contaminant. Relying on *MacKinnon*, the insured then argued that silica still should not be considered a pollutant because it is commonplace in ordinary materials such as sand, glass, and concrete. Rejecting that argument as well, the court held:

Claimant is correct that under *MacKinnon* the mere fact that silica, like almost anything else, may be an irritant or contaminant under some circumstances is not dispositive. Butthe widespread dissemination of silica dust as an incidental by-product of industrial sandblasting operations most assuredly is what is commonly thought of as pollution and environmental pollution. n19

The court further rejected the insureds argument that under *MacKinnon*, the pollution exclusion should apply only to wholesale environmental degradation, such as occurred at, for example, Love Canal, or the Stringfellow Acid Pits. n20

The second case to construe *MacKinnon* was *Ortega Rock Quarry v. Golden Eagle Ins. Co.* n21 There, the Environmental Protection Agency had issued an order and brought a corresponding civil lawsuit concerning the insureds use of leftover dirt and rocks from its quarrying operations to shore up an access road. Allegedly, some of the fill had been discharged into an adjacent creek, in violation of the Clean Water Act. Citing pollution exclusions, the quarrys insurers declined to defend.

The quarry sued, but the insurers obtained summary judgments, which the Court of Appeal affirmed. Although dirt and rocks are found in nature and not ordinarily thought of as pollutants, the court held that they qualified as pollutants under the circumstances because they were dredged or fill material, and the Clean Water Act defines such material as a pollutant in relation to protected waters. Thus, for the second time, a court found the pollution exclusion applicable even under *MacKinnons* narrow interpretation, and even though the asserted pollutant was not a nefarious industrial byproduct nor had it been released over an extensive geographical area.

The third case to construe *MacKinnon* was *Cold Creek Compost, Inc. v. State Farm Fire & Cas. Co.* n22 There, a neighborhood association brought a nuisance claim against a facility that composted organic materials such as yard trimmings, manure, and grape pomace. The association alleged that the composting operations had generated odors so foul and noxious as to cause bodily injuries in the neighborhood. Because of other allegations, State Farm provided a defense, subject to a reservation of rights. Following a trial and a judgment for the plaintiffs, State Farm concluded that the judgment had been based on allegations of pollution, so it declined to pay the judgment or provide appellate counsel.

In the resulting coverage litigation, State Farm obtained summary judgment, and the Court of Appeal affirmed.

Both sides relied on *MacKinnon*, but the court found the case to favor State Farm:

The odors emanating from Cold Creeks facility were unquestionably an impurity, something objectionable and unwanted in the air . . . ; the odors polluted the air, as the term pollute is commonly understood. In the ordinary and popular sense of the words of the pollution exclusion, the odors were discharged and released by the composting and escaped from the facility. The odors spread a mile and a half to the plaintiffs homes--a substantial dissemination to the point of dissipation and dilution ordinarily understood as a dispersal of pollutants into the environment. n23

The court concluded that the widespread dissemination of offensive and injurious odors from a commercial compost facility is environmental pollution under *MacKinnon*, and thus excluded from coverage by the pollution exclusion in the policies. n24 The court declined to disqualify odors as pollutants merely because they do not pose a significant health threat or cause serious injuries. n25

The most recent case to construe *MacKinnon* was *American Cas. Co. of Reading, PA v. Miller*. n26 There, a furniture stripping business released methylene chloride into a public sewer system, resulting in serious injuries to a repairman who was working in the sewer nearby. The businesss insurer declined to defend, and in the ensuing coverage litigation, the insurer obtained a summary judgment.

Affirming the judgment, the Court of Appeal rejected the insureds argument that under *MacKinnon*, a one-time, negligent release of an injurious chemical cannot qualify as pollution. Similarly, the court rejected an argument that under *MacKinnon*, the pollution exclusion is limited to catastrophic events such as large scale environmental pollution. The court explained, The test in *MacKinnon* is not based upon the extent of injury, but upon the type of pollutant and how it is released into the environment. n27

MacKinnon on Tour: Its Legacy in Other StatesBecause many states had already fallen into one camp or the other before the California Supreme Courts decision in *MacKinnon*, the decision probably was never destined to set off a national shockwave. Some may have expected that at least in jurisdictions that had not yet decided where to camp, *MacKinnon* would prove influential. However, that expectation has not been vindicated. For example, in *Heringer v. American Family Mut. Ins. Co.*, n28 a case involving lead paint poisoning, the Missouri Court of Appeals discussed *MacKinnon* in some detail but found it distinguishable because the policy expressly defined pollutant to include lead.

In *Sulphuric Acid Trading Co., Inc., v. Greenwich Ins. Co.*, n29 a contractor was severely injured by a discharge of the insureds sulphuric acid during the handling of a rail tank car. The parties vigorously argued which interpretation of the pollution exclusion the Tennessee court should adopt. The court examined *MacKinnon* at length but declined to endorse it. The court held that the accident in question met *both* the narrow interpretation articulated in *MacKinnon* as well as the broader, literal interpretation adopted in other jurisdictions. On that basis, the court resolved the coverage issue in favor of the insurer, without deciding which interpretation was better.

In *Firemens Ins. Co. of Washington, D.C. v. Kline & Son Cement Repair, Inc.*, n30 a coverage dispute arose concerning a claimants respiratory problems allegedly resulting from inhalation of vapors from an epoxy sealant that had been applied at her workplace. The court noted the diametrically opposed interpretations of the pollution exclusion in various jurisdictions. The court cited *MacKinnon*, among other cases, as adopting a narrow interpretation limiting the exclusions application to traditional environmental pollution. However, the court predicted that the Virginia Supreme Court would enforce the literal, albeit broad, definition in the policy. Consequently, the court applied the exclusion to the claim in question, even though the claim did not involve traditional environmental pollution. ConclusionSo far, *MacKinnons* adoption of the narrower interpretation of the pollution exclusion has not tipped the scales in any other jurisdictions that have been faced with applying the exclusion. Even within California, the impact of the decision has been less than some predicted. Intermediate appellate courts have found the Supreme Courts narrow interpretation still to be broad enough to encompass a range of circumstances. Those courts have clarified:

. Lethal chemicals with complex and scary names are not the only substances that may qualify as pollutants under

MacKinnon. In certain circumstances, a commonplace natural material like silica (*Garamendi* n31), plain old dirt and rocks (*Ortega Rock Quarry* n32), and even foul odors (*Cold Creek Compost* n33) may qualify as pollutants.

. The relevant discharge or dispersal need not be intentional nor result in wholesale environmental degradation, but could involve construction activity in a defined area (*Garamendi* n34), a small stretch of road adjacent to a creek (*Ortega Rock Quarry* n35), or a one-time, negligent release of a chemical onto a nearby worker (*Miller* n36). Despite the change it was predicted to bring, *MacKinnon* is still--years later--the *last* time a California court has declined to apply a pollution exclusion to circumstances meeting the literal definition of pollution in a policy. Policyholders, insurers, and attorneys who thought *MacKinnon* would relegate the pollution exclusion to major environmental nightmares should reconsider the cases impact on claims involving lesser situations.

Return to Text

n1 31 *Cal. 4th* 635 (2003).

n2 *Id.* at 641-642.

n3 *Id.* at 642.

n4 *Id.*

n5 *Id.* at 643.

n6 177 *Ill. 2d* 473 (1997).

n7 *Id.*

n8 *Id.* at 644.

n9 *Id.* at 645.

n10 *Id.* at 645-46.

n11 *Id.* at 646.

n12 *Id.* at 638.

n13 *Id.* at 653.

n14 *Id.* at 654.

n15 *Id.*

n16 *Id.* at 656.

n17 *Id.* at 654.

n18 127 *Cal. App. 4th* 480 (2005).

n19 *Id.* at 486.

n20 *Id.*

n21 141 *Cal. App. 4th* 969 (2006).

n22 156 *Cal. App. 4th* 1469 (2007).

n23 *Id. at* 1480.

n24 *Id. at* 1480-1481.

n25 *Id. at* 1482.

n26 159 *Cal. App. 4th* 501 (2008).

n27 *Id. at* 516.

n28 140 *S.W.3d* 100 (Mo. Ct. App. 2004).

n29 211 *S.W.3d* 243 (Tenn. Ct. App. 2006).

n30 474 *F. Supp. 2d* 779 (E.D. Va. 2007).

n31 *Garamendi v. Golden Eagle Ins. Co.*, 127 *Cal. App. 4th* 480 (2005).

n32 *Ortega Rock Quarry v. Golden Eagle Ins. Co.*, 141 Cal. App. 4th 969 (2006).

n33 *Cold Creek Compost, Inc. v. State Farm Fire & Cas. Co.*, 156 Cal. App. 4th 1469 (2007).

n34 *Garamendi v. Golden Eagle Ins. Co.*, 127 Cal. App. 4th 480 (2005).

n35 *Ortega Rock Quarry v. Golden Eagle Ins. Co.*, 141 Cal. App. 4th 969 (2006).

n36 *American Cas. Co. of Reading, PA v. Miller*, 159 Cal. App. 4th 501 (2008).

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■ 31 Cal. 4th 635 (2003)

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Sonnenschein on Unauth. Prac. of Law Comm. v. Amer. Home Assur. Co.

2009 Emerging Issues 3219

Sonnenschein Nath & Rosenthal, LLP on Unauthorized Practice of Law Committee v. American Home Assurance Co.: How Many Clients Does Insurance Defense Counsel Have, and How Can You Tell?

By William Barker

January 2, 2009

SUMMARY: The central question in *Unauthorized Practice of Law Committee v. American Home Assurance Co.* was whether insurer use of its own employee lawyers ("staff counsel") to defend insureds pursuant to liability insurance policies violated the prohibition on unauthorized corporate practice of law. This commentary describes what the court did, comments on the unauthorized practice issue, and then addresses at length the "how many clients" issue.

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ARTICLE: SUMMARY

The central question in *Unauthorized Practice of Law Committee v. American Home Assurance Co.* n1 was whether insurer use of its own employee lawyers ("staff counsel") to defend insureds pursuant to liability insurance policies violated the prohibition on unauthorized corporate practice of law. The Texas Supreme Court joined the overwhelming majority of other states in concluding that there is no violation as long as the insurer's interests are aligned with those of the insured. In the process, it addressed a broader and more controversial question: does an insurance counsel represent the insurer, as well as the insured. It did not answer that question, but it approved an analytic approach that can be used to find the answer in other jurisdictions.

This commentary will describe what the court did, comment briefly on the unauthorized practice issue, and then address the how many clients issue at length. I conclude that the court got both issues right, but the reader should know that I was one of the counsel on the prevailing side.UNAUTHORIZED PRACTICE

As the Texas Supreme Court explained,

Liability insurance policies commonly provide that the insurer must indemnify the insured from liability for covered claims and give the insurer the duty, and also the right, to defend such claims. The right to defend in many policies gives the insurer complete, exclusive control of the defense. Insurance companies retain attorneys in private practice to represent insureds in defending claims against them, but for decades, in Texas and other states, insurers have

also used staff attorneys -- salaried company employees -- to save costs.

The issue in the case was whether the use of staff counsel to defend insureds constituted practice of law by the insurance company, which is not authorized to practice. The Unauthorized Practice of Law Committee is an arm of the Texas Supreme Court. It had initiated an investigation to determine whether American Home Assurance Co. and one of its staff counsel offices, the Law Offices of Katherine D. Woodruff, were engaged in unauthorized practice. Joined by Travelers Indemnity Co., they sued for a declaration the insurers' use of staff counsel did not violate the unauthorized practice statute. On cross-motions for summary judgment, the district court concluded that the statute had been violated, but stayed the judgment pending review. The court of appeals reversed and the Texas Supreme court largely affirmed the latter court, concluding that an insurer "may use staff attorneys to defend a claim against an insured if the insurer's interest and the insured's interest are congruent, but not otherwise. Their interests are congruent when they are aligned in defeating the claim and there is no conflict of interest between the insurer and the insured." n2

Texas statutes limit practice of law to members of the state bar and prohibit any business corporation from operating in Texas if any of its purposes involves engaging in activity requiring a license to practice law. n3 But the parties agreed that, in accordance with settled law in Texas and elsewhere, "a company does not engage in the practice of law by employing attorneys on its salaried staff to represent its own interests." n4 Because the insurance company will or may be called upon to pay any judgment or settlement on the claim against its insured, it is necessarily interested in the lawsuit against its insured. And the representation of the company may include the representation of others, such as the insured, whose interests are aligned with those of the insurer. n5

The leading Texas case on unauthorized corporate practice was *Hexter Title & Abstract Co. v. Grievance Committee*. n6 In *Hexter*, a "title company," engaging in the business of preparing abstracts of title, was charged with the unauthorized practice of law for preparing "deeds conveying land in which it owned no interest... notes, mortgages and deeds of trust in which it had no interest as borrower or lender and... other instruments affecting title to real estate and liens thereon in which it does not own and is not acquiring an interest." n7 The legal documents were prepared by licensed attorneys who were employed and paid a salary by the title company. The attorneys' work was "performed under the direction and control" of the executive officers and managers of the title company, which itself was acting as the agent of a title insurance company that issued title insurance policies on properties in Texas. n8 The documents were prepared to facilitate the sale and issuance of title insurance policies by the title insurance company on the transactions in question. The Texas Supreme Court held that this was unauthorized practice, because the title company had no preexisting interest in the transactions for which the documents were prepared:

These transactions involve conveyances, releases, and mortgages from grantors to grantees, and to which the insurance company is not a party. They are executed for the purpose of placing good title in the grantee, so that the insurance company may thereafter insure the title if it chooses. Such papers relate to the rights of third parties in which the corporation has *no present interest*, but only a prospective one. They affect the rights of individuals apart from their interest in the title insurance policy. The work of preparing these papers is distinct from the searching and insuring of the title--the legitimate business for which the corporation is incorporated. n9

While *Hexter* was permitted to employ lawyers to advise it on the state of title, it was not authorized to have its employees provide the same services to its customers. n10

For a corporation to be able to use staff counsel on behalf of a third party, (1) it must be serving its own interest, (2) it must have a direct, substantial financial interest in the matters for which it provides legal services, and (3) its interests must be aligned with those of the third party who receives those services. n11 The overwhelming weight of authority outside Texas takes a similar view. n12

Because a liability insurer has a direct interest in the outcome of its insured's defense, the first two requirements were not in doubt. The last point was where the controversy centered. As to that, the court observed that "in the vast majority of cases, a liability insurer and an insured have the same interest in defeating a liability claim, and their

interests differ only when there are coverage questions or when the consequences of the manner in which the defense is rendered affect them differently." n13

The UPLC argued that "the insured-insurer relationship is so fraught with the potential for conflict that an insurer that uses staff attorneys to defend insureds is essentially practicing law." n14 But the court noted that "neither the Committee nor *amici* has been able to cite any empirical evidence -- any actual instance -- of injury to a private or public interest caused by a staff attorney's representation of an insured." n15 So, while there was no question that conflicts sometimes arise in the tripartite relationship among insurer, insured, and defense counsel, "there is nothing to indicate that staff attorneys do not either resolve them as they would be resolved in any other representation or withdraw, just as private attorneys would. n16 In particular, an insurer's reservation of rights to deny coverage creates a potential for conflict of interest and may sometimes create a current conflict regarding the conduct of the defense: in such cases, any conflict can be avoided by staff counsel declining to handle the matter or withdrawing from doing so. n17 In this respect, as in all others examined by the court, staff counsel are governed by the same rules and have the same methods of complying with those rules as outside counsel retained by the insurer to defend insureds. n18 So, there is no per se prohibition on use of staff counsel: "there are a great many cases that can be defended by staff attorneys without conflict and to the benefit of mutual interests. The use of staff attorneys in those cases does not constitute the unauthorized practice of law." n19

Two justices dissented. They did not argue the conflict of interest point. Instead, they argued that the actions of staff counsel were necessarily the actions of the corporation. While the corporation was entitled to represent itself, they did not agree that it could also represent others whose interests were fully aligned. n20

While it was not the focus of the opinion, the dissent did express concern that staff counsel might be led to skimp on defense efforts to save expenses. n21 This ignored strong reasons why neither the company nor staff counsel would be more inclined to skimp on defense costs than when the insurer defends by outside counsel. The most important consideration is that the insurer usually has to pay whatever judgment or settlement results from the lawsuit. Skimping on defense would increase the expected liability payout by more than the savings on defense. Only if some or all of the liability were not covered or in excess of limits could it possibly be profitable to skimp on defense. Moreover, even though a Texas insurer is not vicariously liable for the errors of outside counsel, who are independent contractors, n22 it presumably would be vicariously liable for errors of employee counsel. Even if it would not be vicariously liable, it would surely be directly liable for its own conduct that caused skimping. And the determination whether skimping had occurred and why would be made by a jury, in hindsight, after a verdict awarding noncovered or excess damages against the insured. Such a jury would likely be unsympathetic to the insurer. In short, there is no realistic incentive to skimp on the defense and, should skimping occur, existing liability rules should provide insureds with ample redress. The availability of ample remedies for any mishandling of the defense means that, if this occurred with any frequency, there would be lawsuits to seek redress. The fact that there is no evidence of any problems with staff counsel tends to confirm the analysis suggesting that there should be no such problems.

In petitioning for rehearing, the UPLC asked the court for more definitive guidelines as to when the interests of insurer and insured diverge sufficiently to preclude use of staff counsel. In his commentary on *UPLC*, my friend Lee Shidlofsky raises the same question. n23 I think that is discernible from existing law and will sketch what I think is the answer; n24 I have addressed the point in depth elsewhere. n25 WHO IS A CLIENT Prior Texas Supreme Court Cases

Prior to *UPLC*, the leading Texas case on insurance defense relationships was *Employers Casualty Co. v. Tilley*. n26 While frequently cited as holding that the insurer is not a client, *Tilley* actually pointed the other way.

The case was a declaratory judgment action seeking a determination that late notice relieved Employers of the obligation to defend and indemnify Tilley in an action brought by Starky and others. Employers had undertaken the defense under a nonwaiver agreement. From the outset, Tilley claimed that he had no knowledge of the Starky accident until he was sued (22 months after the accident) and that this lack of knowledge excused his failure to give notice prior to suit. Defense counsel not only defended Tilley in the Starky action, but also worked to develop evidence that Tilley

had known of the accident sooner. The evidence so developed was the basis of the coverage action. The Texas Supreme Court held that Employers was estopped to deny coverage on that basis, even if Tilley had notice of the accident when it occurred.

In holding that defense counsel violated his duties to Tilley by developing coverage evidence adverse to him, the Court relied on the following principles applying to defense under liability insurance policies:

the insurance company's obligation to defend the insure[d] provides that the attorney to represent the insured is to be selected, employed, and paid by the insurance company. Nevertheless, such attorney becomes the attorney of record and the legal representative of the insured, and as such he owes the insured the same type of unqualified loyalty as if he had been originally retained by the insured. If a conflict arises between the interests of the insurer and the insured, the attorney owes a duty to the insured to immediately advise him of the conflict. n27

In itself, this passage simply affirms the lawyer's duty of loyalty to the insured and says nothing about whether the insurer is also a client as long as absence of a conflict permits joint representation. But *Tilley* relied on Canon 5 of the Code of Professional Responsibility dealing "with conduct of a lawyer representing *multiple clients* with conflicting or potentially conflicting interests. Representation of "an insurer and his insured" is mentioned among typically recurring situations involving potentially differing interests." n28 This basis for the holding clearly indicates that the court considered the insurer a co-client with the insured, so that counsel was governed by the usual rules for representation of multiple clients.

The court then quoted and approved "as conforming to the public policy of this State" certain "guiding principles" approved by the American Bar Association National Conference of Lawyers and Liability Insurers:

IV. CONFLICTS OF INTEREST GENERALLY--DUTIES OF ATTORNEY. In any claim or in any suit where the attorney selected by the company to defend the claim or action becomes aware of facts or information which indicate to him a question of coverage in the matter being defended or any other conflict of interest between the company and the insured with respect to the defense of the matter, the attorney should promptly inform *both the company and the insured*, preferably in writing, of the nature and extent of the conflicting interest.

V. CONTINUATION BY ATTORNEY EVEN THOUGH THERE IS A CONFLICT OF INTEREST. Where there is a question of coverage or other conflict of interest, the company and the attorney selected by the company to defend the claim or suit should not thereafter continue to defend the insured in the matter in question unless, after a full explanation of the coverage question, the insured acquiesces in the continuation of such defense. n29

These are essentially the procedures prescribed by the conflict rules for addressing conflicts between clients with differing interests. In particular, the requirement to warn the insurance company of conflicts clearly indicates that it was considered to be a client. Unless it were a client entitled to such a warning, preparatory to sorting out the conflict issue, alerting it to a coverage issue or other conflict would often violate the duty of loyalty to the insured.

The point here is not to treat the guiding principles as a statement of current law. In fact, the development of the law since *Tilley* suggests that these guiding principles are no longer sufficient to assure fulfillment of a lawyer's duties in a joint representation of insurer and insured. n30 But those principles were necessarily based on the premise that the insurer is a co-client. Prior to *UPLC*, that premise seemingly remained embedded in Texas law.

The most recent prior case in which the Texas Supreme Court had addressed the insurance defense relationship was *State Farm Mutual Automobile Insurance Co. v. Traver*. n31 Traver was the executor of Davidson, a State Farm insured who had suffered a judgment of about \$475,000 for an accident in which State Farm's liability limit was \$25,000. Traver alleged that State Farm breached its duty to settle within limits and that defense counsel, Bradshaw, committed malpractice. Traver also alleged that State Farm was vicariously liable for Bradshaw's alleged malpractice. The trial court granted summary judgment for State Farm on all claims. The court of appeals affirmed as to claims not related to malpractice but held that State Farm would be vicariously liable for any malpractice by Bradshaw and

remanded for further proceedings. The Texas Supreme Court held that an insurer is not vicariously liable for malpractice by defense counsel, but remanded to allow Traver an opportunity to plead and prove that State Farm was liable on some theory other than vicarious liability.

The court saw the vicarious liability issue as depending on "whether the principal has the right to control the agent with respect to the details of [the agent's] conduct." An insurer has a considerable right to control, but not enough to support vicarious liability:

We have recognized that a liability policy may grant the insurer the right to take "complete and exclusive control" of the insured's defense. Here, the standard form Texas Personal Auto Policy provides that the insurer "will settle or defend, as [it] consider[s] appropriate, any [covered] claim or suit ." The insurer's control of the defense under this policy includes the authority to accept or reject settlement offers and, where no conflict of interest exists, to make other decisions that would normally be vested in the client, here the insured. However, even assuming that the insurer possesses a level of control comparable to that of a client, this does not meet the requisite for vicarious liability.

A defense attorney is an independent contractor, has discretion regarding the day-to-day details of the defense, and is not subject to the client's control regarding those details. While the attorney may not act contrary to the client's wishes, the attorney "is in complete charge of the minutiae of court proceedings and can properly withdraw from the case, subject to control of the court, if not permitted to act as he thinks best." Moreover, because the lawyer owes unqualified loyalty to the insured, the lawyer must at all times protect the interests of the insured if those interests would be compromised by the insurer's instructions. Under these circumstances, the insurer cannot be vicariously responsible for the lawyer's conduct. n32

Nothing in this is inconsistent with the insurer being a co-client with the insured if there is no conflict of interest. The court explicitly assumed that the insurer has "a level of control comparable to that of a client" and said that this was not enough. Moreover, the lawyer's duties to the insured limit the ability of the insurer to direct, whether or not the insurer is a co-client. If the insurer is a co-client, the lawyer must still "protect the interests of the insured if those interests would be compromised by the insurer's instructions." The lawyer does this by finding that the instructions create a conflict, consulting with the clients, and withdrawing from the joint representation unless either the insured gives informed consent to those instructions or the insurer withdraws them. n33 In no event may the lawyer adversely affect the insured's interests without the insured's informed consent.

Moreover, three of the authorities relied upon to support the final sentence of the quoted passage were from California n34 and Florida n35--states that clearly hold that the insurer is a co-client unless there is a conflict of interest n36--and Pennsylvania n37--where the law seems to support that view. n38 The court also relied on a treatise that supports that view. n39 The other authorities cited were from New York and North Carolina, where the law on insurer clienthood (absent a conflict of interest) is not clearly settled. n40 So, if the authorities cited suggested anything, they pointed in the direction of treating the insurer as a co-client.

Finally, *Traver* itself was a case in which State Farm had a potential conflict of interest. The accident had involved two State Farm insureds, Davidson and Klause. Bradshaw defended Davidson and another law firm defended Klause, with Klause getting a defense verdict. According to Justice Gonzalez, "Traver's theory is that State Farm deliberately caused malpractice in the defense of [Davidson] to protect itself from excess liability of [Klause]." n41 In particular, he suggested that State Farm might be liable for tortious interference with Davidson's attorney-client relationship:

In most insurer-insured disputes, it would not be appropriate to attempt to prove that the insurer has willfully injured its insured, since this would be akin to the insurer putting a gun to its own head. Clearly, such a claim may not be asserted for mere incompetence on the part of the attorney or for a miserly defense. However, when there is a conflict between the interests of the insured and the insurer, as is alleged in this case, in which the insurer has a financial incentive to see to it that the insured fares poorly in the litigation, a claim for tortious interference may arise. n42

Even if State Farm acted entirely properly, the very possibility that it could have an incentive to protect itself or Klause at Davidson's expense created a conflict that would seem to entitle Davidson to independent counsel. n43 So *Traver* itself seems to be a case where Bradshaw ought not to have represented State Farm and State Farm ought not to have exercised control over Davidson's defense. Accordingly, *Traver* ought not to be read as addressing the relationship between the insurer and defense counsel in cases without conflicts unless the court clearly intended to address such cases. The *UPLC* Opinion

In the course of the *UPLC* opinion, the court devoted a paragraph to the issue of who qualifies as a client of insurance defense counsel:

The Committee argues that under Texas law insurance defense counsel represents only the insured, not the insurer, and that staff attorneys -- who necessarily represent the insurer -- cannot defend insureds without violating this rule. But we have never held that an insurance defense lawyer *cannot* represent both the insurer and the insured, only that the lawyer *must* represent the insured and protect his interests from compromise by the insurer. And we have noted that "an insurer's right of control generally includes the authority to make defense decisions *as if it were the client* 'where no conflict of interest exists.'" Rule 1.06 of the Texas Disciplinary Rules of Professional Conduct allows a lawyer to represent more than one client in a matter if not precluded by conflicts between them. Whether defense counsel also represents the insurer is a matter of contract between them. n44

The last sentence cited a law review article by Prof. Charles Silver, *Does Insurance Defense Counsel Represent the Company or the Insured?*. n45 That article applies the legal standard governing formation of attorney-client relationships in other contexts, an approach since approved by the Restatement (Third) of the Law Governing Lawyers. n46 We will now examine that approach and the answer it gives to the how many clients question. How Is Client Status Determined?

The most concise and authoritative statement of the relevant general principles is found in the Restatement. It says that it is a question of fact whether the lawyer appointed by the insurer to defend the insured in a given case also represents the insurer:

It is clear . . . that the lawyer designated to defend the insured has a client-lawyer relationship with the insured. The insurer is not, simply by the fact that it designates the lawyer, a client of the lawyer. Whether a client-lawyer relationship also exists between the lawyer and the insurer is determined under § 14. n47

Section 14, in turn, prescribes the following test:

A relationship of client and lawyer arises when:

(1) a person manifests to a lawyer the person's intent that the lawyer provide legal services for the person; and either

(a) the lawyer manifests to the person consent to do so; or

(b) the lawyer fails to manifest lack of consent to do so, and the lawyer knows or reasonably should know that the person reasonably relies on the lawyer to provide the services. n48 Intent in Insurance Representations

In the normal course of events, the attorney-client relationships are formed as a result of the insured tendering the defense to the insurer and the insurer retaining counsel pursuant to that tender. The insured's tender authorizes the insurer to retain counsel on behalf of the insured. n49 Of course, the insurer could ask the lawyer to provide legal services only for the insured, in which case it would not be a client. But the insurer's own interests are at stake in litigation of a claim where it may be called upon to indemnify, so it has reason to want the lawyer to perform legal services for itself as well. Insurers whose policies entitle them to control the defense generally wish to exercise that right, and that exercise is facilitated if the insurer is also a client. In particular, there would at least be a question

whether communications between insurer and attorney would be privileged if the insurer were not a client, while there would be no doubt if the insurer is a client.

When an insurer with these interests calls upon a lawyer to defend an insured, one would expect that the insurer desires legal services for itself as well as for the insured. Doubts as to the existence of an attorney-client relationship are generally construed against the attorney, who bears the burden of clarifying ambiguity (as illustrated by subdivision (1)(b) of § 14). So even if it is not explicit that the insurer intends to be a client, that should be the result unless either the insurer or the lawyer specifically indicates otherwise. Is There a Need for a Special Informed Consent?

The contrary argument is that the lawyer may not undertake a joint representation without first having the informed consent of both clients. Neither the insurance policy nor the tender of the defense assures that the insured has consented to a joint representation or that any such consent is informed. Moreover, it is suggested, once properly informed, the insured ought normally to refuse consent, thereby preventing the insurer from being a co-client. n50

I offer a two-step response. n51 First, I challenge the proposition that informed consent is required *before* commencement of the representation. Suppose an insured tenders defense of a claim to an insurer on the eve of a potential default. The insurer calls a lawyer seeking to have an appearance entered to prevent a default. The lawyer sees a potential for conflict which would arise upon filing an answer. But there is no conflict as to the filing of the appearance itself. I suggest that the lawyer could properly undertake a joint representation of insurer and insured (if that were requested), as long as the insurer were advised of the problem and of the potential need for substitution of other counsel if the conflict problem is not resolved prior to the time at which an answer must be filed. n52 After the appearance is filed, the problem could be explored and, if it proved genuine, both clients could be consulted about any necessary consent (if consent were otherwise appropriate). If consent were necessary and not available, the joint representation could be terminated and new counsel obtained.

Second, I challenge the proposition that the insured is free (once consultation about the risks of joint representation does occur) to refuse that consent, except at the cost of jeopardizing the right to indemnification. The insurer's promise of indemnification is based on the insured's cession of the right to control the defense and agreement to cooperate with that defense. Joint representation facilitates the insurer's exercise of these rights. At least unless joint representation endangers some interest of the insured which the insured has not agreed to forego, I would argue that refusal of consent breaches both the express terms of the contract and the insured's duty of good faith, not to gratuitously render the insurer's performance more difficult or expensive.

On the latter point, the Restatement takes no position. It properly points out that it addresses only the law governing a lawyer representing an insured person, not the law governing the relationship between insurer and insured. n53 Of equal importance, that is not an issue on which counsel representing the insured could take a position adverse to the insured's possible interest in withholding the consent, if one were required.

But the Restatement does say:

The lawyer's acceptance of direction from the insurer is considered in [other provisions]. With respect to client consent . . . in insurance representations, when there appears to be no substantial risk that a claim against a client-insured will not be fully covered by an insurance policy pursuant to which the lawyer is appointed and to be paid, consent in the form of acquiescence of the client-insured to an informative letter to the client-insured at the outset of the representation should be all that is required. The lawyer should either withdraw or consult with the client-insured when a substantial risk that the client-insured will not be fully covered becomes apparent. n54

The requirement for consent concerns the insurer's exercise (or potential exercise) of control. So it does not apply to the mere formation of the attorney-client relationship, which necessarily occurs before any such exercise. The reference to acquiescence in an informative letter was designed to codify one aspect of ABA Formal Opinion 96-403. Early drafts of the Restatement had problematic language stating that the insured's informed consent is a "precondition" to the

representation. With the removal of this language, I think the Restatement analysis is now fully consistent with my own on this point.

The Minnesota Supreme Court has imposed requirements that must be satisfied before defense counsel can treat the insurer as a co-client with the insured. n55 The court recognized that under the usual rules governing formation of attorney-client relationships, the insurer would almost always be a co-client, absent a conflict of interest precluding joint representation of insurer and insured. n56 It also recognized that a few courts have held that an insurer may never be a co-client with the insured. n57 The court declined to adopt so extreme a rule. n58 But it did conclude that the risks of conflicts of interest posed by dual representation were so great as to justify imposing special requirements of consultation and consent. n59 So, to permit dual representation, there must be both an absence of conflict and an express consent by the insured after consultation with counsel. n60

This requirement seems misguided. The basis of the court's concern is not any perception that conflicts are common, and conflicts are actually uncommon. The concern is that, were a conflict to arise, the temptation to favor the insurer would be strong. n61 But the temptation to favor one client is likely to be present in many conflicts. That is why the law requires a lawyer, absent informed consent to a conflict, to decline a conflicted dual representation and to withdraw from dual representation if an unexpected conflict arises. That requirement should prevent defense counsel from ever having any opportunity to favor one client at the expense of the other. The court offers no reason for thinking that insurance defense counsel are any more likely than other lawyers to disobey this rule. Yet, if they comply, there is no special risk to support the special requirement for an express consent.

Having said that, there is no reason to believe that getting an express consent would be difficult. In most cases where there is no conflict evident at the outset, there will be very little risk that an unexpected conflict will arise. Counsel can explain that to the insured. Counsel can also provide assurance that counsel will always be alert to any possible conflict that might arise and will promptly bring that to the insured's attention if it occurs. If any conflict cannot be satisfactorily resolved, then it will be eliminated by withdrawal of counsel from the dual representation. Most insureds, and especially those being represented by staff counsel, are unlikely to see much of a problem with dual representation and will likely give the consent if it is requested. Professor Hazard Interprets the Restatement

Prof. Geoffrey C. Hazard, Jr., Director of the American Law Institute when the Restatement was adopted and Reporter of the Model Rules of Professional Conduct, provided an expert opinion analyzing the effect of the Restatement:

The Restatement takes the position that the insurer may or may not be a client, depending on the facts surrounding the creation of the attorney-client relationship. Given the facts [of the typical insurance representation], in my opinion the Restatement standard would produce the same result as current Montana law [which treats the insurer as a client]. n62Limitation: Conflicts of Interest Precluding Joint RepresentationGeneral Conflict of Interest Analysis. Because the insured is a client (and regardless of whether the insurer is also a client), defense counsel owes the insured undivided loyalty. n63 In ordinary cases this presents no problem, for the insurer's interests will be fully consistent with those of the insured. As a California court has explained:

In the insured-insurer relationship, the attorney characteristically is engaged and paid by the carrier to defend the insured. The insured and the insurer have certain obligations each to the other, as previously noted, arising from the insurance contract. Both the insured and the carrier have a common interest in defeating or settling the third party's claim. If the matter reaches litigation, the attorney appears of record for the insured and at all times represents him in terms measured by the extent of his employment.

In such a situation, the attorney has two clients whose primary, overlapping and common interest is the speedy and successful resolution of the claim and litigation. Conceptually, each member of the trio, attorney, client-insured, and client-insurer has corresponding rights and obligations founded largely on contract, and as to the attorney, by the Rules of Professional Conduct as well. The three parties may be viewed as a loose partnership, coalition or alliance directed

toward a common goal, sharing a common purpose which lasts during the pendency of the claim or litigation against the insured. Communications are routinely exchanged between them relating to the joint and common purpose--the successful defense and resolution of the claim. Insured, carrier, and attorney, together form an entity--the defense team--arising from the obligations to defend and to cooperate, imposed by contract and professional duty. This entity may be conceived as comprising a unitary whole with intramural relationships and reciprocal obligations and duties each to the other quite separate and apart from the extramural relations with third parties or with the world at large. Together, the team occupies one side of the litigating arena. n64

But joint representation is not possible, without informed consent, if there is a conflict of interest between the insurer and insured regarding the way in which the tort case is to be defended. Insureds are thus protected against any unconsented conflict, in exactly the same way as other types of jointly represented clients are protected. n65 Under the Model Rules, the primary standard for determining whether there is a conflict is Rule 1.7(a):

Except [with informed consent of each affected client], a lawyer shall not represent a client if the representation involves a concurrent conflict of interest. A concurrent conflict of interest exists if:

- (1) the representation of one client will be directly adverse to another client; or
- (2) there is a significant risk that the representation of one or more clients may be materially limited by the lawyer's responsibilities to another client or to a third person, or by a personal interest of the lawyer. n66

A material limitation (as that term is used in paragraph (a)(2) of the rule) exists when a lawyer "cannot consider, recommend or carry out an appropriate course of action for the client because of the lawyer's other responsibilities or interests." n67 In applying this standard to insurance representations, courts have demanded special sensitivity to any situation where the choices made by defense counsel could benefit the insurer at the insured's expense.

The lawyer could have incentives to favor the insurer in such circumstances. It is the insurer who selected counsel and pays the fee, thereby earning a measure of gratitude not shared by the insured. More importantly, it is to the insurer, rather than the insured, that counsel looks for future referrals: "[t]he attorney's relationship with the insurer is usually ongoing, supported by strong financial interest . . . and, like other long-term relationships, sometimes strengthened by real friendships." n68 Thus, it is all too easy for defense counsel to wish to protect the insurer from fraud or lack of cooperation by the insured or even to aid it in coverage disputes with the insured, forgetting the loyalty owed to the insured. As a result, a number of cases have found it necessary to condemn such acts of disloyalty and to impose appropriate remedies against counsel or the insurer whose interests counsel sought to advance against the client insured. n69

Where the existence of divergent interests in the conduct of the defense is inherent in the case, the conflict of interest rules require that the representation be declined, unless all affected clients give informed consent. n70 The primary example in insurance representations occurs when some factual issue bearing on the insured's liability also bears on the existence of coverage. A fact of this sort has been described as a "pivotal fact," n71 whose existence is the most common source of conflicts requiring independent counsel (sometimes referred to as "*Cumis* counsel").

For example, if the insured is sued on alternative theories of negligence and battery, the former will typically be covered but the latter will not. Of course, the insurer and the insured share an interest in defeating the suit entirely and in minimizing any judgment. But if liability is found, the insured would prefer that it be based on (covered) negligence, while the insurer's interest would be served if it were based on (noncovered) battery. Because the way in which the case is defended has a real possibility of affecting the basis on which any liability would be found, this divergence of interest creates a conflict of interest for any defense counsel seeking to advance the interests of both insurer and insured. n72

If the case involves a "pivotal fact," and if the conflict on that issue cannot reliably be avoided by procedural means, then there will be an irreconcilable conflict. Counsel must advocate a position regarding the pivotal fact and any position will be contrary to the interests of one client or the other. By shaping the defense, counsel could thus shift

liabilities found by the court between covered and non-covered status. Where the coverage issues present such an opportunity, the insured is entitled to independent counsel unless the insured gives informed consent to the conflict. In the absence of such consent, counsel for the insured *cannot* also represent the insurer in such a case.

In Texas, this rule is reinforced by giving the insured a right to demand independent counsel of the insured's selection whenever the insurer reserves its right to deny coverage. n73 So the question of insurer clienthood only arises with respect to cases in which there is no conflict and, additionally, there is either no coverage question of any sort or the insured has not exercised the right to demand independent counsel. Such cases constitute the vast bulk of those where insurers retain defense counsel to represent insureds. Do Insurance Cases Require a Special Rule? The Montana Supreme Court has held, in *In re Rules of Professional Conduct*, n74 that a defense lawyer appointed by an insurer never represents the insurer. It based this holding on a misuse of the Rules of Professional Conduct and on an unsupported (and unsupportable) assertion that conflicts are so pervasive that the usual case-by-case methods of addressing such conflicts are inadequate.

Preexisting Montana law held that the insurer is a co-client, and one with an absolute right of control. n75 The court nevertheless dismissed the prior law for its failure to consider whether an insurer is a client "under the Rules of Professional Conduct." n76 Ironically, Montana previously had adopted the Model Rules, which expressly refrain from addressing that particular issue. Instead, the Scope statement to the Model Rules declares that "for purposes of determining a lawyer's authority and responsibility, principles of substantive law external to these Rules determine whether a lawyer-client relationship exists. Whether a client-lawyer relationship exists for any specific purpose can depend on circumstances and may be a question of fact." n77 Thus, the Rules of Professional Conduct could not provide any basis, in the absence of a conflict of interest, for rejecting insurer clienthood and right to control. Montana did not adopt the Scope Statement, but it did adopt the text of the Rules, which were drafted not to address when an attorney-client relationship exists.

The Montana court also necessarily rejected the normal rifle-shot, case-by-case handling of conflicts in favor of a blunderbuss prohibition on insurer direction *even when there was no conflict and only the insurer's money was at stake*. The Montana court sought to justify this by asserting that insurer/insured relationships are so "permeated with potential conflicts" that case-by-case solutions are inadequate. n78 The supposed pervasiveness of conflicts is a *factual* statement. This, however, was an original proceeding responding to a question unilaterally framed by the lawyers who sought the court's intervention. *There was no factual record and the court refused the respondent insurance companies the opportunity to present evidence* on issues including the infrequency of conflicts and the nonexistence of harm to insureds resulting from such conflicts. n79 Anyone familiar with insurance defense practice knows that conflicts are both far less common and far more easily managed than the Montana court assumed. Other courts ought not to follow the Montana opinion, and certainly not without allowing presentation of evidence on the factual assertion which is the necessary premise for that decision.

The Montana rule has been rejected by the only court to consider whether to follow that case on this issue. In *Paradigm Insurance Co. v. Langerman Law Offices*, n80 the Arizona Supreme Court followed the Restatement analysis and held that an insurer can be a co-client with the insured unless the risk of a conflict in the particular case is so great that joint representation is precluded:

the potential for conflict between insurer and insured exists in every case; but we note that the interests of insurer and insured frequently coincide. For instance, both insurer and insured often share a common interest in developing and presenting a strong defense to a claim that they both believe is unfounded as to liability, damages or both. Thus, by serving the insured's interests the lawyer can also serve the insurer's, and if no question arises regarding the existence and adequacy of coverage, the potential for conflict may never become substantial. *In such cases, we see no reason why the lawyer cannot represent both insurer and insured.* n81 CONCLUSION

Under the usual common-law standard for formation of an attorney-client relationship, Texas insurance defense counsel should ordinarily represent both insurer and insured, unless there is a conflict of interest precluding joint

representation. Because the same common law standard applies in almost all states, the same conclusion generally should be reached in states that have yet to pass on this question.

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n1 *Unauth. Prac. of Law Comm. v. Amer. Home Assur. Co.*, 261 S.W.3d 24 (Tex. 2008) ("UPLC").

n2 *Id.* at 26-27.

n3 *Id.* at 33, citing Tex. Govt. Code § 81.102 (prohibiting unauthorized practice); Tex. Bus. Corp. Act., §2.01(B)(2) (prohibiting corporate practice).

n4 *Id.* at 34.

n5 *Id.* at 35.

n6 *Hexter Title & Abstract Co. v. Grievance Committee*, 179 S.W.2d 946 (Tex. 1944).

n7 *Id.* at 950.

n8 *Id.* at 951.

n9 *Id.* at 952 (emphasis added).

n10 *Id.* at 954.

n11 *UPLC*, 261 S.W.3d at 38-39.

n12 *Id.* at 43-44 (collecting authorities, showing 24 states permitting use of staff counsel and two forbidding that).

n13 *Id.* at 38-39.

n14 *Id.* at 39.

n15 *Id.*

n16 *Id.* at 39-40.

n17 *Id.* at 40. Most jurisdictions hold that a current conflict affecting the conduct of the defense entitles the insured to independent counsel, paid for by the insurer. *E.g.*, *San Diego Navy Fed. Credit Union v. Cumis Ins. Soc'y, Inc.*, 208 Cal. Rptr. 494 (Cal. Ct. App. 1984); *Brohawn v. Transamerica Insurance Co.*, 347 A.2d 842 (Md. 1975); *Maryland Casualty Co. v. Peppers*, 355 N.E.2d 24 (Ill. 1976); *Tank v. State Farm Fire & Cas. Co.*, 715 P.2d 1133 (Wash. 1986). Texas has never directly addressed that question.

n18 *UPLC*, 261 S.W.3d. at 39-43.

n19 *Id.* at 43.

n20 *Id.* at 46-54.

n21 *Id.* at 53-54.

n22 *State Farm Mut. Auto. Ins. Co. v. Traver*, 980 S.W.2d 625 (Tex. 1998). See discussion at notes 31-43, below.

n23 See the Emerging Issues Analysis of Shidofsky on UPLC v. American Home Assurance: The Use of Staff Counsel by Insurers in *Texas at 2008 Tex. LEXIS 233*.

n24 See discussion at notes 63-81, *infra*.

n25 William T. Barker, *Insurer Control of the Defense: Reservations of Rights and the Right To Independent Counsel*, 71 Def. Coun. J. 16 (2004).

n26 *Employers Casualty Co. v. Tilley*, 496 S.W.2d 552 (Tex. 1973).

n27 *Id.* at 558.

n28 *Id.* (emphasis added).

n29 *Id.* at 559 (emphasis added), *quoting* National Conference of Lawyers and Insurers--Guiding Principles, 20 Fed. Ins. Coun. J. 95 *et seq.* (1970).

n30 In particular, defense counsel who learns of a coverage question not implicating the issues in the tort case and not creating a conflict of interest (e.g. was the car the insured was driving one insured by the policy) should not inform the insurer of this issue. If there is a conflict, continued representation requires an affirmative consent rather than simply acquiescence.

n31 *State Farm Mut. Auto. Ins. Co. v. Traver*, 980 S.W.2d 625 (Tex. 1998).

n32 *Id.* at 627-28. The court also dismissed as erroneous dictum a passage in *Ranger County Mutual Insurance Co. v. Guin*, 723 S.W.2d 656, 658 (Tex. 1987), asserting that the insurer would be vicariously responsible for defense counsel malpractice. 980 S.W.2d at 628.

n33 A recent explanation of the procedure the lawyer must follow is provided by American Bar Ass'n Standing Comm. on Ethics & Prof. Resp., Formal Op. 01-421 (Ethical Obligations of a Lawyer Working Under Insurance Company Guidelines and Other Restrictions). The ABA found that essentially the same procedure would apply regardless of whether the insurer is a co-client, so it took no position on that issue.

n34 *Id.* at 628, citing *Merritt v. Reserve Ins. Co.*, 110 Cal. Rptr. 511, 526 (Ct. App. 1973) ("In our view independent counsel retained to conduct litigation in the courts act in the capacity of independent contractors, responsible for the results of their conduct and not subject to the control and direction of their employer over the details and manner of their performance").

n35 *Id.*, citing *Aetna Cas. & Surety Co. v. Protective Nat'l Ins. Co.*, 631 So. 2d 305, 306-07 (Fla. Dist. Ct. App. 1993 (adopting *Merritt's* reasoning)).

n36 *State Farm Mut. Auto. Ins. Co. v. Federal Ins. Co.*, 72 Cal. App. 4th 1422, 1429, 86 Cal. Rptr. 2d 20, 24 (1999) ("the attorney represents two clients, the insured and the insurer"; disqualifying attorney from unrelated representation adverse to insurer that retained attorney to defend insured); *In Re Rules Governing Attorneys*, 220 So. 2d 6, 7 (Fla. 1969) (rejecting rule precluding insurers from using employee lawyers to defend insureds because rule improperly "emphasize[s] the employer-employee relationship as the element which would distinguish the lawyer's responsibility to one of two clients whose interests might develop conflicts" when the problems are no different if defense counsel is an outside lawyer (emphasis added)).

n37 *Ingersoll-Rand Equip. Corp. v. Transportation Ins. Co.*, 963 F. Supp. 452, 454-55 (M.D. Pa. 1997) ("The attorney's ethical obligations to his or her client, the insured, prevent the insurer from exercising the degree of control necessary to justify the imposition of vicarious liability").

n38 *Sweldoff v. Philadelphia Transp. Co.*, 187 A.2d 152 (Pa. 1963) (referring to the insurance company and the insured as clients of the attorney); *Molitoris v. Woods*, 618 A.2d 985 (Pa. Super. Ct. 1992) (recognizing

attorney can represent both an insured and insurer's subrogation interest).

n39 *Traver*, 980 S.W.2d at 628, citing Allan D. Windt, Insurance Claims & Disputes, § 4.40 (3d ed. 1995) ("There is no theoretical justification for imputing a defense counsel's negligence to the insurer"). That treatise also states:

An attorney provided by an insurance company to represent an insured owes that person the same unswerving allegiance that would be owed if the attorney were retained and paid personally by the insured. The attorney also, however, owes an equal allegiance to the insurer. Consequently, counsel with reason to believe that the discharge of the duty to either the insured or the insurer would conflict with the discharge of the duty to the other cannot, absent the informed consent of both clients, continue to represent both.

Id. § 4.19, at 215-16 (footnotes omitted).

n40 *Tilley* cited *Feliberty v. Damon*, 531 N.Y.S.2d 778, 527 N.E.2d 261 (N.Y. 1988); *Brown v. Lumbermens Mut. Cas. Co.*, 369 S.E.2d 367, 372 (N.C. Ct. App 1988), *aff'd* 390 S.E.2d 150 (N.C. 1990).

New York has conflicting cases as to the status of an insurer where there is no conflict of interest. Compare *Goldberg v. American Home Assurance Co.*, 439 N.Y.S. 2d 2 (N.Y. App. Div. 1981) (insurer is client), with *Woodson v. American Transit Insurance Co.*, 720 N.Y.S.2d 467 (N.Y. App. Div. 2001) (insurer is not client). North Carolina has no cases addressing that issue.

n41 *Traver*, 980 S.W.2d at 630 (concurring and dissenting opinion).

n42 *Id.* at 632.

n43 See *O'Morrow v. Borad*, 167 P.2d 483 (Cal. 1946) (suit by one insured against another creates conflict); *Murphy v. Urso*, 430 N.E.2d 1079, 1083-84 (Ill. 1981) (suit against two insureds with inconsistent defenses creates conflict).

n44 *UPLC*, 261 S.W.3d at 42 (footnotes omitted).

n45 *Id.* n.78, citing Charles Silver, *Does Insurance Defense Counsel Represent the Company or the Insured?*, 72 Tex. L. Rev. 1583, 1603-1604 (1994)

n46 Restatement (Third) of the Law Governing Lawyers (Perm. Vol. 2000) ("Restatement").

n47 *Id.* § 134, cmt. f.

n48 *Id.* § 14.

n49 Charles Silver & Kent Syverud, *The Professional Responsibilities of Insurance Defense Lawyers*, 45 *Duke L.J.* 255, 280-83 (1995); Charles Silver, *Does Insurance Defense Counsel Represent the Company or the Insured?*, 72 *Tex. L. Rev.* 1583 (1994); *Countryman v. Breen*, 263 N.Y.S. 603, 605-08 (N.Y. Sup. Ct. 1933), *rev'd on other points*, 271 N.Y.S. 744 (N.Y. App. Div. 1934), *aff'd* 198 N.E. 536 (N.Y. 1935); *Moritz v. Medical Protective Co.*, 428 F. Supp. 865, 871-72 (W.D. Wis. 1977); ABA Comm. on Prof'l Ethics & Formal Op. 282 (1950).

n50 This argument is developed in Stephen L. Pepper, *Applying the Fundamentals of Lawyers' Ethics to Insurance Defense Practice*, 4 *Conn. Ins. L.J.* 27 (1997-98).

n51 This response is developed at length in William T. Barker, *Insurance Defense Ethics and the Liability Insurance Bargain*, 4 *Conn. Ins. L.J.* 75 (1997-98), prepared as a commentary on Prof. Pepper's article, see note 50 above.

n52 In the example given, joint representation is probably unnecessary in terms of either protecting the insured or minimizing claim costs. But if professional responsibility rules do not forbid such representation, it should not matter that it is not strictly necessary. Besides, the example is deliberately unrealistic, and more complicated examples could be constructed where (initial) joint representation would serve claim cost minimization purposes.

n53 Restatement, § 134, cmts. a, f. I regard this point as an important one. I have previously argued that many of the problems in dealing with the tripartite relationship stem from a misconceived effort to protect insureds against all forms of mishandling of the defense of claims against them through the law of professional responsibility, when many of those problems are better handled by insurance law. William T. Barker, *The*

Tripartite Relationship and Protection of the Insured: Beyond Professional Responsibility, 18 Ins. Litig. Rptr. 528 (1996). And, as explained in the preceding paragraph, insurance law may solve some of those problems by obliging the insured to give some of the consents required by the law of professional responsibility.

n54 Restatement, § 134, cmt. f. (cross-references omitted)

n55 *Pine Island Farmers Coop v. Erstand & Riemer*, 649 N.W.2d 444 (Minn. 2002).

n56 *Id.* at 451. See Charles Silver, *Does Insurance Defense Counsel Represent the Company or the Insured*, 72 Tex. L. Rev. 1583 (1994).

n57 649 N.W.2d at 449.

n58 *Id.*

n59 *Id.* at 450-51.

n60 *Id.* at 451.

n61 *Id.* at 450-51.

n62 Opinion of Geoffrey C. Hazard, Jr., 11-12, *In re Rules of Prof. Cond.*, 2 P.3d 806 (Mont. 2000) (footnote omitted). In the omitted footnote, Professor Hazard cites "Restatement (Third) of the Law Governing Lawyers § 215, cmt. f (Prop. Final Dr. No. 2 1998). Section 215 of the draft [was] amended before being approved [and renumbered as § 134], but the amendment did not affect this point." *Id.* n.6.

The (former) Montana law referenced by Prof. Hazard is *Palmer v. Farmers Ins. Exch.*, 261 Mont. 91, 108, 861 P.2d 895, 905 (1992) (insurer "employs the attorney to represent the interests of both the insured and the

insurer"); *State ex rel. United States Fid. & Guar. Co. v. Montana Second Jud. Dist. Ct.*, 240 Mont. 5, 10, 783 P.2d 911, 914 (1989) ("Absent a conflict of interest, the attorney hired by the insurance company to defend its insured, represents both"); *Safeco Ins. Co. v. Ellinghouse*, 223 Mont. 239, 252-53, 725 P.2d 217, 226 (1986) (same). Those principles are still the law in most jurisdictions, even though the Montana Supreme Court repudiated them in the case where Prof. Hazard gave his opinion.

n63 *E.g.*, Restatement, § 16 & cmt. e (describing duty); *Cinema 5, Ltd. v. Cinerama, Ltd.*, 528 F.2d 1384, 1386 (2d Cir. 1976) (attorney owes undivided loyalty to every client).

n64 *American Mutual Liab. Ins. Co. v. Superior Court*, 113 Cal. Rptr. 561, 571 (Cal. Ct. App. 1974).

n65 The Texas Association of Defense Counsel, as *amicus* on rehearing argued that "[t]he employee-lawyer[] has a duty to discuss even routine' conflicts with the client and obtain informed consent, regardless of congruence." Brief of Amicus Curiae Texas Association of Defense Counsel in Support of Petitioner's Motion for Rehearing, at 15. If the facts show a substantial risk that such a conflict will actually arise, that would be true, but there was no evidence that counsel faced with such risks do not either withdraw to allow defense to be handled by nonconflicted counsel or obtain the necessary informed consents. If, instead, there is no more than a speculative possibility of conflict, that issue need not be addressed until a concrete risk actually arises.

n66 Model Rules of Prof'l Conduct R.1.7(a) (2008). Rule 1.06 of the Texas Disciplinary Rules of Professional Conduct is similar, except that the Texas rule appears to permit adverse representations in unrelated matters that would be forbidden by the Model Rule. That possible difference has no relevance to the issue considered here.

n67 Model Rules of Prof'l Conduct R.1.7 cmt. [8] (2008).

n68 Ronald E. Mallen & Jeffrey M. Smith, *Legal Malpractice*, § 29.3, (5th ed. 2000).

n69 *See, e.g., Betts v. Allstate Ins. Co.*, 201 Cal. Rptr. 528 (Cal. Ct. App. 1984) (defense counsel encouraged insured to adopt "no-settlement" position which improperly exposed insured to serious risk of personal liability); *Parsons v. Continental Nat'l American Group*, 550 P.2d 94 (Ariz. 1976) (disclosure to insurer of confidential information indicating that insured's actions were intentional rather than negligent); *Employers*

Cas. Co. v. Tilley, 496 S.W.2d 552 (Tex. 1973) (exploitation of position as defense counsel to develop late notice defense on behalf of insurer); *Fidelity & Cas. Co. v. McConnaughy*, 179 A.2d 117, 121-24 (Md. 1962) (taking deposition to establish lack of cooperation); and cases cited therein.

n70 Even if both insurer and insured are properly clients at the outset of the representation, conflicts may arise during the representation from sources not foreseen at the outset. If the clients cannot resolve such a conflict (and do not consent to proceed despite the conflict), the lawyer will have to withdraw from joint representation. This is the usual rule for joint representations of any sort.

n71 The term is that of Ronald Mallen. Mallen, *A New Definition of Insurance Defense Counsel*, 53 Ins. Coun. J. 108, 114-15 (1986).

n72 E.g., *San Diego Federal Credit Union v. Cumis Ins. Soc'y Inc.*, 208 Cal. Rptr. 494 (Cal. Ct. App. 1984) (suit for both negligent and intentional injuries); *Brohawn v. Transamerica Ins. Co.*, 347 A.2d 842 (Md. 1975) (same); *Maryland Casualty Co. v. Peppers*, 355 N.E.2d 24 (Ill. 1976) (same).

n73 *Rhodes v. Chicago Ins. Co.*, 719 F.2d 116, 120 (5th Cir. 1983); *Steel Erection Co. v. Travelers Indem. Co.*, 392 S.W.2d 713, 716 (Tex. Civ. App. 1965 writ ref'd n.r.e.).

n74 2 P.3d 806 (Mont. 2000). The Montana Supreme Court provides vendor-neutral citations (in this case, 2000 MT 110) by numbering the paragraphs of its opinions. This brief will cite to the paragraph numbers ("Mont Op. ___") instead of the page numbers.

n75 See cases purportedly distinguished in Mont. Op. 24-33.

n76 *Id.* 23.

n77 American Bar Ass'n, *Annotated Model Rules of Professional Conduct*, xvii (3d ed. 1995). This language has been adopted in Texas, as paragraph 12 of the Preamble to the Texas Disciplinary Rules of Professional Conduct.

n78 *Id.* 37.

n79 Similar statements were made, also without the benefit of any factual record, in another advisory opinion. *American Ins. Ass'n v. Kentucky State Bar*, 917 S.W.2d 568 (Ky. 1996), another advisory opinion.

n80 24 P.3d 593 (Ariz. 2001).

n81 *Id.* at 598 (*emphasis added*). The court went on to say that "in the unique situation where the lawyer actually represents two clients, he must give primary allegiance to the one (the insured) to whom the other (the insurer) owes a duty of providing not only protection, but of doing so fairly and in good faith." *Id.* There is no reason here to inquire whether Texas or other states would or should follow this aspect of the Arizona rule, or whether there are any actual circumstances in which an insured would derive any protection from that rule not already provided by the lawyer's duty of undivided loyalty.

The Arizona court also appeared to perceive (or fear) conflicts in a wider range of circumstances than suggested here. *Id.* at 597 & n.1, 598. Again, there is no need to debate this here. If there is a sufficient risk of conflict, as that may be defined under local law, joint representation will be precluded under the analysis here. If there is not such a risk, this analysis and the Arizona Court agree that a joint representation would be proper.

RELATED LINKS: See Sonnenschein Nath & Rosenthal LLP on Unauthorized Practice of Law Committee v. Amercian Home Assurance Co.

■ 261 S.W.3d 24 (Tex. 2008)

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Robert C. Clifford on Wilson v. 21st Century Ins. Co., 2007 Cal. LEXIS 13314

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Robert C. Clifford on Wilson v. 21st Century Ins. Co., 2007 Cal. LEXIS 13314

By Robert C. Clifford

December 12, 2008

SUMMARY: Robert C. Clifford discusses the issues raised by the California Supreme Court's decision in *Wilson v. 21st Century Ins. Co., 2007 Cal. LEXIS 13314 (Cal. 2007)*. The California Supreme Court held that before an insurer denies a first party claim, the insurer must thoroughly investigate the facts and undertake a fair evaluation of its insured's claim.

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ARTICLE: *Introduction.* In *Wilson v. 21st Century Ins. Co., 2007 Cal. LEXIS 13314 (Cal. 2007)*, the California Supreme Court addressed two significant issues. First, the Court discussed an insurer's duty to fully investigate an insured's claim for first party policy benefits. Secondly, the court considered the application of the genuine dispute doctrine, as described in *Chateau Chamberay Homeowners Ass'n v. Associated Internat. Ins. Co., 90 Cal. App. 4th 335, 347 (Cal. Ct. App. 2001)*. In this particular instance, the Court held that summary judgment was improperly granted in favor of the insurer on the insured's bad faith action because triable facts existed which, if true, would support a jury's finding that the insured unreasonably failed to investigate the nature and extent of the insured's injuries before it denied the insured's claim for underinsured motorist (UIM) benefits.

I. Lack of Thorough Investigation and Fair Evaluation

Counsel involved in claims against insurers to recover first party policy benefits should be conversant with the holding of *Wilson v. 21st Century Insurance* and the insurer's duty to thoroughly investigate the facts that underlie the insured's claim. While the Court conceded that an insurer has no obligation under the implied covenant of good faith and fair dealing to pay every claim its insured submits, it stressed that the insurer cannot deny the claim "without fully investigating the grounds for its denial." *Wilson v. 21st Century Ins. Co., 2007 Cal. LEXIS 13314 (Cal. 2007)* citing *Frommoethelydo v. Fire Ins. Exch., 42 Cal. 3d 208, 215 (Cal. 1986)*. To protect its insured's contractual interest in security and peace of mind, "it is essential that an insurer fully inquire into possible bases that might support the insured's claim" before denying it. *Wilson v. 21st Century Ins. Co., 2007 Cal. LEXIS 13314 (Cal. 2007)* citing *Egan v. Mutual of Omaha Ins. Co., 24 Cal. 3d 809, 819 (Cal. 1979)*.

A trier of fact may find that an insurer acted unreasonably if the insurer ignores evidence available to it which supports the claim. The insurer may not focus only on those facts which justify denial of the claim. *Wilson v. 21st Century Ins. Co.*, 2007 Cal. LEXIS 13314 (Cal. 2007) citing *Mariscal v. Old Republic Life Ins. Co.*, 42 Cal. App. 4th 1617, 1623 (Cal. Ct. App. 1996); and *Shade Foods v. Innovative Prods. Sales & Mktg.*, 78 Cal. App. 4th 847, 880 (Cal. Ct. App. 2000).

Here, the insured -- a 21-year-old woman who was involved in an auto accident with an underinsured motorist -- submitted documentation from her treating orthopedist which stated that she had "degenerative disk changes as a result of occult disk injury at the levels in her neck from her high speed motor vehicle accident," and that these spinal changes were atypical for her age and "almost certainly" caused by the automobile accident. *Wilson v. 21st Century Ins. Co.*, 2007 Cal. LEXIS 13314 (Cal. 2007). The insurer's claims representative discounted the orthopedist's opinion and denied the insured's UIM policy limits demand on grounds that the insured's symptoms were caused by preexisting degenerative disc disease. Significantly, the claims representative reached his opinion without seeking an independent medical evaluation or record review from another physician. Instead, he based his denial on his own interpretation of the insured's medical records, including an MRI scan of the cervical spine, and the fact that the insured was vacationing in Australia when her attorney tendered the policy limits demand.

After the insurer denied the claim, the insured's counsel demanded arbitration. During discovery leading up to the arbitration hearing, the insurer's counsel deposed the insured's treating physicians and learned that spinal surgery had been recommended. The insurer then obtained an independent medical evaluation of the insured, and the examining physician subsequently reported findings that supported the insured's treating orthopedist's initial conclusion that the insured's injuries were caused by the subject motor vehicle accident. Faced with this new and independently obtained information, the insurer offered its policy limits, but this did not occur until two years after the insurer first denied the insured's claim, and the Court determined that the initial failure to investigate, coupled with the two year delay in payment, could sufficiently support a jury's finding that the insurer acted in bad faith.

An insurer is not obliged to accept the insured's expert witnesses' opinion without scrutiny or investigation. There are actions that an insurer can take if it questions the basis of the insured's claim. For example, to the extent it has good faith doubts, an insurer is within its rights to investigate the basis for the expert's claim by asking the expert to reexamine or further explain his or her findings, having another expert review all the submitted material and offer an opinion, or, if necessary, have its insured examined by other experts. What an insurer cannot do, consistent with the implied covenant of good faith and fair dealing, is to ignore the insured's expert's conclusions without any attempt at adequate investigation, and reach contrary conclusions lacking any discernable foundation. *Wilson v. 21st Century Ins. Co.*, 2007 Cal. LEXIS 13314 (Cal. 2007) citing *Egan v. Mutual of Omaha Ins. Co.*, 24 Cal. 3d 809, 819 (Cal. 1979); and *Mariscal v. Old Republic Life Ins. Co.*, 42 Cal. App. 4th 1617, 1623 (Cal. Ct. App. 1996).

II. The Genuine Dispute Rule

An insurer's denial of, or delay in, paying benefits gives rise to tort damages only if the insured shows the denial or delay was unreasonable. *Frommoethelydo v. Fire Ins. Exch.*, 42 Cal. 3d 208, 214 (Cal. 1986). As a close corollary of that principle, it has been said that "an insurer denying or delaying the payment of policy benefits due to the existence of a genuine dispute with its insured as to the existence of coverage liability or the amount of the insured's coverage claim is not liable in bad faith even though it might be liable for breach of contract." *Chateau Chamberay Homeowners Ass'n v. Associated Internat. Ins. Co.*, 90 Cal. App. 4th 335, 347 (Cal. Ct. App. 2001). This "genuine dispute" or "genuine issue" rule was originally invoked in cases involving disputes over policy interpretation, but in recent years courts have applied it to factual disputes as well. See *Chateau Chamberay Homeowners Ass'n v. Associated Internat. Ins. Co.*, 90 Cal. App. 4th 335, 348 (Cal. Ct. App. 2001); *Fraley v. Allstate Ins. Co.*, 81 Cal. App. 4th 1282, 1292 (Cal. Ct. App. 2000), *Guebara v. Allstate Ins. Co.*, 237 F.3d 987, 992 (9th Cir. 2001).

Here, the insurer contended that its denial of the insured's policy limit demand was not unreasonable and fell within the ambit of the genuine dispute rule. The Court quickly rejected this argument, reiterating that the insurer

ignored the insured's supporting medical documentation and simply made the unsupported contention that her injuries resulted from a pre-existing, degenerative condition. *Wilson v. 21st Century Ins. Co.*, 2007 Cal. LEXIS 13314 (Cal. 2007). Counsel should be aware that the genuine dispute rule does not relieve an insurer from its obligation to thoroughly and fairly investigate, process and evaluate the insured's claim. A genuine dispute exists only where the insurer's position is maintained in good faith and on reasonable grounds. *Wilson v. 21st Century Ins. Co.*, 2007 Cal. LEXIS 13314 (Cal. 2007) citing *Chateau Chamberay Homeowners Ass'n v. Associated Internat. Ins. Co.*, 90 Cal. App. 4th 335, 348 (Cal. Ct. App. 2001), and *Guebara v. Allstate Ins. Co.*, 237 F.3d 987, 996 (9th Cir. 2001).

An insurer is entitled to a summary judgment based on a genuine dispute over coverage or the value of the insured's claim only where the summary judgment record demonstrates the absence of triable issues. *Wilson v. 21st Century Ins. Co.*, 2007 Cal. LEXIS 13314 (Cal. 2007) citing Cal Code Civ Proc § 437c(c). In light of the court's holding, the practitioner must understand that a dispute based upon an unreasonable (i.e., unsupported) position is not genuine and summary judgment is therefore not proper.

Conclusion. One lesson to be learned is that although *Wilson v. 21st Century Insurance Co.* involved an insured's claim for underinsurance benefits, the implications of the holding go well beyond underinsurance coverage and must be considered in all first party coverage situations. The duty to fully investigate is particularly significant in such first party claims as disability and medical coverages, where the insurer's refusal to provide benefit payments can have a dire effect on the insured and subject the insurer to a claim of bad faith. The following practice tips can be distilled from this case:

Strategic Point -- Respondent: Counsel for the insurer should advise the insurer of the necessity of obtaining all information surrounding the insured's claim. In situations where the nature and extent of the insured's injuries come into question, counsel should promptly recommend that an independent medical examination and record review (or at the very least, a medical record review by a qualified physician) be conducted as soon as reasonably possible. Failure to fully consider the facts may have serious consequences in defending a subsequent bad faith claim against the insurer.

Strategic Point -- Claimant: Counsel representing first party claimants should be sure to provide the insurer with competent facts that support the claim at the earliest opportunity, and to retain copies of all supporting documentation that was provided to the insurer. If the insurer denies the claim, or makes what appears to be a substandard offer, counsel should consider the *Wilson v. 21st Century Insurance* decision and determine whether the insurer fully considered all facts surrounding the claim before responding to the insured's claim.

Cross References. For further information on bad faith actions arising from uninsured or underinsured motorist claims under California Law, see Robert C. Clifford, 2-24 California Uninsured Motorist Law 24.syn.

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Ernst & Young on Reflections on Current Market Conditions

2008 Emerging Issues 3108

Ernst & Young on Reflections on Current Market Conditions for the Insurance Industry

By Peter Porrino and Robert Stein

December 2, 2008

SUMMARY: This Emerging Issues Analysis assesses the implications of the current financial and credit crisis for insurance companies and recommends actions they can take to help safeguard ratings and assets and mitigate exposure to potential losses.

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ARTICLE: The events in financial markets over the last year, and in particular the past few months, are a stark reminder that insurance enterprises have exposures well beyond the risks assumed from their insurance policies. The credit crisis, which initially began with an increase in the incidence of defaults on US subprime mortgages, has quickly extended to every corner of the global financial market and resulted in a dramatic change in the competitive dynamics of the financial services sector.

We do not know when the crisis will come to an end or whether the actions of the Global Central Banks and regulators will stem the tide. The residential mortgage market continues to deteriorate, with delinquencies and defaults rising even in the prime mortgage market, as home prices fall and the economy weakens. Distress has now spread to auto loans, credit card receivables, commercial mortgage-backed securities and, increasingly, corporate debt. More broadly, new credit is virtually non-existent. Liquidity is hard to come by, and as the economy continues to slow, retail and business spending remains weak.

At this critical juncture, insurance company management needs to protect the organizations assets and capital base, maintain liquidity, and mitigate the exposures to losses that may be developing. These and other actions should be taken to protect ratings and to maintain the confidence of customers and distributors.

Business Implications

The business model for insurance enterprises is not likely to fundamentally change. However, a number of the implications of the current crisis are apparent.

The impact from equity and fixed income markets. In a persistent equity market downturn, life insurers will likely experience a sales decline in equity-based products. Depressed equity markets result in reduced fees, increased

guarantee values and diminished variable annuity/variable life earnings. Volatile equity markets have driven hedging costs higher, further reducing profitability. Products without guarantees may suffer a noticeable decline in cash inflows.

Additionally, products with guaranteed interest rates will need to be evaluated to determine how the current environment impacts the organizations obligations. Moreover, the regulatory pressures that emanated from the banking sector will renew insurance regulators focus on product suitability and disclosure issues related to customer offerings.

Clearly, all types of insurance organizations have significant exposure to the debt and equity markets in their investment portfolios. Unrealized losses will further weaken balance sheets and Other Than Temporary Impairment (OTTI) changes will depress year-over-year earnings. As the profitability of certain lines of business is evaluated, management will need to consider whether its deferred acquisition cost asset is impaired.

Securities lending programs. Securities lending programs have historically been an avenue for insurance and other organizations to earn additional income from their investment portfolios. In these transactions the insurance organization may have the right to use the collateral provided by the borrowing entity and invest the funds in other securities. However, insurance organizations should be mindful that the collateral is typically short term in nature. Investing collateral in illiquid or less liquid positions can result in a duration mismatch when the collateral is required to be returned.

Securitizations. Insurance securitizations might be viewed as the industrys version of packaged mortgage-backed securities. In the short term, the constriction of credit markets is eliminating the ability to execute these transactions. Heavy users of securitizations and off-balance sheet corporate vehicles to manage capital needs will come under greater scrutiny as investors evaluate these structures and the magnitude of such risk transfers. This is critically important for life insurance companies with significant XXX and AXXX exposures where bank letters of credit are becoming extremely scarce and expensive.

Global regulatory co-ordination. Insurance regulators worldwide are expressing concern about how multiple national regulators will manage the meltdown of a global institution. Without clear protocols for regulatory coordination, local regulators may reflexively strengthen their claims on local resources, dramatically reducing the benefits of geographic risk diversification and increasing consolidated capital requirements.

Capital requirements. Available capital will be adversely affected by investment portfolio devaluations and impairment charges, increased life and annuity product guarantee values and weaker business volume. As regulators and rating agencies reevaluate capital issues, it is likely that requirements will increase. Upward pressure will come from mounting credit risk provisions and requirements for structured products, mortgage-backed securities and equities. Additional capital will be needed to cover reinsurance risks and provide protection from exposure to credit and liquidity risks.

Next Steps

The implications of the credit crisis require insurance organizations to take steps both to protect the organization and, at the same time, to create potential opportunities. Continued volatility and uncertainty are likely to pervade the markets for the foreseeable future. Inactivity would clearly result in increased losses for organizations that do not understand their current exposures or establish processes to cope with the uncertainties. At a minimum, the following considerations should be evaluated by management in the context of the current crisis:

- **Pricing of investments and derivatives portfolios.** Management should evaluate its pricing and price validation

policies and procedures to determine whether the current processes adequately address escalating current issues. This overview should include: the increasing demand for improved governance, stronger price validation controls, more comprehensive independent model review and enhanced management reporting. If the market perceives a lack of strength in managements pricing process or if errors occur, a crisis in confidence could rapidly result in a dramatic destruction of shareholder value.

■ **Counterparty exposure analysis.** Management needs to quickly identify and aggregate exposures to companies in distress or at risk. Actively mitigating pre-and post-bankruptcy exposures through netting, and identifying, exercising and managing transactional trigger events will be critical to loss mitigation. No one knows if, when or which financial institution will be the next to suffer a loss of confidence and start a downward spiral. Organizations need to understand their exposures to all material counterparties and have sound mitigation strategies that provide rapid response in the event of a new crisis.

■ **Liquidity and cash flow analysis.** The quality of liquidity management, cash flow forecasting and working capital management should be challenged and revised to recognize the current market environment. Management typically relies on a presumed set of available sources of cash to meet working capital and liquidity needs. However, management should now consider whether those sources of cash will be available in times of crisis. Stress scenarios and cash alternatives need to be considered or organizations could find themselves in situations where funds are unavailable at the time they are needed most. Regulators may become more rigorous in requiring companies to demonstrate that they can enforce their financial support arrangements.

■ **Operational requirements.** Management should evaluate the impact of the recent financial crisis and its implications for the organizations operational needs. An immediate need will be to minimize the impact of counterparty bankruptcy or future insolvencies. This action requires identifying and exercising bankruptcy/insolvency trigger events, determining which contracts will automatically terminate upon bankruptcy, and utilizing master netting provisions and cash-settling contracts before they become entangled in bankruptcy courts. Managing the movement of cash and netting of exposures, putting in place new netting and novation agreements and actively managing exposures before bankruptcy are critical. These actions can have a material impact on realizing cash recoveries in a timely manner. Many organizations will discover that they are not able to address critical needs due to resource constraints. Timely loss mitigation is heavily dependent on flawless operational execution over the next few months.

■ **Transactions and restructuring.** Insurance organizations are in the process of evaluating sales of distressed, as well as prized operations to unlock liquidity and survive financial turmoil. Early planning, tight management of due diligence, ability to identify and understand the key issues rapidly and effective negotiation skills are critical in todays environment of short/compressed deal deadlines or restructuring events. Some significant assets may become available. Organizations that cannot take advantage of these opportunities will discover their more prepared and nimble competitors have achieved a strategic advantage.

■ **Tax basis analysis.** In connection with an evaluation of the sale of a business or legal entity, management must begin the cumbersome process of evaluating the tax basis of those entities. For those that were purchased or created many years ago, information can be scarce, and the ability to properly demonstrate tax basis in the sold entity will be difficult.

■ **Regulatory compliance.** Companies need to ensure that their reporting and compliance frameworks are capable of meeting demands that regulators are likely to place on any insurer whose financial stability is questionable. Additionally, insurance organizations can expect that insurance regulators are likely to review and increase the capital

requirements for all insurance enterprises, further pressuring the profitability of operations.

■ **Model validation.** A model's ability to accurately anticipate the impact of market conditions in times of stress has been severely tested in this credit crisis. However, models are growing in number, importance and complexity in the risk, investment, actuarial and tax areas. Accordingly, it is essential to gain an understanding of the assumptions, data quality and other technology controls related to these models. Identifying and understanding the limitations and assumptions as well as the risks not captured in each model will be critical to avoiding product mispricing. Failure to do so could have significant financial, regulatory and reputational impact. Furthermore, regular, independent and structured testing is necessary to provide assurance that the models are functioning as intended. In particular, validating the source and accuracy of the data is a key high-risk area for review.

■ **Tax analysis.** As the period of uncertainty unfolds, management will need to be keenly aware of tax issues that could arise. Any write-down in asset values may create a deferred tax asset (requiring evaluation and determination as to whether it may be recognized). In addition, the losses sustained by some companies will result in tax losses that may be carried back or forward. The losses may be limited in an acquisition context or may impact the recognition of other tax attributes such as the foreign tax credit. Understanding the tax implications both cash tax and financial statement impact of these changes is critical in viewing the broader picture.

While uncertainty lies ahead, the recent market events illustrate that insurers can take action to help safeguard ratings and assets, and to mitigate exposure to loss. Organizations that are well positioned, prepared and nimble may well be able to capitalize on the dislocation in the market.

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Reed Smith LLP on the Potential for Federal Regulation of Insurance

2008 Emerging Issues 3091

Reed Smith LLP on the Potential for Federal Regulation of Insurance in Light of AIG, Inc.'s Financial Collapse

By Paul Walker-Bright Esq.

November 19, 2008

SUMMARY: The recent financial difficulties of AIG, Inc., have reignited debate as to whether the federal government should take a greater role in the regulation of insurance. The modern structure of the financial services industry, including insurance, and the increasing national and international scope of insurance companies, call into question the efficacy of traditional state-based regulatory systems and highlight the need for a national approach.

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ARTICLE: Introduction

The financial collapse of AIG, Inc., one of the world's largest groups of insurance companies, has had and will continue to have significant impacts on the financial services industry, including the regulation of that industry. Although AIG stresses that its insurance company subsidiaries are well capitalized and have a collective surplus of \$26.7 billion available to pay claims, ⁿ¹ it is reasonable to suppose that the enormous size of AIG's losses ⁿ² alone would have some impact on the insurer subsidiaries' ability to operate in the future. For example, A.M. Best has commented that its financial strength, issuer credit and debt ratings for AIG's insurance companies remain under review with negative indications due to the continuing financial problems of the parent company and uncertainty over whether the federal bailout will succeed. ⁿ³ Moreover, AIG's collapse highlights the extent to which insurance has become intertwined with other aspects of the financial services industry, including the markets for securities, futures, collateralized debt obligations, credit default swaps, and other complex financial instruments. The high stakes at risk due to AIG's financial collapse have reinvigorated the debate over whether the federal government should play a role in regulating the business of insurance. ⁿ⁴

The States' Historic Right to Regulate the Business of Insurance

In 1869, the United States Supreme Court ruled that issuing a policy of insurance is not a transaction of commerce for purposes of the Constitution's Commerce Clause. ⁿ⁵ This left the states free to regulate the business of insurance without much interference from the federal government. What evolved was a scheme in which each of the states developed its own agencies, laws and regulations to regulate insurance over the next 75 years, including the creation of the National Association of Insurance Commissioners (NAIC) in 1871. ⁿ⁶ However, in 1944 the Supreme Court reversed itself, holding that, whatever the accuracy of the Court's description of insurance in the nineteenth century, by

the middle of the twentieth century it was obvious that the business of insurance included interstate commerce and thus fell within the reach of federal laws and regulations, including antitrust laws. n7

The insurance industry and the states feared that the *South-Eastern Underwriters* decision heralded the onset of intensive federal regulation of insurance that would upset the existing scheme. Therefore, insurance companies and the states lobbied Congress for a law that would restore the status quo. In 1945 they were rewarded with the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.*, which provides that,

No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance. . . . n8

The McCarran-Ferguson Act reverses the normal precedence of laws and provides that state laws regulating the business of insurance pre-empt federal laws that may impact insurance, except for federal laws that specifically concern insurance. This reverse pre-emption effectively returned to the states the right to regulate insurance. n9

The states (along with the District of Columbia and five territories) have continued to hold the field in regulating insurance from 1945 to the present day. The result is a patchwork of laws and regulations individually enacted and enforced by the states. Although the NAIC promulgates and promotes uniform standards for such laws and regulations, n10 it has no authority to enact or enforce them. Even a brief perusal of state laws and regulations reveals significant differences among the states on many insurance issues. n11

Previous federal involvement in the regulation of insurance has been limited. In the late 1980s and early 1990s the failure of several prominent insurance companies prompted a Congressional study into the causes of the failure and proposals for a federal regulatory system. n12 These proposals, however, did not lead to any significant federal regulations. In 1999, Congress passed the Gramm-Leach-Bliley Act, also known as the Financial Services Modernization Act (FSMA). n13 The FSMA allowed commercial banks, investment banks and insurance providers to consolidate, creating the modern financial services industry. n14 The FSMA reaffirmed the states right to regulate insurance and protects 13 specific areas of state insurance regulation from federal preemption. n15 The FSMA also required the states to enact uniform insurance agent licensing laws and reciprocity measures. n16

The Debate: Is the Current Regulatory Scheme Sufficient to Cope with the Demands of a Modern, International Insurance Industry?

In 2007 the United States Treasury Department conducted a comprehensive study of the regulatory structure in place for the financial services industry, including insurance. This study culminated in the Treasury Departments March 2008 report, *Blueprint for a Modernized Financial Regulatory Structure*. With respect to the insurance industry, the Treasury Department concluded that the state-based regulatory system was not the most efficient or effective way to regulate an industry that has become global in its scope. n17 The Treasury Department also recognized that insurance is only one aspect of the broader financial services industry, and that the lines dividing banking, securities, futures and insurance have become increasingly blurred. n18 Thus, the current functional division of regulatory responsibility among these industry sectors has the risk of creating conflicts among the responsible agencies and gaps in the regulatory schemes. n19

In order to address these deficiencies, the Treasury Department recommends establishing an optional federal charter (OFC) that would provide a system of federal chartering, licensing, regulation and supervision of insurers, reinsurers and insurance producers. n20 Insurers, reinsurers and insurance producers could opt for federal regulation or remain in the existing state system. n21 The Treasury Department also recommends creating an Office of National Insurance (ONI) and an Office of Insurance Oversight (OIO). n22 The ONI would create and oversee the necessary regulatory, supervisory, enforcement and rehabilitative powers of the OFC. n23 The OIO would promote international insurance regulatory policy for the United States and serve as an advisor to the Secretary of the Treasury on major

domestic and international insurance policy issues. n24 In short, the Treasury Department is in favor of a comprehensive scheme of federal regulation that would replace much, if not all, of the existing state-based regulatory regime. n25

Reaction to the Treasury Departments recommendations has been mixed. The NAIC, not surprisingly, is not in favor of the OFC approach. n26 Apart from the understandable aversion to having the powers of the state insurance commissioners significantly reduced, the NAIC points to the financial strength of AIGs insurance subsidiaries as proof that the state regulatory scheme works to ensure that insurance companies are insulated from adversity in their parent companies. n27 However, had the state insurance commissioners timely recognized that credit default swaps are a form of insurance subject to their regulations, arguably AIGs financial collapse could have been avoided or at least substantially mitigated. The NAICs belated admission that insurance regulations apply at least to some types of credit default swaps is a classic case of closing the stable door after the horses have bolted, and moreover still leaves approximately 90% of all credit default swaps unregulated. n28 Current discussions among federal and state regulators and legislators on how to regulate credit default swaps, and whether the Securities and Exchange Commission, the Commodity Futures Trading Commission, the state insurance departments, or some combination of federal and state regulators, should be responsible for regulating credit default swaps, highlight the need for a more systematic and broader level of regulation. n29

Other observers have expressed concern over the state regulators initial response to the AIG financial crisis, which was to agree to a plan where AIG would obtain \$20 billion of its insurance subsidiaries investment-grade securities in exchange for securities of questionable liquidity so that AIG could use the investment-grade securities as collateral. n30 One key motivation was the desire to protect, not the insurance companies or policyholders, but the jobs of thousands of AIG employees in the state of New York. n31 This demonstrates that state regulators are susceptible to local political and economic concerns that may interfere with the ability to make decisions that affect insurance companies and policyholders nationally and internationally.

The NAIC was created to address the need to coordinate regulation of multistate insurers, and one of its primary goals is the development of uniform policy when uniformity is appropriate. n32 To the extent that the NAIC claims success in coordinating the regulation of multistate insurers (which includes most insurance companies now) and developing uniform policies for the regulation of insurance that apply throughout the United States, this very success can be viewed as an argument in favor of a national regulatory system. The NAIC essentially is a trade organization that assists state insurance commissioners in regulating insurance. n33 It has no enforcement powers and no authority over the insurance commissioners or insurance companies. The cooperation of the individual insurance commissioners and their willingness to accept uniform insurance policies developed within the NAIC structure indicate the commissioners recognition of the need for such uniformity. A federal insurance regulator not only would develop the needed uniform policies but would be able to implement and enforce them as well. The OFC/ONI approach would create a truly national set of uniform laws and rules that coordinate the regulation of multistate and multinational insurance companies. The NAIC is seeking to achieve this same result, but without the ability to impose that regulation throughout the country. Thus, a federal insurance office would at least theoretically be better placed to accomplish the NAICs goals.

For example, in response to the AIG financial crisis the NAIC has created an AIG Special Task Force, comprised of all NAIC members, which is charged with overseeing the regulatory activities related to the AIG insurance subsidiaries and coordinating interaction among state regulators, federal government officials, company representatives, and international regulatory interests. n34 Had a federal Office of National Insurance existed at the time AIGs financial problems surfaced, it already would have been overseeing the regulatory activities related to the AIG insurance subsidiaries (assuming they had opted in to the federal charter) and coordinating the interaction among all affected entities. This interaction also would have been more efficient because the involvement of 50 different state insurance commissioners would have been greatly reduced.

Other insurance organizations support the Treasury Departments OFC approach. The American Insurance Association (AIA), the leading property and casualty insurance trade organization in the United States, n35 and the

Risk and Insurance Management Society, Inc. (RIMS), the professional association for corporate and government risk managers, n36 both are in favor of an OFC. n37 These entities believe that an OFC regulatory scheme would modernize the insurance industry, allow insurers to develop and deliver products more efficiently and effectively, and increase competition. n38

Currently there are several bills pending before Congress that would effect some federal regulation of insurance to a greater or lesser degree. The National Insurance Act of 2007 would put in place an OFC regulatory system substantially similar to the one subsequently recommended by the Treasury Department in its Blueprint. n39 The Insurance Information Act of 2008 proposes the creation of an Office of Insurance Information (OII) within the Treasury Department. n40 The OII would collect, analyze, and disseminate information and issue reports regarding insurance, establish federal policy on international insurance matters, and advise the Treasury Secretary on major domestic and international insurance policy issues. n41 The Insurance Information Act can be seen as an intermediate step on the way to establishing the full OFC regulatory scheme. The Nonadmitted and Reinsurance Reform Act of 2007 would streamline the regulation of nonadmitted insurance and reinsurance by applying single-state regulation and uniform standards to nonadmitted and surplus insurers and reinsurers. n42

Conclusion

The insurance industry has changed in many dramatic and fundamental ways since 1869. However, the current system of regulation in the United States, in which each state is individually responsible for regulating insurance, essentially has been unchanged for the past 139 years. The globalization of insurance markets and the increasing interrelationships of insurance and other financial products designed to hedge or mitigate risk are strong arguments in favor of modernizing the current system to some degree. Whether a comprehensive OFC/ONI approach will be enacted remains to be seen, but it seems likely that some form of federal insurance regulation eventually will be in place to address the real and perceived inefficiencies in the state-based regulatory system and the need for true national regulation of insurance in the modern financial world.

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n1 See AIG Commercial Insurance Press Release, Sept. 17, 2008; Andrew G. Simpson, *AIG Commercial Insurance Unit Financially Fit and Fighting Back*, Insurance Journal, Oct. 14, 2008.

n2 Federal loans to AIG are now close to \$144 billion, and AIG may borrow still more. See Mary Williams Walsh, *Fed Adds \$21 Billion to Loans for A.I.G.*, N.Y. Times, Oct. 31, 2008; Gavin Magor, *AIGs Fed Bailout Reaches \$143.8 Billion*, TheStreet.com, Oct. 31, 2008 (available at <http://www.thestreet.com/story/10445350/1/aig-has-drop-in-fed-borrowing-update.html>).

n3 See A.M. Best Maintains Under Review Negative Status on American International Group, Inc. Operations Designated for Sale, BestWire, Oct. 3, 2008 (available at <http://www.ambest.com>).

n4 See *AIG Crisis Restarts Debate Over State vs. Federal Insurance Regulation*, Insurance Journal, Sept. 17, 2008 (available at <http://www.insurancejournal.com/news/national/2008/09/17/93798.htm>); Mark A. Hofman, *Bailout Drama Fuels Debate on Regulation of Insurance*, Business Insurance, Sept. 28, 2008.

n5 *Paul v. Virginia*, 8 Wall. 168, 183, 19 L.Ed. 357 (1869).

n6 See NAICs website, http://www.naic.org/index_about.htm.

n7 *United States v. South-Eastern Underwriters Assn*, 322 U.S. 533, 551-53, 64 S. Ct. 1162, 1172-73, 88 L. Ed. 1440 (1944).

n8 15 U.S.C. § 1012(b).

n9 See, e.g. *United States Dept. of the Treasury v. Fabe*, 508 U.S. 491, 113 S. Ct. 2202, 124 L. Ed. 2d 44 (1993); *SEC v. National Sec., Inc.*, 393 U.S. 453, 89 S. Ct. 564, 21 L. Ed. 2d 668 (1969).

n10 See, e.g., NAIC, Model Laws, Regulations and Guidelines (2008).

n11 See, e.g., NAIC, Compendium of State Laws on Insurance Topics (2008).

n12 See House Subcomm. on Oversight and Investigations, Comm. on Energy and Commerce, 101st Cong., *Failed Promises: Insurance Company Insolvencies* (Comm. Print 1990).

n13 Pub. L. No. 106-102, 113 Stat. 1338 (1999).

n14 Pub. L. No. 106-102 §§ 101-02, 113 Stat. 1341.

n15 Pub. L. No. 106-102 § 104(d)(2)(B), *113 Stat. 1353-1356*.

n16 Pub. L. No. 106-102 § 321, *113 Stat. 1422*.

n17 U.S. Dept. of the Treasury, Blueprint for a Modernized Financial Regulatory Structure 9-10 (2008) (Treasury Department Blueprint). The complete text of the Treasury Department Blueprint is available from the Departments website at <http://www.treas.gov/press/releases/reports/Blueprint.pdf>.

n18 *Id.* at 3-5.

n19 *Id.* A real world example of a regulatory gap is the credit default swap, the financial instrument at the root of AIGs collapse. A credit default swap basically is insurance for default on a debt like a municipal bond or a security backed by debt obligations, like mortgage-backed securities. *See* Wayne Pinsent, *Credit Default Swaps: An Introduction* (available at <http://investopedia.com/articles>); Gretchen Morgenson, *Arcane Market Is Next to Face Big Credit Test*, N.Y. Times, Feb. 17, 2008. In the Commodity Futures Modernization Act, Pub. L. No. 106-554, *114 Stat. 2763 (2000)*, Congress prohibited the federal government from regulating swaps, including credit default swaps. Pub. L. No. 106-554, § 407. Despite the fact that credit default swaps bear all the hallmarks of insurance, state insurance departments did not regulate them either. In other words, these arcane financial instruments, with a market worth **trillions** of dollars, were completely unregulated. *See* Nicholas Varchaver and Katie Benner, *The \$55 Trillion Question*, Fortune, Sept. 30, 2008 (available at http://money.cnn.com/2008/09/30/magazines/fortune/varchaver_derivatives_short.fortune/index.htm). The consequences of this lack of regulation are now obvious.

n20 Treasury Department Blueprint 10.

n21 *Id.*

n22 *Id.* at 10-11.

n23 *Id.*, p. 11.

n24 *Id.*

n25 The Treasury Department does note that insurers could still be subject to continued compliance with some state laws, such as tax laws, compulsory coverage for workers compensation and individual auto insurance, and participation in mandatory residual risk mechanisms and guarantee funds. *Id.*, p. 10.

n26 See NAIC, *NAIC Response to Treasury Report*, Mar. 31, 2008; NAIC, *NAIC Offers Views on Three Insurance Bills at Subcommittee Mark-Up*, July 9, 2008 (available at http://www.naic.org/Releases/2008_docs/insurance_bills_mark_up.htm) (Every insurance commissioner strongly believes that an OFC is the worst possible public policy choice for insurance.)

n27 See NAIC, *State Regulators: AIG Insurers Able to Pay Claims*, Sept. 17, 2008; *AIG Crisis Restarts Debate Over State vs. Federal Insurance Regulation*, Insurance Journal, Sept. 17, 2008 (available at <http://www.insurancejournal.com/news/national/2008/09/17/93798.htm>).

n28 See R.J. Lehmann, *NAIC Proposes Insurers Disclose Swaps, Other Derivatives*, BestWire Services, Oct. 29, 2008 (accessed at <http://fpn.advisen.com/articles/article84666243-1334308299.html>).

n29 *Id.*

n30 See David S. Hilzenrath and Zachary A. Goldfarb, *N.Y. Will Let AIG Borrow \$20 Billion from Its Own Subsidiaries*, Washington Post, Sept. 15, 2008.

n31 *Id.*; Lilla Zuill, *AIG Gets New Yorks Help in Accessing \$20 Billion*, Reuters, Sept. 15, 2008.

n32 See http://www.naic.org/index_about.htm.

n33 *Id.*

n34 See http://www.naic.org/committees_ex_aig.htm.

n35 See <http://www.aiadc.org/aiapub/landing.aspx?m=1>.

n36 See <http://www.rims.org/aboutRIMS/Pages/MissionandDescription.aspx>.

n37 See RIMS, *RIMS Reinforces Support of Optional Federal Charter Legislation*, July 26, 2007 (available at <http://www.rims.org/governmentaffairs/Statements/Pages/federalcharter07-26-07.aspx>); AIA, *AIA Applauds Recommendation of OFC in Blueprint*, Mar. 29, 2008.

n38 *Id.*

n39 See S.40, 110th Cong. (2007); H.R. 3200, 110th Cong. § 1102(b) (2007) (describing the powers of the Commissioner of National Insurance).

n40 See H.R. 5840, 110th Cong. (2008).

n41 H.R. 5840, 110th Cong. §313(c)(1)-(2).

n42 See S. 929, 110th Cong. (2007); H.R. 1065, 110th Cong. (2007).

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Bullivant Houser Bailey PC on Long v. Century Indemnity Co.

2008 Emerging Issues 3086

Bullivant Houser Bailey PC on Long v. Century Indemnity Co.: New Guidance On The Mechanics Of The Tripartite Relationship

By Maren Holmboe

November 18, 2008

SUMMARY: An insurance company defending under a reservation of rights must allow the insured to retain independent counsel if the reservation creates a conflict between the insured's interests and the insurer's interests. Although there is much law on the concept of independent counsel and when independent counsel is required, there has been less law on the mechanics of the independent counsel relationship after the relationship has been established.

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ARTICLE: Introduction

An insurance company defending under a reservation of rights must allow the insured to retain independent counsel if the reservation creates a conflict between the insured's interests and the insurer's interests. Although there is much law on the concept of independent counsel and when independent counsel is required, there has been less law on the mechanics of the independent counsel relationship--such as resolution of billing disputes--after the relationship has been established. Now, along comes *Long v. Century Indemnity Co.*, 163 Cal. App. 4th 1460 (2008), to provide some guidance.

I. The Tripartite Relationship

The term tripartite relationship describes the contractual relationship created when an insurance company owes a duty to defend its insured under a liability policy. The relationship between the insurance company, its insured, and the attorney hired by the insurance company to defend the insured, can create an ethical dilemma for defense counsel when the interests of the insurance company and the insured conflict. Such a conflict can--but does not always--arise when the insurance company owes a duty to defend under the policy while reserving the right to dispute coverage or seek reimbursement of defense costs. *James 3 Corp. v. Truck Ins. Exch.*, 91 Cal. App. 4th 1093, 1102 (2001).

When defense counsel represents both insurance company and insured, the relationship can raise difficult ethical problems. The insurance company pays the bills, but defense counsel owes a primary duty of loyalty to the insured. See

Model Rules of Professional Conduct R. 5.4(c) (A lawyer shall not permit a person who recommends, employs, or pays the lawyer to render legal services for another to direct or regulate the lawyer's professional judgment in rendering such legal services.)

California has addressed these potential conflicts inherent in the tripartite relationship through statute, requiring the insurance company to provide independent counsel to the insured where the policy imposes a duty to defend and there is a conflict of interest between the insured and the insurance company. California Civil Code § 2860(a) (codifying landmark California decision, *San Diego Federal Credit Union v. Cumis Ins. Society, Inc.*, 162 Cal. App. 3d 358 (1984)). While the statute grants the insured the right to select independent counsel, it also limits the rates that independent counsel may charge and mandates that, where the policy is silent regarding settlement of attorney fee disputes, attorney fee disputes shall be resolved by final and binding arbitration by a single neutral arbitrator selected by the parties to the dispute. Section § 2860 limits attorney fees for independent counsel to the rates which are actually paid by the insurer to attorneys retained by it in the ordinary course of business in the defense of similar actions in the community where the claim is being defended.

II. Long v. Century Indemnity Company n1

Liability insurer INA agreed to defend its insured, Harris, under a reservation of rights when Harris was sued by the California Department of Toxic Substances Control in a large hazardous waste cleanup action. INA asked attorney Long to defend its insured, as Long had previously represented Harris in another matter. Long and INA could not agree on an hourly rate for Long's services, as INA believed that Long was subject to the rate limits of California Civil Code § 2860(c). Long agreed to undertake the representation at the restricted hourly rate, but reserved the right to seek his normal hourly rate from INA later. Long only represented Harris in the underlying action and INA did not have an attorney representing its interests.

The case was settled as to Harris in July 2002. In July 2005, Long sought the additional fees from INA, demanding the difference between his standard hourly rate and the amount paid under the rate cap of section 2860, and demanding that INA submit to arbitration on the rate issue. INA refused both the payment and arbitration demands. Long filed a lawsuit against INA in February 2006. The trial court sustained INA's demurrer, deciding that it did not have jurisdiction to hear the case under section 2860(c), as Long's claim was essentially an attorney fee dispute.

Long argued that because INA was not represented in the underlying case there was no conflict or potential conflict that would trigger section 2860, and the fee limits should not apply. Long's argument was based on the language of section 2860(b), which states that a conflict of interest may arise when an insurer reserves its rights on a given issue and the outcome of that coverage can be controlled by counsel *first retained by the insurer for the defense of the claim*. (emphasis added). This language, Long argued, suggests that the duty to provide independent counsel to an insured will not arise unless the insurance company retains its own counsel.

The appellate court disagreed with Long and affirmed the trial court's decision, holding that the election of an insurance company not to retain counsel to protect its own interest does not obviate the need to provide *Cumis* counsel if a conflict or potential conflict exists. Under section 2860, It is not the presence of the insurer-selected attorney that creates the conflict, but rather, the existence of the conflict or potential conflict creates the need for independent' or *Cumis* counsel--an attorney who owes his allegiance solely to the insured. Rather, the Long court held, a potential conflict exists because the interests of the insurer and its insured diverge, thereby precluding the use of counsel (absent a waiver by the insured) who purports to jointly represent the interests of both the insurer and insured.

In so holding, the court recognized the ethical dilemmas that arise when a conflict of interest between insurer and insured arises in third-party litigation and counsel beholden to the insurer, if retained, might be faced with divided, but unequal loyalties. Consistent with the Model Rules of Professional Conduct, the *Long* court identified the animating principle of the [*Long*] decision . . . is protecting the insured.

III. Implications

Both insurance companies and defense counsel should be aware of the potential ethical issues of the tripartite relationship. Attorneys assuming defense of an insured should be aware that the fact that an insurance company's interests are not represented in the lawsuit does not negate a conflict of interest created by the adverse interests of the insurance company and the insured. The inquiry in this situation is whether the divergent interests of the insurer and its insured would preclude an attorney from representing the interests of both insurer and insured under section 2860. If such a conflict would exist, then courts will apply the attorney fee limits, arbitration requirement, and other requirements of section 2860.

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ⁿ¹ In this case, Century Indemnity Company was the successor to Insurance Company of North America (INA). In its opinion, the Long court elected to refer to all potential insurance company defendants as INA.

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About Bullivant Houser Bailey PC.

Bullivant Houser Bailey PC is a business and litigation law firm with approximately 155 attorneys and six offices on the West Coast. The firm is headquartered in Portland, Oregon and maintains offices in Sacramento and San Francisco, California; Seattle and Vancouver, Washington; and Las Vegas, Nevada. In 2008, Multicultural Law magazine named Bullivant a Top 100 law firm for workplace diversity. Please visit bullivant.com to learn more about Bullivant Houser Bailey and its Insurance Industry Services Group.

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Changes Under the Mental Health Parity and Addiction Equity Act of 2008

2008 Emerging Issues 3067

Ending Insurance Discrimination: The Mental Health Parity and Addiction Equity Act of 2008

By Publishers Editorial Staff 2008

November 4, 2008

SUMMARY: Congresss passage of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 significantly amended the federal mental health parity requirements. This Emerging Issues Analysis discusses the changes under the Act and the possible preemption of portions of state mental health parity laws when the Act takes effect.

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ARTICLE: Introduction

Health care plans once offered mental health benefits under the same terms as medical and surgical benefits, but due to the rising cost of health insurance in the 1970s and 1980s, many plans cut mental health benefits because the cost of coverage was high while the number of plan participants using such benefits was low. *See* Dana L. Kaplan, *Can Legislation Alone Solve America's Mental Health Dilemma? Current State Legislative Schemes Cannot Achieve Mental Health Parity*, 8 *Quinnipiac Health L.J.* 325, 328 (2005). By the 1990s, health care plans that provided mental health benefits offered coverage that was far more restrictive than coverage for other medical benefits. *Id.* at 329. Congress responded by enacting the Mental Health Parity Act of 1996 (1996 Act), 104 *P.L.* 204, § 702, which added parity provisions to the Employee Retirement Income Security Act (ERISA), 29 *USCS* § 1185a, and the Public Health Service Act, 42 *USCS* § 300gg-5, that prohibited health plans from capping annual or lifetime benefits for mental health coverage at lower amounts than annual or lifetime benefits for medical and surgical coverage.

However, the 1996 Act had little overall effect in achieving parity as health care plans continued to require higher out-of-pocket payments or placed additional treatment limits on mental health services over those provided for medical and surgical benefits. *See* Patrick J. Kennedy, *Why We Must End Insurance Discrimination Against Mental Health Care*, 41 *Harv. J. on Legis.* 363, 366 (Summer 2004). For several years, members of Congress worked to craft legislation that would close these loopholes. The Senate passed the Mental Health Parity Act of 2007, 2007 *S.* 558, and the House passed the Paul Wellstone Mental Health and Addiction Equity Act, 2008 *H.R.* 1424. Once the House and the Senate reached an agreement over the differing terms in each Act and reached an agreement on funding for the legislation, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 was enacted

as §§ 511 and 512 of the Emergency Economic Stabilization Act of 2008, *110 P.L. 343*, on October 3, 2008. News reports have suggested that the parity legislation was added to the Financial Bailout Bill because of its bipartisan support in an effort to get the Stabilization Act passed.

The legislation sets a new federal floor for mental health parity requirements of plans covering employers of 50 or more employees. This will have an impact on state parity legislation if a state has no parity laws or the requirements of their laws are less strict than the new statute. This article will discuss the new parity requirements and the areas in which state law may be preempted by the new legislation.

Discussion

I. Amendments to the Mental Health Parity Provisions of ERISA, the Public Health Service Act, and the Internal Revenue Code

A. Expansion of Definition

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Act), *110 P.L. 343*, builds upon the 1996 Act and applies to group health plans that cover more than 50 employees. Sections 512(a), (b), and (c) of the Act amend the mental health parity provisions of § 712 of the Employee Retirement Income Security Act, 29 *USCS* § 1185a, § 2705 of the Public Health Service Act, 42 *USCS* § 300gg-5, and § 9812 of the Internal Revenue Code, 26 *USCS* § 9812. The most significant amendment to these sections is that parity is now extended to substance use disorder benefits. It is important to note, however, that a group health care plan is not required to provide mental health or substance use disorder benefit coverage. This Act only provides that if a plan offers such coverage, it must be in parity with the medical and surgical benefits the plan offers.

B. Financial Requirements and Treatment Limitations

Under the Act, parity has now been extended to financial requirements, such as deductibles, copays, coinsurance, and out-of-pocket expenses as well as treatment limitations, such as frequency of treatment, number of visits, and other limitations. What this means is that the rules for financial requirements and treatment limitations must be the same for mental health or substance use disorder benefits as they are for medical and surgical benefits. The Act also extends parity to out-of-network coverage, requiring a plan that offers out-of-network medical and surgical benefits to provide out-of-network mental health and substance use disorder benefits as well.

C. Disclosure

The Act amends the mental health parity provisions of ERISA, the Public Health Service Act, and the Internal Revenue Code to provide that a group health plan that offers mental health or substance use disorder benefits must disclose the medically necessary criteria for such coverage to plan participants and beneficiaries upon request. The Act also requires a plan to disclose the reasons for the denial of benefits to plan participants or beneficiaries upon request.

D. Cost Exemption

The Act provides an exemption from the mental health parity requirements if a group health plan can prove that it has experienced an increase in its total costs due to parity. For the first year of the Acts implementation, the increase must be more than two percent. For every year after, the increase in total costs is one percent. However, a plan must implement the federal parity requirements for at least six months before it seeks the cost exemption. The exemption will only be extended to a plan for one plan year. An employer has the option of continuing to provide mental health and substance use disorder benefits regardless of the cost increase.

In seeking the exemption, a qualified actuary must make a determination as to the increases in actual costs under the plan in a written report. The plan must promptly notify the Secretary of Labor (if is self-funded) or the Secretary of Health and Human Services (if it is fully insured), the appropriate state agencies, and plan participants and beneficiaries if the plan seeks an exemption. Further, notification to the Secretary of Labor or the Secretary of Health and Human Services must include a description of the number of covered lives under the plan as well as the actual costs of coverage for which the plan is seeking the exemption. The Secretary of Labor, the Secretary of Health and Human Services, or a state agency that has been notified of the exemption may audit the plans books and records, including actuarial reports, to determine that the plan was complying with the Act when it sought the exemption.

E. Enforcement

Pursuant to § 512(d) of the Act, the Secretary of Labor, the Secretary of Health and Human Services, and the Secretary of the Treasury must promulgate regulations to carry out § 512(a), (b), and (c) respectively within one year of the date of Acts enactment. Section 512(f) of the Act requires that the Secretaries coordinate their policies with respect to the enforcement of the mental health parity requirements to ensure that the requirements of the Act are given the same effect with respect to each Secretarys rulings, regulations, and interpretations, to avoid duplication of efforts, and to assign priorities in enforcement. The agencies that will likely issue the regulations and be tasked with the coordination effort are the Employee Benefits Security Administration of the Department of Labor, the Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services, and the Internal Revenue Service of the Department of the Treasury. Because of the impact the regulations could have on the interpretation of the Act, it will be important for practitioners to be aware of when these regulations are adopted and take effect.

F. Effective Date

Section 512(e) strikes the sunset provisions of the mental health parity requirements of ERISA, the Public Health Service Act, and the Internal Revenue Code and makes the mental health parity requirements permanent as of January 1, 2009. The Act will apply to group health plans beginning in the first plan coverage year that is one year after the date of enactment of the Act. In other words, the effective date for compliance with the Act for most plans will be January 1, 2010. However, group health plans maintained under collective bargaining agreements that were ratified before the Act took effect are not subject to the terms of the Act until the collective bargaining agreement terminates.

G. Reports

Under § 512(a)(6), the Secretary of Labor is required to submit a report on compliance with the Act to Congress in 2012 and every two years after that. Subsection (a)(6) also requires the Secretary of Labor, in cooperation with the Secretaries of Health and Human Services and the Treasury, to provide information for group health plans, their participants and beneficiaries, state agencies and the National Association of Insurance Commissioner about the requirements of the Act. Pursuant to § 512(h), the General Accounting Office (GAO) is to provide Congress with a report on the impact that the Act has had on mental health and substance use disorder coverage within three years of the Acts passage. The GAOs report shall include which diagnoses are the most commonly covered and excluded, specific rates for coverage of mental health conditions and substance use disorders, and the impact of covering and/or excluding specific diagnoses on plan participants health, health care coverage, and the costs of treatment.

II. Preemption of State Parity Laws

The Act only applies to group health plans for employers of 50 or more people. Any state law governing health plans for employers with less than 50 employees will remain unchanged. Further, any state law that provides stricter parity mandates than those included in the Act will not be preempted. For example, Vermonts recent parity law, 2008 Vt. ALS 142, requires that a health plan provide mental health coverage and includes a provision that forbids a health

plan from excluding from its network or list of authorized providers any licensed mental health or substance use disorder treatment provider within its geographic coverage area if the provider meets the terms and conditions for participation in the plan.

Because of the Act's new requirements regarding substance use disorders, a state provision such as Tex. Ins. Code 1355.006, which provides that a group health benefit plan does not have to provide coverage for addiction to a controlled substance or mental illness that results from use of a controlled substance, will be preempted. While the Act does not require a group health plan to offer mental health benefits, if it does, it will now be required to offer substance use disorder benefits. Montana's law, Mont. Code Anno., § 33-22-703, which allows for caps on the number of treatment days for mental health benefits and the amount of annual and lifetime benefits for substance use disorders, will be preempted. Any state law that allows out-of-network coverage for medical and surgical treatment but restricts or prohibits out-of-network coverage for mental health or substance use disorder treatments will be preempted. Further, any state law that has different requirements for or provides a permanent cost exemption will be preempted by the Act. Because the provisions of the Act become effective on January 1, 2009, it will be important for practitioners to examine how their state parity laws vary from the Act and to be aware that provisions might be preempted.

Conclusion

Although the 1996 Act was a good beginning, Congress has recognized that it did not go far enough in ending insurance discrimination for those suffering from mental illness, and it has attempted to remedy inequity in the financial requirements and treatment limitations for mental health benefits. The new Act has also expanded parity requirements by including substance use disorders in its definitions. The Act attempts to tighten up the rules regarding a cost exemption for group health plans. Because the new Act imposes so many additional requirements on mental health parity rules, it is likely that portions of several states' parity laws will be preempted. It will be necessary for practitioners to understand the changes imposed by the Act and how it may change state parity provisions.

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Insurers Asbestos Lessons as Applied to Nanoparticles

2008 Emerging Issues 83

Insurers Asbestos Lessons as Applied to Nanoparticles

By Publisher's Editorial Staff 2008

October 2, 2008

SUMMARY: This Emerging Issues Commentary examines the course of the asbestos litigation and steps that the insurance industry can take to minimize its risks.

PDF LINK: Core Emerging Issues Commentary (\$)

ARTICLE: ARTICLE: Introduction

Nanotechnology is being hailed as revolutionary and being called the next plastic because of its potential widespread use. Nanotechnology is the science of working with applications at a molecular level by designing, producing, and using structures and devices having one or more dimensions of less than 100 nanometers. A nanometer is one billionth of a meter and invisible to the naked eye. A common example used to offer perspective is that the width of a human hair is approximately 80,000 nanometers. Nanotechnology creates nanoparticles, which are particles with at least one dimension less than 100 nanometers. Nanoparticles are already being incorporated into a wide range of products to enhance their performance. Nanoparticles are currently used in electronic, biomedical, pharmaceutical, and cosmetic applications. A project set up by the Woodrow Wilson International Centre for Scholars on Emerging Nanotechnologies currently has 580 products in its database, which represents an increase of 175% since the database was released in March 2006. Lloyd's, *Nanotechnology Recent Developments, Risks, and Opportunities*, (Dec. 2007), p. 19, (available at http://www.lloyds.com/Lloyds_Market/Tools_and_reference/Emerging_risks.htm). The products can range from items such as paints, sunscreens, and moisturizers to tennis balls, burn and wound dressings, stain-resistant clothing, mattresses, and ink. <http://www.nano.gov/html/facts/appsprod.html>. The possible uses and applications for nanoparticles appear to be limitless and offer great promise. While the Environmental Protection Agency, the Food and Drug Administration, and the Occupational Health and Safety Administration can potentially control the use of nanoparticles under their existing statutory authority, there are currently no statutes aimed at specifically governing the use of nanoparticles.

However, scientists have started to voice concern about nanoparticles and their effect on the human body. Because of their size, nanoparticles can be ingested, inhaled, or absorbed through the skin. They can travel throughout the body and possibly cause injury. Because of their widespread dissemination, there is also concern that nanoparticles could potentially pollute air or water, ultimately contaminating groundwater and soil. Although nanoparticles have proven beneficial in removing toxic metals and other unwanted chemicals from the environment, using them in this manner

could be "solving one problem and replacing it with another, namely the unknown effect of placing large amounts of nanoparticles in the environment." Lloyd's, *Nanotechnology Recent Developments, Risks, and Opportunities*, (Dec. 2007), p. 17, (available at http://www.lloyds.com/Lloyds_Market/Tools_and_reference/Emerging_risks.htm). At this point in time, not much is known about the toxicity of nanoparticles. However, the insurance industry has the fallout from one of the former "wonder" products, asbestos, on its mind and is concerned about the possibility that nanoparticles might spawn the next mass toxic tort litigation. In an effort to avoid the asbestos debacle, it is important for insurers to follow the development of this technology and develop their own strategies that encourage the growth of this technology without risking the widespread and ongoing litigation that resulted from the use of asbestos.

Are Nanoparticles the Next Asbestos?

Comparison of Nanoparticles and Asbestos

Not so long ago, it was asbestos that was being hailed as the miracle material that was going to revolutionize industry. Asbestos was used in a wide range of products because of its fire resistant properties and its durability. However, it was later discovered that while asbestos was not toxic itself, the size and form of its fibers, when inhaled, caused grave damage to lung tissue. SwissRe, *Nanotechnology, Small Matter, Many Unknowns*, (2003) p. 41 (available at <http://www.swissre.com/>). Asbestos is a carcinogen that has a typical latency period of 20 to 40 years from exposure. Environmental Law Practice Guide § 36.02. It can cause several forms of lung cancer as well as asbestosis, a fibrosis of the lung and pleural tissues, which is a chronic and progressive disease. *Id.* One particular cancer risk is mesothelioma, which can result from a minimal exposure to asbestos and is fatal. Thus, it was not until asbestos was in widespread usage that its dangers became clear.

In an effort to avoid that scenario, scientists have been studying the toxicity of nanoparticles. Unlike asbestos, nanoparticle is a generic term that encompasses a myriad of different substances. Thus, research must be done on each type of nanoparticle because they are comprised of different chemicals and they interact in different ways. Further, initial research has shown that some nanoparticles are acutely toxic compared to larger particles that are composed of the same material, meaning that like asbestos, the material itself may not be toxic, but the size and composition of the material could cause a problem. Lloyd's, *Nanotechnology Recent Developments, Risks, and Opportunities*, (Dec. 2007), p. 13, (available at http://www.lloyds.com/Lloyds_Market/Tools_and_reference/Emerging_risks.htm). Scientists have currently identified three types of nanoparticles that they think might be harmful to the human body, one of which is the carbon nanotube. Karen Schmidt, *The Great Nanotech Gamble*, New Scientist, July 14, 2007, p. 38. The carbon nanotube is similar in form and size to asbestos fibers, and thus, there is concern that it will have a similar effect on the human lung if inhaled. Much like asbestos, the potential danger posed by nanoparticles is believed to be chronic, rather than acute. SwissRe, *Nanotechnology, Small Matter, Many Unknowns*, (2003) p. 43 (available at <http://www.swissre.com/>). If one or more nanoparticles prove hazardous if ingested, inhaled or absorbed through the skin, it could be some time before any harm is discovered. An additional concern is that nanoparticles have been shown to cross the blood-brain barrier, which protects the brain against toxic contamination. Guy Carpenter, *Nanotechnology--The Plastics of the 21st Century?*, pg. 8 (July 2006) (available at <http://www.guycarp.com/portal/>). While this can be an advantage for medicine, allowing the development of drugs designed to enter the brain for treatment, unwanted nanoparticles can also cross that barrier and accumulate in the brain, potentially causing harm. Lloyd's, *Nanotechnology Recent Developments, Risks, and Opportunities*, (Dec. 2007), p. 13, (available at http://www.lloyds.com/Lloyds_Market/Tools_and_reference/Emerging_risks.htm). Because nanoparticles are being increasingly used in products, the potential for a series of claims and losses like those that occurred with asbestos is a possibility insurers could be facing.

Asbestos Litigation

Since asbestos litigation began in the late 1960s, approximately 730,000 claims have been filed and an estimated 1

to 3 million more could be filed before the litigation ends. Environmental Law Practice Guide § 36.01. Companies have paid approximately \$70 billion in claims thus far. *Id.* The floodgates of asbestos litigation were opened with the decision of the United States Court of Appeals for the Fifth Circuit in *Borel v. Fibreboard Paper Products Corp.*, 493 F.2d 1076 (5th Cir. 1973), which held that manufacturers of products containing asbestos could be held strictly liable for failure to provide a warning to people who might be injured by their products. The manufacturers named as defendants were found jointly and severally liable for the plaintiff's injuries.

The litigation in the 1970s was confined to approximately 300 companies that processed asbestos or made heavy use of it. Environmental Law Practice Guide § 36.01. However, in the 1980s, filings increased dramatically. As a result, counsel as well as the courts began to develop systems in order to manage the huge volume of claims, and parties routinely entered into administrative settlements. In 1991, several plaintiffs and defendants attempted a class certification of a mass settlement, which the United States Supreme Court rejected in *Amchem Prods. v. Windsor*, 521 U.S. 591 (1997). The Court held that a shared interest in the settlement and exposure to asbestos were not sufficient to satisfy the predominance requirement of *Fed. R. Civ. P. 23(b)(3)*. *Amchem Prods. v. Windsor*, 521 U.S. 591, 623 (1997). Further, the Court held that the proposed class failed to satisfy the commonality requirement because of variations in exposure periods, variations in the degree and type of physical injuries, and variations in medical histories and other health factors. *Amchem Prods. v. Windsor*, 521 U.S. 591, 623-624 (1997). After the *Amchem* decision, another wave of asbestos claims hit. Initially, claims involving latent injuries from asbestos were filed by employees who worked for asbestos manufacturers and were exposed in the workplace, but by the 1990s, claimants included any individuals who had any exposure to asbestos. Individuals who had little or no physical impairment began to file claims, and over 8,400 companies across all types of industries that did anything remotely related to asbestos or asbestos-containing products were named as defendants. Environmental Law Practice Guide § 36.01. As one commentator has said, "In the five years following *Amchem*, the asbestos litigation system nearly collapsed." Patrick Hanlon & Anne Smetak, *Asbestos Changes*, New York University Annual Survey of American Law (2007), 62 *N.Y.U. Ann. Surv. Am. L.* 525, 547. However, more than 30 years after *Borel* opened the floodgates, reform through state legislatures and state courts appear to be slowing the filings and applying sensible rules to asbestos filings. See 20-23 Mealey's Litig. Rep. Asb. 19 (2006).

The insurance industry responded to the asbestos crisis by creating an asbestos exclusion in commercial general liability (CGL) policies. These exclusions started to appear in the CGL policies in the mid-1980s to the mid-1990s. 2-6 Mealey's Litig. Rep. Mold 35 (2002). However, most claimants were exposed to asbestos far earlier than the exclusions were written into the policies, and most of the policies in effect were "occurrence" policies that protected the policyholder from lawsuits for bodily injury or property damage as long as the policy was in effect when the injury occurred. Because of this and the latent nature of the injury, if a claim was filed in a jurisdiction that recognized the exposure rule, the injury-in-fact rule or the multiple trigger approach, an insurer was required to respond to the claim. The exposure rule was defined in *Insurance Co. of N. Am. v. Forty-Eight Insulations*, 633 F.2d 1212 (6th Cir. 1980), which held that an initial exposure to asbestos fibers in any given year triggered coverage. Each insurer was liable for its pro rata share of the injury. Under the injury-in-fact inquiry, the injury did not have to have manifested, but it did have to exist. *Abex Corp. v. Maryland Casualty Co.*, 790 F.2d 119, 124-125 (D.C. Cir. 1986). The trier of fact did not have to pinpoint the exact date of injury, but there had to be reasonably reliable evidence that the injury more likely than not occurred during the coverage period. *Abex Corp. v. Maryland Casualty Co.*, 790 F.2d 119, 128 (D.C. Cir. 1986). The multiple trigger approach was adopted by *Keene Corp. v. Insurance Co. of N. Am.*, 667 F.2d 1034 (D.C. Cir. 1981), which held that coverage under a CGL policy was triggered by either inhalation exposure to asbestos, exposure between the initial exposure and the manifestation of symptoms, or manifestation of the disease. Thus, the development of the exclusion was too little, too late to protect insurers from thousands of claims due to asbestos exposure.

What Can Insurers Do?

While the National Nanotechnology Initiative has been set up to coordinate the efforts of 26 federal government agencies in research and education concerning nanotechnology, there is currently a "regulatory vacuum" in the United States for governing the use of nanotechnology. See <http://www.nano.gov/>. Thus, a substantial burden has been placed on the private insurance market to underwrite the risk of nanotechnology. Insurers have an important role to play in

helping corporations manage the risks in this emerging technology. However, insurers need to be able to assess the probability and severity of potential losses in order to calculate a premium that justifies the risks being taken. Insurers need to develop a strategy of working with manufacturers, the government, scientists and regulatory agencies to be able to identify and quantify nanotechnology's risks. Insurers need to avoid learning the lessons of the risks of nanotechnology through long-term experience, such as what happened with asbestos. Because as with asbestos, there have been indications that certain nanoparticles may only be recognized as harmful after a considerable time, insurers must know "about the application areas and the dissemination of potentially suspect nanoproducts as well as about the precautionary and loss-prevention measures being taken." SwissRe, *Nanotechnology, Small Matter, Many Unknowns*, (2003) p. 44 (available at <http://www.swissre.com/>).

In the absence of regulation, private industry is working to develop best practices of their own. For example, DuPont and Environmental Defense, an advocacy group, teamed up to create a framework that "covers appropriate risk management in the process of developing a new nano product from initial conception through sales to eventual recycling and disposal." Lloyd's, *Nanotechnology Recent Developments, Risks, and Opportunities*, (Dec. 2007), p. 13, (available at http://www.lloyds.com/Lloyds_Market/Tools_and_reference/Emerging_risks.htm). The framework recommends that companies involved in the use of nanotechnology have experts on their teams that cover the fields of risk management, toxicology, industrial hygiene, and environmental issues. *Id.*

One thing the asbestos debacle has shown is that workers creating and working with nanoparticles are at the greatest risk if a nanoparticle turns out to be harmful to human health. However, if a decision is made like that in *Borel*, that a manufacturer is strictly liable for the injuries caused by a product using a toxic nanoparticle because it failed to warn of the dangers, multiple lines of insurance could be impacted, including General Liability, Product Liability, and Commercial Umbrella. GenRe, *Nanotechnology--Will Minute Items Have a Huge Impact on the P/C Industry?* *Hazardous Times*, p. 5, (Sept. 2004) (available at <http://www.genre.com/>). It is too soon to write exclusions for nanoparticles because the risks to the general public are unknown. But more importantly, the uses of nanoparticles encompass a wide range of applications "without a uniform description and with very different risk characteristics." Guy Carpenter, *Nanotechnology--The Plastics of the 21st Century?*, p. 11 (July 2006) (available at <http://www.guycarp.com/portal/>). Further, nanoparticles are often the initial building blocks, deep-seated in the manufacturing process and are used as binders or coatings within products, rather than stand-alone products themselves. David M. Brenner, *Thoughts in the Night: Nanoparticles=Asbestos? Greenhouse Gas=Superfund?* *Mealey's Global Insurance Forum*, Nov. 15, 2007, at p. 18. Thus, not only would creating an exclusion be incredibly difficult at this stage, but imposing such a restriction on corporate insurance clients as more and more manufacturers find uses for nanoparticles is an unattractive option without a clear and obvious necessity. *Id.* Such an exclusion would also have a serious impact on small, specialized nanotech firms and could impede the progress of this developing technology.

However, there are some steps insurers can currently take to minimize their risks. Most nanotechnology risks are currently written on occurrence policies. *Id.* Many reinsurers are suggesting that nanotechnology risks be switched over to claims-made coverage. Claims-made coverage protects against covered lawsuits only if the policy was in effect when the injury occurred and the policy is still in effect when the claim is made. Thus, it provides protection from latent injury cases, such as the thousands of asbestos claims that arose under occurrence coverage. Switching to claims-made coverage would also help minimize the risk because the "stacking of policy limits" over successive years could be avoided through loss definitions and exact descriptions under which a loss may be said to have occurred. SwissRe, *Nanotechnology, Small Matter, Many Unknowns*, (2003) p. 45 (available at <http://www.swissre.com/>). Further, coverage should be written in such a way as to avoid claims made by the "worried well." In other words, individuals who might have been exposed to a potentially harmful nanoparticle or who show indications of exposure but have no symptoms of disease.

There is currently some question as to whether the standard pollution exclusions in commercial liability policies would apply to nanotechnology. However, such a defense to something akin to the asbestos litigation claims seems to be unlikely to be successful. GenRe, *Nanotechnology--Will Minute Items Have a Huge Impact on the P/C Industry?* *Hazardous Times*, p. 5, (Sept. 2004) (available at <http://www.genre.com/>).

What the Future Could Hold

If insurers begin to believe that nanotechnology coverage carries more risk than they initially thought, they could begin to withdraw from the market. If that happens, small, specialized nanotech firms would likely feel the brunt. There is the possibility that the government could then step in to provide solutions to the lack of available insurance to the industry. Guy Carpenter, *Nanotechnology--The Plastics of the 21st Century?*, p. 12 (July 2006) (available at <http://www.guycarp.com/portal/>). State-run pools could be created to "assume the most volatile aspects of writing nanotechnology-related business by mutualizing and balancing the funding of exposures across all constituencies and thus enabling insurers to provide a lower-cost product to clients." *Id.* The report from Guy Carpenter proposes that if the risks remain unknown, "government may have to act as a backstop to limit the liability of those industries that design or use nanotechnology-driven products or processes." *Id.* The report also suggests that to deal with the unknown risks, insurers may establish a no-fault system which would fund the first layer of claims, and any claims over that amount would be covered by the federal government. *Id.* One commentator has even proposed a "Nanotechnology Insurance Fund" (NIF) that would provide compensation to workers or consumers who can prove injury from nanoparticles and would provide any required environmental cleanup costs. George J. Mannina, Jr., *Nanotechnology: Don't Delay Liability Risk Assessments and Solutions*, Legal Backgrounder, Dec. 8, 2006. The NIF would be funded through consumer surcharges, a fee assessed against manufacturers of goods using nanoparticles, and possibly, congressional appropriations. *Id.*

Conclusion

Given that the uses of nanotechnology could be limitless and incorporated into all manner of our daily lives along with the potential risk of latent injury from a nanoparticle, a wait-and-see approach on behalf of the insurance industry is not advisable. While it is too early to write specific coverages concerning nanotechnology, risks can be managed in the short-term by switching nanotechnology coverage over to claims-made coverage. In order to manage risks in the long-term, insurers should work together with manufacturers, government, the scientific community and regulatory agencies to create strategies for product safety and crisis management should the use of nanoparticles pose an asbestos-like threat. By staying on top of this rapidly advancing technology and ensuring that policyholders are engaging in best practices and working to reduce their risks as dangers become known, insurers can try to adapt coverage and manage risks. If the risks become too much for the industry to bear, insurers can work with the state and federal governments to create compensation plans that will allow the insurance industry to continue to provide affordable coverage to policyholders working with nanotechnology.

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Legal Developments in the Life Insurance Settlement Industry

2008 Emerging Issues 2955

Legal Developments in the Life Insurance Settlement Industry

By Daniel W. Gerber and Jeffrey L. Kingsley

September 26, 2008

SUMMARY: Selling the proceeds of one's own life insurance policy to another may appear to be outside the scope of traditional insurance practices, but recently a growing number of policyholders have attempted to find additional sources of income as medical costs continue to rise. Courts, state regulators and even insurance companies themselves have started to reexamine traditional practices to address the growing demands of policyholders in this area.

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ARTICLE: THE RAPID GROWTH OF THE LIFE INSURANCE SETTLEMENT INDUSTRY

Any analysis of the growth of life insurance settlement industry must begin with a brief understanding of the life settlement transaction itself. The transaction usually involves four separate parties: (1) the viator (the insured); (2) the life insurance company; (3) the life settlement company; and (4) the investors. The viator enters into an agreement with the life settlement company where the company purchases the life insurance policy from the viator for less than the expected death benefits. Often, the life settlement company is merely a broker who matches a viator with a group of investors who will purchase the policy. After the viator dies, the investors receive a portion of the death benefits under the policy.

In the 1980s, these types of transactions were attractive to young terminally ill individuals, many of whom had life insurance policies, but because of their illness were unable to work or afford their costly medical treatments [Appleman on Insurance 2d § 178.02[C]]. Given the growing cost of medical care in the United States, the life insurance settlement option has expanded beyond the terminally ill and is now being marketed to chronically ill individuals, namely senior citizens, who need the additional revenue stream to address the rising cost of medical care.

To address this shift in the industry, the National Association of Insurance Commissioners (NAIC) recently modified their definition of a life settlement contract. The NAIC now defines a life settlement contract as any agreement establishing the terms under which compensation or anything of value will be paid, which compensation or value is less than the expected death benefit of the insurance policy or certificate, in return for the viators assignment, transfer, sale, devise, or bequest of the death benefit or ownership of any portion of the insurance policy or certificate of insurance [National Association of Insurance Commissioners, Viatical Settlements Model Act § 2L (2005)].

As the life insurance settlement market continues to grow, however, traditional principles in both the insurance and securities industries are being reexamined.

THE INSURABLE INTEREST DILEMMA

One issue that regularly faces practitioners in this field is whether the investor has an insurable interest in the life insurance policy. A fundamental requirement for all types of insurance, especially life insurance, is that the person or entity who purchases a policy must have a insurable interest in the subject of the insurance at the time of purchase. Without an insurable interest, the policy is declared void thereby denying an investor any claim to the proceeds of the policy.

Typically, an insurable interest is established when a person or party has a close relationship to the insured. In the life insurance context, states have typically defined that relationship between the parties as an association by blood or law engendered by love and affection or a lawful and substantial economic interest in the life of the insured [*see, e.g., N.Y. Ins. Law § 3205(a)(1)*].

Unlike the traditional insurable interest relationship, however, the life insurance settlement industry attempts to establish an insurable interest based solely on an arms length transaction. In doing so, courts and regulators across the country are now struggling to redefine the term insurable interest to address this development.

Expanding the Insurable Interest Definition: Corporate-Owned Life Insurance Policies. One of the most common areas in which courts have examined the insurable interest issue is in the context of corporate-owned life insurance (COLI) policies. Under a COLI program, a company purchases life insurance policies on the lives of its employees, ranging from the executive management group to the rank-and-file employees. The issue courts face is whether companies, who typically name themselves as beneficiaries, have an insurable interest in the life insurance policies of their employees.

Although the courts are not entirely in agreement on this issue, the cases, taken as a whole, have established that employers in certain circumstances do have an economic interest in the insured employees to create an insurable interest. Factors considered in finding a corporate insurable interest in an employee are: (1) whether the employer actively informed the employee of the existence of the policy; (2) whether the employee was a key employee with special importance; (3) whether the state in which the policy was issued has defined the term insurable interest; and, (4) whether the human resources department can establish a policy that views money spent to attract and keep employees as a general cost of doing business [*Tillman v. Camelot Music, Inc., 408 F.3d 1300 (10th Cir. 2005)*; *Lewis v. Wal-Mart Stores, 2005 U.S. Dist. LEXIS 34461 (N.D. Okla. 2005)*; *Mayo v. Hartford Life Ins. Co., 354 F.3d 400 (5th Cir. 2004)*].

Rise of the Secondary Market of the Life Settlement Industry. Though courts seem inclined to entertain expanding the scope of insurable interest to include certain employer-employee relationships, a practitioner must be aware that this issue remains a constant concern in the life insurance settlement market where there is no recognizable relationship between the parties prior to the transaction. As such, courts are required to conduct a detailed analysis of the transaction in order to determine whether the investor has an insurable interest. One potential scenario which highlights the complexity of the transaction is when the investor purchases a life insurance policy with loaned funds from a financial institution with the intent to resell the policy. Recently, one states insurance department office declared that such a transaction violated its insurable interest provision by stating the transaction is merely a speculative investment for the ultimate benefit of a disinterested third party [2005 NY Insurance GC Opinions LEXIS 280]. Therefore, the issue of insurable interest remains a concern in the life insurance settlement industry.

Practice Insight: In order to protect and maintain an insurable interest through the life of an insurance policy, a practitioner representing various parties in the secondary market should consider the following:

- Analyze whether the investor or viatical settlement company has financing behind the transaction at issue;
- Seek disclosure of all parties to the transaction, including those who may have an interest at a later time;
- Analyze who is purchasing the policy and for what purpose (i.e., as an investment, for resale, etc.);
- If there is a lender involved in the transaction, analyze (a) whether the lender takes ownership of the policy at any point; and (b) whether the lender has any additional agreements in place transferring ownership of a policy to another party at a certain time;
- Analyze whether there is a requirement at the time of purchase that the investor must sell the policy to satisfy some financing requirements; and
- Analyze whether the life insurance settlement policy has been purchased before.

If the transaction is more complicated than it first appeared, a practitioner should carefully examine recent case law in the applicable jurisdiction to advise the client on how to proceed, if at all.

BREACH IN SECURITY: DOES A LIFE INSURANCE SETTLEMENT CONTRACT QUALIFY AS A SECURITY?

The life insurance settlement market is not guided exclusively by the insurance industry. Given the investment nature of the transaction, security regulations must also be considered. Courts have started to analyze whether a life insurance settlement can be defined as a security and thus be subject to the Securities Act of 1933 and the Securities Exchange Act of 1934. If such an arrangement is deemed a security, then the sellers of these policies are required to disclose certain information regarding the risks and performances of these so-called investments in order that potential buyers have the knowledge to make an informed decision prior to purchase [see Anna D. Halechko, *Viatical Settlements: The Need for Regulation to Preserve the Benefit While Protecting the Ill and Elderly From Fraud*, 42 Duq. L. Rev. 803 (2004)]. Unfortunately, there has been no definitive decision on this issue forcing practitioners to evaluate each transaction individually.

The Life Partners Decision: A Step Away from Regulation. The highest federal court to consider this issue is the United States Court of Appeals for the District of Columbia. In the case of *S.E.C. v. Life Partners, Inc.* [87 F.3d 536 (D.C. Cir. 1996)], the viatical settlement company, Life Partners, marketed the potential profits of purchasing life insurance policies to a variety of investors. Despite the obvious investment overtones in this type of transaction, the court found that this type of transaction did not qualify as a security because the viatical settlement company performed no essential entrepreneurial services after the purchase of the contract. This ruling had a profound effect on the life insurance settlement industry and has been widely criticized for allowing life insurance settlement transactions to go unregulated.

The States Respond: A Turn Back Towards Security. In the wake of the *Life Partners* decision, a variety of fraudulent practices arose in the life insurance settlement industry. Situations such as viators exaggerating their illnesses in an effort to receive additional benefits and viatical companies defrauding senior citizens concerning the terms of their life insurance policy, became common. [Miriam R. Albert, *The Future Death of Futures: Why Viatical Settlements Must Be Classified As Securities*, 19 Pace L. Rev. 345, 359 (1999)]. To respond to this growing problem, many states took it upon themselves to attempt to regulate the industry. In recent years, several states have determined that life insurance settlement contracts are considered securities under their blue sky laws and thus require additional disclosure [see *Accelerated Benefits Corp. v. Peaslee*, 818 N.E.2d 73 (Ind. Ct. App. 2004); *Poyser v. Flora*, 780 N.E.2d 1191 (Ind. Ct. App. 2003); *Joseph v. Viatica Mgmt. LLC*, 55 P.3d 264, 267 (Colo. Ct. App. 2002); *Siporin v. Carrington*, 200 Ariz. 97 (Ariz. Ct. App. 2001)]. As the United States Supreme Court has yet to consider this issue, the life insurance settlement market continues to be outside the parameters of federal security regulations.

Practice Insight: Given the uncertainty in the law on whether this type of transaction qualifies as a security, a practitioner might consider the following:

- The extent of managerial and entrepreneurial activities after the investment was purchased;
- Whether investors were asked to identify a desired maturity date; and

- Whether there was a promise of return on the investment [see

New Appleman Insurance Law Practice Guide § 34.09].

THE SECRET DANGER: TAX IMPLICATIONS REGARDING THE LIFE INSURANCE SETTLEMENT INDUSTRY

As with any other transaction, selling a life insurance policy has tax implications. Most senior citizens considering selling their life insurance policies rarely explore this issue before making such a decision.

Under a traditional life insurance policy, if the policyholder maintained ownership of the policy, all proceeds distributed by reason of the insured's death are excluded from the beneficiary's gross income. The same cannot be said if the life insurance policy is transferred to a third party. Up until 1997, the money received in the transfer was subject to federal income tax as well as state income tax consequences. That changed January 1, 1997, however, when Congress enacted legislation that allowed certain types of viatical settlements, life settlements and accelerated death benefits to be exempt from federal tax implications under certain circumstances [see Appleman on Insurance 2d § 178.02[D]].

To be eligible for the tax relief, a policyholder must be either terminally ill or chronically ill as defined by the statute. To be classified as terminally ill, there must be a reasonable degree of certainty that an individual will die within 24 months [see 26 U.S.C. § 101(g)(4)(A)]. For an individual to be considered chronically ill, the person must be unable to perform (without substantial assistance from another individual) at least two daily living activities for a period of at least 90 days due to a loss of functional capacity [see 26 U.S.C. § 101(g)(4)(B); Appleman on Insurance 2d § 178.02[D]]. As the law is currently written, senior citizens who fail to meet the strict requirements will be subject to adverse tax consequences and must plan accordingly.

The federal law also places requirements on the settlement itself. In order for a viatical settlement to qualify for favored tax treatment, it must demonstrate either: (1) that the life insurance contract was sold to a licensed company in the same state where the policyholder resides; or (2) that the total amount of the transaction has met the guidelines as outlined by the NAIC [see 26 U.S.C. § 101(g)(2); Appleman on Insurance 2d § 178.02[D]].

Practice Insight: A practitioner might want to examine the following:

- Whether the policyholder qualifies as a terminally ill or chronically ill individual under either federal or state law;
- Whether the third party is licensed in the state where the policyholder resides; and
- Whether you can create other arrangements for the policyholder, such as a trust, to shield the policyholder from the tax consequences imposed by the policy's sale.

INSURANCE COMPANIES RESPOND: THE BIRTH OF ACCELERATED DEATH BENEFITS

In order to capture a portion of the life insurance settlement market, insurance companies have begun to modify their life insurance policies to include an accelerated death benefits clause. The accelerated death benefits provision is similar to a viatical settlement in that it allows the policyholder the option of receiving between 25% to nearly 100% of their death benefits while alive [see Life Insurance Market Research International (LIMRA) & American Council of Life Insurance and Accelerated Death Benefits: 1998]. In its earlier forms, accelerated death benefits provisions were allowable to those policyholders who had a life expectancy of less than 12 months or required long-term care [see Life Insurance Market Research International (LIMRA) & American Council of Life Insurance and Accelerated Death Benefits: 1998]. This definition, however, is in the process of being modified to coincide with the markets shift towards the chronically ill policyholder. Some states such as New Jersey and New York are considering amendments to expand the accelerated death benefits definition to include the chronically ill [see 11 N.Y.C.R.R. § 41.2, proposed amendment (2005); N.J. Admin. Code § 11:4-30.3, proposed amendment (2002)].

While the expansion of the accelerated death benefits provision is viewed as a positive development for policyholders, it is a cause of concern for practitioners. A number of states have enacted laws in which they prohibit, in certain circumstances, a life insurance settlement provider from negotiating or entering into a life insurance settlement contract involving a policy that contains an accelerated death benefits provision [see Viatical and Life Settlements; Florida Department of Financial Services issued by the Office of Financial Regulation at www.fldfs.com]. In essence, the industry itself is attempting to minimize the influence of the life insurance settlement market. Despite the rise of accelerated death benefits provisions in life insurance policies, the life settlement market continues to expand and grow.

Practice Insight: A practitioner might want to consider the following if the life insurance policy contains an accelerated death benefit provision:

- Examine if the viatical settlement company can provide benefits that exceed the amount provided for in the accelerated death benefit provision;
- Disclose the viatical settlement companys offer to the life insurance company.

CONCLUSION

Given the unregulated nature of the life insurance settlement market, a policyholder exploring the possibility of selling his or her life insurance policy to a third party faces a multitude of issues. As demonstrated in this overview, there is no simple answer and often it varies on a case by case basis with certain factors such as location and the policyholders health playing major roles. From a practitioners perspective, one needs to be aware of both federal and state regulations together with the changes that occur in legal precedent to adequately inform your client of his or her options.

RELATED LINKS: For Discussion of Insuring Provisions of Life Insurance Policies, see

- Appleman on Insurance 2d § 178.01 et seq. (LexisNexis Matthew Bender)

For Discussion of Understanding Corporate Owned Life Insurance (COLI) and Viatical Investments, see

- New Appleman Insurance Law Practice Guide § 34.09 (LexisNexis Matthew Bender).

For Discussion of Accelerated Death Benefits and Viatical Settlements, see

- The Law of Life and Health Insurance § 5.06A

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Bullivant Houser Bailey PC on Northrop Grumman Corp. v. Factory Mutual Ins. Co.

2008 Emerging Issues 2935

Bullivant Houser Bailey PC on Northrop Grumman Corp. v. Factory Mutual Ins. Co.

By Peter Roldan

September 23, 2008

SUMMARY: Hurricanes in California? No, but in *Northrop Grumman Corp. v. Factory Mutual Ins. Co.*, 2008 U.S. App. LEXIS 17270 (9th Cir.), the Ninth Circuit applies California law to an insurance coverage dispute arising out of Hurricane Katrina. The court finds that a flood exclusion encompasses water driven by wind even when it does not expressly say so.

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ARTICLE: Hurricanes in California? No, but in *Northrop Grumman Corp. v. Factory Mutual Ins. Co.*, 2008 U.S. App. LEXIS 17270 (9th Cir.), the Ninth Circuit applies California law to an insurance coverage dispute arising out of Hurricane Katrina. The court finds that a flood exclusion encompasses water driven by wind even when it does not expressly say so. In reaching its decision, the Ninth Circuit also holds that primary and excess policies are to be construed as separate documents.

BACKGROUND

Hurricanes and Flood Exclusions

In the wake of Hurricane Katrina, a number of courts have had occasion to consider whether a storm surge is a flood within the meaning of an insurance policy exclusion. Not surprisingly, those decisions have principally arisen in the jurisdictions directly affected by Katrina. In the most prominent series of opinions to address this issue following Hurricane Katrina, Judge L.T. Senter, sitting in the Southern District of Mississippi, held that damage caused by a storm surge was clearly excluded under a flood exclusion. *See Buente v. Allstate Ins. Co.*, 2006 U.S. Dist. LEXIS 23742 (S.D. Miss.); *Tuepker v. State Farm Fire & Casualty Co.* 2006 U.S. Dist. LEXIS 34710 (S.D. Miss.), *affd* in part, reversed in part by *Tuepker v. State Farm Fire & Casualty Co.*, 2007 U.S. App. LEXIS 25786 (5th Cir.); *Leonard v. Nationwide Mutual Ins. Co.*, 2006 U.S. Dist. LEXIS 60079 (S.D. Miss.). Each of the homeowners policies involved included exclusions for water damage caused by water or flood, whether or not driven by wind.

Interpretation of Excess Policies

While recognizing that insurance policies must be construed in context, California courts have also held that the

interpretation of an excess policy should not depend on the language of the underlying primary policy. In *Smyth v. USAA Property & Casualty Ins. Co.*, 5 Cal.App.4th 1470, 1992 Cal. App. LEXIS 578, the California Court of Appeals rejected the insureds argument that an ambiguity existed in an excess policy because it defined a term differently than the underlying primary policy. However, in *Powerine Oil Company, Inc. v. Superior Court*, 37 Cal.4th 377, 2005 Cal. LEXIS 9547, the California Supreme Court, in finding that the language of an excess policy was clear and unambiguous, compared and contrasted the language at issue to language contained in the primary policy. Conceivably, this opinion could be read to mean that California courts interpreting excess policies could now look to the underlying primary policy for guidance in determining whether the language of the excess policy was ambiguous.

THE NORTHROP CASE

As a result of Hurricane Katrina, Northrop Grumman allegedly sustained approximately \$1.2 billion in losses at its shipyards in Mississippi and Louisiana. Factory Mutual was a 15% participant in Northrops first \$100 million layer of a primary all risk property insurance policy. The primary policy covered flood (albeit subject to a sublimit) and defined it as whether driven by wind or not. Factory Mutual also provided a layer of excess insurance, which excluded flood.

Under the primary policy, Factory Mutual paid its share of both the wind and flood damage. However, Factory Mutual denied that Northrop had excess coverage for flood. Northrop argued that the hurricanes storm surge was not a flood within the meaning of the excess policy because unlike the primary policy, the excess policy did not define flood with reference to wind-driven water.

Northrop filed suit in California, where it is headquartered. The U.S. District Court for the Central District of California agreed with Northrop that the excess policy was ambiguous. Construing the ambiguity in favor of coverage, the District Court granted summary judgment for Northrop. On appeal, the Ninth Circuit reversed.

The court held that storm surge falls squarely within the plain and ordinary meaning of the word flood, even when that term is not amplified by a clause such as whether driven by wind or not. The Ninth Circuit also held that no ambiguity existed simply because the excess policy defined a term differently than the primary policy. The Court was not convinced by Northrops argument that primary and excess policies should be construed as one contract, and held that California law did not support the application of such a rule.

IMPLICATIONS:

As the case demonstrates, while hurricane losses occur in the Gulf and Atlantic states, hurricane claims can be made anywhere. Because California courts have had limited opportunities to interpret the language of flood exclusions, the *Northrop* decision provides practitioners with some much-needed guidance on this issue. The opinion confirms that flood exclusions encompass damage caused by storm surges and other inundations of water arising out of hurricanes and other windstorms, a position that insurers were taking in many jurisdictions prior to this decision and which would be consistent with the recent line of high-profile decisions issued by the Southern District of Mississippi.

However, the decision introduces--without applying--a classic issue of California law. Although the Ninth Circuit found the flood exclusion to encompass storm surge, and although the court reversed the summary judgment in favor of Northrop on that basis, the court did not order summary judgment for Factory Mutual. Instead, the court remanded the case for a determination of whether Californias efficient proximate cause doctrine leads to coverage notwithstanding the flood exclusion. However, the Ninth Circuit did not explain how the trial court is supposed to address that issue.

In a broader context, the significance of the *Northrop* decision lies in the Ninth Circuits holding that primary and excess policies are to be construed separately. Although California law previously recognized that primary and excess policies do not necessarily constitute one contract, the California Supreme Courts decision in *Powerine* left the door open for insureds to argue that a difference between a primary and excess policy could create an ambiguity. Under *Northrop*, insurers issuing excess policies that provide narrower coverage than the underlying primary policy can now be more confident that California courts will not use the primary policy to find broader coverage under the excess

policy than the insurer intended to provide, so long as the language of the excess policy is clear and unambiguous on its face.

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About Bullivant Houser Bailey PC.

Bullivant Houser Bailey PC is a business and litigation law firm with approximately 155 attorneys and six offices on the West Coast. The firm is headquartered in Portland, Oregon and maintains offices in Sacramento and San Francisco, California; Seattle and Vancouver, Washington; and Las Vegas, Nevada. In 2008, Multicultural Law magazine named Bullivant a Top 100 law firm for workplace diversity. Please visit bullivant.com to learn more about Bullivant Houser Bailey and its Insurance Industry Services Group.



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Bullivant Houser Bailey PC on City of Hollister v. Monterey Insurance Company

2008 Emerging Issues 2936

Bullivant Houser Bailey PC on City of Hollister v. Monterey Insurance Company

By Samuel H. Ruby

September 23, 2008

SUMMARY: Property insurance policies typically impose conditions precedent to recovery on a replacement cost basis. Often, those conditions must be satisfied within a certain time period. But what happens when the insurer allegedly frustrates the insureds ability to meet the deadlines? This commentary analyzes the background, holdings, and implications of *City of Hollister v. Monterey Insurance Company*.

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ARTICLE: Replacement Cost Coverage

Property insurance policies usually allow recovery on a replacement cost basis if the insured actually replaces the damaged property. Prior to actual replacement, insurers usually are obligated only to pay on an actual cash value basis. If the insured eventually replaces the damaged property (and in so doing spends more than the actual cash value payment), the insured usually may make a supplemental claim to recover the difference.

However, replacement cost policies typically impose *time limits* on when the insured may make a replacement cost claim. Often, the policy will require the insured to replace the property within a year, two years, or else a reasonable time after the loss. Replacement cost policies may also impose additional conditions, such as requiring the insured to give *notice of its intentions* within a certain amount of time after the loss.

Waiver and Estoppel

Courts in most jurisdictions have upheld conditions of replacement cost coverage, so long as they are clear and conspicuous. However, although the *validity* of such conditions is generally free from doubt, insureds have sometimes successfully invoked the principles of waiver or estoppel to preclude an insurer from *enforcing* time limits, based on how the insurer handled the claim. In *Waller v. Truck Ins. Exchange*, 11 Cal. 4th 1 (1995), the California Supreme Court took pains to define and distinguish the doctrines of waiver and estoppel, which have often been conflated and abused.

Waiver, the *Waller* court explained, is the intentional relinquishment of a known right after knowledge of the facts. *Id.* at 31. The waiver may be either express, based on the words of the waiving party, or implied, based on conduct

indicating an intent to relinquish the right. *Id.* Estoppel, in contrast, depends not on the intent behind a party's words or actions, but rather on their *effect*. Specifically, the Waller court explained, estoppel requires a showing of detrimental reliance by the injured party. *Id.* at 33.

In *Spray, Gould & Bowers v. Associated Internat. Ins. Co.*, 71 Cal. App. 4th 1260 (1999), an intermediate appellate court applied the principles of estoppel in finding that an insured's lawsuit was not barred by a suit limitation clause in the policy. Citing California claim handling regulations, the court held that an insurer has a duty to inform an insured about statutes of limitations, including contractual suit limitation clauses. The court determined that where the insurer fails to do so, where the insured does not independently learn of the limitation, and where an insured would have filed a timely action had it know of the limitation, the insurer may be estopped from asserting the limitation as a defense to the action.

The City of Hollisters Claim

A fire damaged a building at the Hollister Municipal Airport. Hollister had insured the building under its policy with Monterey Insurance Company. An endorsement provided that subject to certain terms and conditions, Monterey would pay the least of (1) the hypothetical cost to replace the damaged building on the same site, with a less costly building that is functionally equivalent to the damaged building, (2) the amount actually and necessarily spent to replace the building with less costly material if available, and (3) the policy limit. To recover on this functional building valuation basis, Hollister was obligated by the terms of the endorsement to contract for repair or replacement . . . within 180 days of the damage.

Within about six weeks of the fire, Monterey sent Hollister a letter, bringing to its attention the endorsement and in particular the contracting clause. According to Hollister, the contracting clause was also discussed in a meeting two weeks after the letter, and during that meeting, Monterey's representative indicated that Monterey would not grant an extension of the 180-day time limit. Later, Monterey did grant a 60-day extension but refused a further extension. When the extension expired, Hollister still had not contracted for the repair or replacement of the building, allegedly because Monterey was equivocating as to whether it would pay for a replacement building.

The Trial Court Proceedings

Hollister filed an action for declaratory relief. Specifically, Hollister requested a judicial determination that notwithstanding Monterey's refusal to extend the time limit on the contracting condition, Hollister could still complete the public bidding process and execute a construction contract to build a functional replacement. After hearing evidence for five days, the trial court found in favor of Hollister. The court entered a declaratory judgment that Monterey was estopped from enforcing or otherwise relying on the 180-day provision . . . provided that [Hollister] enters into a contract to replace Airport Building no. 25 within 180 days after notice of entry of the judgment. Monterey appealed, but the Court of Appeal affirmed.

The Court of Appeals Decision

Discussing the general principles of estoppel, the appellate court opined that the term refers less to a doctrine than to a conceptual pattern, first articulated in the courts of equity, which has come to pervade our law. When a party successfully invokes that conceptual pattern, the court in effect closes its ears to a point--a fact, argument, claim, or defense--on the ground that to permit its assertion would be intolerably unfair. Finding traditional formulations of the elements of estoppel to be somewhat misleading, the court offered a new formulation: (1) The party to be estopped has engaged in blameworthy or inequitable conduct; (2) that conduct caused or induced the other party to suffer some disadvantage; and (3) equitable considerations warrant the conclusion that the first party should not be permitted to exploit the disadvantage he has thus inflicted upon the second party.

Applying that formulation, the appellate court found that the trial court had properly held Monterey to be temporarily estopped from asserting the time limit in the contracting clause as a defense to liability for replacement

cost. Taking a cue from *Spray Gould*, the court reviewed California claim handling regulations and concluded that Monterey had engaged in blameworthy or inequitable conduct by, among other things, not promptly and unequivocally confirming that the building was a total loss and that the replacement cost coverage would apply if Hollister would timely enter into a construction contract. The appellate court found the evidence sufficient to support the trial courts finding that Monterey's conduct caused the delay, because but for that conduct, Hollister would have timely entered into a construction contract.

Implications

On its most basic level, *City of Hollister* merely confirms what most California practitioners have probably taken for granted since *Spray Gould*. Generally, the doctrine of estoppel is applicable in the insurance context; and specifically, it may be invoked (in appropriate circumstances) in response to a defense based on a time limit in a policy. *City of Hollister* extends *Spray Gould* by holding that estoppel may arise not only where the insured is *not informed* of a time limit, but also where the insured is informed but is *prevented* by the insurers conduct from *satisfying* the condition. Given the trend in other jurisdictions, one might have anticipated this holding--but now that a California court has finally spoken on the issue, practitioners finally have a California case to guide them.

The Court of Appeals decision is a victory for a policyholder, but practitioners should note the limited scope of relief that was sought in the case. Hollister did not seek immediate recovery of replacement cost benefits. Instead, Hollister merely sought--and was merely granted--declaratory relief that it would have additional time to enter into a construction contract and thereby satisfy a condition precedent to recovery on a replacement cost basis. To actually recover replacement cost benefits, Hollister still will have to enter into a construction contract and actually replace the building. Thus, *City of Hollister* does not stand for the proposition that when an insurers conduct frustrates an insured's ability to satisfy conditions precedent to replacement cost coverage, those conditions are suspended for all time and the insured may immediately recover on a replacement cost basis without ever satisfying the conditions.

Also, *City of Hollister* pointedly emphasizes that causation is essential to estoppel. Only after a lengthy review of the evidence did the appellate court conclude that Hollister could in fact have satisfied the contracting condition and would have done so but for the insurers conduct. Thus, where an insured should have been able to satisfy a condition despite the insurers conduct--or where the insured would have been unable to satisfy the condition for other reasons--an estoppel should not arise.

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About Bullivant Houser Bailey PC. Bullivant Houser Bailey PC is a business and litigation law firm with approximately 155 attorneys and six offices on the West Coast. The firm is headquartered in Portland, Oregon and maintains offices in Sacramento and San Francisco, California; Seattle and Vancouver, Washington; and Las Vegas, Nevada. In 2008, Multicultural Law magazine named Bullivant a Top 100 law firm for workplace diversity. Please visit bullivant.com to learn more about Bullivant Houser Bailey and its Insurance Industry Services Group.



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TX High Court Holds Coverage Cannot Be Expanded By Waiver & Estoppel

2008 Emerging Issues 2900

Wiley Rein LLP on Texas High Court Holds Coverage Cannot Be Expanded By Waiver and Estoppel: Ulico Casualty Co. v. Allied Pilots Association

By Paul Dame and Laura Henderson Scanlon

September 11, 2008

SUMMARY: In an important ruling this month, *Ulico Cas. Co. v. Allied Pilots Ass'n*, 2008 Tex. LEXIS 769 (Tex. Aug. 29, 2008), the Texas Supreme Court has made clear that the doctrines of waiver and estoppel cannot be used to re-write a contract of insurance and provide coverage for risks not insured.

PDF LINK: [Click Here for Enhanced PDF of Commentary](#)

ARTICLE: In an important ruling this month, the Texas Supreme Court has made clear that the doctrines of waiver and estoppel cannot be used to re-write a contract of insurance and provide coverage for risks not insured. *Ulico Cas. Co. v. Allied Pilots Ass'n*, 2008 Tex. LEXIS 769 (Tex. Aug. 29, 2008). The Texas high court held that the insurer was not obligated to reimburse a policyholder for defense costs arising from a claim noticed after the expiration of a claims-made-and-reported policy, although the insurer initially agreed to reimburse the policyholder for defense expenses, subject to a reservation of rights.

Ulico Casualty Co. (Ulico) issued to the Airline Pilots Association (the APA) a claims-made Union Liability Policy (the Policy). The policy period was extended twice, until October 25, 1999, whereupon the Policy expired without the APA having made any claims. On November 5, 1999, the APA submitted a claim arising out of the defense of a lawsuit (the *Allen* suit) that had been initiated before October 25, 1999. Ulico initially issued two letters in which it agreed to reimburse the policyholder for defense expenses, pursuant to a reservation of rights. Ulico then filed a declaratory judgment action asking the trial court to declare that it had no obligation to reimburse the APAs defense costs. The Policy at issue was a claims-made policy and did not provide a duty to defend. Rather, the insurer agreed to reimburse all loss which [the policyholder] shall become legally obligated to pay on account of any claim made . . . during the Policy Period. The Policy defined loss to include defense costs.

At trial, the parties stipulated to the following facts: (1) the APA selected the trial counsel of its choice, without input or assistance from Ulico; (2) Ulico did not direct or control the defense of the *Allen* Action; (3) Ulico did not make or assist the APA or its counsel in making any substantive or procedural decisions in defense of the *Allen* Action; (4) the APA would not have defended the *Allen* suit any differently had Ulico properly denied the APAs coverage claim; and (5) apart from the fact that the APA did not get its defense costs reimbursed, Ulicos initial position regarding reimbursement of defense costs did not prejudice the APAs defense of the *Allen* suit in any way.

The trial court instructed the jury that, to establish waiver or estoppel, the APA had to prove Ulico assumed the defense of the APA in the *Allen* suit and that the APA was prejudiced as a result. The jury answered both questions in the affirmative.

On appeal at the intermediate level, the Texas Court of Appeals recognized the basic principle that estoppel and waiver cannot be used to create insurance coverage when none exists under the policy. The Texas Court of Appeals ruled that a three part test determines whether an exception to the estoppel rule would apply: (1) an insurer must have assumed the defense of the underlying litigation; (2) without an effective reservation of rights, and (3) in so doing, prejudiced the insured. In upholding the jury verdict, the court held that there was legally sufficient evidence that Ulico had waived the defense, or was estopped from asserting, that there was no coverage under the Policy. In so holding, the Texas Court of Appeals relied on the exception enunciated in *Farmers Tex. County Mut. Ins. Co. v. Wilkinson*, 601 S.W.2d 520 (Tex. Civ. App. 1980). In *Wilkinson*, the Texas Court of Appeals stated that if an insurer assumes the insureds defense without obtaining a reservation of rights or a non-waiver agreement and with knowledge of the facts indicating noncoverage, all policy defenses, including those of noncoverage, are waived, or the insurer may be estopped from raising them. *Id.* at 521-22.

Despite the stipulations at trial recognizing that the APA was represented by counsel of its own choice, Ulico did not attempt to influence or control the APAs counsel, and Ulico never made a payment to the APA or its counsel, the Court of Appeals held that the agreement to pay defense costs, coupled with its asserted right to approve all such costs, created a *potential* for conflict that satisfies the first element of the test for estoppel.

The Court of Appeals also held that the APA was prejudiced in two ways, despite the fact that it prevailed on summary judgment in the *Allen* suit. First, the Court of Appeals held that, absent Ulico initially agreeing to reimburse the APA subject to a reservation of rights, the APA might have obtained an extended reporting period and thereby gained coverage for the *Allen* suit. Second, the Court of Appeals reasoned that Ulicos filing of a declaratory judgment action, instead of notifying the APA earlier by letter, forced the APA to incur further attorneys fees and expenses to defend itself in the coverage action.

In its key ruling earlier this month, the Texas Supreme Court reversed the intermediate appellate courts decision on the waiver and estoppel issue, holding that the doctrines of waiver and estoppel cannot be used to expand the contractual coverage of an insurance policy. In this regard, the Texas Supreme Court disagreed with *Wilkinson*s statement to the effect that noncoverage of a risk is the type of right an insurer can waive and thereby effect coverage for a risk not contractually assumed.

The Texas Supreme Court further held that the apparent conflict of interest that might arise when the insurer represents the insured in a lawsuit against the insured and simultaneously formulates its defense against the insured for noncoverage, though typically noted as justification for the *Wilkinson* rule, is insufficient justification for judicially rewriting the parties agreement. Although it acknowledged that [a]n insurers actions can result in it being estopped from refusing to make its insured whole for prejudice the insured suffers because the insurer assumed the insureds defense, the Texas high court made clear that estoppel does not work to create a new insurance contract that covers a risk not agreed to by the contracting parties.

The Texas Supreme Court also considered two jury findings that the trial court had set aside on a motion for judgment notwithstanding the verdict, in both instances rejecting the policyholders appeal. In one of the points set aside, the jury had found that the insurer impliedly granted an extended reporting period, and the policyholder argued that this finding was supported by an entry in the insurers computer system and by communications from the insurer agreeing to pay for defense expenses. The court determined that no evidence supported this jury finding, however, because the general conditions of the policy required all modifications to be made by a written endorsement signed by an authorized representative of the insurer. In the other finding set aside, the jury had found that the insurer agreed, separate from the policy, to reimburse the policyholder for its defense costs. The policyholder argued that the insurers communications agreeing to pay for defense costs was a promise separate from the policy, and that the policyholder accepted this

separate promise by cooperating with the insurer. The Texas Supreme Court determined that these actions were not evidence of consideration because the insurer received no benefit from the policyholders cooperation and the policyholder did not suffer any detriment, pointing to evidence that the policyholders defense counsel did not take or fail to take any action in defending the policyholder because of the insurers representations.

In this case, the Texas Supreme Court did note that an insurer bears the risk of being held liable for damages where the insurers handling of a policyholders claim or defense results in actual prejudice to the policyholder. Accordingly, insurers should continue to exercise care in evaluating coverage, securing a non-waiver agreement or proceeding under a reservation of rights as appropriate, ensuring that the defense of a policyholder is conducted by competent counsel. Most importantly, however, the Texas Supreme Court reiterated the importance of insurance policy language. It squarely rejected any attempt to rewrite insurance contracts through the application of the doctrines of waiver and estoppel.

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Meckler Bulger Tilson Marick & Pearson on Am. Cas. v. Health Care Indemnity

2008 Emerging Issues 2903

Meckler Bulger Tilson Marick & Pearson LLP on American Casualty Company of Reading, Pa. v. Health Care Indemnity, Inc.:Oklahoma Law Mandates Pro Rata by Policy Limits Allocation of Both Defense Costs and Indemnity Payments among Concurrent Insurers

By J. Robert Hall

September 11, 2008

SUMMARY: American Casualty v. Health Care Indemnity addresses the priority of coverage and allocation of defense costs issues among two concurrent professional liability insurers. It involves the interplay between the "other insurance" clauses contained in the policies and addresses whether one co-primary insurer which pays more than its "pro rata by policy limits" share of defense costs has a right of contribution against another co-primary insurer.

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ARTICLE: *American Casualty Company of Reading, Pennsylvania v. Health Care Indemnity, Inc.*, 520 F.3d 1131 (10th Cir. 2008) addresses the priority of coverage and allocation of defense costs issues among two concurrent professional liability insurers with respect to a nurse insured by both of them. It involves the interplay between the other insurance clauses contained in the policies and addresses whether one co-primary insurer which pays more than its pro rata by policy limits share of defense costs has a right of contribution against another co-primary insurer. Applying Oklahoma law, the Tenth Circuit held that both policies contained irreconcilable excess-type other insurance clauses, that defense costs and indemnity payments should be allocated on a pro rata by policy limits basis, and, contrary to a recent Oklahoma Appellate Court decision, that the insurer which paid more than its allocable share of defense costs was entitled to equitable contribution from the insurer which underpaid.

Background Facts

In May 2004, Mary Pat Rooks (Nurse Rooks), a registered nurse, was named as a defendant in a wrongful death action filed in Oklahoma state court, arising out of injuries sustained by a patient. *Id.* at 1132. At the time of the incident, Nurse Rooks was insured under a professional liability insurance policy she purchased from American Casualty Company of Reading, Pennsylvania (American Casualty). *Id.* She also qualified as an insured under a professional liability policy issued by Health Care Indemnity, Inc. (HCI) to the hospital where she was employed. *Id.* at 1133.

Because American Casualty and HCI disagreed about their respective defense and indemnity obligations to Nurse Rooks, American Casualty filed a declaratory judgment action in the United States District Court for the Western

District of Oklahoma. *Id. at 1133*. In its lawsuit, American Casualty asserted that both policies contained excess-type other insurance clauses (*i.e.*, clauses which state that coverage is provided only after other insurance is exhausted), and that the two clauses were irreconcilable or mutually repugnant. *Id.* American Casualty also contended that defense costs and indemnity payments should be allocated between the two insurers on a pro-rata by policy limits basis, under which allocation American Casualty would be responsible for only 1/11 of the defense costs and indemnity payments (since the HCI policy's limit of liability was \$10 million and the American Casualty policy's limit of liability was only \$1 million). *Id.* Finally, American Casualty sought contribution from HCI for the defense costs it paid in excess of its 1/11 share. *Id.*

HCI responded that it had no present defense or indemnity obligations, because its policy applied excess to the American Casualty policy, and it sought a declaration to that effect. *Id. at 1134*. HCI acknowledged that its own policy contained an excess-type other insurance clause, but contended that the American Casualty policy's other insurance clause could not be given effect because it was either a pro rata clause (*i.e.*, a clause which addresses allocation among co-primary insurers) or an escape clause (*i.e.*, a clause which disclaims all coverage under the policy if other insurance applies). *Id. at 1133, 1136*. HCI also took the position that even if both policies contained mutually repugnant excess clauses, under Oklahoma law American Casualty would not be entitled to contribution for defense costs because, unlike indemnity payments, an insurer cannot obtain equitable contribution for them. *Id. at 1133*.

On cross-motions for summary judgment, the district court concluded that both policies contained mutually repugnant excess clauses and that indemnity payments and defense costs must therefore be shared on a pro rata basis according to the ratio each respective policy limit bears to the cumulative limit of all concurrent policies. *Id.* The district court determined that American Casualty had spent \$134,578.43 toward Nurse Rooks defense, and HCI had contributed \$353,001.71. *Id.* Since American Casualty had paid more than its 1/11 share of defense costs, the district court entered a judgment for American Casualty in the amount of \$90,252.96, so that the net defense cost payments by the parties would be in the same ratio as their limits of liability. *Id.* HCI appealed.

Tenth Circuit Analysis

The Tenth Circuit began its analysis by discussing the relevant principles of Oklahoma law as to coordination-of-coverage disputes:

Primary coverage is provided when, under the terms of the policy, the insurer is liable without regard to any other insurance coverage available. *Excess coverage* or *secondary coverage* is provided when, under the terms of the policy, the insurer is liable for a loss only after any primary coverage--*other insurance*--has been exhausted. . . . An *escape clause*, also known as a *no liability clause*, disclaims any and all liability if other insurance is available.

Id. at 1131 (quoting Equity Mutual Ins. Co. v. Spring Valley Wholesale Nursery, 1987 OK 121, 747 P.2d 947, 954 (Okla. 1987) (emphasis in original)). The Court also noted that, under Oklahoma law, if two policies cover the same risk for the same insured, an excess clause controls over an escape clause and conflicting other insurance clauses cancel each other, in which case the allocation between the policies is determined according to the ratio each respective policy limit bears to the cumulative limit of all concurrent policies. *Id. at 1133*.

After noting there was no dispute that the HCI policy contained an excess other insurance clause, the Court turned to the proper interpretation of the American Casualty policy's other insurance clause, which read as follows:

Any loss resulting from any claim insured under any other insurance policy or risk transfer instrument, including but not limited to, self-insured retentions, deductibles, or other alternative arrangements, which applies to this loss, shall be paid first by those instruments, policies or other arrangements. This insurance will not serve as primary insurance where there is other applicable insurance. It is the intent of this policy to apply only to loss which is more than the total limit of all deductibles, limits of liability, self-insured amounts or other valid and collectible insurance or risk transfer arrangements, whether primary, contributory, excess, contingent, or otherwise. This insurance will not contribute with

any other applicable insurance. In no event will we pay more than our limit of liability.

Id.

The Tenth Circuit held that the American Casualty policy's other insurance clause, like the HCI policy's other insurance clause, was an excess clause. *Id.* It rejected HCIs argument that the clause was actually a pro rata clause because it contemplated providing primary coverage. *Id.* It was an excess clause because it stated that any loss shall be paid first by other policies and that the policy will not serve as primary insurance where there is other applicable insurance. *Id.* The Court also rejected HCIs argument that, in order to be an excess clause, an other insurance clause must utilize the specific word excess, reasoning that the Court must look to the substance of the policy language, not whether any particular magic word is used. *Id.* at 1133-34.

The Court also was not persuaded by HCIs alternative argument that its policy was excess to the American Casualty policy because the other insurance clause in the American Casualty policy was an escape clause. *Id.* at 1131, 1134. The Court determined that the American Casualty policy does not disclaim any and all liability if other insurance exists, the defining feature of an escape clause, nor does it accomplish that result indirectly. *Id.* at 1134. Rather, [l]ike the HCI policy, it provides coverage once the coverage of other policies has been exhausted. *Id.* The Court then contrasted the language of the American Casualty policy's other insurance clause with another clause which the Tenth Circuit had held to be an escape clause, which provided that insurance shall not apply to any liability or loss against which the insured . . . has other collectible insurance applicable thereto, in whole or in part. *State Farm Mut. Auto. Ins. Co. v. Mid-Continent Cas. Co.*, 518 F.2d 292, 297 (10th Cir. 1979). Unlike the other insurance clause at issue in *State Farm*, the American Casualty policy's other insurance clause did not disclaim all liability if other insurance applied, but rather only sought to provide coverage in excess of all other insurance. *American Casualty*, 520 F.3d at 1134. As such, it was not an escape clause but rather an excess clause, and American Casualty and HCI shared co-primary obligations based on their policies mutually repugnant excess clauses. *Id.*

The Tenth Circuit then turned to HCIs challenge to the district court's contribution award. *Id.* HCI argued that that American Casualty's defense cost contribution claim was foreclosed by *United Services Automobile Association v. State Farm Fire & Casualty Co.*, 110 P.3d 570 (Okla. Civ. App. 2004) (USAA), an Oklahoma Court of Appeals case which held that one insurer cannot obtain equitable contribution from another for defense costs (but rather only for indemnity payments). The Tenth Circuit disagreed and declined to follow USAA for two reasons. *Id.* First, the holding in USAA is contrary to an earlier Tenth Circuit decision applying Oklahoma law, *St. Paul Mercury Ins. Co. v. Underwriters at Lloyds of London, England*, 365 F.2d 659, 662 (10th Cir. 1966). *St. Paul* controlled over USAA because a decision by a state intermediate appellate court is not binding on us with respect to matters of state law, and a panel of this court cannot overturn one of our precedents on such authority. *Id.* at 1135. Second, the Tenth Circuit believed that USAA may have been wrongly decided, in that it failed to give weight to a recent Oklahoma Supreme Court case which suggested that equitable contribution among co-primary insurers might be allowed. *Id.*, citing *U.S. Fid. & Guar. Co. v. Fed. Rur. Elec. Ins. Corp.*, 37 P.3d 828, 832 (Okla. 2001). Accordingly, the Tenth Circuit upheld the district court's \$90,252.96 contribution award in favor of American Casualty. *Id.*

Potential Impact

Several aspects of the *American Casualty* decision may impact the respective rights and obligations of concurrent insurers. **First**, the Tenth Circuit clarified that, in interpreting an other insurance clause, it is the purpose and effect of the clause as a whole which matters, rather than the presence or absence of any magic words. *Id.* at 1133. Many other insurance clauses policies contain language which has not yet been interpreted in reported decisions. *American Casualty* suggests that other insurance clauses always should be interpreted as a whole, according to their plain meaning, and that no talismanic language is required.

Second, the *American Casualty* court applied the rule, adopted by a majority of courts, that defense costs and indemnity payments are allocated among co-primary insurers according to the pro rata by policy limits method, under

which each insurer contributes proportionately based on the ratio of the limits of liability of its policy to the total limits of liability provided by all applicable policies. *See, e.g., Great N. Ins. Co. v. Mount Vernon Fire Ins. Co.*, 708 N.E.2d 167 (N.Y. 1999). In a minority of jurisdictions, by contrast, defense costs are allocated among concurrent insurers on a pro rata by equal shares basis, under which each insurer pays an equal share of defense costs, regardless of the limits of liability of the policies or how any indemnity ultimately will be allocated. *Am. Cas. Co. of Reading, Pa. v. PHICO Ins. Co.*, 702 A.2d 1050, 1053-54 (Pa. 1997). Although in *American Casualty* the method of allocation was not specifically challenged on appeal, the case nonetheless suggests that the pro rata by policy limits method should be applied even where there is a significant disparity between the limits of liability of the policies at issue (in this case, the American Casualty policy's limit of liability was \$1 million, compared to \$10 million for the HCI policy).

Third, and most significantly, the *American Casualty* decision held that defense costs, like indemnity payments, are subject to allocation and that an insurer can equitably contribute for them from another co-primary insurer. In doing so, the court adopted the majority position in other jurisdictions. *See, e.g., U.S. Fid. & Guar. Ins. Co. v. Executive Ins. Co.*, 893 F.2d 517, 520 (2d Cir. 1990) (New York law); *Sharon Steel Corp. v. Aetna Cas. & Sur. Co.*, 931 P.2d 127, 140-42 (Utah 1997); *Employers Ins. Co. of Wausau v. Travelers Indem. Co.*, 141 Cal. App. 4th 398 (2006). *American Casualty* rejected the rationale of the Oklahoma Appellate Courts' *USAA* decisions and other similar decisions which hold that, because every concurrent insurer is jointly and severally required to provide a complete defense to the insured, defense costs therefore are not subject to equitable contribution. *See Jostens, Inc. v. Mission Ins. Co.*, 387 N.W.2d 161, 167 (Minn. 1986); *Sloan Constr. Co. v. Central Natl Ins. Co.*, 236 S.E.2d 818 (S.C. 1977).

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Meckler Bulger Tilson Marick & Pearson on Zurich Am. Ins. v. OHara Reg. Center

2008 Emerging Issues 2904

Meckler Bulger Tilson Marick & Pearson LLP on Zurich American Ins. Co. v. OHara Regional Center for Rehabilitation: No Duty to Defend False Billing Claims under Professional Liability Policies

By Michael M. Marick and J. Robert Hall

September 11, 2008

SUMMARY: Zurich American v. OHara Regional Center addresses whether professional liability insurers have a duty to defend False Claims Act and common law false billing claims brought against an insured nursing home and its owners. Applying Colorado law, the Tenth Circuit held that the false billing claims did not give rise to a duty to defend because they did not arise from any act or omission of the insureds in providing professional services.

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ARTICLE: Background Facts

The insureds (collectively, OHara) owned and operated a long-term care facility in Denver. OHara had entered into provider agreements with the United States and the State of Colorado (collectively, the Government) under the Medicare and Medicaid programs. *Id.* at 918. Following an audit of OHaras billing practices, the Government determined that, over a period of several years, OHara had submitted inflated invoices for patient services. *Id.* at 918-19. In 2004, the Government filed a lawsuit against OHara (the False Claims Action), asserting claims under the False Claims Act and state common law, to recover the sums it had overpaid based on OHaras false Medicare and Medicaid bills, plus statutory penalties. *Id.* at 919.

During the years at issue, OHara was insured under a series of occurrence-based professional liability insurance policies issued by Zurich American Insurance Company (Zurich), Valley Forge Insurance Company (Valley Forge), and Certain Underwriters at Lloyds, London (Lloyds). *Id.* OHara tendered its defense in the False Claims Action to all three insurers. *Id.* Lloyds disclaimed coverage; Valley Forge and Zurich defended the insureds subject to a full reservation of rights, including the right to recoup defense expenses. *Id.* at 920.

As the False Claims Action proceeded, all three insurers filed separate declaratory judgment actions against OHara, which were consolidated in the United States District Court for the District of Colorado. *Id.* All three insurers sought declaratory judgments that they had no duty to defend the False Claims Action; Valley Forge and Zurich also sought to recoup defense costs from OHara. *Id.* On the parties cross motions for partial summary judgment, the district court held that none of the insurers had a duty to defend and that Valley Forge and Zurich were entitled to recoup their defense costs. *Id.* The district court certified the judgment pursuant to 28 U.S.C. § 1291. OHara appealed the duty to defend issue to

the Tenth Circuit. *Id.*

Tenth Circuit Analysis

On appeal to the Tenth Circuit, OHara made two principal arguments as to why the False Claims Action gave rise to a duty to defend under the insurers professional liability policies. *Id.* First, OHara asserted that the misconduct alleged in the False Claims Action arose from OHaras professional negligence in the design and implementation of health care practices, namely, the failure to provide professionally adequate nursing or medical services, because if a proper level of nursing care had been provided, the bills would not have been false. *Id.* Second, OHara asserted that its billing practices its preparation and submission of Medicare and Medicaid bills pursuant to its provider agreements with the Government also themselves constituted professional services within the meaning of the policies. The Tenth Circuit rejected both arguments.

The Court first considered and dismissed OHaras argument that the Governments alleged overpayments arose from OHaras failure to provide professionally adequate nursing services. Noting that all of the policies at issue essentially require that the insured cause injury by negligently providing nursing, medical, or professional services generally, Colorado law nonetheless requires more than a but for relation between the covered activity and the injury. *Id.* at 921. It mandates that the claimant must [also] show that the [covered activity] and the injury are directly related or inextricably linked so that no independent significant act or [omission] interrupted the but for causal chain between the covered [activity] and the injury. *Id.* at 921 n.7 (bracketed text in original) and 924. The insured must establish a direct causal connection, without any significant intervening independent act or omission, between the covered activity and the injury for which the underlying plaintiff seeks to hold the insured liable.

Thus, the Court reasoned that, in this case, the insureds had to establish a direct causal connection between the covered activity (*i.e.*, the insureds provision of nursing or medical services) and the injury for which the Government sought to hold them liable (*i.e.*, the governments payments due to the insureds inflated invoices). They failed to do so. The Court opined that [t]he Governments injury was not caused by OHaras failure to provide professional services, but instead resulted from OHaras submission of false and fraudulent claims for reimbursement. *Id.* at 921. Stated differently, the direct cause of the Governments injuries, its overpayments of Medicare bills, was OHaras intervening act of submitting inflated bills to the Government, not the earlier provision of inadequate professional services. From the Governments perspective, [t]he problem was not the actual level of services provided to OHaras patients, but rather that OHara billed for services it did not provide namely, enhanced services. *Id.* at 921-22. Dismissing OHaras arguments as an attempt to bootstrap liability for False Claims Act violations into the coverage provided by the professional liability policies, the Court held that no direct causal connection existed between OHaras failure to perform nursing services and the relief sought by the Government. As a result, none of the insurance policies even potentially provided coverage. *Id.* at 923.

The Tenth Circuit also rejected OHaras alternative argument that its preparation and submission of Medicare and Medicaid bills which tasks, it contended, were difficult and required advanced training constituted professional services. *Id.* at 924. Although some form of the phrase professional services was used in each of the three policies, the phrase was not defined in any of them. *Id.* Because Colorado courts had not clarified the meaning of professional services in a liability insurance policy, the Tenth Circuit applied a definition frequently relied on by courts:

A professional act or service is one arising out of a vocation, calling, occupation, or employment involving specialized knowledge, labor, or skill, and the labor or skill involved is predominately mental or intellectual, rather than physical or manual.

Id. (citing *Marx v. Hartford Acc. & Indem. Co.*, 157 N.W.2d 870, 871-72 (Neb. 1968)). Applying this standard, the Court reasoned that, although processing Medicare and Medicaid claims may be difficult and time consuming, it nonetheless does not require the level of particularized knowledge necessary to be characterized as a professional service; rather, it has been held to constitute nothing more than an ordinary activit[y] achievable by those lacking the

relevant professional training and expertise. *Id.* at 924-25. Significantly, the Court also rejected, as a matter of law, the insureds attempt to establish the difficulty and complexity of Medicare and Medicaid billing practices through an affidavit it submitted. *Id.* n.9. It noted that the insureds affidavit could not create any genuine issue of material fact because [p]reparing bills is an ordinary activity of business, and, while federal regulations may be complex, such an activity does not constitute a part of the professional services of a nursing home. *Id.* The Court emphasized the distinction between an insureds professional services, on the one hand, which could potentially be covered, and its activities incidental to those services, on the other hand, which could not. Because OHaras billing practices were incidental to its business as an operator of a nursing home facility, they were not professional services. *Id.*

Having rejected OHaras arguments, the Tenth Circuit concluded that none of the insurers had a duty to defend or indemnify OHara and affirmed the judgment in favor of the insurers. *Id.* The court remanded the case to the District Court for further proceedings on Valley Forge and Zurich's defense cost recoupment claims. *Id.* at 926.

Potential Impact

In our view, the potential impact of the *OHara* case is three-fold. **First**, the decision presents a significant hurdle for insureds seeking coverage under professional liability policies for suits involving the truth or accuracy of the bills they submit for professional services. In that regard, the case adds to a growing body of case law holding that insurers have no duty to defend or indemnify their insureds in connection with such claims. See *Horizon West, Inc. v. St. Paul Fire & Marine Ins. Co.*, 214 F. Supp. 2d 1074 (E.D. Cal. 2002), *aff'd mem.*, 45 F. App'x 752 (9th Cir. 2002); *Hampton Med. Group v. Princeton Ins. Co.*, 840 A.2d 915, 917-18 (N.J. Super. Ct. App. Div. 2004).

Second, the case provides guidance as to scope of the activities that may qualify as professional services, particularly under Colorado law, and the legal (as opposed to factual) nature of the inquiry. Specifically, the Tenth Circuit made a clear distinction between services an insured furnishes in a professional capacity (such as nursing services) and services it provides which are merely incidental to the profession (such as billing for those services). The Tenth Circuit endorsed the oft-cited definition of professional services set forth in *Marx v. Hartford Acc. & Indem. Co.*, 157 N.W.2d 870, 871-72 (Neb. 1968) and clarified that billing activities do not become professional services simply because they are difficult and time consuming. In addition, the case is noteworthy in that it rejected as a matter of law an insureds attempt to use an affidavit of a proffered expert to establish that Medicare and Medicaid billing is so complex it requires specialized knowledge, labor, or skill and is so predominantly mental or intellectual that it is within the definition of professional services set forth in *Marx*.

Third, the case may also have broader significance outside the context of a professional insureds billing activities, in that it addresses the causation requirement between the covered activity and the injury under a liability insurance policy. Specifically, the Court expanded on prior Colorado case law holding that a liability insurance policy requires a sufficiently direct causal connection between an activity covered under the policy and the injury at issue. In *OHara*, although it was alleged that a covered activity (*i.e.*, negligently inadequate staffing) was a but for cause of the governments injury (*i.e.*, overpayment for services not provided), OHaras deliberate submission of false bills was an intervening cause which broke the chain of direct causation. Accordingly, *OHara* and its causation requirement may well be significant in other cases in which an insureds potentially covered negligent conduct is a but for cause of an injury, while the insureds noncovered intentional conduct is an intervening cause of that injury.

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Wiley Rein LLP on the March Towards New Health Care Privacy Legislation

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Wiley Rein LLP on the March Towards New Health Care Privacy Legislation

By Kirk J. Nahra

September 11, 2008

SUMMARY: Electronic medical records, personal health records and additional use of information technology may dramatically improve our health care system. They also raise questions about whether existing privacy rules are appropriate in this evolving information environment. Today, as Congress begins to act, there is a real risk that privacy and security concerns ultimately may impede, reduce or eliminate many benefits of these new electronic records.

PDF LINK: Core Emerging Issues Commentary (\$)

ARTICLE: America needs to move much faster to adopt information technology in our health care system. . . . Electronic health information will provide a quantum leap in patient power, doctor power, and effective health care. We can't wait any longer.

Health information technology can improve quality of care and reduce medical errors, even as it lowers administrative costs. It has the potential to produce savings of 10 percent of our total annual spending on health care, even as it improves care for patients and provides new support for health care professionals.

(Then) U.S. Department of Health and Human Services (HHS) Secretary Tommy Thompson, announcing the initiative to promote health information technology (available at <http://www.hhs.gov/news/press/2004pres/20040721a.html>).

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Electronic medical records will improve medical effectiveness. These records will cut administrative costs for the health care system. These records will reduce medical errors. Health information technology has the potential to transform the delivery of health care in America for the better -- and to do so without heavy-handed regulation or upheaval in the health care sector. n1 And personal health records, under individual control, will inspire individual patients to take more control of their health, in much the same way that consumer driven health plans have given patients an economic incentive for their treatment, saving health care costs for individuals, employers, health insurers and governments.

So why have we had such a hard time finding a way to implement health information technology, and to give health

care providers the appropriate incentives, encouragements and obligations to incorporate these records into the treatment of patients? It is clear that many in and out of the health care system view electronic medical records, personal health records and additional use of health information technology as a means of creating dramatic improvement in our health care system. At the same time, these records along with some of these benefits are creating a new debate as to whether the existing health care privacy and security rules are reasonable and effective in today's evolving health care information environment.

So, while clearly not the only relevant factor, privacy has become a stumbling block of sorts to development of health information technology. And, as Congress begins to move more quickly on the legislative front dealing with these records, privacy threatens to become an even bigger concern, with the real risk that privacy and security concerns ultimately may impede, reduce or eliminate many of the benefits of these new electronic records.

The overall debate over electronic health records has focused on two primary areas. First, from a pure policy perspective, what should the rules be for the collection, use and exchange of these electronic records? As we struggle to develop appropriate means of designing information exchange networks, and entities across the country, both public and private, face challenges in determining appropriate ground rules, will we be able to develop systems that will provide the benefits identified by government advocates while still protecting patient privacy through appropriate means?

Beyond this policy debate, the questions about these electronic health records are now moving to the legislative arena with Congress actively evaluating various health information technology bills that are designed to promote the use of health information technology while providing appropriate privacy and security protections.

This commentary looks at three components of this debate. First, it briefly defines the relevant terms and describes the marketplace for health information technology, to provide a common baseline for the discussion that follows. Second, it reviews the key policy issues that should be considered in implementing health information systems across the country. Third, it reviews the current legislative proposals and identifies the key areas of concern from these ongoing legislative efforts.

The Relevant Concepts

The debate over electronic healthcare records has spawned not only a wide range of new terminology and products, but also has created new categories of market participants who are using and disclosing vast amounts of health care information. It has been difficult to develop common terminology, and some of the difficulties in the current debate stem from disagreements (explicit or implicit) as to the scope of certain concepts. While the definitions used below are not necessarily uniform and unanimously accepted, they will be utilized here to discuss the relevant arguments.

Electronic Medical Records. The first idea is electronic medical records. Electronic medical records (EMRs) are medical records created and used by health care providers as part of providing care to patients. The idea of electronic medical records is simple take the records that doctors, hospitals and other healthcare providers have traditionally maintained, and move them from paper to electronic formats. When maintained electronically, these records may be more easily accessible to health care providers, can be combined and consulted, and may be subject to reduced costs and more standardization.

Personal Health Records. These records, by contrast, are essentially driven by marketplace initiatives, outside of an existing regulatory structure. The idea of a personal health record (PHR) is to give the health care consumer the patient an ability to compile and maintain information about that individual (or his/her parents or children), in an electronic format (although, of course, this collection of information could be on paper as well). The concept is pro-consumer, and is arguably consistent with the movement towards consumer-driven health plans give the consumer control over his or her health care information, and medical results will improve. Because these records typically (a) are

under the consumers control (at least nominally) and (b) require another entity to develop the vehicle for the record, these records often may be entirely outside the scope of protections provided by the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) [Pub. L. No. 104-191]. If an Internet company offers a consumer a product to gather and store health care information, that activity is outside the scope of HIPAA unless the offering entity happens to be a health care provider or a health insurer. Clearly, some providers and insurers are offering these products; at least as often, however, these products are being offered by companies with no effective control under HIPAA.

Health Information Exchange. The next key piece to the puzzle involves health information exchanges. While these exchanges can take many forms (and all of the relevant forms are still evolving), health information exchanges (HIEs) offer the opportunity for one entity often, but necessarily a health care provider to exchange electronically health care information with other entities. The prototype idea is the ability of a hospital to learn through a health information exchange that the patient who was brought into the emergency room was treated by one doctor for a particular condition, and received drugs from a pharmacy for another symptom. The goal of these exchanges is to improve medical outcomes and reduce medical errors for example, by identifying a potential drug interaction with the drug provided by the pharmacy. These exchanges clearly are a work in progress. Many of these entities typically called regional health information exchanges or RHIOs are being developed as quasi-governmental entities, focusing on a limited geographic region. These exchanges are developing on a very modest level, and are struggling not only to deal with a variety of difficult legal issues, but also to develop a sustainable economic model. These exchanges however, are raising many of the broadest privacy and security concerns. If the goal of these exchanges is to make available information that either was unavailable before, or realistically inaccessible, are there additional privacy and security protections that need to be put in place to control the flow of information? If an electronic health record simply involves a health care provider converting paper records to electronic formats, no one is too concerned. When these records start being exchanged with others at local, state, regional, or national levels then privacy and security become bigger concerns.

Personal Health Record Networks. Perhaps the most significant development of the past year has been the opening salvos in a much broader competition in the personal health record marketplace, with enormous companies proposing to develop what are essentially PHR-driven networks for the exchange of personal health information. In recent months, three leading entities Google, Microsoft and Dossia (an employer-driven coalition) have announced efforts to restructure the PHR marketplace, using the Internet and other electronic vehicles to provide consumers with a self-controlled personal health record while, at the same time, allowing information to flow between these records and health care providers around the country largely under the control of individual consumers. Many other companies Revolution Health, WebMD and others also are participating in this market. With each effort differing in some important details (and many of the details still being worked out), these activities present the possibility of making RHIOs obsolete before they move beyond their infancy. By operating under consumer control, these entities may be able to avoid or reduce some of the complexities that arise for RHIOs because of state law restrictions. Moreover, these deep pocketed entities can utilize significant resources to develop these programs and partner with entities around the country to participate in these programs, without the geographic restrictions of most RHIOs.

The Current Status and the Key Questions.

Today, there is lots of debate and discussion by lots of people about the very challenging issues presented by EMRs, PHRs and HIEs. While this debate proceeds with no clear end in sight the marketplace is moving forward without rules, both with healthcare providers building significant electronic medical records systems and through personal health record vendors developing increasingly broad product offerings. Moreover, regardless of how this debate proceeds, the rules are not likely to catch up with the marketplace any time soon. For health care providers, insurers, employers, aspiring PHR vendors, and others, it is critical to be aware of this uncertainty, and to understand the need to develop systems that can be effective today, but that also can be sufficiently flexible to adjust to future

regulatory requirements.

From a privacy and security perspective, I identify below (in my personal view) the top questions implicated in the development of electronic medical records, personal health records and health information exchanges.

Is there a need for new privacy rules that apply to the broad variety of participants in health information exchanges who are not covered by HIPAA today? The development of health information exchanges and personal health records has highlighted some of the gaps of the existing HIPAA privacy and security structure. There clearly are significant participants in these efforts who, today, have no regulatory obligations at all under HIPAA. Accordingly, one of the first questions to be addressed will involve whether there needs to be rules created for these entities. Most of the advisory groups that have opined on this topic have recommended that either the HIPAA rules be extended to these participants in health information exchanges and personal health records, or that new rules be created for these entities.ⁿ² Another alternative is for these entities to be required to develop appropriate privacy notices and policies (perhaps under some kind of government certification standard), with the Federal Trade Commission acting as the enforcement agency for violations of these notices. The question of what to do with these non-HIPAA entities is a critical one, and one that drives much of the concern about building trust in these electronic networks.

Are there sufficient differences in the HIE environment to justify different privacy rules than exist today? The current health care privacy structure is exceedingly complicated. The HIPAA structure is the primary set of rules. In addition, covered entities need to factor into their compliance efforts a wide variety of other federal laws and regulations (*e.g.*, the federal substance abuse rules) and an enormous, often inconsistent and exceedingly confusing array of state laws, that may or may not create more stringent obligations than HIPAA. With this extensive set of existing obligations, one of the key issues for the current debate is whether there is a specific reason to justify adding a new set of legal obligations. Many of the entities that have advocated for new rules simply do not like the existing rules; that is a fair position to take, but it does not address the question of whether there should be specific rules for this electronic health exchange environment. Instead, it is critical to evaluate whether there is something different about this environment to justify having new rules. It is hard to say as some have argued that the electronic nature of this information is different from the HIPAA environment, because electronic information clearly is encompassed within the HIPAA Privacy Rule, and is the clear and exclusive focus of the HIPAA Security Rule.

Nonetheless, there clearly are some differences. For example, the new kinds of participants in these efforts have led several groups to recommend extending the HIPAA rules to these new participants. If this step is taken, then, are there other substantive differences that justify new rules? Phrased differently, why should we create rules for this electronic health exchange environment that are different from the remainder of the health care universe?

What will be the implications of creating different rules specifically for information exchanged through HIEs? If a decision is made that there are reasonable bases to justify new rules for this environment, the follow-up question is what the impact will be from a situation where there will be two sets of rules for many entities, particularly healthcare providers one rule for HIPAA information, and a different set of rules for information that flows through the HIE. It is clear that the multiplicity of rules that exist today in the health care system on their own lead to confusion and concern, and create in some situations adverse consequences simply because of confusion. We can create significant new risks if we create a parallel set of rules, with confusion and complexity on how these rules should be applied. This concern about confusion should serve as a counterweight to the arguments that support new rules based on differences in the existing structure, particularly if these differences are not significant.

If there are going to be new rules created because of HIEs, should these rules extend to the overall health care privacy environment? As a related discussion, the question arises as to whether the need if there is one to create different rules for the electronic HIE environment justifies altering the rules throughout the health care system. Having two sets of rules creates a difficult set of complexities. Presumably, having one set of rules creates a cleaner

environment but then the question arises whether all of the health care rules should be changed because of the ongoing development of this health exchange environment. The current debate has served to highlight some of the HIPAA gaps, and has created a realistic view of the need for a true health information privacy regime. While a broader set of principles clearly would be beneficial -- in terms of the entities subject to these rules it is far less clear that the principles of HIPAA need to be fixed, altered or revised in any way. In fact, while there are some areas of concern, there is no widespread evidence that the HIPAA regime isn't working at least where it is applicable. So, before we embark on a new effort to revise how the health care industry handles patient privacy, we should make sure that there is a real need for new rules at all.

What kind of consumer consent should be required for HIE environments? One of the key issues in this debate involves the question of whether individuals should have additional consent rights than they do today under HIPAA. Patients and consumers have very limited consent rights in the HIPAA structure today. They essentially have no HIPAA consent rights for uses and disclosures of health care information for treatment, payment or health care operations purposes covering an enormous percentage of the typical uses and disclosures of information. They also have no consent rights for the public policy purposes established by the rule. The primary consent right is the requirement that individuals authorize disclosures outside of these core areas.

In the HIE environment, many advocates are promoting additional consumer choice and consent as a means of ensuring that consumers have trust in and participate in the system. That is certainly an appropriate topic for debate. Many of the same concerns were raised at the time of the HIPAA rule implementation. Once the HIPAA decision was made, and amid much concern about how patients would react, there is virtually no evidence supporting the idea that patients have been withholding information because of a lack of a consent model. Therefore, it is critical to evaluate this question of consumer consent fairly, with both an understanding of the current context (and the experience that stands behind this context) at the same time that we are evaluating the prospective nature of the health information exchange environment.

It also is critical to factor in the PHR component of this debate. Virtually all of the primary PHR models are promoted and marketed as consumer driven and consumer controlled. The premise of the PHR is that a consumer can choose (1) what information goes into the PHR and (2) who is given access to or provided information from the PHR. Obviously, there are significant challenges to making this general commitment a reality. There also are significant issues with how information that is disclosed even with consumer choice will be treated by the recipient. But, a marketplace that creates and develops PHRs faster and more broadly than the EMR environment and the development of health information exchanges may reduce the need to debate and decide on the appropriate role of consumer choice in an HIE environment. We also need to include in this discussion the question of whether consumer choice if provided is sufficient, given significant evidence that individuals do not fully understand the privacy choices they are given in the health care setting, particularly for situations that may or may not arise in the future.

If consumers are given additional consent rights, how will this affect the overall benefits of the health information exchange system? Continuing the idea, if there are additional consent rights granted to consumers which will affect the amount and nature of the information that will be exchanged through these exchange environments how will this affect the overall benefits of health information exchanges? This is probably the ultimate big picture question in this situation. Obviously, there are specific details that need to be addressed for example, would consent be opt-in or opt-out? Will the choice be all or nothing or more granular? If granular, and consumers are given the ability to withhold specific kinds of information, how will this affect the ability of health care providers and others to rely on this information? At the end of the day, the key question will be whether the consent model that is selected creates a situation where HIEs have so many gaps that the benefits of the exchanges in terms of medical errors, improved quality of care and reduction in administrative costs disappear because of privacy and security concerns.

Legislative Developments

As this policy debate has progressed, we now are seeing a parallel movement in Congress. On the one hand, Congress has been reviewing health information technology legislation for several years, designed to promote the use of health information technology and create an appropriate regulatory framework for this development. These bills have languished in Congress, both because of concerns about the goals of this legislation and, most recently, because of the perceived need to develop new privacy and security rules for this new environment. While this debate in Congress has been moving quickly, it is far from over. Moreover, as it now stands, the privacy and security proposals create the risk of both undercutting the incentives to use health information technology and imposing significant new burdens on health care entities in the name of patient privacy, without any concrete new privacy benefits or clear problems with the current privacy environment.

As we move into the fall of 2008, there is progress in both houses of Congress to move legislation to the Floor. In the Senate, the primary legislation at issue is the Wired for Health Care Quality Act, S. 1693, sponsored by Senator Kennedy. Focused on efforts to enhance the adoption of a nationwide interoperable health information technology system and to improve the quality and reduce the costs of health care in the United States, the legislation was passed by the Senate Health, Education, Labor and Pensions Committee more than a year ago, but had been held up from further action by concerns about the appropriateness of the privacy protections in the bill. Now, recent reports indicate that new privacy language has been agreed to by the key Senators involved in this debate, allowing this legislation to move forward in the Senate.

On the House side, the primary piece of legislation so far the PRO(TECH)T Act of 2008 (or the Protecting Records, Optimizing Treatment, and Easing Communication through Healthcare Technology Act of 2008.). This legislation was passed by the House Energy and Commerce Committee this summer. The House Ways and Means Committee also intends to introduce its own bill shortly, drafted by Congressman Stark, which threatens to delay any progress of this legislation in the House. In both houses of Congress, there is ongoing debate about both the technology portions of the bill, as well as the privacy and security proposals. While the likelihood of passage of legislation in 2008 is small, these principles clearly are gaining momentum, and will continue to be part of an ongoing debate in the new Congress in 2009.

The key driving force for this new legislation (which is still evolving in both Houses of Congress) is the need to promote health information technology. Accordingly, the bulk of the legislative language for these bills involves a series of goals relating to this technology, including:

- . Promotion of health information technology;
- . Establishment of appropriate government offices for regulation of health information technology;
- . Development of health information technology standards;
- . Incentives to health care providers for use of health information technology; and
- . Promoting interoperability among electronic health care records.

As these bills move forward, there clearly is a question as to whether Congress can agree on incentives to use new electronic technologies along with appropriate standards and infrastructure. If so, there is the related question of whether a bill that promotes use of health information technology necessarily requires the addition of new privacy and security provisions. Similarly, if Congress determines that new privacy provisions are required (as the bills today indicate), will these changes be limited to dealing with the effects of this new environment, or will they cross over into other areas not directly related to health information technology? Also, will these new changes be consistent with the idea of motivating use of these new technologies?

As of now, the privacy and security provisions seems inextricably linked to the health information technology legislation. There are a variety of key privacy provisions in this proposed legislation. First, there are a variety of

provisions that have nothing directly to do with the technology or systemic issues raised by the movement towards electronic records. For example, the House proposal would apply the HIPAA privacy and security rules directly to business associates vendors to health care companies. Currently, business associates must execute an appropriate contract with a HIPAA covered entity (such as a doctor, hospital or health insurer), but the business associate is subject only to a breach of contract action if it fails to meet its obligations. This provision would apply the rules directly to these vendors, exposing all HIPAA business associates to direct HIPAA enforcement. This is not necessarily a bad idea, but it clearly has nothing to do with electronic records.

Similarly, the House provisions would apply the HIPAA criminal enforcement provisions directly to employees of a covered entity. Today, following an interpretation by the Department of Justice, it is difficult to prosecute an employee for a HIPAA violation (although this difficulty has not stopped a series of prosecutions). The proposal would apply the criminal provisions to employees of covered entities, again without any tie to electronic records.

On a more significant note, the House bill includes a security breach notification provision that would extend far beyond the provisions of almost all state laws. All health care information would be covered including the wide range of information covered by HIPAA (such as name, address, phone number, etc), that is health information only by virtue of its inclusion within the scope of HIPAA. The current version contains no harm threshold (as do most relevant state laws), meaning that notice would be provided to individuals in the event of any breach of security involving any health care information. There is no description of the relevant harms that are intended to be covered again, unlike most state laws, which focus on identity theft risks.

Next, the House bill requires covered entities to withhold information from health insurers, if the patient objects to the disclosure to health insurers and the patient pays out of pocket for health care expenditures. While there clearly is a privacy interest at stake here, it also appears that the main impact of this provision would be to shield certain information from health insurers that their customers wish to hide. This clearly is a provision that should be challenged on public policy grounds. Regardless of ones view on this subject, however, this again is a provision that bears no relationship to the issues raised by electronic records.

There is one important provision in the legislation that is directly tied to electronic records, without raising significant disincentives for these records. Both bills would apply the HIPAA rules, to some extent, to various entities who today are not HIPAA covered entities, but in the new environment would be participating in health information exchanges or other uses or disclosures of health information through electronic records. This provision, while still evolving, mirrors the recommendations of various advisory groups, including the Confidentiality, Privacy and Security Work Group of the American Health Information Community, a group that I co-chair.

There are, however, a series of provisions that seem to create specific *disincentives* for the implementation of electronic records, by imposing specific new obligations on entities that use electronic records. For example, both the House and Senate proposals create a new patient right of access, providing broader access rights with quicker timetables, if an entity maintains information in electronic medical records. Similarly, this provision creates a greatly expanded HIPAA accounting right (a right that is virtually unused by individuals today), requiring covered entities that use electronic medical records to provide a complete audit trail of all internal and external access to an individuals medical information. This obligation creating enormous new costs and record retention obligations seems to be operating in direct opposition to the incentives portions of this legislation.

The single worst provision of the House legislation also creates substantial disincentives to use electronic records, one that could create significant operational problems for any health care entity. The House legislation contains a provision that requires patient consent for the disclosure of information for health care operations purposes, if a health care provider is using an electronic record. In this authors opinion, this is the single worst provision in either of these bills, with substantial risks of creating not only strong disincentives to use electronic health care records but also significant negative effects on the health care system, without any clearly defined privacy benefit.

The idea of this legislative language is that patients would provide consent for all health care operations uses and disclosures by providers, uses that involve the administrative operations of a health care business. This consent is presumed today in the HIPAA environment. There is no discussion in this legislation of how this consent would actually be obtained would patients be given a take it or leave it option, or would patients be provided with a list of dozens, or perhaps hundreds, of potential uses and disclosures for health care operations purposes, and instructed to pick and choose among them? Aside from the fundamental absurdity of this choice, it is very difficult to see how a health care provider could in fact operate its business, if it was forced to develop such an extensive system of new rules for how to run its business.

Moreover, the effects of these provision would extend far beyond health care providers. For example, health insurers would be precluded from using data they receive for their own health care operations purposes, unless the patient provided consent. This would (in the latest draft) even apply to information that the health insurer received for payment purposes, but would not be able to use for health care operations purposes. This step would threaten such important programs as pay for performance, health care quality reviews and a wide variety of cooperative quality related programs that currently are being promoted throughout the health care system. So, aside from enormous questions about how a provision like this would work and what harms it would create there is no definable privacy interest at stake, particularly one that is somehow greater through use of an electronic health record.

The Senate legislation, while generally narrower, also includes some confusing or problematic provisions. One publicized provision of the legislation involves a modest change to the marketing provisions of the HIPAA Privacy Rule. While marketing concerns drive a lot of commentary by privacy advocates under HIPAA, marketing has not been a topic that has generated a significant number of complaints to the HHS Office of Civil Rights. Nonetheless, without much explanation, the proposal would modify the definitions under the marketing provisions to require HIPAA authorizations in certain situations where they are not required today. Specifically, the language requires an authorization in connection with an arrangement whereby a covered entity, in exchange for direct or indirect remuneration, makes a communication to an individual to recommend or direct value-added health-related products or services or products or services not directly related to that individuals health.

While the language of the legislation is somewhat ambiguous, it is clear that the actual language is both unnecessary in some circumstances and confusing. For example, the HIPAA Privacy Rule today permits the use of patient information to send marketing communications about certain value-added and health related services, without the need for patient permission. If the communication is about a product or service that is not health-related, the Privacy Rule today requires an authorization. So, the legislative language about not directly related to that individuals health is unnecessary, unless the language is somehow drawing a distinction between health-related and directly related to an individuals health.

Next, in connection with a section entitled transparency, the legislation requires HIPAA covered entities, when contracting with a vendor who is not covered by the HIPAA Privacy Rule, whether off-shore or not, to:

- Take reasonable steps to select and retain third party service providers capable of maintaining appropriate safeguards for the security, privacy and integrity of protected health information; and
- Require by contract that such service providers implement and maintain appropriate measures designed to meet the requirements [imposed on covered entities.]

While there have been some legitimate questions raised about off-shore service providers, it is hard to read this language and believe that the drafters are aware at all of the existence of the HIPAA business associate provisions. *Arguably*, there is no due diligence obligation imposed by HIPAA. But how is it possible that new legislation would be needed to require by contract appropriate privacy protections for vendors, when the HIPAA Privacy Rule already imposes this exact obligation (with significantly more detail) on covered entities when vendors are hired today? Moreover, the legislation then requires the HHS Secretary to ensure that there is an effective means for enforcing the obligation . . . on any overseas services providers or other providers not covered by HIPAA, without giving the Secretary any tools whatsoever to do this. This language ignores that the HHS Secretary in fact has no enforcement

jurisdiction whatsoever over *any* business associate today, regardless of where the business associate is located, because of the limited jurisdictional reach of the HIPAA rules. Instead, the only option available to the Secretary is to impose enforcement risk on the covered entity if it fails to execute the appropriate contract.

Conclusion -- Where Do We Go From Here?

Clearly, there is a virtually unlimited set of issues arising from this debate. There also likely is no reasonable end in sight, so that there will be an ongoing policy-oriented debate, with many audiences being heard from, without any easy means of synthesizing or implementing these recommendations.

On the legislative front, there are significant risks that Congress will create more harm than good from its provisions. Congress appears determined to revisit carefully drawn HIPAA compromises without any credible need, thereby creating significant new costs and burdens for health care entities without any corresponding benefits. At a time when Congress is trying to motivate health care entities to implement electronic records programs, it also seems determined to impose new obligations on companies that do choose to implement these records, thereby creating incentives and disincentives in the same piece of legislation.

Congress should evaluate carefully whether there is a need at this time to develop new privacy and security rules. The technology portions of the legislation can proceed without any specific new privacy rules. These provisions while important mainly serve to motivate and guide a process of development of electronic health records over time. There are not new privacy risks created by this legislation even assuming there are in fact any new risks created at all by the movement towards electronic records. Rather than slow down these important technological issues, Congress should step back from new privacy and security rules, so that the push towards these rules does not create undue burdens without a corresponding benefit (particularly in a health care privacy system that generally is working well for covered entities and patients), while not impeding the important progress towards development of more comprehensive systems of electronic health records from health care providers across the country.

Return to Text

n1 HHS Press release, July 21, 2004 (available at <http://www.hhs.gov/news/press/2004pres/20040721.html>).

n2 For example, the American Health Information Community's Confidentiality, Privacy and Security Work Group, which I Chair, has recommended that entities participating in an HIE network be required to meet a standard that is at least consistent with HIPAA. See CPS Recommendation Letter, available at http://www.hhs.gov/healthit/documents/m20070612/cps_letter.html.

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Wiley Rein LLP on Don's Bldg. Supply, Inc. v. OneBeacon Ins. Co.

2008 Emerging Issues 2890

Wiley Rein LLP on Don's Bldg. Supply, Inc. v. OneBeacon Ins. Co.: Texas Adopts "Actual Injury" Trigger of Coverage for Property Damage Claims

By Benjamin Theisman and Gregory J. Langlois

September 10, 2008

SUMMARY: The U.S. Court of Appeals for the Fifth Circuit, the Supreme Court of Texas recently held, subject to variations in policy language, that general liability policies providing coverage for property damage that "occurs during the policy period" are triggered by "actual injury" or "injury-in-fact." The court did not follow the manifestation trigger theory representing a shift in Texas authority on property damage claims governed by Texas law.

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ARTICLE: Answering two certified questions from the U.S. Court of Appeals for the Fifth Circuit, the Supreme Court of Texas recently held, subject to variations in policy language, that general liability policies providing coverage for property damage that occurs during the policy period are triggered by actual injury or injury-in-fact. The policies at issue in this case therefore applied to underlying suits alleging damage to homes where the damage was alleged to have been present during the policy period but undetectable until after the policies expired. *Don's Bldg. Supply, Inc. v. OneBeacon Ins. Co.*, 2008 Tex. LEXIS 753 (Tex. 2008). In this ruling, the Texas high court did not follow earlier Texas cases endorsing the manifestation trigger, which had been the prevailing trigger theory according to both the United States Court of Appeals for the Fifth Circuit and Texas intermediate appellate courts. This shift in Texas authority will require a new perspective on property damage claims governed by Texas law as they are submitted to general liability insurers in the future. In addition, it may pose claim handling questions with respect to property damage claims for which coverage was denied or for which an insurer reserved its rights under Texas law based on the manifestation trigger.

A. The Ruling, Actual Injury or Injury-In-Fact

In this case, the policyholder, Dons Building, installed sold and distributed Exterior Insulation and Finish System (EIFS) siding, which was installed on numerous homes between December 1993 and December 1996. The policies in force during this time period provided coverage for property damage only if it is caused by an occurrence that takes place in the coverage territory and if the property damage occurs during the policy period. The policies defined property damage to include [p]hysical injury to tangible property, including all resulting loss of use of that property, noting that [a]ll such loss of use shall be deemed to occur at the time of the physical injury that caused it. Between 2003 and 2005, various homeowners filed lawsuits in state court against Dons Building, alleging that the product allowed moisture to

seep into cavities behind the siding, causing interior wood rot and other damages. The homeowners argued that the damages began to occur as of the first penetration of moisture allegedly six months to a year after the product was applied. Seeking to avoid statutes of limitation, however, the homeowners alleged that their damages were not discoverable or readily apparent until after the policies had expired because they were hidden behind the exterior siding, which had remained undamaged. The insurer filed a declaratory judgment action in federal court seeking a ruling that it owed no duty to defend or indemnify the policyholder. The district court held that the policies providing a duty to defend would not be triggered until damage became identifiable.

On appeal, the Fifth Circuit noted that a number of Texas courts of appeal in Dallas, San Antonio, and Austin had adopted the manifestation trigger theory, citing *Summit Custom Homes, Inc. v. Great Am. Lloyds Ins. Co.*, 202 S.W.3d 823, 827 (Tex. App.--Dallas 2006, pet. filed); *State Farm Fire & Cas. Co. v. Rodriguez*, 88 S.W.3d 313, 322 (Tex. App.--San Antonio 2002, pet. denied); *State Farm Mut. Auto Ins. Co. v. Kelly*, 945 S.W.2d 905, 910 (Tex. App.--Austin 1997, writ denied); *Cullen/Frost Bank of Dallas v. Commonwealth Lloyds Ins. Co.*, 852 S.W.2d 252, 258 (Tex. App.--Dallas 1993, writ denied); *Dorchester Dev. Corp. v. Safeco Ins. Co.*, 737 S.W.2d 380, 383 (Tex. App.--Dallas 1987, no writ). In contrast, the court noted that Houston courts have applied an exposure trigger in the context of EIFS damages, citing *Pilgrim Enterprises, Inc. v. Maryland Cas. Co.*, 24 S.W.3d 488, 490-91 (Tex. App.--Houston [1st Dist.] 2000, no pet.); *Pine Oak Builders, Inc. v. Great American Lloyds Ins. Co.*, 2006 WL 1892669, *7-8 (Tex. App.--Houston [14th Dist.] July 6, 2006, no pet.). The Fifth Circuit, accordingly, certified the following questions:

1. When not specified by the relevant policy, what is the proper rule under Texas law for determining the time at which property damage occurs for purposes of an occurrence-based commercial general liability insurance policy?

2. Under the rule identified in the answer to the first question, have the pleadings in lawsuits against an insured alleged that property damage occurred within the policy period of an occurrence-based commercial general liability insurance policy, such that the insurers duty to defend and indemnify the insured is triggered, when the pleadings allege that actual damage was continuing and progressing during the policy period, but remained undiscoverable and not readily apparent for purposes of the discovery rule until after the policy period ended because the internal damage was hidden from view by an undamaged exterior surface?

See *OneBeacon Ins. Co. v. Dons Bldg. Supply, Inc.*, 496 F.3d 361 (5th Cir. 2007).

The Texas Supreme Court accepted certification and addressed the certified questions in turn. The court noted that the first question asked for a determination of the proper rule under Texas law for determining the proper time at which property damage occurs under an occurrence-based general liability policy. The court, however, declined to fashion a universally applicable rule for determining when an insurers duty to defend a claim is triggered under an insurance policy, as such determinations should be driven by the contract language. Noting that the policies provided coverage only for property damage that occurs during the policy period and that property damage was defined as [p]hysical damage to tangible property, the court held that the property damage in this case arose when actual physical damage to the property occurred and thus when a home suffered wood rot or other physical damage. According to the court, it was irrelevant that the damage had not yet been discovered.

The court characterized its conclusion as an application of the actual injury or injury-in-fact rule triggering coverage at the time of an actual injury or injury-in-fact, regardless of the date of so-called exposure or manifestation. It noted that other courts have applied a manifestation rule, under which coverage is triggered only if the property damage becomes evident or was discoverable during the policy term, while still others have applied the exposure rule, under which coverage is triggered if the plaintiff is exposed to whatever agent ultimately results in personal injury or property damage during the policy period. Which approach is used often depends on differences in specific policy language under review, the court noted, as well as different factual circumstances.

The Texas high court determined that the widely-used policy language at issue here did not support application of either the manifestation rule or the exposure rule, stating that [t]his policy links coverage to damage, not damage

detection and that [o]ccurred means when *damage* occurred, not when *discovery* occurred. The court concluded that following the manifestation rule, as the insurer urged, would blur the distinction between this occurrence-based policy and a claims-made policy. The court also criticized application of an exposure rule, explaining that the policy provides coverage if the property damage occurs during the policy period rather than providing coverage if property is, during the policy period, exposed to a process, event, or substance that later resulted in bodily injury or physical injury to tangible property. Although noting that identifying the precise moment of injury is sometimes hard, the court stated that it was bound to apply contracting parties chosen language. In support of its conclusion, the Texas Supreme Court also cited a leading treatise stating that the injury-in-fact approach is likely more consistent with the policyholders and insurers actual intentions.

The second certified question asked whether the underlying complaints, which alleged that property damage took place during the policy period but was only detectable after the policies expired, triggered the insurers duty to defend. Based on its determination that the actual injury rule applied to the policies, the court held that the insurer owed a duty to defend, as a claim alleging that any amount of physical injury to tangible property occurred during the policy period and was caused by [the policyholders] allegedly defective product triggers [the insurers] duty to defend.

B. The Consequences

The Texas high courts ruling in this case marks a significant shift in Texas law. As noted by the Fifth Circuit and the Texas Supreme Court, intermediate appellate courts in Texas previously had largely been following a manifestation trigger theory. The rejection of that theory in favor an actual injury or injury-in-fact approach will require case-by-case analysis of the factual circumstances underlying a claim to determine if coverage is triggered. Such an analysis will likely raise further issues regarding whether multiple policy periods have been triggered and whether allocation is applicable. Accordingly, this ruling may signal the need for additional guidance from the Texas Supreme Court on related issues posed by long tail property claims under general liability policies.

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Artigliere on Essex Insurance Company v. Mercedes Zota , et al.

2008 Emerging Issues 2891

Circuit Judge (Retired) Ralph Artigliere on the Florida Supreme Courts Latest Opinion on the Agency Relationship Between an Insured and an Independent Insurance Broker: Essex Insurance Company v. Mercedes Zota , et al., 2008 Fla. Lexis 1112 (Fla. 2008)

By Ralph Artigliere

September 10, 2008

SUMMARY: The Florida Supreme Court holds in *Essex Ins. Co. v. Zota* that the the common law presumption that an insurance representative, serving as an independent insurance broker, acts on behalf of the insured for purposes of receiving proof of insurance has not been altered by statutes requiring delivery of the policy to the insured.

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ARTICLE: What the state and federal courts did in this case. A brief history of this dispute and its procedural path is essential to understanding the implications of the decision. The insured in this case, one of the defendants, Lighthouse Intracoastal, Inc., was in the business of building spec houses. Lighthouse secured various types of insurance to cover its activities as a homebuilder through an independent insurance broker, R.A. Brandon & Company. When one aspect of liability coverage was not available, Brandon procured surplus lines coverage for Lighthouse from the insurer, Essex, through Essex agent, McDuff Underwriters, Inc. The policy was delivered by Essex to Brandon as the securing broker, but Brandon never provided a copy of the policy to Lighthouse. When a person working on one of Lighthouses jobs named Mercedes Zota fell and was injured, Zota sued a number of parties in state court, including Lighthouse. Lighthouse did not receive a copy of the policy until the day after Zota was injured, and due to a faxing error the policy exclusions relied upon by Essex to deny coverage for the injuries were not included in the transmittal of the policy. 2008 Fla. Lexis 1112, FN 3. Lighthouse and the other parties challenged the ability of Essex to deny coverage based on the Florida statutory requirement to deliver a copy of the policy and its exclusions to the insured. *See* Fla. Stat. Fla. Stat. § 626.922 and § 627.421. Coverage issues raised by Essex were removed to federal district court in which a summary judgment was issued against Essex on the grounds that Essex was estopped from denying coverage because Essex had not delivered a copy of its policy to Lighthouse as required by Florida statute. *Essex Ins. Co. v. Zota, et al.*, 466 F. 3d 981, 2005 U.S. Dist. LEXIS 25255 (S.D. Fla. 2006). The case came to the Florida Supreme Court on five certified questions from the 11th Circuit based on unsettled Florida law. *Essex Ins. Co. v. Zota*, 466 F. 3d 981, 2006 U.S. App. LEXIS 25255 (11th Cir. 2006). However, in entering summary judgment, the federal district court simply estopped the surplus-lines insurer from relying on the language of the relevant policy exclusions and did not examine or develop many of the factual issues implicated by the Eleventh Circuit's certified questions. Accordingly, the Florida Supreme Court short circuited several issues by directing its efforts to the first certified question, the answer to which answered

the second and part of the fifth questions and created fact questions for the rest. Thus, the holding of the case addresses the first certified question, which is whether Fla. Stat. § 626.922 or § 627.421, or both, require delivery of evidence of insurance directly to the insured, so that delivery to the insureds agent is insufficient. The Court answered the first question no and held that sections 626.922 and 627.421, Florida Statutes (2003), have not abrogated the common-law agency analysis that it had previously applied in insurance-broker cases. Both aspects of the case, (1) the statutory analysis on the applicability of Chapter 627 to surplus lines carriers, and (2) the common law agency analysis, deliver important lessons for practitioners.

How the Florida Supreme Court reached its decision. On its face, the case appears uncomplicated because it does not change any law and it applies rather settled agency law to the operative facts: delivery to ones agent acting within the scope of the agents authority *presumably* constitutes delivery to the principal. However, in reaching that holding, the Court was required to first deal with a multifaceted statutory construction issue because Essex contended that, as a surplus lines carrier, it was excluded from the requirements of Chapter 627. A scrivener's error in the Florida insurance laws complicated the question of whether the relevant sections of the insurance law requiring delivery of an insurance policy to the insured apply to surplus lines insurance carriers. The Court dealt with the statutory construction issue by applying standard statutory construction and referring to its prior case that dealt with a species of the same issue, *Natl Corporacion Venezolana, S.A. v. M/V Manaure V*, 511 So. 2d 968 (Fla. 1987). This aspect of the case is important for surplus lines carriers because it holds that surplus lines carriers are not exempt from certain requirements of Chapter 627, including policy delivery, attorneys fees provisions, and more.

Once the Court found that the provisions of Chapter 627 requiring delivery of the policy to the insured was NOT exempted by statutory exclusions for surplus lines carriers, it was necessary for the Court to answer the first certified question: did the statutory requirement override common law of Florida in which delivery of the policy to the insureds agent (in this case the broker, Brandon) *presumably* comprises delivery to the insured? On the question of whether delivery of the policy to the agent was sufficient, the case turned in favor of the Essex. The Court strictly construed statutory impingement on the common law of agency and reiterated the vitality of its common law. Simply put, the insured was unable to overcome the presumption because there was no evidence of a special relationship between the surplus carrier and Brandon, the independent broker that procured the insurance for Lighthouse.

What the Florida case does. Despite limiting the scope of its decision on coverage due to lack of factual development in the district court case, the decision carries implications for carriers, brokers and insureds and lessons for in house counsel and private lawyers who represent them.

Exclusionary provisions and surplus lines carriers. Just how much protection is afforded to surplus lines carriers under the exclusionary provisions of section 627.021(2)? The Essex Court, relying on statutory construction analysis and the *Manaure* case held that the exclusionary provisions were intended to apply only to Part I of Chapter 627, the ratemaking portion of the statute. 2008 Fla. LEXIS 1112 at 18. Before *Essex*, surplus lines carriers relying on their exclusions from Chapter 627 may have expected broader exclusion from Chapter 627, as exemplified by the position of the insurer in the *Essex* case, which asserted that, as a surplus lines carrier, it was excluded from *all requirements* of Chapter 627. The Court rejected that notion outright. 2008 Fla. LEXIS 1112 at 18 (Therefore, Essex is incorrect in the assertion that none of the statutory provisions of chapter 627 apply to surplus-lines insurance.) The statutory construction holding clearly finds that surplus lines carriers in Florida are subject to not only the attorneys fees and policy delivery provisions at issue in the *Essex* case, they are subject to other requirements of that chapter. Since many surplus lines and foreign insurers may be unaware of the various technical requirements of Florida law, and may well have issued policies or engaged in practices that are not in compliance with those requirements, lawyers on both sides of cases involving surplus lines carriers and in-house counsel should review the policy and company practices for compliance with Florida law. Counsel should be cautioned that failure to comply with applicable statutory requirements could have serious implications for carriers providing coverage in Florida.

Requirement to deliver policy to the insured. When addressing the issue of whether delivery to the broker

constitutes delivery to the insured, the Courts analysis in the *Essex* opinion is instructive for carriers and insurance brokers. To say this case holds that carriers delivering policies to the insureds broker have met the Florida policy delivery requirements fails to address the full import of the case. The analysis of this issue is fact based; i.e., whose agent is the broker anyway? As stated by the *Essex* Court:

[A]n insurance broker acts as an agent of the insured, not the insurer, where the broker is employed by the insured to procure insurance. The presumption can be overcome by the existence of special circumstances [i.e., indicia of agency] indicating that the brokers arrangement with the insurer was not a standard relationship. (emphasis in original)

For surplus lines carriers, reliance on a presumption that delivery to the agent is effectively delivery to the insured is not a very safe harbor in which to weather a storm. The case-specific facts involving the relationships among the broker and the carrier and the insured will be considered. First, is the broker acting as an agent of the insured? If the broker is employed by the insured to procure insurance, there is a common law presumption that the broker is the agent of the insured. However, that presumption may be overcome by facts presented by the insured that there are special circumstances. *See 2008 Fla. LEXIS 1112 at 23-29*. Surplus lines carriers will need to assess whether to risk delivery of the policy to brokers is a safe practice in light of the potential forfeit of exclusions if the policy does not get to the insured.

Potential liability for brokers may arise when insureds that rely on brokers to procure insurance are not aware that the action or inaction of their agent in procuring information from the carrier is binding on them. Practitioners who represent independent agents should remind their clients to make the import of the agency relationship clear to the insured. Best practice dictates however that the agent/broker maintain a procedure for ensuring that all materials are forwarded to the insured, along with a method for documenting the delivery.

In light of the Courts holding in *Essex*, if the Florida legislature wants to require personal delivery of the policy and exclusions to the insured in all cases rather than to a broker or other intermediary, then that requirement will need to be clearly set out in an amendment to the statute.

What the Florida case does not do. Three of the certified questions were not addressed by the Florida Supreme Court because the factual issues were not developed in the federal case. As pointed out in the 11th Circuit *Essex* opinion, the Florida statutes and prior Florida cases are unsettled on the remedy for non-compliance with the statutory delivery requirement, whether Lighthouse met or did not meet the insurance definition of builder, contractor, developer, and whether the injured party Zota was an employee of Lighthouse under the policy. *Essex Ins. Co. v. Zota, et al.*, 466 F. 3d 981, 2006 U.S. App. LEXIS 25255 (11th Cir. 2006). In the absence of necessary facts, the Florida Supreme Court did not signal how it might answer the certified questions, so certain specific coverage issues remain unsettled under Florida statutory and case law. Perhaps the most important of these is the remedy available for non-compliance with the statute, which carries with it the question of whether exclusions can be lost and whether coverage that is not afforded by a policy can be created when statutory requirements are not followed. *See, 466 F. 3d at 986-988, 2006 U.S. App. LEXIS 25255 at 9-19.*

ABOUT THE AUTHOR(S):

Judge (ret.) Ralph Artigliere graduated with honors from the United States Military Academy at West Point in 1969 and high honors from the University of Florida School of Law in 1977. After a twenty-four year career as a civil trial lawyer with Holland & Knight (1977-81), Lane, Trohn, Clarke, Bertrand & Williams, P.A. (1981-91-Managing Partner), and Anderson & Artigliere, P.A. (1991-2001), Judge Artigliere was appointed to the Circuit Bench for the Tenth Judicial Circuit by Governor Jeb Bush in 2001. As a trial lawyer, Judge Artigliere represented insurance companies, insureds, and plaintiffs in personal injury and medical malpractice cases for 24 years. Judge Artigliere is a member of the faculties of the Florida Judicial Colleges and has been an instructor at the Florida Bars Advanced Trial Advocacy Course since 2001. Judge Artigliere sits on the Florida Civil Rules and Supreme Court Standard Civil Jury Instruction Committees. He co-authored with William Artigliere the Florida Bars FasTrain Manual: How to Write and

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Mark Vespole on American Wrecking v. Burlington Ins.

2008 Emerging Issues 2892

Mark Vespole on American Wrecking v. Burlington Ins.:Has New Jerseys Handful of Pro-Insurer Decisions Morphed a Few One-Off Aberrations into a Trend?

By Mark R. Vespole

September 10, 2008

SUMMARY: In American Wrecking v. Burlington Ins., a case of first impression in New Jersey, the Appellate Division, presaging the NJ Supreme Court's June 5, 2008 decision in Villa v. Short, upheld a cross-suit exclusion in an additional insured context. Perhaps what may have been perceived previously as an isolated aberration or two in a precious few pro-insurer coverage decisions emanating from NJ Courts now has the preliminary trappings of a trend.

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ARTICLE: American Wrecking was a high-risk demolition contractor which had two sister companies, Island and SECO. In 2003-2004, American Wrecking was performing demolition services under separate contracts with DSM and TCNJ at several locations. The respective contracts required that American Wrecking add the owners and general contractors for the two projects as additional insureds under their CGL policies. American Wrecking apparently subcontracted some of its demolition work for the projects to its two sister companies. Between November, 2003 and July, 2004, three employee's of the sister companies were injured at the worksites and filed separate negligence lawsuits against American Wrecking and the owners and general contractors of the two projects.

In 2001, American Wrecking obtained a comprehensive general liability insurance policy from Burlington Insurance Company ("Burlington"), a surplus lines insurer, through its agent, NIA Insurance Group ("NIA"). Because Burlington was a non-admitted surplus lines insurer., NIA obtained the coverage through Burlington's surplus lines agent, Partners Specialty. The first Burlington policy was in effect from November 14, 2001-November 14, 2002, and did not have a cross-suit exclusion.

On October 14, 2002, NIA submitted a renewal application on behalf of American Wrecking to the surplus lines agent, which issued a quote for a renewal policy. The renewal quote was for \$133,000 in premium, and added new exclusions and other policy language, including a cross-suit exclusion. On behalf of American Wrecking, NIA negotiated with the surplus lines agent for changes in the policy, including the deletion of the cross-suit exclusion and a reduction of the premium. Negotiations continued even after the policy was issued. As a result of the negotiations, the premium was eventually reduced by \$48,000 to \$85,000, and there were several changes to the policy. However, Burlington refused to delete the cross-suit exclusion.

As issued, the Burlington renewal policy contain the following relevant provisions applicable to a cross-liability exclusion endorsement, and separation of insured and additional insured issues:

EXCLUSION CROSS LIABILITY

This endorsement modifies insurance provided under the following:

COMMERCIAL GENERAL LIABILITY COVERAGE PART

This insurance does not apply to any actual bodily injury, property damage, personal injury, or advertising injury to:

3. A present, former, future or prospective partner, officer, director, stockholder or employee of any insured:

7. Separation of Insureds

Except with respect to the Limits of Insurance, and any rights or duties specifically assigned in this Coverage Part to the first Named Insured, this insurance applies:

- a. As if each Named Insured were the only Named Insured; and
- b. Separately to each insured against whom claim is made or suit is brought.

ADDITIONAL INSURED OWNERS, LESSEES OR CONTRACTORS

-- AUTOMATED STATUS WHEN REQUIRED IN CONSTRUCTION AGREEMENT WITH YOU

This endorsement modifies insurance provided under the following:

COMMERCIAL GENERAL LIABILITY COVERAGE PART

A. Who is An Insured (Section II) is amended to include as an insured any person or organization for whom you are performing operations when you and such person or organization have agreed in writing in a contract or agreement that such person or organization be added as an additional insured on your policy. Such person or organization is an additional insured only with respect to liability arising out of your ongoing operations performed for that insured. A persons or organizations status as an insured under this endorsement ends when your operations for that insured are completed.

Declaratory judgment actions arising out of the three lawsuits were consolidated and argued together before the trial court. The trial court granted summary judgment to the additional insureds seeking coverage under Burlington's policy, finding that although the cross-suit exclusion was not ambiguous, it was nonetheless inconsistent with the reasonable expectations of the insureds and with public policy. On appeal, the Court considered the issues of ambiguity, reasonable expectation of the insureds and violation of public policy.

Conclusion:

1. The Court first addressed the insureds' ambiguity argument, acknowledging the well- worn principles that while ambiguity will be interpreted against insurers to provide coverage, exclusions are presumptively valid, so long as they are clear, prominent, specific, and not contrary to any public policy. The court made two critical observations:

A. The Burlington policies cover commercial risks and were procured through a broker/agent and included parties on both sides of bargaining table who were sophisticated about insurance.

B. American Wrecking was engaged in a high-risk demolition business for which coverage can only be obtained through a surplus lines insurer.

The Court observed that the cross-liability or cross-suit exclusion states that the insurance policy does not apply to "bodily injuries" claimed by "an employee of any insured" (emphasis added). The Court's analysis of the quoted language is as follows:

standing by itself, the phrase "employee of any insured" is crystal clear. In short, "any" does not mean "the insured, it means "any" insured, which, of course, is its ordinary meaning.

Curiously, this interpretation preceded a remarkably similar interpretation of the same policy language in a different exclusion three weeks later by the New Jersey Supreme Court in *Villa v. Short*.

2. Again, curiously mimicking the subsequent decision in *Villa*, the Court considered the ambiguity argument in the context of the "separation of insured" or "severability" clause of the policy. As in *Villa*, the Court held that the severability or separation of insured clause did not render the policy ambiguous, because it was not located within a policy provision which grants coverage, and because its scope appears to be restricted to the issue of the limits of coverage as to each insured.

3. Addressing the reasonable expectations of doctrine, the Court distinguished between the applicability of the doctrine for commercial and homeowners policyholders. Relying upon *Nunn v. Franklin Mutual Insurance Co.*, 274 N. J. Super. 543 (App. Div. 1994), the Court held that in personal lines policies, the policy's plain meaning can be overridden if the insured's reasonable expectations of coverage are thwarted. On the other hand, however, when dealing with commercial policies, policyholder are typically more sophisticated and, therefore, an insured's reasonable expectations will not overcome the plain meaning of the policy. Given the significant negotiations between the policyholder's agent and the surplus lines agent in this case, the Court had no trouble concluding that the clarity of the cross-liability exclusion trumped the insured's reasonable expectations.

4. The Court concluded by finding that the cross-liability exclusion did not violate public policy, because public policy considerations, in and of themselves, do not result in a finding of coverage if the contested language of the policy is unambiguous in the first instance.

Finally, this case illustrates the importance of some of the distinctions a court will make when dealing with policy issued by a surplus lines insurer instead of an admitted insurer. Practitioners should clearly take note.

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Debate over the State Children's Health Insurance Program (SCHIP)

2008 Emerging Issues 2818

Odeh and Harbage on No Reauthorization Results in Status Quo Extension of the State Childrens Health Insurance Program (SCHIP) Through March 2009

By Michael Odeh and Peter Harbage

September 6, 2008

SUMMARY: This commentary describes what the State Childrens Health Insurance Program (SCHIP) provides, discusses the issues in the reauthorization debate that culminated in SCHIPs extension through March 2009, and comments on the implications for the future of this federal-state partnership program.

PDF LINK: Core Emerging Issues Commentary (\$)

ARTICLE: Introduction

Childrens health insurance was one of the hottest political topics in the 110th Congress during 2007. What began as strong support for childrens health care eventually turned into an ideological battle over the future role of government in health care in the U.S.

After ten years, the State Childrens Health Insurance Program (SCHIP) has achieved success in expanding access to coverage for low-income children. The programs reauthorization in 2007 was an opportunity to build on and strengthen the aspects of SCHIP that made it a successful and popular program, as well as to address and fix the aspects of SCHIP that created obstacles and challenges to its success. However, despite bi-partisan support, Congress was unable to override President Bushs vetoes of two successive pieces of SCHIP reauthorization legislation.

The SCHIP policy disagreements represented a fundamental ideological disagreement over governments role in health care. The failure of a comprehensive reauthorization resulted in an extension that maintains current SCHIP programs as they are through March 2009. In the meantime, SCHIP remains a highly political issue. The outcome of the upcoming election will have a large impact on the future of SCHIP, but the ongoing uncertainty is problematic from an operational perspective. This commentary describes what introduces SCHIP provides, discusses the 2007 reauthorization debate that culminated in SCHIPs extension through March 2009, and comments on the implications for the future of the program.

Background: The State Childrens Health Insurance Program (SCHIP)

In 1997, following the failure of achieving comprehensive universal health reform, Congress found strong bi-partisan support to create the State Childrens Health Insurance Program (SCHIP).ⁿ¹ SCHIP is a federal-state partnership where the federal government matches state expenses for expanding childrens public health coverage. At the time of its creation, SCHIP was the largest federal health care reform initiative since the creation of Medicare and Medicaid in 1965. Politically, SCHIP is significant for the bipartisanship support with which it was created (SCHIP was passed by a Republican-controlled Congress and signed by a Democratic President) and for its success and popularity at the state level.

One of the hallmarks of the SCHIP partnership is state flexibility, whereby states have federal support to expand childrens coverage beyond its current level as best fits their needs and resources. Congress intentionally designed SCHIP to offer states flexibility, per federal approval, to design and operate their programs. States could use federal SCHIP funds to expand their existing Medicaid program, create a new separate SCHIP program, or do a combination of both. Federal law gives states flexibility to determine SCHIP income eligibility levels for children whose family incomes are too high to qualify for Medicaid under the rules the state had in place as of June 1997.

Another significant feature of the SCHIP partnership is the design of the federal financing arrangement. Congress appropriated \$40 billion for SCHIP over 10 years, with annual amounts distributed to the states and territories according to a formula set out in law. The distribution formula is primarily based on the estimates of the number of low-income children and low-income uninsured children in each state; and state costs are matched with federal funds at a higher rate than Medicaid. But more importantly, SCHIP is a block grant program that provides states with a set amount of funding that must be matched with state dollars.ⁿ² Unlike Medicaid, SCHIP is *not* an entitlement and a state *can* run out of federal SCHIP funds. This was a compromise lawmakers struck in order to make federal spending on SCHIP predictable (and limited). Given the limited nature of SCHIP funds, states are allowed three years in which to use each annual allotment; after that time unused funds must be returned to the federal government to be redistributed to states in need.

Success and Shortfalls: Ten Years of Experience With SCHIP

Within three years of the creation of SCHIP, every state had submitted plans to receive federal SCHIP funds for childrens coverage through a Medicaid expansion and/or separate SCHIP program. States have taken advantage of the programs flexibility, and each states program is designed to meet the states unique needs with respect to structure, eligibility requirements, delivery system, provider reimbursement, and administration.ⁿ³

SCHIP is responsible for a decade of improvements in childrens health, and has succeeded in providing uninsured children with coverage.ⁿ⁴ In 2007, more than 7.1 million children were covered through SCHIP-financed coverage at some point during the year (2 million in Medicaid expansions and 5.1 million in separate SCHIP programs).ⁿ⁵ Together, Medicaid and SCHIP decreased the rate of uninsured low-income children by one-third over the past decade.ⁿ⁶ From this success, SCHIP quickly became and has remained a popular program among the public, administrators, and policymakers alike.

In the 10 years of federal and state experience with SCHIP, the major challenge has been the financing structure. SCHIP funding was set in law in 1997, before there was any experience with the program. SCHIP allotments provided an influx of money early on for states to establish their programs. A handful of states, usually because they had significant pre-SCHIP Medicaid expansions for children, received federal approval to use SCHIP funds for adult coverage, usually parents.ⁿ⁷ It took some time, however, for the majority of states to ramp up their programs; in some cases enrollment exceeded expectations and soon some states were spending their entire allotment.

The federal SCHIP funding mismatch was significant and became more apparent as SCHIP matured. Some states had more than double the federal SCHIP funds they needed. As SCHIP spending has grown, the pool of funds available for redistribution has shrunk. n8 An increasing number of states, in part caused by their enrollment success, exhausted *all* of their available federal SCHIP funds leading some to make policy changes such as by capping enrollment, in order to avoid a funding shortfall. n9

Increasingly, Congress has taken action to redistribute funds among states, or even to appropriate new funds to fill the SCHIP shortfalls. n10 This contributed to the growing calls for a comprehensive reform of the program. For example, SCHIP directors called for SCHIP funding to be renewed and increased substantially to provide sufficient and predictable funds for states to effectively manage programs and reduce the number of uninsured [children]. n11

Disagreement: SCHIP Reauthorization Efforts

Throughout 2007, but particularly leading up to SCHIPs expiration on September 30, 2007, reauthorization was an active political topic. There was much debate and disagreement, largely along political and ideological lines, over the future of SCHIP.

Original Proposals. In February 2007, President Bush proposed reauthorizing SCHIP with a \$5 billion funding increase above the baseline over a five-year period. n12 Advocates and states widely viewed this as inadequate, and urged the Democratic-led Congress to consider a stronger reauthorization package with an increase large enough to meet the growth that had occurred in state programs, as well as provide room for further expansions that many states were planning. n13 Congress responded by passing a budget resolution in May 2007 that included \$50 billion for SCHIP over a five-year period, n14 double what President Bush had proposed.

First Presidential Veto. In August 2007, both the House and the Senate passed SCHIP reauthorization legislation. n15 In late July 2007, Representative Dingell (D-MI), Chairman of the Energy and Commerce Committee, introduced the Childrens Health and Medicare Protection Act (CHAMP, H.R. 3162). The package included almost \$50 billion for childrens health coverage under Medicaid and SCHIP, financed through a tobacco tax increase and reductions in payments to Medicare Advantage plans. The House quickly passed CHAMP days later on August 1, 2007 by a vote of 225 to 204.

The next day, on August 2, 2007, the Senate passed, by a vote of 68 to 31, the Childrens Health Insurance Program Reauthorization Act (CHIPRA, S. 1893). This \$35 billion reauthorization package, also financed through a tobacco tax, was based on the bi-partisan work of Finance Committee members, Senators Baucus (D-MT), Grassley (R-IA), Hatch (R-UT), and Rockefeller (D-WV). The bill also created performance payment incentives for states to enroll more low-income children, and expanded coverage to more than four million uninsured children. n16

After making some changes to the financing and benefit provisions in the Senate version, the House adopted CHIPRA (relabelled as H.R. 976 for technical reasons) on September 25, 2007 by a vote of 265 to 159. To ensure that the Senate and the House had adopted identical bills, the Senate approved the Houses version of CHIPRA (H.R. 976) by a vote of 67 to 29.

Arguing that CHIPRA went too far toward federalizing health care and would expand coverage for moderate-income uninsured children at the expense of poorer children, n17 President Bush vetoed CHIPRA on October 3, 2007. n18 In explanation, President Bush stated in a radio address, When it comes to SCHIP, we should be guided by a clear principle: Put poor children first. n19 On October 18, 2007, the House failed, by roughly a dozen votes of the two-thirds needed (273 to 156), to override the Presidents veto of CHIPRA.

Despite agreement with the general concept that children should have health coverage, some Republican policymakers, including President Bush, opposed several provisions and features of CHIPRA. Some concerns were rooted in programmatic and funding disagreements; for example, some Congressional members expressed concern about the appropriateness of financing childrens coverage through a tobacco tax. At other times, the intentions and provisions of CHIPRA were stated in vitriolic terms as SCHIP became an ideological and partisan issue. For example, Rep. King (R-IA) described SCHIP as Socialized Clinton-style Hillarycare for Illegals and their Parents on the House floor and Representative Feeney (R-FL) described it as Socialized, Cuba-style Health care. n20

As mentioned above, the SCHIP reauthorization debate was always ideological in nature, but hardened after the failure of CHIPRA. The disagreement over SCHIP reauthorization centered on the following main policy points:

. *Tobacco tax financing.* There was some concern among policymakers and the public over the appropriateness of raising federal tobacco taxes to fund childrens health care, and the implications for smokers, farmers, sellers, and state budgets. n21 In addition, there was disagreement over whether a tobacco tax would disproportionately affect low-income families and whether or not financing child health coverage through a tobacco tax is sustainable. n22 Congress, however, did not seriously discuss other financing options for the program.

. *Coverage of immigrant children.* Immigration was a key issue in the SCHIP reauthorization debate. Under current law, most legal immigrant children are not eligible for Medicaid or SCHIP during their first five years in the country and undocumented immigrant children are ineligible for Medicaid and SCHIP (however, immigrants may be eligible for emergency Medicaid services only). n23 Some conservatives alleged that the SCHIP reauthorization bills would make it easier for immigrants, specifically illegal immigrants, to obtain coverage, and thus increase fraud. n24 In reality, the bills would have tightened federal restrictions on Medicaid and SCHIP coverage of undocumented immigrants and created new citizenship verification documentation requirements for SCHIP applicants. n25

. *SCHIP-financed adult coverage.* As described above, a number of states that had extra SCHIP funds received federal waiver approval to expand coverage for adults. In most cases, coverage was expanded to the parents of children enrolled in Medicaid or SCHIP, but in some cases also to childless adults. n26 In 2007 approximately 587,000 adults were enrolled in SCHIP, 84 percent of which were parents or pregnant women. n27 There is empirical evidence that parental coverage improves childrens coverage and health. n28 Regardless, SCHIP spending on adult coverage became a highly political issue. The compromise CHIPRA bill would have phased-out SCHIP coverage for adults over two years. However, the issue actually represented a fundamental ideological difference about the governments role in health care, with some conservative policymakers calling for the immediate elimination of adult SCHIP coverage. n29

. *Coverage of moderate-income children (and the crowding-out of private coverage).* Perhaps most controversial was the issue of expanding SCHIP to uninsured children in moderate-income families. Some states had already expanded coverage to higher income levels, but opponents of an SCHIP expansion argued that coverage of middle-income children would be the first step toward a new entitlement program and socialized health care. n30 The President and other conservatives believed that Medicaid and SCHIP should be restricted to poor and low-income children. n31 However, in their opposition, they failed to acknowledge that CHIPRA actually gave states new incentives to enroll the lowest-income children and took steps to minimize the crowd out of existing private coverage.

Much of the policy debate revolved around how hard to make an SCHIP income eligibility cap, but the underlying main concern was that expanding eligibility for SCHIP would crowd out existing private coverage as families would drop or forgo private coverage and substitute it with subsidized SCHIP coverage. Indeed, there is evidence that some crowd out does exist (as it will in any health reform that expands coverage through public programs or subsidies). However, the magnitude of SCHIP crowd out estimates varies widely and there is some debate within the health policy community over the circumstances under which coverage substitution may be considered acceptable. n32

In fact, public coverage is considered by some to be an important stop-gap against the decline of employer-sponsored coverage due to economic factors. A well-respected economist and one of the leading researchers

on crowd out, Dr. Jonathan Gruber, has said, I want to emphasize a conclusion that has been consistent throughout my research: public insurance expansions are by far the most cost-effective means of expanding coverage in the U.S. today. n33 Furthermore, many SCHIP programs already include anti-crowd out policies that appear to be working, such as waiting periods before children become eligible. n34

The ideological divide over crowd out was further hardened in the middle of the Congressional debate when the Administration issued a directive to state SCHIP directors on August 17, 2007. n35 The new directive effectively shuts down state flexibility as it imposes new crowd out requirements for states expanding coverage to moderate-income children. n36

More specifically, the directive establishes eight new conditions that states must meet to use federal funds to provide SCHIP coverage to children in families with a gross income above 250 percent of the federal poverty level. As conveyed in the directive, the conditions require states to:

- Monitor health insurance status at the time of application.
- Verify family insurance status through insurance databases which must include information regarding coverage provided by a non-custodial parent.
- Prevent employers from changing dependent coverage policies that would favor a shift to public coverage.
- Ensure that, the cost sharing requirement under the State plan compared to competing private plans not be more favorable to the public plan by more than one percent of the family income, unless the public plans cost sharing is set at the 5 percent family cap.
- Establish a minimum of a one year waiting period of uninsurance for individuals prior to receiving coverage.
- Assure that the State has enrolled at least 95 percent of the children in the State below 200 percent of the FPL who are eligible for either SCHIP or Medicaid.
- Assure that the number of children in the target population insured through private employers has not decreased by more than two percentage points over the prior five year period.
- Assure, that the State is current with all reporting requirements in SCHIP and Medicaid and reports on a monthly basis data relating to the crowd out requirements.

In essence, the directive creates a two-tier SCHIP program, as some rules apply only to higher income children. This presents a barrier for states seeking to expand or streamline their programs. The Bush administration has asserted that the conditions in the August 17th directive are designed to ensure the SCHIP program would maintain its focus on the lowest-income children, as well as limit the potential crowd out of private coverage.

State officials, the advocacy and policy communities, and many lawmakers have expressed concern that the new requirements effectively limit program growth and could significantly change state operations. Concerns have also been raised that the Bush administration has not followed appropriate regulatory procedures in calling for the conditions to be implemented.

Second Presidential Veto. In order to address some of the objections and criticisms, CHIPRA was revised by: n37

- . Further restricting state flexibility to cover children in moderate-income families;
- . Strengthening incentives for states to enroll the *lowest* income children;
- . Eliminating SCHIP-financed coverage for adults within one year instead of two; and
- . Modifying the citizenship documentation requirements in Medicaid and SCHIP.

The slightly modified bill, CHIPRA 2 (H.R. 3963) was passed by the House on October 25, 2007 by a vote of 265 to 142 and passed by the Senate on November 1, 2007 by a vote of 64 to 30. Opponents of the original CHIPRA were

not swayed by the revisions in CHIPRA 2. n38 Asserting that CHIPRA 2 did not assure that poor children have coverage first and citing his continued concerns over the crowding-out of private coverage, n39 President Bush vetoed CHIPRA 2 on December 12, 2007. n40 The House subsequently failed to override the veto on January 23, 2008.

Despite SCHIPs popularity, the debate ultimately ended without a comprehensive reauthorization and various statements on who bore blame for the failure:

- . House Democrats accused the President and Republicans of shifting the reasons for their opposition of SCHIP reauthorization bills. n41 By one description, the Republican strategy was to, Thwart the new Democratic leadership at every turn, and then run next year against a do-nothing Congress. n42

- . Senator Kyl (R-AZ) stated that through SCHIP, Democrats, unfortunately, saw an opportunity to play politics. n43

- . After changing her support for CHIPRA temporarily, Senator Hutchinson (R-TX) urge[d] the Democrat leadership to abandon this political gamesmanship and work toward a bill the president will sign." n44

- . With the added tension of other issues, like the Iraq war, Democrats in the House and Senate started to blame each other. n45

By the time CHIPRA 2 was vetoed by President Bush, further attempts to negotiate a comprehensive SCHIP reauthorization were seen as fruitless by many. n46 Unable to comprehensively reauthorize SCHIP, Congress extended the program in the short-term as described below.

Short-term Solution: Seeking a Temporary Extension to SCHIP

SCHIP technically expired at the end of fiscal year (FY) 2007, on September 30, 2007. While the SCHIP program could continue to exist without being reauthorized, the federal government would be unable to make payments without legislation to provide new SCHIP funds. n47 In order to continue SCHIP while allowing Congress to continue debating a full reauthorization, Congress passed and the President signed two short-term extensions that funded SCHIP at FY 2007 levels. The Continuing Resolutions were signed by President Bush on September 29, 2007 and November 13, 2007 to extend SCHIP through November 16, 2007 and December 15, 2007, respectively.

On the heels of President Bush's veto of CHIPRA 2, the unlikely possibility of overriding that veto, and the expiration of the second short-term extension, a comprehensive reauthorization seemed dubious at best. Democratic leaders began working on a short-term solution to continue funding for SCHIP. Republican Congressman Barton (R-TX) also offered a similar extension proposal (H.R. 3584). Along with other unfinished health policy business, Congress extended SCHIP by passing the Medicare, Medicaid and SCHIP Extension Act (S. 2499) on December 19, 2007. It was signed into law (Pub. L. No. 110-173) by President Bush on December 29, 2007. n48

The Extension Act is designed to maintain state SCHIP programs at current funding levels through March 31, 2009, and does not provide new funds for expansions. n49 The bill continues the baseline allotment of \$5 billion per year, and only provides additional funds for budget shortfalls due to growth in health care costs and inflation. The additional funds total just \$1.6 billion in FY 2008 and \$275 million for the first two quarters of FY 2009. These additional funds are necessary to fill shortfalls that states are expected to face in trying to run their programs through FY 2008 at FY 2007 funding levels. Congress may be pressured to address those shortfalls at some point, as the new funds under the Extension Act are not sufficient to cover many additional SCHIP-eligible children or to support significant expansions in eligibility to higher income levels. n50 Although the Extension Act keeps SCHIP programs intact for now, the

longer-term future of SCHIP remains uncertain.

Next Stage: Implications for the Future of SCHIP

The 2007 SCHIP reauthorization debate ended with a hardening political divide, leaving childrens coverage increasingly on the line. ⁿ⁵¹ Ultimately, Congress and the President were able to agree upon extending the program and generally maintaining the status quo. This move prolongs SCHIP as an issue through the November election, and likely leaves the fate of the program in the hands of the next administration. Operationally, however, this move allows states to maintain their programs, despite the huge cloud of uncertainty over the future of federal SCHIP financing.

The SCHIP reauthorization debate more broadly represented an ideological divide (it has also been called a proxy war) over the governments role in health care. ⁿ⁵² While the legislation put before President Bush would have expanded coverage to about 4 million children, many Republican policymakers fundamentally disagreed with the concept that the government should address the uninsured by directly providing coverage. Many Democrats, however, sought to do just that. It is this fundamental divide that further contributes to the uncertain future of SCHIP.

Broad health care reform has been a key topic in the 2008 presidential election, and the election will have a direct impact on SCHIP. For example, under Senator McCains proposal, SCHIP would likely stay the same (or shrink if funding does not keep pace with costs); whereas the program could be significantly expanded under Senator Obamas proposal.

However, regardless of who is elected President, SCHIP reauthorization *must* be addressed by its next expiration date, March 2009. The Congressional Research Service has already estimated that 42 states will have exhausted all their federal SCHIP funds by April 1, 2009. ⁿ⁵³ This offers a relatively small amount of time for the new Congress and the new President taking office in January 2009 to agree upon a longer-term reauthorization plan, although Congress could take up SCHIP reauthorization again before then, and may in fact do so. ⁿ⁵⁴

States may have to prepare for the unlikely, but possible, case that SCHIP does expire and/or that no new federal SCHIP funds will be available. ⁿ⁵⁵ States may not be required to immediately disenroll children, but there will likely be no new outreach and little new enrollment. States would inevitably prepare to restructure their programs (e.g., expand Medicaid in place of a separate SCHIP program) or simply shut down their SCHIP programs altogether. If new SCHIP funds are eventually made available (through either reauthorization or an extension), there would have been much wasted effort as states must again readjust to account for the new funding and opportunities. Functioning on this uncertainty is not efficient as it diverts state efforts to operate their programs and enroll eligible children.

One important issue that was not addressed in the Extension Act is the August 17th SCHIP directive on crowd out. The directive would have been nullified by the SCHIP reauthorization bills had they become law, but the directives ideological basis made it difficult to address through the Extension Act.

On May 7, 2008, Centers for Medicare & Medicaid Services (CMS) released a second letter to state health officials offering clarification of several of the new policies outlined in the August 17th directive. The letter asserted that the conditions only apply to new enrollees, not current beneficiaries, and that states are not required to apply some of the cost sharing and waiting period conditions to applicants with family incomes below 250 percent of the federal poverty level.

The August 17th letter requires states already covering children with family incomes above 250 percent of the

federal poverty level to comply with the conditions by August 18, 2008. California has explored ways in which to address the directive, n56 and on August 12, 2008, California, which operated the nations largest SCHIP program, informed CMS that they would not be able to comply. n57 CMS responded by stating, We are determining whether the relevant states are in compliance with the existing requirements, as also clarified in the Aug. 17, 2007, letter. Moreover, we will continue to assist the states in developing policies that will ensure that the most vulnerable, low-income children are covered first, without moving them from private to public coverage. At this time, we are not taking compliance action." n58

It may be that no further policy response will be needed because Congress or the courts will halt implementation. State and federal policymakers, however, have already begun exploring options to challenge the directive. New York, New Jersey, Illinois, Maryland, and Washington have challenged the directive in federal court, with the support of a number of other states, child health advocates, and health policy experts.

Both the Government Accountability Office and the Congressional Research Service have issued opinions questioning CMS legal authority in issuing or enforcing the new requirements. While these agencies do not have the power to rescind the directive, their findings have been the subject of Congressional hearings and legislation that would nullify its proposed changes.

Congressional and agency efforts put into understanding and addressing the directive ultimately detracts focus and energy from a larger comprehensive reauthorization of SCHIP. Even if the directive is overturned, its central issue, addressing crowd out, will likely be one of the major issues in the next stage of SCHIP reauthorization.

In fact many of the issues that created the ideological divisions that resulted in the failure of the 2007 SCHIP reauthorization effort are likely to be the same issues that arise in the 2008-2009 SCHIP reauthorization effort. This is because there remains a fundamental ideological difference on governments role in health care, which will not and cannot be resolved through SCHIP. Prospects for, and the structure of, SCHIP reauthorization, as well as health reform more generally, are ultimately dependent on the results of the election, the overall political landscape, and the economic climate to provide clear leadership on this issue.

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n1 [i] SCHIP, or Title XXI of the Social Security Act, was created through passage of the Balanced Budget Act of 1997.

n2 [ii] For more on SCHIP financing, see Center for Children and Families, Georgetown University Health Policy Institute, SCHIPs Financing Structure (Oct. 2006); J. Ryan, The Basics SCHIP Financing, National Health Policy Forum (March 28, 2007); Congressional Budget Office, State Childrens Health Insurance Program, (May 2007).

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n5 [v] Centers for Medicare & Medicaid Services, Annual SCHIP Enrollment Report, FY 2007 (Feb. 7, 2008).

n6 [vi] L. Dubay, J. Guyer, C. Mann, & M. Odeh, Medicaid at the Ten-Year Anniversary of SCHIP: Looking Back and Moving Forward, 26 *Health Affairs* 370-381 (2007).

n7 [vii] S. Artiga & C. Mann, Family Coverage Under SCHIP Waivers?, Kaiser Commission on Medicaid and the Uninsured (May 2007); and Government Accountability Office, State Childrens Health Insurance Program: Program Structure, Enrollment and Expenditure Experiences, and Outreach Approaches for States that Cover Adults, (Nov. 2007).

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n9 [ix] See I. Hill, B. Courtot, & J. Sullivan, Coping With SCHIP Enrollment Caps: Lessons from Seven States Experiences, 26 *Health Affairs* 258-268 (2007).

n10 [x] See National Academy for State Health Policy, Federal and State Financing, *Chipcentral.org*.

n11 [xi] National Academy for State Health Policy, Reauthorizing SCHIP: Principles, Issues and Ideas from State Directors (April 2007).

n12 [xii] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, "2008 Budget in Brief" (Feb. 5, 2008), p. 65. Baseline funding is a technical term for the amount of money that is assumed will be allocated to SCHIP over the next five years. Currently, the Congressional Budget Office assumes SCHIP will be reauthorized at baseline funding levels -- \$25 billion over the next five years. Any

funding above \$25 billion would count against federal pay-as-you-go budget requirements.

n13 [xiii] *See, e.g.,* E. Park & M. Broaddus, SCHIP Reauthorization: Presidents Budget Would Provide Less than Half the Funds that States Need to Maintain SCHIP Enrollment, Center on Budget and Policy Priorities (rev. March 13, 2007); Families USA, SCHIP Reauthorization: Whats at Stake for the States? (May 2007); V. Smith, et al., SCHIP Turns 10: An Update on Enrollment and Outlook on Reauthorization from the Program Directors, Kaiser Commission on Medicaid and the Uninsured (May 2007); and Center for Children and Families, Georgetown University Health Policy Institute, Childrens Health Coverage: States Moving Forward (2007).

n14 [xiv] *See* Democrats Propose \$2.9T FY 2008 Budget Resolution That Includes Additional SCHIP Funding, *Kaiser Daily Health Policy Report* (May 17, 2007).

n15 [xv] For a comparison of the House and Senate bills (CHAMP and CHIPRA), see E. Baumrucker, et al., Medicaid and SCHIP Provisions in H.R. 3162 and S. 1893/H.R.976, Congressional Research Service (Aug. 15, 2007); Kaiser Family Foundation, SCHIP Reauthorization: Key Questions in the Debate, (Aug. 29, 2007); G. Kenney, A. Cook, & J. Pelletier, SCHIP Reauthorization: How Will Low-Income Kids Benefit under House and Senate Bills?, Urban Institute (Sept. 2007); National Academy for State Health Policy, SCHIP Directors Principles: Comparisons with SCHIP reauthorization legislation approved in August 2007 by the United States Senate and United States House of Representatives (2007).

n16 [xvi] Congressional Budget Office, Cost and Coverage Estimates for H.R. 976 (Sept. 24, 2007).

n17 [xvii] Statement of Administration Policy for H.R. 976 (Sept. 25, 2007).

n18 [xviii] White House Message to the House of Representatives (Oct. 3, 2007).

n19 [xix] The White House, Presidents Radio Address, (Oct. 6, 2007).

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Maister & Schulz on In Vogue: A-Side DIC D&O Insurance Coverage

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Maister & Schulz on In Vogue: A-Side DIC D&O Insurance Coverage

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SUMMARY: A majority of publicly traded companies have now added A-side DIC (Difference In Conditions) D&O insurance to their insurance programs. This commentary explains the fundamentals of such coverage, how it differs from traditional D&O coverage, and provides issues to think about when considering the purchase of an A-side DIC D&O policy. These policies essentially constitute the last line of defense for an individual D&Os personal assets.

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ARTICLE: Introduction

In the wake of Enron, WorldCom, Sarbanes-Oxley, derivative litigations spawned by options backdating cases, and a faltering economy, directors and officers are not surprisingly looking beyond their corporate indemnification rights, and traditional directors and officers (D&O) insurance, to protect their personal assets. Insurance brokers inform us that a majority of publicly traded companies now carry A-Side DIC D&O insurance, and that independent D&Os in particular have led the charge in pushing their companies to carry such coverage. This commentary is intended to explain what that coverage is, how it may differ from traditional D&O coverage, and provide some issues to think about when considering the purchase of an A-side DIC D&O insurance policy.

Traditional D&O Insurance

Traditional D&O insurance has evolved over the last few decades. Historically, D&O insurance was intended to afford protection solely to corporate directors and officers for liabilities arising in connection with their activities on behalf of the corporation. There was no protection for the corporation itself. The early D&O policies provided what are now known as A-side and B-side coverages. A-side coverage is usually a coverage of last resort solely for the D&Os. It protects them against loss arising out of their actual or alleged wrongful conduct in connection with the corporation, but only when they are not indemnified by the corporation. The key distinction from other coverages in the policy is that A-side coverage only applies after the corporation fails, refuses or is not permitted to provide the D&O with indemnification for the loss (depending on the policy language). Recognizing that such non-indemnified loss would otherwise have to be paid by the individual insureds themselves out of their own personal assets, A-side coverage generally does not have a self-insured retention or deductible that must be met prior to coverage being triggered. A-side coverages are most often triggered when the corporation is insolvent or when the individual insureds have to pay

settlement/judgment costs incurred in connection with a derivative securities claim. As to the latter, corporations may not be permitted to indemnify D&Os with respect to those types of losses.

B-side coverage is very similar to A-side coverage. It provides coverage for liability of the D&Os (not liability of the corporation), but differs from A-side coverage in that it reimburses the corporation for the corporations indemnification of the D&Os. In other words, the insurer essentially pays the corporations obligation to indemnify the D&Os. Often, this coverage is subject to a sizable self-insured retention. Most traditional D&O policies contain a clause specifying that the corporation will be presumed to be indemnifying its D&Os to the fullest extent permitted by law, thereby triggering the B-side coverage and the self-insured retention. Consequently, most claims for loss in connection with D&Os, including securities claims, fall under the policies B-side coverage.

Over time, however, disputes developed between corporations and insurers regarding allocation in connection with policies providing solely A-side and B-side coverages. In particular, securities claims were typically brought not only against individual D&Os, but also against the corporation. Where conflicts did not preclude joint representation, the D&Os and the corporation would often share defense counsel. Also, settlements of securities litigations would jointly resolve the claims against the D&Os and the corporation. Arguing that the corporations were reaping coverage benefits that had not been paid for, insurers began pushing for an allocation of costs which would only require them to pay for defense and indemnity incurred on behalf of the covered D&Os. Frequently, there were disputes between the insurers and the insureds as to the proper allocation the insurers would assert that a greater percentage of the loss was allocable to the corporation and thus not covered, and the insureds would argue that the loss was predominantly allocable to the D&Os and thus covered.

In the mid-1990s, there were a series of cases limiting an insurers ability to allocate loss to the non-covered corporation. *See, e.g., Nordstrom v. Chubb & Son*, 53 F. 3d 1424 (9th Cir. 1995); *Safeway Stores, Inc. v. National Union Fire Ins. Co. of Pittsburgh, PA*, 64 F.3d 1282, 1288 (9th Cir. 1995); *Raychem Corp. v. Federal Ins. Co.*, 853 F. Supp. 1170 (N.D. Cal. 1994); *Caterpillar, Inc. v. Great Am. Ins. Co.*, 864 F. Supp. 849, 852 (C.D. Ill. 1994). Around the time of these cases and thereafter, insurers decided to eliminate these costly coverage disputes and began to offer and charge a premium for what is now commonly referred to as C-side coverage. Such coverage is also known as entity coverage, and provides coverage to the corporation itself for a limited set of claims. Entity coverage is typically limited to coverage for securities claims (usually defined in the policy), and may be further limited to instances where the claim is first initiated and continuously maintained against a director or officer. Entity coverage often has a separate self-insured retention, and the policy limit applicable to such coverage is almost always shared with the policy limits applicable to A-side and B-side coverages. n1

Of course, while the addition of entity coverage to the traditional D&O policy did have the effect of diminishing disputes over allocation between insureds and D&O insurers, and often provided a benefit to the corporation in the form of coverage for securities claims, there were certain adverse consequences caused by the inclusion of entity coverage that soon became evident. First, the shared limits between the A-side, B-side and entity coverages meant that loss incurred by the corporation on a covered claim would dilute the limits available to pay loss incurred by the D&Os or on behalf of the D&Os by the corporation. Indeed, a single securities claim solely against the insured corporation could erode the entire policy. Second, the inclusion of entity coverage meant that the policy was an asset that was shared by both the D&Os and the corporation. Consequently, if the corporation became insolvent, the automatic stay of bankruptcy (pursuant to 11 U.S.C. § 362(a)(3)) could cause the entire policy to be tied up and rendered unable to respond to loss incurred by the D&Os. *See, e.g., In re Pintlar Corp.*, 124 F.3d 1310, 1313 (9th Cir. 1997); *In re Adelphia Communs. Corp.*, 298 B.R. 49 (S.D.N.Y. 2003). As such, a director or officer could face the nightmarish scenario of having a claim that he or she must continue to defend (absent an injunction under 11 U.S.C. §105(a), the automatic stay only protects the corporation, not the individual D&Os), all without indemnification from the corporation (due to insolvency) or coverage from the D&O insurance. Because events precipitating bankruptcy often give rise to claims against D&Os, the risk of simultaneously losing indemnity and insurance coverage was unacceptable to D&Os. Consequently, a number of newer D&O policies have provisions that seek to protect against D&Os from losing their coverage in the event of corporate insolvency, including priority of payments provisions. n2 However, such

provisions are largely untested and may be unenforceable in bankruptcy.

The Evolution of A-Side DIC Coverage

To protect against the risk of limits dilution created by the inclusion of entity coverage in the traditional insurance program, some companies began to purchase separate pure A-side excess policies solely for the benefit of the D&Os. Such policies typically provided A-side coverage on a following form basis (i.e., they provided coverage under the same or similar terms to those contained in the underlying insurance), and required the exhaustion of all of the underlying insurance before it applied (or at least that the insureds incur liabilities exceeding the amount of the underlying insurance). In other words, if the full underlying limits of traditional D&O insurance had been paid on a claim, the A-side excess policy would provide the individual D&Os with protection against any unresolved liability for which they could not be indemnified by the corporation. Because these A-side policies only provided coverage to the individual D&Os and not the entity, it was less likely that they would be subject to the automatic stay upon insolvency of the corporation.

The problem is that these pure A-side excess policies only applied in very limited circumstances and were often expensive. And, they did not address another concern plaguing D&Os making sure that there was coverage where the corporation and the underlying traditional insurance fails or refuses to provide indemnification/coverage (whether due to insolvency of the corporation or the insurer, the application of policy exclusions, or otherwise). For instance, if the underlying traditional D&O insurance became impaired by corporate insolvency, there was no assurance that the A-side excess policies would step in and provide any coverage to the D&Os, because the condition precedent to coverage *i.e.*, exhaustion of the underlying traditional D&O insurance had not occurred. Thus, while the pure A-side excess policies were not subject to being directly impaired by corporate insolvency, they could become indirectly impaired due to the failure (or inability) to exhaust the underlying policies. In that situation, the pure A-side coverage would effectively become stranded coverage, absent policy language to the contrary or unless someone filled the underlying gap.

In response, several entrepreneurial insurers began marketing A-side excess policies that also contained a Difference In Conditions (DIC) provision for the purpose of providing broader coverage (and competing with a similar product previously marketed by Corporate Officers & Directors Assurance Ltd., commonly known as CODA). Typically, DIC provisions specify that the policy drops down to respond as primary coverage if the corporation *and* the underlying insurers fail or refuse to indemnify the D&O (whether rightfully or wrongly) or cannot provide such indemnity to the D&O (whether due to legal prohibition, financial impairment or otherwise). As such, this new, broader coverage promises to drop down (to dollar one if necessary) to protect D&Os in the event that underlying traditional coverage becomes impaired by corporate insolvency or insurer insolvency.

While it is fair to say that A-side DIC coverage is largely still a doomsday coverage for D&Os, the reality is that these policies essentially constitute the last line of defense for an individual directors or officers personal assets, and many consider such coverage to be the second most important layer of D&O insurance (after the primary policy on the traditional tower). Indeed, A-side DIC coverage has increasingly been called upon to respond to claims, including for indemnification of judgment/settlement costs incurred in connection with derivative litigation (options back-dating cases, in particular); coverage after the corporations insolvency impairs the traditional D&O policies (bankruptcies are at a record high); and coverage of costs incurred in responding to interviews of former D&Os who have been denied indemnity by the new board (interviews typically do not constitute a Claim under traditional D&O policies). A-side DIC policies could also drop down to provide indemnification to D&Os for gaps created by below-limits settlements entered into between the insureds and the underlying insurers, at least where the corporation has also failed or refused to provide indemnity for such gap (*e.g.*, in the context of a derivative litigation settlement).³ A-side DIC policies may also provide drop-down protection where underlying traditional insurers seek rescission of their policies (*e.g.*, where a traditional insurer seeks rescission based on restated corporate financials), or where the underlying traditional insurance provides coverage on terms that are narrower than the A-side DIC policy. A-side DIC policies are typically non-cancellable and non-rescindable.

Practical Considerations Regarding A-Side DIC Insurance

Since their introduction, A-side DIC policies have continued to evolve into a highly-specialized insurance product in their own right. While the policy forms and coverages of many A-side DIC policies vary extensively, there are, nonetheless, certain common considerations that a prospective purchaser of such policies should examine before making a decision to bind coverage. Among these considerations in no particular order are the following:

- . Use a good insurance broker who is familiar with these specialized products.
- . Purchase the best coverage you can afford.
- . Purchase insurance from a financially stable insurer.
- . Purchase a policy that reflects fair pricing.
- . Consider the claims handling experience of the insurer.
- . Consider your relationship with the insurer, if any.
- . Consider establishing a D&O insurance committee to make purchasing decisions.
- . Purchase adequate limits to defend against a significant claim.
- . Coordinate the A-side DIC tower with your other coverage.
- . Consider the positives and negatives of insurers providing overlapping coverage.

Each of these considerations will now be discussed.

Use a Good Insurance Broker Familiar With A-side DIC Products

Purchasing D&O insurance is a bit like buying a car options can be added or removed (sometimes for a price), and many of the terms are negotiable. Of course, some policy provisions, and even certain types of policies, are more negotiable than others. For instance, while traditional D&O policies have long been viewed as mandatory coverage for a corporation, A-side DIC policies have been (until recently) viewed as optional coverage by many. With an increasing number of companies looking to purchase at least some amount of A-side DIC insurance, the market for these insurance products has become very competitive. A-side DIC insurers, anxious to capitalize on this developing market, have often been willing to provide broad coverage enhancements not available on traditional D&O policies.

A strong insurance broker with extensive experience in placing D&O insurance policies can help ensure that you obtain the best coverage possible on an A-side DIC policy. Generally speaking, good brokers are subject-matter experts familiar with numerous policy forms on the market, including the strengths and weaknesses of those forms. Many have experience in working with counsel to create specialized manuscript forms, if necessary. As such, a broker can help you navigate through the myriad of various forms to help you pick the one which best fits the particular risks that you are seeking to cover, and which also best fits within the context of your total D&O insurance program. Choose a broker that is on top of the current forms and who is already looking to enhance the current forms to provide you with broader coverage. Insurance brokers should also be able to provide you with credible benchmarking/analytical information on purchasing trends, pricing, market capacity, among other things. Moreover, strong insurance brokers can also provide invaluable assistance when a claim happens they might be able to use their relationship with the insurers to get claims paid.

Working in tandem with the broker, coverage counsel can be another useful tool in negotiating the purchase of an A-side DIC policy or in handling coverage questions when a claim happens. This is because coverage counsel typically

knows how the policies are responding to current claims and what arguments the insurers are making to deny coverage on claims. Coverage counsel may also identify problematic language and pitfalls that can be avoided through the use of endorsements and manuscript language. Accordingly, coverage counsel may be able to provide the broker with concrete examples which justify the policy changes being sought by a broker, and may be able to effectively anticipate and refute coverage arguments by insurers.

Purchase The Best Coverage You Can Afford

Since they first came into existence, A-side DIC policies have provided extensive protections to D&Os. Recently, many D&O insurers have introduced a second generation of A-side DIC insurance policies that expand upon these protections and incorporate many of the enhancements that have been most commonly sought by insureds and most commonly granted by insurers. Such enhancements include:

- . The elimination of a notice requirement within the policy period as a condition precedent to coverage;
- . Affirmative provisions providing that the policy is fully non-rescindable;
- . Fully severable exclusions and policy application precluding the imputation of knowledge or conduct of one insured to any other insured;
- . Limited or no insured versus insured exclusion (*i.e.*, no company versus individual insured exclusion);
- . Conduct exclusions not applicable to Defense Costs and that also require a final adjudication in the underlying claim;
- . Broadened definition of Claim to include coverage for formal and informal interviews, investigations and extradition coverage;
- . No pollution or cleanup cost exclusion;
- . No exclusion for bodily injury and property damage;
- . No exclusion for ERISA;
- . Affirmative provisions providing that the insurer will not dispute coverage for claims alleging violation of Section 11 or 12 of the Securities Act of 1933 (*i.e.*, the insurer will not assert no loss and seek to avoid coverage based on public policy concerns as to disgorgement); and
- . Broadened Difference-In-Conditions trigger of coverage (providing drop down coverage if the insured corporation and the underlying insurers fail or simply refuse to pay, for any reason whatsoever).

Other enhancements may be available and/or negotiated as a concession from the insurer. For instance, some insurers also offer coverages which recognize the potential competing interests between inside (*i.e.*, employee) and outside (*i.e.*, independent) D&Os. These policies (often called Independent Directors' Liability, or IDL policies) have separate limits applicable to those insured groups to preclude dilution of policy limits and reduce the risk of elevating one insured group's interests at the expense of another insured group. ⁿ⁴ Insureds should seek certain enhancements to their A-side DIC policies' subrogation provisions, particularly where there is an overlap between insurers in the traditional and A-side DIC insurance towers. Such enhancements should include provisions specifying that the insured has a right to pursue the non-paying D&O insurer if the A-side DIC insurer fails or refuses to do so, and also that any recoveries from the non-paying D&O insurer (less costs) will be applied to replenish the depleted A-side DIC policy limits.

In all events, however, insureds should seek to ensure that their A-side DIC policies provide coverage that is at

least as broad as or (preferably) broader than the coverage provided by their underlying traditional D&O policies, and that the A-side DIC policies do not contain any inconsistent language that may cause gaps in coverage between the traditional and A-side excess towers. Indeed, such inconsistencies/gaps should be expected due to the fact that most A-side DIC policies are stand-alone policies with their own internal terms and conditions (i.e., they do not follow form), and may be avoided by the inclusion of conforming endorsements.

Purchase Insurance From a Financially Stable Insurer

The potential for insurer insolvency is one of the many factors to consider when placing all D&O insurance policies, including A-side DIC policies. D&O claims typically take a long time to resolve (4 to 6 years is not unheard of), and are often referred to in the industry as long tail claims. Because of this, you want to first and foremost pick insurers that will be there to pay. You want to pick insurers that are financially stable and that are unlikely to withdraw from the market or become insolvent during times of economic uncertainty or in the face of extensive claims obligations.

The advent of A-side DIC policies provided insureds with some protection against insurer insolvency by including a drop down trigger of coverage following the insolvency of an underlying insurer. But this is only for A-side non-indemnifiable claims. Ratings of insurers are provided by A.M. Best Company, Standard and Poors and Moodys (among others). Do not presume that just because a broker has an insurer on its approved list that the insurer is financially stable. Check out the ratings yourself. Brokers have many relationships with insurers and are often loathe to take an insurer off of its approved list because it may effectively put the insurer out of business. That said, most brokers are mindful of the importance of A-side insurers and seek strong insurers that could function as de facto primary insurers.

Purchase a Policy That Reflects Fair Pricing

Getting the broadest coverage for the best price is easier said than done. Suffice it to say, it is not difficult to convince an insured that it should not overpay for the insurance coverage it is receiving. However, insureds often make a mistake when they seek to purchase the least expensive insurance policy available. The old adage you get what you pay for often applies to such a circumstance. Insurers are businesses, not charitable institutions, and they are in business to make a profit. Inexpensive insurance often reflects an insurance policy which provides narrower coverage and/or contains broader exclusions than those found in other more expensive policies. Also, insurers charging substantially lower premiums in connection with the underwriting of a policy may prove to be more reluctant to part with those premium dollars when a claim occurs. They may also be selling the coverage this year at a discount so they can steadily increase the premium over the next few years. In any event, the choice between broader coverage and lower premium costs is a balancing act which insureds should knowingly undertake when making their insurance purchasing decisions. That being said, the A-side D&O market has become increasingly competitive over the years, and premium costs have fallen as a result. If the insured company's financials are strong with a good balance sheet, insureds should expect competitive pricing on the A-side DIC program.

Consider the Claims Handling Experience of the Insurer

Hardly anyone interviews the claims personnel of an insurer. Yet, those individuals may be the most important people of all to an insured. When a claim occurs, insureds want an insurer who is not a mere passive observer to the claim, but one who instead is an active advocate on the insureds behalf. After all, an insured pays premiums for the sole purpose of having responsive coverage when a claim occurs. It is how you are treated when a claim occurs that counts. In that regard, it is a good idea for insureds to consider the claims handling experience of prospective insurers, and to seek an insurer with experience and resources that will help resolve the claim favorably. If the insured does not have any direct experience with the insurer, the insured can ask their broker questions like, Which insurers have a reputation for timely paying claims? and Which insurers have the most experience paying claims? Through talking with their clients and assisting in the processing of certain

claims, brokers often have insight into an insurers recent claims handling patterns and practices. An insurer that appears to invent roadblocks to coverage may deserve to be jettisoned from the D&O insurance program, even if it is providing coverage for a lower premium cost than other insurers. Coverage counsel and securities counsel may also be useful in identifying the insurers that are difficult to deal with and/or aggressively deny claims. D&O insurance differs from other lines of insurance based on the complexity of the claims as applied to the terms and conditions of the policy, and D&O insurers differ greatly in the philosophy, mindset and experience that they bring to the claims process.

Likewise, it is important to consider that new insurer entrants into the D&O market may or may not have the level of expertise or claims handling experience of the larger, more established insurers. Inexperience in this area may mean that such insurers will be less effective or efficient at handling and resolving your claims. Such inexperience may translate into a failure to timely pay defense costs, or even a failure to perceive a current settlement offer as a golden opportunity to avoid a much costlier litigation and settlement or judgment down the road. Inexperience may also lead to the hiring of less qualified counsel to defend the claim. Experienced insurers will usually recognize the folly of such penny-wise/pound-foolishness. And, keep in mind, if your insurer causes poor litigation results, you ultimately pay the adverse judgment or increased premiums going forward.

Consider Your Relationship With the Insurer, If Any

In the world of D&O insurance, relationships matter, and having a favorable underwriting and/or claims history with a particular insurer or insurers is a significant factor to consider when placing both traditional D&O insurance, as well as A-side DIC insurance. Indeed, such relationships (whether in connection with D&O insurance alone or arising out of other policy lines) often lead to insurers agreeing to provide the insureds with broader policy enhancements, higher limits and/or greater premium discounts as a reward for their loyalty. Policy renewals are easier if an insurer already knows your company, and insurers with whom you have long-term relationships have banked your premium and are more likely to stick with you in difficult times. Moreover, placing coverage with an established insurer that you have a relationship may help to avoid the headaches that might occur when coverage is placed with newer entrants. For instance, newer entrants to the D&O insurance market may be among the first to leave the market if it becomes unprofitable or otherwise hardens, leaving the insured scrambling to fill gaps in coverage at renewal. Established insurers are more likely to remain in the market during such difficult times.

On the other hand, it is always good to make new friends. A lack of claims or underwriting history with a particular insurer often arising in connection with one of the new insurer entrants to the D&O insurance market should not act as a sole reason to preclude an insured from placing such insurer on the program. There are many new insurers who are newly formed entities, but the personnel running them have been in the business for decades. However, a lack of history altogether is a factor to consider, depending on the people involved, and one which may weigh in favor of a smaller participation by such insurer in the program to start.

Many insureds will stick with insurers with whom they have a history because the insureds consider the insurers to be partners in a relationship, and may even pay more for their coverage to solidify that partnership for the inevitable day when a claim is received. Insurers can instill loyalty by providing a superior claims handling experience and open lines of communication with their insureds.

Consider Establishing an Insurance Committee to Make Purchasing Decisions

Purchasing D&O insurance is a complex task for many corporations, and one which is of increasing interest to the individual directors and officers. Often, there are competing interests which add to the complexity of the task, with each set of these divergent interests being concerned with preserving the limits available to them and avoiding the potential dilution of coverage that results from the inclusion of the other competing interests. Such competing interests not only include those of the company and the D&Os (which may lead to a conflict over how much traditional v. A-side DIC coverage to buy), but also among the directors themselves (*e.g.*, inside v. outside director interests). Outside directors

may push for higher limits on a specialized A-side DIC policy with dedicated limits (*e.g.*, an IDL policy), while inside directors may wish to allocate more premium dollars towards increasing the traditional or A-side DIC policies' limits. Further, outside directors may prefer conduct exclusions in D&O policies which become operative upon a plea or trial court conviction, while inside directors may desire such exclusions not to become operative until all appeals on the conviction are exhausted. Officers, on the other hand, may be more interested in the balance sheet protection afforded by the risk transfer component of the insurance and will push to have the corporation purchase additional traditional coverage, often at the expense of A-side only coverage.

As such, corporations should consider setting up a committee of board members and/or officers to work with the brokers in placing the D&O insurance coverage that best accommodates the divergent interests of the various D&Os and the corporation. A further advantage of establishing such a committee may come from the fact that many directors serve on multiple boards, and can probably provide some insight as to their experiences with D&O insurance in connection with those other directorships. In all events, delegating the completion of insurance policy applications and the negotiation of insurance placement or renewal to lower level employees of the company is unwise, because if mistakes are made in the application or in the placement, it is the D&Os who may personally pay for those mistakes.

Purchase Adequate Limits to Defend Against a Significant Claim

Often, we see insureds purchasing \$5 million of A-side DIC coverage for their D&O insurance program. While such limits may be adequate for the circumstances of those particular D&Os if other coverage responds, they may not be if the A-side DIC is the only insurance that responds to a claim. When considering what limits should be maintained on an A-side DIC tower, it is important to remember that A-side DIC coverage is triggered when neither the corporation nor the underlying traditional insurance are paying the loss incurred by the D&Os, and that defending securities claims can be very expensive. Consequently, D&Os should consider maintaining A-side DIC limits which are at least sufficient to fund defense costs for such a litigation, along with some amount of limits to provide for the payment of settlement or judgment costs. Further, it is also important to remember that with the divergent interests of D&Os, it is likely that conflicts between insured persons may require multiple sets of defense counsel, which will further accelerate the depletion of policy limits. Often, a broker will be able to provide market analysis to assist insureds in determining the appropriate level at which to set the A-side DIC limits.

Coordinate the A-Side DIC Tower With Your Other Coverage

As A-side policies have increased in prominence and popularity, many D&O insurance programs have been structured with multiple layers of pure A-side coverage excess of a traditional ABC D&O insurance tower. Often, brokers will place an A-side DIC policy as the lead layer of that A-side tower, with following-form pure A-side excess policies above the lead A-side DIC layer. However, where such stacking of multiple A-side policies occurs, it is advisable that each policy in the A-side tower also contain a DIC provision. This will help to ensure that each A-side DIC excess policy not only drops down if the traditional D&O insurance tower fails or refuses to pay, but also if an underlying A-side DIC insurer fails or refuses to pay. n5 Absent such a DIC provision, the pure excess A-side policy may provide little value to the insureds, as the policy will likely require the underlying insurers to admit liability for or actually pay the full underlying limits of insurance. Indeed, pure A-side excess policies lacking a DIC provision could conceivably become stranded coverage where the underlying policies fail to pay their full limits due to insolvency or a below limits settlement. Consideration should also be given towards whether a tiered A-side DIC tower makes sense (*e.g.*, one that provides A-side DIC coverage to all D&Os at lower levels, with A-side DIC insurance for independent directors only at higher levels).

Consider the Positives and Negatives of Insurers Providing Overlapping Coverage

Some brokers argue that you should never have insurers providing overlapping coverage (*i.e.*, one providing some coverage in the underlying traditional ABC D&O insurance tower and some coverage in the A-side DIC insurance tower). That may be good advice or it may not, depending on the structure of the program, the coverage available and

which insurers you are talking about. One has to balance the factors set forth in this article, among others, to reach a conclusion (broad coverage versus financial stability versus relationship versus price, etc.).

Brokers sometimes advise against such overlapping coverage because one wants the A-side DIC insurers to be solvent and drop down if the underlying traditional coverage refuses to pay or is insolvent. Obviously, having the same insolvent insurer at multiple layers is not a good thing. This risk is much greater in a small program, and the program can frequently be structured to try to avoid the risk. However, in a large program that has several A-side DIC layers, the risk may not be as significant because the layers above the insolvent A-side DIC insurer, if any, should drop down. Also, in large sophisticated programs insureds may reasonably make the determination that having the broadest coverage possible with many different insurers that are financially superior alleviates this risk. After all, having a solvent insurer is important, but it means nothing if the coverage purchased is not broad enough to respond to the claim. Having coverage placed with an insurer that has a poor claims payment history is equally unsatisfying. And, the fact that you have the coverage placed with two different insurers may not ensure solvency, especially if the lead A-side DIC insurer is a financially inferior insurer to another insurer already on the program that is willing to write some of the A-side DIC coverage. Frankly, insurers themselves are reluctant to take too much of a program and will generally regulate themselves on the issue. Last, from a pure solvency perspective, there may be no difference between purchasing \$5 million of underlying traditional coverage from a particular insurer and another \$5 million of A-side DIC coverage from that insurer as opposed to purchasing \$10 million of either traditional or A-side DIC insurance alone from the insurer (other than where the coverage attaches).

Brokers also correctly point out that there is the potential for game playing by an insurer with overlapping coverage, particularly if the insurers A-side DIC participation is required to drop down upon a refusal of that same insurers traditional coverage to pay a claim. Such insurer could theoretically refuse to pay its traditional coverage participation and force its own A-side DIC coverage participation to drop down and pay, effectively reducing the insurers exposure on the claim. In that instance, the concern is that the insurer will simply fail to pursue its traditional coverage participation in subrogation, thereby effectively reducing the insureds available limits. Such conduct would be bad faith, and there is no doubt that the insured should have the right to sue the insurer that is refusing to pursue the non-paying insurer (*i.e.*, itself) because the insured is economically harmed through the reduction of its available insurance limits. In any event, this risk can be eliminated by the addition of language making it clear that if the A-side DIC insurer does not diligently pursue its subrogation claims against itself (or any of its affiliates or any other insurer, for that matter) the insured may do so. We believe that the insured may have the right to do so anyway, but it is always a good idea to make such rights clear. All things being equal, it is good to consider structuring a D&O insurance program to avoid overlapping coverage, but pragmatically, it may not be possible (or even optimal) to do so in a sophisticated program. Difficult choices often have to be made, and various considerations have to be weighed and balanced.

Indeed, many of the leading insurers providing A-side DIC coverage also play an extensive role in the traditional D&O insurance market. Such insurers include AIG (through National Union and others), Chubb (through Federal Insurance Company and others), Ace (through Ace American, Westchester, CODA and others), XL Insurance and Arch, among others. Consequently, it is unlikely that an insured will be able to purchase a traditional D&O insurance tower and an A-side DIC insurance tower with limits in excess of \$50 million without at least some overlap of insurers between the traditional and A-side DIC towers. While diversification of risk is usually preferred (if possible), it is but one factor in making a decision regarding insurance placement. As stated above, the risks arising in connection with such overlap may be outweighed by the fact that such insurers may be able to provide coverages or limits on substantially more favorable terms than their competitors (especially if the insured has a favorable prior relationship with the insurer). Also, many of the above-referenced insurers tend to be the most financially stable insurers in the marketplace. While it seems counterintuitive, diversification of risk through the use of smaller, financially unstable insurers may actually prove to increase not decrease the risks of insolvency in the insurance program. In the end, if insurer overlap is inevitable, its risks can be ameliorated to some extent by placing the traditional D&O insurance and the A-side DIC insurance with different affiliated companies within the same insurance group.

Concluding Thoughts About Structuring and Placing A-Side DIC Insurance

Structuring an insurance program can be simple or complicated, and one size does not fit all. That is why you need a good broker when placing D&O insurance. Some D&O insurance programs have a total of three different insurers, while others might have 20 (or more) insurers, some with quota shares of the same layer. When structuring a D&O insurance program, there are many competing interests to consider each year:

- . Be proactive. Having your D&O insurance program reviewed before there is a claim can help to avoid future problems and ensure that there is time to correct any deficiencies.

- . Consider the structure that is best for the individual insureds at that time, balancing the insureds' various competing interests (*e.g.*, coverage versus cost versus stability versus claims experience). Having a good broker really matters with respect to this issue because most insureds have very little input on the exact structure of their program beyond the primary layers.

- . At a minimum, ensure that each policy in the A-side excess tower provides DIC drop-down coverage that is at least as broad as the coverages contained in the underlying traditional tower.

- . Have a backup insurer in the wings who wants to write the primary A-side DIC business this will help to keep the existing lead A-side DIC insurer competitive.

- . Chopping and changing insurers every year can save money, but it does little to develop a partnership with your insurer (it may also create coverage limitations if the insurers seek to apply retroactive dates). The primary reason to purchase D&O coverage is for your insurer to pay a claim if you get one. Loyalty may matter. Certainly, claims handling experience matters.

- . Is it better to have two or more insurers so that you have less risk with each insurer or one insurer that is financially superior? This can be a hard choice, especially on a smaller program. Having the risk spread among insurers is good, unless they go out of business or simply quit the volatile D&O insurance market. It may also be a problem if the insurers are small players who are not experienced with paying claims. So, it depends which insurers you are comparing. You have to weigh competing factors and decide which factors are the most important to you and best fit with your goals for the D&O insurance program. As discussed above, long-term relationships with insurers that are committed to staying in the D&O market and that have banked your premium over many years can be more important than diversity.

- . Never say never. Program structure should be reconsidered **every** year. It is easy to fall into a pattern of keeping the same structure from year to year. That is the least amount of work. But, the D&O market changes every year. New forms come out. Broader coverage terms become available. Multi-year policies become available. An insurer's financial health changes. Premium prices change. Claims happen. Coverage lawsuits happen. An insurer's willingness to pay certain claims can change. Relationships change. One or more of these market changes may render it advisable to make changes to the structure of the D&O insurance program.

- . Depending on the insureds and their loss history, they may not have a broad choice of insurers willing to provide coverage on their D&O insurance program. If the insureds are coming off of a big claim, it may be that the only insurer willing to underwrite the risk is the incumbent insurer (often for a larger premium). There are a limited number of insurers in the D&O market. If you want to place coverage with an insurer that is financially sound, gives you a fair deal and the broadest coverage, your choices may be limited.

- . Remember A-side DIC coverage is the backstop created to protect D&Os' personal assets when all other protections fail. As such, you should ensure adequate limits are maintained to take care of what can be an expensive doomsday scenario.

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n1 [1] Some traditional D&O policies also provide a separate, limited entity coverage for the investigation costs incurred by the entity in connection with responding to shareholder derivative demands. This coverage typically has a sublimit of less than \$500,000. Additionally, many small to mid-sized companies may be able to obtain coverage for the corporation that is not limited to securities claims.

n2 [2] Such provisions are usually intended to ensure that the policy proceeds are freed from the automatic stay of bankruptcy by giving individual directors and officers priority over the corporation with respect to such proceeds. More sophisticated priority of payments provisions can be negotiated to provide further differentiation on payments, such that independent directors have priority over inside directors and officers.

n3 [3] A "below limits" settlement is where an insurer pays less than its full policy limits towards the settlement of a claim, typically in exchange for a release of any further right of coverage on the claim or related claims.

n4 [4] Other innovative products available in the marketplace include Personal Directors Liability ("PDL") coverage (which is designed to provide personal asset protection to a director who sits on one or more boards), and Retired Directors Assurance ("RDA") (which is designed to provide legacy protection to directors and officers when they leave the corporation (usually designed to hedge against organizational changes that may occur after the director or officer departs)).

n5 [5] Properly drafted DIC provisions should likewise reduce the risk created by insolvency of an underlying insurer providing coverage on a quota share basis (whether on a traditional D&O insurance participation or on an A-side excess participation) by dropping down to fill gaps created where the underlying insurance fails or refuses in whole or in part to indemnify the insureds. Quota share policies are commonly found in policies issued by Lloyds of London.

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Marc S. Maister is a partner with Irell & Manella LLP. He is a member of the litigation group and head of the insurance group. He specializes in handling high-profile insurance matters and general civil litigation. He is currently defending several legal malpractice claims and is defending several consumer class action claims. He also assists clients, brokers and risk managers with the structuring of insurance programs and works with our transactional attorneys on various sophisticated insurance matters. In 2008, Mr. Maister was named to the Southern California "Super Lawyers" list by Los Angeles Magazine for the fourth consecutive year, identifying only five percent of lawyers in the country to earn the honor. Mr. Maister has been selected for inclusion in the prestigious Best Lawyers in America for 2007 and 2008 in the specialty area of insurance law. Mr. Maister is also listed in Cambridge Who's Who among

Executives, Professionals and Entrepreneurs for 2008. Mr. Maister's expertise in matters involving business and property insurance is widely recognized. Both business entities and individuals involved in complex business litigation frequently retain Mr. Maister to identify and assist them in pursuing coverage under policies of commercial general liability insurance, professional liability insurance, fidelity and crime insurance, directors and officers liability insurance, multi-media insurance, employment practices liability insurance, environmental insurance, and umbrella and excess liability insurance. Clients have also sought his help in obtaining benefits under policies of life insurance, fire and multi-peril insurance, business interruption and extra expense insurance, and marine insurance. When necessary to recover policy benefits, Mr. Maister leads the insurance group in representing clients in litigation against insurers in both state and federal courts across the country, as well as in arbitration proceedings. Mr. Maister also assists clients in evaluating their insurance needs before losses occur or claims have been asserted. He heads a group of attorneys who are experienced in reviewing a client's current coverage and evaluating whether it provides sufficient protection against loss and liability. They also negotiate and enforce various agreements pertaining to self-insured retentions, minimum premium arrangements, captive insurance and reinsurance programs, group and association agreements, and similar arrangements.

Harry J. Schulz, III was an associate with Irell & Manella LLP when this article was written but has subsequently moved back home to San Antonio, Texas. He practices general litigation and was involved, on behalf of the State of California, in litigating a major CERCLA case, *United States v. Montrose Chemical Corporation of California*, before the United States District Court for the Central District of California. That litigation resulted in a dismissal of all claims pending against the state and a settlement by the defendants to the state and the United States for \$73 million. More recently, Mr. Schulz served as a lead attorney in drafting the main settlement of a complex litigation before the United States District Court for the District of Oregon. That settlement was the largest in Oregon history and the largest ERISA case in the country at the time. Mr. Schulz's insurance practice crosses both transactional and litigation spheres. He has been involved in the negotiation and drafting of numerous directors and officers, environmental, entertainment and other commercial policies, as well as contractual provisions for insurance and indemnity. Mr. Schulz has also successfully pursued insurance coverage on behalf of numerous clients in coverage disputes. Underlying Mr. Schulz's insurance practice is his six years of experience as an adjuster handling commercial and personal lines insurance claims and coverage disputes.

The views expressed in this article do not necessarily reflect the views of Irell & Manella LLP or its clients, and are not intended to provide legal advice. In examining your directors and officers liability insurance program, please consult with legal and insurance professionals. The authors wish to thank the following individuals for the comments and insights they provided during the course of the drafting of this article: Chris Crawford of Willis North American Executive Risks; Robert Smith of Aon Corporation; Dana Kopper of Lockton Insurance Brokers, Inc.; Bito Borovinsky of Marsh Inc.; and Brian Z. Bark of Irell & Manella LLP.



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Haycock and Harbage on National Health Insurance Reform Proposals

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Haycock and Harbage on National Health Insurance Reform Proposals: Comparison of John McCain's and Barack Obama's Plans

By Hilary Haycock and Peter Harbage

September 3, 2008

SUMMARY: Health care reform has been a hot topic in the presidential campaign. Both major parties nominees, John McCain and Barack Obama, have proposals to reform the current system. Although both plans address the same issues, from expanding access to coverage to containing costs to changing the insurance market, the candidates have very diverse approaches, as well as diverse expected outcomes. This commentary analyzes and compares the two plans.

PDF LINK: Core Emerging Issues Commentary (\$)

ARTICLE: Introduction

With 45.7 million Americans without health insurance or access to care, and with health care costs growing higher, health care reform has been a top topic throughout the presidential campaign. Both parties' nominees, Senator John McCain and Senator Barack Obama, have put forward proposals to reform the current system.

This commentary is an analysis of the major elements of their plans. Following an overview of the candidates' approach written from their perspectives, this commentary compares the candidates' plans on the critical elements of expanding access to coverage, cost containment and how each candidate proposes to finance these reforms.

Overview of Reform Goals and Plans

Although both the Democratic and Republican plans address the same areas of reform, from expanding access to coverage to containing costs to changing the insurance market, the candidates have very different approaches--as well as different expected outcomes. Sen. McCain's plan rests on laissez-faire ideology, while Sen. Obama has embraced the concept of "shared responsibility" that builds on the current system.

Republican Presidential Nominee, Senator John McCain. While Sen. McCain calls for "access to health care for every American," he does not outline a plan to achieve universal coverage. Instead, Sen. McCain's health reform plan has three stated goals:

- Making health insurance innovative, portable and affordable: McCains plan would try to improve competition in the health care marketplace to achieve this goal. McCain would replace the current system of providing tax exclusions for employer-sponsored coverage with a tax credit for every individual and family. Then, individuals and families are to shop around for the best product to meet their needs according to statements by the campaign. Sen. McCains plan also calls for expanding Health Savings Accounts, which allow individuals and families more control over choosing and paying for their own medical care while lowering monthly premium costs.
- Ensuring care for high risk patients: This is to be achieved by working with states to strengthen and promote high risk pools, which provide coverage for the medically uninsurable.
- Lowering health care costs: The McCain plan is to contain costs through a series of initiatives, including disease management and care coordination, expanding health information technology, provider payment reform and increased transparency.

Each major element of this plan as it relates to expanding coverage or reforming the insurance market is discussed in greater detail below.

Democratic Presidential Nominee, Sen. Barack Obama. Sen. Obama does call for universal coverage in his health reform plan, which also has three stated goals:

- Providing affordable, comprehensive and portable health coverage for every American: Every American would be guaranteed issue of coverage, meaning no applicant could be denied insurance on the basis of their medical condition or other factors. Creating a public health plan option and a National Health Insurance Exchange would all facilitate the purchase of coverage. Sen. Obama's plan would strengthen employer-based coverage by requiring employers to pay or play, meaning they must contribute to providing insurance to their employees or contribute a to-be-determined percentage of payroll to financing the national health plan. His plan would also expand coverage by mandating parents to ensure their children have coverage. Expanding Medicaid and the State Childrens Health Insurance Program (SCHIP, a federal-state partnership), and creating income-related subsidies and limits on rates would help make insurance affordable.
- Modernizing the U.S. health care system to contain spiraling health care costs and improve the quality of patient care: Initiatives for disease management, care coordination, cost and quality transparency, provider payment reform, and investment in health information technology as well as enhanced competition in insurance and drug markets are all ways the Obama plan would seek to contain costs. In addition, Obama would support comparative effectiveness research and tackle disparities in care.
- Promoting prevention and strengthening public health, to prevent disease and protect against natural and man-made disasters: Obama would encourage workplace and school wellness programs, expand our health care workforce, and support other programs to strengthen public health.

Each major element of this plan as it relates to expanding coverage or reforming the insurance market is discussed in greater detail below.

Cost Containment

Spiraling health care costs are placing increasing economic pressure on individuals, businesses and governments. Total health care spending reached \$2.1 trillion in 2006, n1 as insurance premiums have nearly doubled over the previous six years n2 and an ever increasing number of Americans now 45.7 million go uninsured. n3

Both Sen. McCain and Sen. Obama acknowledge that health care costs are a top problem which must be addressed by any health care reform plan. Many of their proposals for containing costs are based on similar concepts, including expanding health information technology, improving transparency and competition, and encouraging care coordination and management.

Chronic Disease and Prevention. Americans with chronic diseases account for more than 75 percent of total health care spending in the United States. n4 Many individuals with chronic diseases could benefit from better care management and preventive medicine. Both Sen. McCain and Sen. Obama state that improving care for chronic diseases is an important part of cost containment.

Sen. McCain has called for promoting prevention, early intervention, healthy habits, new treatment models, new public health infrastructure and the use of information technology. Also, Sen. McCain would support smoking cessation programs. However, his commitment to preventive care has been questioned given his support of expanding the individual market, where benefit packages are less likely to cover preventive care and more likely to require high deductibles. n5 High deductibles have been linked to lower preventive care utilization. n6

In contrast, Sen. Obama would require publicly funded plans (Medicare and Medicaid) to help individuals with high cost chronic diseases manage their conditions, with the stated goals of improving quality and lowering costs by doing so. He would also support employer and community efforts to improve health and wellness.

Coordinating Care. Our current health care system generally compensates providers on a per-service basis, which often discourages providers from spending time helping patients with the big picture of their medical needs. Both Sen. McCain and Sen. Obama have suggested that public programs should change their provider payment methods to pay providers per episode of care, which should compensate providers for their time in ensuring patients receive the correct and full spectrum of care for their medical condition. This can lower costs by ensuring patients get the right care when they need it, reducing unnecessary duplication in care and preventing expensive medical complications.

Both candidates also support a ban on public program payments to providers for medical errors. Sen. Obamas plan takes the next step of requiring public programs and the insurance Exchange to reward providers for delivering high quality care.

Transparency. An important first step to improving quality and reducing costs is improving our understanding of the quality and costs of the current system. Even just the reporting of cost and quality information has been shown to prompt providers to make improvements. n7 Sen. McCains plan calls for more information about the costs and quality of care in order to help consumers make smart choices. However, his plan does not call for any mandatory reporting requirements.

In contrast, Sen. Obama would require hospitals and providers to measure and report cost and quality information, and insurers will be required to report how premium dollars are spent on patient care versus administrative costs. In

addition, his plan would call on public programs to reward providers who reached high quality benchmarks.

Health Information Technology. Where other American industries have embraced the efficiencies and cost savings made possible by information technology, health care remains a largely paper-based industry. n8 Health information technology (HIT) is not only likely to help control costs, but it has also been shown to improve quality of care and save lives. n9 Many policymakers are looking for ways to reform our healthcare system to encourage the broader adoption and use of HIT.

Sen. McCain includes health information technology in his list of cost containment proposals, but the only specific purpose he defines for HIT is to enable doctors to treat patients across state lines.

Where Sen. McCain lacks specificity in his HIT commitment, Sen. Obama's plan calls for a \$10 billion federal investment in standards-based electronic health information systems, including electronic health records. Sen. Obama also acknowledges the need for any HIT program to address patient privacy concerns.

Pharmaceuticals. Prescription drug spending in the United States in 2005 (the most recent year for which there is data) was more than \$200 billion, a six percent increase from the year before. n10 Both Sen. McCain and Sen. Obama have proposed increasing the availability of both generic and re-imported prescription drugs as two ways to help reduce those costs for patients.

Unlike Sen. McCain, Sen. Obama would also allow Medicare to negotiate directly with pharmaceutical companies to buy drugs for lower prices. This could result in significant savings, as public spending on prescription drugs will have jumped from 27 percent in 2005 to 39 percent of total pharmaceutical spending in 2006, following implementation of the Medicare Part D prescription drug program. n11

Workforce. The United States is facing an increasing shortfall of needed healthcare professionals, particularly as our population continues to age. For example, by 2020, there will be 35 percent fewer nurses than the country needs, compared to a shortfall of less than 10 percent in 2005. n12 And the number of doctors per 100,000 residents is expected to fall more than 10 percent over the same time period. n13 This raises costs as providers have an increasing monopoly in the market and can demand higher reimbursement rates.

Sen. Obama's plan would increase funding to build the workforce, including supporting individuals seeking to enter the health care workforce with loan repayment, and supporting training programs through curricula grants. His plan also addresses retention issues by funding infrastructure support to improve working conditions and adequate reimbursement.

Sen. McCain's plan does not include a comprehensive workforce proposal.

Approach to Expanding Access to Coverage

As described above, Sen. McCain and Sen. Obama have very different approaches to the same goal of increasing access to health care for Americans. Sen. Obama focuses on expanding coverage, as health insurance is generally considered the primary mechanism by which Americans access care. Sen. McCain's plan seeks to give individuals greater power to make decisions on purchasing insurance and care.

This section discusses the major ways each candidate's plan would change the way Americans access health insurance, as well as how their plans would change health insurance regulation.

Coverage Requirements. One of the most significant differences between Sen. McCain and Sen. Obama's plans

are the Democrats inclusion of coverage mandates for children and employers.

Under Sen. Obama's plan, children would be required to have health insurance. In addition, employers will be required to offer their employees meaningful coverage, or they will have to contribute a percentage of payroll costs to help subsidize a national public plan. Sen. Obama's plan does not go so far as to include an individual mandate for every American to acquire coverage, as did the plans of several other Democratic presidential nominees. In contrast, Sen. McCain's plan not only does not include any coverage mandates, the candidate has announced his opposition to the concept. n14

As a result, experts estimate that Sen. McCain's plan would cover just 5 to 7 million additional Americans, n15 where Sen. Obama's inclusion of a mandate means that his plan would likely cover 30 million of the 45 million currently uninsured Americans. n16

Pooling Risk. Most Americans 61 percent of those under age 65 n17 currently receive health insurance through their employer, and thus on the group market. These individuals benefit from a number of advantages for group market policy holders, from fewer premium dollars spent on administrative costs to richer benefits packages to stronger consumer protections. Importantly, the group market pools risk, spreading the costs of care for the few who need it across a broader group.

It is often more difficult to obtain coverage on the individual market, which currently serves just five percent of all Americans. n18 On the individual market, insurers perform underwriting on applicants to determine their risk of incurring medical costs. Underwriting determines whether an applicant will be offered coverage, the rate of their premium and identifies coverage exclusions. Applicants with preexisting conditions may find they are denied coverage in the 45 states which do not require insurers to issue coverage to all. Alternatively, applicants may be offered coverage which is very expensive and which does not cover medical services for their condition.

Sen. McCain's plan calls for a greatly expanded individual market, particularly through his proposal to end the favorable tax treatment for employer-based coverage. His plan acknowledges that some Americans will not be able to obtain or afford coverage on the individual market due to a preexisting condition. For these individuals, his plan calls for the federal government to partner with states to operate what he calls a Guaranteed Access Plan, otherwise known as a high risk pool. Sen. McCain has called for \$10 billion in federal funding n19 for the Guaranteed Access Plan, or GAP, which would offer plans with reasonable limits on premiums, and some subsidies for low-income enrollees.

Sen. McCain's plan to expand the individual market, and supplement it through the GAP proposal, has been criticized by some, with warnings that the \$10 billion in funding promised by Sen. McCain may be insufficient to ensure access to care. n20

In addition, one report estimates that Sen. McCain's plan to expand the individual market would result in \$20 billion in new administrative costs as individuals move from employer coverage, with its relatively low administrative overhead of 12 percent of premium dollars, to the less efficient individual market, where administrative costs reach nearly 30 percent of premiums. n21

In contrast, Sen. Obama's plan includes several efforts to improve risk pooling and protections on the individual market. His plan would maintain the current tax treatment of employer-based health benefits. In addition, he would create a National Health Insurance Exchange where anyone could access health insurance. This Exchange would make the following changes to the individual market:

. *Fair and Reasonable Premiums:* Insurers must charge fair and stable premiums that will not depend upon health status.

. *Comprehensive Benefits:* Both public and private plans will be available on the Exchange, and all must offer similar benefits and meet standards for quality and efficiency.

. *Income-Based Subsidies*: Subsidies would be available for individuals and families who need them, on a sliding-scale basis.

The most efficient pool is one which includes every individual. Some have criticized Sen. Obama's plan for not including an individual coverage mandate, and thus for not including everyone in the risk pool.

Insurance Regulation on the Individual Market. Both Sen. McCain and Sen. Obama propose significant changes to how health insurers are regulated in the United States. The changes proposed by each candidate closely reflect their philosophy for health reform; Sen. McCain would pursue extensive deregulation where Sen. Obama has said that he wants stronger regulations to protect access and quality for consumers.

Today, insurers must adhere to the insurance regulations imposed by the state in which their policyholders reside. Some of those regulations include:

. *External Review*: In 44 states and the District of Columbia, consumers can apply for a required external review if their insurer denies a claim or benefit. n22

. *Guaranteed Issue*: Five states require insurers to sell products to any applicant, regardless of their health condition, or other factors. n23

. *Rating Limits*: Eighteen states impose some limit on the rates an insurer can charge, with ten imposing rate bands and eight requiring adjusted or pure community rating. n24

. *Preexisting Conditions*: States are all over the map on the requirements imposed on insurers regarding the definition of a preexisting condition, if and for how long insurers can exclude the condition from coverage, how far back into an applicant or policyholder's medical record underwriting research can go, and whether insurers are required to give applicants credit for prior coverage. n25

The major insurance regulation change proposed by Sen. McCain would be to allow insurers to sell their products across state lines. Sen. McCain asserts that this change will increase competition, helping to drive down costs and improve quality and choice for policyholders.

Others have suggested that this deregulation will lead to reduced consumer protections, as insurers will likely move to the state with the most lax regulations much as credit card companies did following similar deregulations in the late 1970s. n26

In contrast, Sen. Obama would extend many consumer protections to all Americans, including:

- *Guaranteed Issue*: Applicants could not be denied coverage for preexisting conditions.

. *Medical-Loss Ratios*: In 16 states one insurer dominates more than half the private insurance market and in 38 states one insurer dominates at least 30 percent of the private insurance market. n27 Sen. Obama's plan would force

insurers to pay out a reasonable share of their premiums for patient care instead of keeping exorbitant amounts for profits and administration in markets where the insurance business is not competitive.

- *Greater Transparency:* Insurance companies would have to report how much of premium dollars are spent on administrative costs versus medical care for patients.

Premium Subsidies and the Tax Code. Today, the federal government essentially subsidizes health coverage for Americans who receive it from their employer through a tax exclusion for the cost of employment health benefits. Sen. McCain's plan would end this benefit for payroll and income taxes, and replace it with a tax credit of \$2,500 for individuals and \$5,000 for families. n28 Sen. McCain has asserted that offering patients control means offering them tax credits to purchase insurance through work or on the individual market. And if patients purchase health insurance for less than the amount of the tax credit, the remaining funds can be transferred to a health savings account (HSA) to help pay for copayments and deductibles. As a top advisor to Sen. McCain has said, the tax credit will give all Americans equal ability to go in search of coverage: **"you get the same amount whether youre rich or poor, \$5,000 for every working family."** n29

Opponents have criticized this plan for several reasons.

- . Several estimates have suggested that the tax credit may not be enough to allow all families to purchase coverage, or would only cover the costs of catastrophic care policies that require high out-of-pocket cost sharing for routine care. n30 While the credit is worth \$5,000 to a family, the average family policy today costs \$12,000.

- . Unlike the current tax exclusion, which increases at the same pace as the actual cost of health insurance to individuals and employers, McCain's plan does not include a factor for medical inflation. Thus, over time the tax credit will decline in value and be worth less to individuals relative to the ever-increasing costs of insurance and medical care. n31

- . Sen. McCain's tax credit is the same flat amount for everyone; only individuals enrolled in high risk pools (which tend to have higher costs) could be eligible for income-related subsidies. The tax credits would not reflect the wide variation in insurance costs on the individual market due to policyholders' age, gender, medical condition and other factors.

In contrast, Sen. Obama would keep the current health benefit tax exclusion. Although the current exclusion tends to offer higher income families a higher benefit, Sen. Obama's plan includes income-based subsidies that low income families who are ineligible for a public program can use to purchase public, private or employer-based insurance.

Sen. Obama's plan also includes subsidies to help business shoulder the costs of health coverage. Small businesses which are increasingly less likely to offer coverage n32 would be exempt from the employer mandate. However, Sen. Obama's plan would encourage them to offer coverage by providing a tax credit to small business that is worth up to 50 percent of what they spend on employee premiums.

Sen. Obama's plan would also seek to bring down costs for all employers by subsidizing catastrophic health costs. Just 20 percent of Americans generate 80 percent of all health care spending. n33 Sen. Obama's plan calls for reimbursing employers for part of these high costs through a plan of reinsurance as long as the savings are passed on to workers through reduced premiums.

Public Programs: Medicaid & SCHIP. Public programs have played an increasingly important role in ensuring access to coverage for many Americans. Medicaid has long been the backbone of our health care safety net, providing coverage to nearly 59 million low-income and medically needy individuals in federal fiscal year (FY) 2005. n34

Another 4.4 million children were enrolled in State Children's Health Insurance Programs (SCHIP) in June 2007. n35

Sen. Obamas health care plan would expand eligibility for these programs, which would allow them to serve a larger population of low-income Americans, and increase overall funding for the health care safety net.

In contrast, Sen. McCain's plan does not advocate using Medicaid and SCHIP to expand coverage. In fact, Sen. McCain recently expressed his opposition to expanding public programs during the 2007 SCHIP reauthorization debate. Sen. McCain voted against a bill which would have reauthorized the program and expanded coverage to 10 million additional children, and then called the President's veto of the legislation the right call. n36

Sen. McCain has asserted that he would work to make public programs perform more efficiently by encouraging states to experiment with alternative forms of access, coordinated payments per episode covered under Medicaid, use of private insurance in Medicaid, alternative insurance policies and different licensing schemes for providers.

Reform Financing

Any major change in health care in the United States will come with a cost for implementation.

Sen. McCain's plan does not include many specifics on how he would fund any new initiatives. However, his plan would replace the current employer-sponsored insurance income tax exclusion with refundable tax credits for individuals and families. Congress estimates that the current tax exclusion will cost the federal government nearly \$120 billion in 2008, and more than \$140 billion annually by 2011. n37 This would be shifted to cover the costs of the tax credits. n38 Essentially, the McCain plan reduces federal funding for taxes by eliminating the tax exclusion--and as a result, increasing taxes. For his one major new government-sponsored initiative, the Guaranteed Access Plan, Sen. McCain has proposed federal funding of \$7 to \$10 billion dollars, saying he will work with Congress, the governors, and industry to make sure this approach is funded adequately.

On the other hand, Sen. Obama has explicitly spoken to how he plans to fund his health care reform proposal. His campaign estimates the cost of the plan, once fully phased in, to be between \$50 and \$65 billion annually. Sen. Obama proposes ending the Bush tax cuts for Americans earning more than \$250,000 a year, which would cover half the cost. n39 Some critics have questioned the time frame under which Sen. Obamas cost savings would materialize. n40 For example, Sen. Obamas plan uses estimates of HIT savings calculations from a study which suggests that \$77 billion in savings may not be achieved for many years. n41

Conclusion

Both Sen. Barack Obama and Sen. John McCain have offered health reform proposals with the potential to significantly change the health care system in the United States. While each candidate covers similar themes in their proposals, their approaches diverge broadly. Sen. Obama's plan builds on the existing system of both public and private coverage, and has pledged significant federal investments in subsidies and cost containment investments to make health care more affordable and efficient. His goal is cost-containment and universal coverage.

While Sen. McCain does not share the goal of universal coverage, his plan is no less far reaching. By reforming the tax code, Sen. McCain would shift coverage in America from the employer market where most Americans currently receive insurance to the individual market. In keeping with his philosophy of laissez-faire economics, the other elements of his plan largely rely on market forces and voluntary efforts by the industry to achieve cost savings and great efficiency.

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Chandler on Hartford Accident & Indem. Co. v. Argonaut Ins. Co

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Chandler on Hartford Accident & Indem. Co. v. Argonaut Ins. Co: Following the Fortunes

By Seth J. Chandler

August 27, 2008

SUMMARY: Although judicial resolutions of discovery disputes may often seem not to involve major issues of law, often, with their embedded standards of relevancy and their notions of burden, they provide insight on the boundaries and priorities of the law. This opinion resolves a discovery dispute in a lawsuit between an insurer and its reinsurer in which the scope of the follow the fortunes doctrine is a key element.

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ARTICLE: Although judicial resolutions of discovery disputes may often seem not to involve major issues of law, often, with their embedded standards of relevancy and their notions of burden, they provide insight on the boundaries and priorities of the law. Such is the case with a recent decision, *Hartford Accident & Indem. Co. v. Argonaut Ins. Co.*, 2008 U.S. Dist. LEXIS 47985 (D. Conn., June 23, 2008)). The opinion resolves a discovery dispute in a lawsuit between an insurer and its reinsurer in which the scope of the follow the fortunes doctrine is a key element. That doctrine, more expressively known as follow the settlements, and often though not invariably embodied by explicit clauses contained in a reinsurance agreement, generally restricts the ability of a reinsurer to question a settlement reached by the primary insurer. Instead, the doctrine obligates the reinsurer simply to pay its settling reinsured the amount owed according to the formula in the reinsurance agreement. Follow the fortunes clauses are a centerpiece of reinsurance agreements, particularly those whose coverage is concurrent with that of the primary insurance (follow-form policies), as they essentially delegate to the insurer substantial power over the meaning of the reinsurance (and insurance) agreements even when the insurer may be an interested party in a particular interpretation of those agreements in a particular dispute. The clause thus represents acceptance of a potentially biased adjudicator in the interests of finality and inexpensive dispute resolution. The relationship of utmost good faith that is supposed to exist between insurer and reinsurer, see *Unigard Sec. Ins. Co. v. North River Ins. Co.*, 4 F.3d 1049 (2d Cir. 1993), coupled with the ability of the modestly small world of reinsurers not to do business again with insurers that abuse the follow the fortunes doctrine, is thought to make the arrangement more palatable to reinsurers given the potential vulnerability it creates.

The *Hartford* case described above shows just how far this doctrine can go in at least some jurisdictions and highlights the increasing disarray of follow the fortunes law that has emerged over the past decades as reinsurance disputes have moved from arbitral forums to judicial ones. See Charles F. Corcoran III, *Reinsurance Litigation: A Primer*, 16 W. New Eng. L. Rev. 41 (1994). The facts of the case, discerned both from the original opinion available in the blogosphere at <http://www.reinsurancefocus.com/uploads/HartfordArgonautorigOrder.pdf> and from the opinion on a

motion for reconsideration available on LEXIS, are as follows. Argonaut facultatively reinsured Hartford's liability in 1974-75 to a manufacturer that used asbestos. Argonaut was apparently responsible for 50% of Hartford's liability from \$250,000 to \$1 million per occurrence for one year. There was no aggregate limit with respect to non-products claims. When the manufacturer incurred asbestos liability for acts apparently arising over a multi-year period, Hartford in 2004 engaged in an allocation of a \$54 million settlement in a fashion that was allegedly harmful to Argonaut, the reinsurer for a limited time period. Argonaut thus sought discovery of materials that would suggest whether Hartford's allocation was reasonable and consistent with Hartford's practices, including a related 2001 settlement. The court denied the discovery request. Although there was an issue of burden involved apparently Hartford maintained its files in a fashion that would require it to consume thousands of person-hours in complying with the discovery request the court rested its refusal to permit discovery on the alleged irrelevance of the material sought. Material that would show imperfections in the alignment of interests between the insurer and insured were not a proper subject of inquiry and neither were materials that would show inconsistencies between the 2004 settlement and its predecessors. Thus, if Argonaut were to prove the sort of bad faith or unreasonableness that would permit to avoid being bound to a settlement entered into by the ceding insurer, it would have to do so largely without the discovery that has long been a hallmark of most American civil litigation.

Perhaps the most surprising element of the decision in *Hartford* is that it can not be criticized as entirely inconsistent with precedent. In recent times, the law relating to the reinsurer's ability to question its liability under its contract has exhibited increasing disarray. The disarray lies roughly on two dimensions: (1) the implication issue: should a follow the fortunes clause be implied into reinsurance contracts that lack an explicit one and (2) the boundaries issue that appears to have been central in *Hartford*: how far should an insurer be permitted to go in binding the reinsurer to settlement decisions that fail to minimize the joint liability of the insurer and reinsurer but instead allocate unusually high losses to the reinsurer. n1

On the implication issue, American courts have essentially taken three positions: (1) implication as a matter of law, *See International Surplus Lines Ins. Co. v. Certain Underwriters at Lloyds London*, 868 F. Supp. 917, 920-21 (S.D. Ohio 1994); (2) implication as a matter of fact, *see National Am. Ins. Co. v. Certain Underwriters at Lloyd's London*, 93 F.3d 529 (9th Cir. Cal. 1996) (custom and usage evidence could imply follow the fortunes requirement where no explicit clause existed); *Aetna Cas. & Surety Co. v. The Home Ins. Co.*, 882 F. Supp. 1328 (S.D.N.Y. 1995) (implying follow fortunes requirement into facultative reinsurance after finding alleged industry custom in support); *See North River Ins. Co. v. Employers Reins. Corp.*, 197 F. Supp. 2d 972, 984-86 (S.D. Ohio 2002) (proof must be clear and explicit); and possibly (3) no implication. *See Michigan Township Participating Plan v. Federal Ins. Co.*, 233 Mich. App. 422, 431 (1999)

On the boundaries issue, American courts likewise have a spectrum of views. Some courts take the position that, absent fraud or collusion (a term whose meaning in this context is a bit unclear), the follow the fortunes doctrine binds the reinsurer. And this is apparently true even where, as in some cases, the insurer's economic interests directly conflict with those of the reinsurer (*see American Employers Ins. Co. v. Swiss Reinsurance America Corp.*, 413 F.3d 129, 136 (2d Cir. 2005)) and there is no reason to think that, had the reinsurer foreseen the particular situation, it would have agreed to place the interpretation of its contract into the hands of an extraordinarily biased decision maker. Thus, in *The North River Ins. Co. v. ACE American Reinsurance Co.*, 361 F.2d 134 (2d Cir. 2004), the court quite explicitly held that the absence of any alignment between the economic interests of the insurer and those of the reinsurer did not bar application of the follow the fortunes doctrine: if the insurer had time-allocated settlement costs so as to reduce its own liability and, as it happened, commensurately increased those of its reinsurer, the reinsurer was stuck n2 in mass asbestosis litigation, so long as the allocation was in good faith, reasonable, and within the applicable policies. n3 Similar rulings may be found in many cases, including *Travelers Casualty & Surety Co. v. Gerling Reinsurance Corp.*, 419 F.3d 181, 189 (2d Cir. 2005); *National Union Fire Ins. Co. v. American Re-Insurance*, 441 F. Supp. 2d 646 (S.D.N.Y. 2006) *But see Allstate Ins. Co. v. American Home Assurance Co.*, 837 N.Y.S.2d 138 (N.Y. App. 2007) (reinsurer is not bound by the follow-the-fortunes doctrine where the reinsured's settlement allocation, at odds with its allocation of the loss with its insured, designed to minimize its loss, reflects an effort to maximize unreasonably the

amount of collectible reinsurance). It is this line of cases that the court in *Hartford* appears to be embellishing: now evidence of economic motivations to act selfishly and to the prejudice of a reinsurer is not even discoverable.

Other courts resolve the boundaries issue by taking the position that the doctrine binds the reinsurer if the settlement is arguably within the scope of the insurance coverage. *Christiania General Insurance Corp. v. Great American Insurance Co.*, 979 F.2d 268, 280 (2d Cir. 1992). Thus, in the recent case of *City of Renton v. Lexington Insurance Company*, 2007 U.S. Dist. LEXIS 69959 (2007), the court declined to bind the reinsurer to a \$248,892 settlement of a construction dispute where the court found that an inherent vice exclusion in the primary policy clearly barred payment. Although the court does not specifically advert to the matter, the court may have been helped in its conclusion by recognizing that a primary insurer attempting to preserve good relations with a significant client (the City of Renton) might have motivation to pay too much to settle a dispute where it could foist all but \$25,000 of the bill on to its reinsurer. See also *Texas Farmers Ins. Co. v. Lexington Ins. Co.*, No. CV 06-08220 (C.D. Cal., Feb. 22, 2008) (court declines to apply the follow the fortunes doctrine in the face of a facultative reinsurance agreement under which, if settlement occurred the insurer owed essentially nothing and the reinsurer owed \$4 million whereas if settlement did not occur, the insurer risked owing \$5 million, although there were complicating special factors possibly affecting the courts decision).

Still others appear to take the view that the reinsurer is not liable under the follow the fortunes doctrine, at least where no explicit follow the fortunes clause exists, unless the reinsurance policy actually covers the loss. *North River Ins. Co. v. Employers Reinsurance Corp.*, 2002 U.S. Dist. LEXIS 11711 (S.D. Ohio 2002). Losses that are arguably covered but, on closer inspection, are not covered, do not obligate the reinsurer to pay. This district court opinion is not entirely a rogue holding. Most courts have refused, for example, to make the reinsurer pay for what amounts to excluded punitive damages where the insurer appears to have recharacterized those damages as compensatory damages as part of the settlement, see *American Ins. Co. v. North American Company for Property and Casualty Ins.*, 697 F.2d 79 (2d Cir. 1982); or where the reinsurer has been asked to pay amounts greater than its liability cap as a result of a settlement whose amount was apparently based in substantial part on expenses incurred by the insured to defend itself in litigation that the insurer should have paid for, *Bellefonte Reins. Co. v. Aetna Cas. & Sur. Co.*, 903 F.2d 910 (2d Cir. 1990).

Space does not permit an attempt fully to resolve here the current disarray in this vital area of reinsurance law. A few principles may be helpful, however. First, there should only be default rules and not mandatory rules in this arena: whatever rules the courts craft, the sophisticated parties to a reinsurance transaction should always be able to contract around it, particularly given that different circumstances and different relationships may call for different balancings of the desirability for certainty versus the desirability of an independent adjudicator.

Second, courts should attempt to develop clear and bright line default rules for standard follow the fortune clauses: the reduction in dispute resolution costs said to be created by a follow the fortunes doctrine is almost eliminated if there is dispute about the scope and nature of the rule itself or if the applicability of rule is defined by some hazy, multi-factor balancing test. Even if the default rule is not optimal, clarity gives the parties to a reinsurance transaction knowledge as to the scope and content of any effort at customization.

Third, states ought strongly to consider unifying their rules in this area perhaps through the auspices of organizations such as the National Association of Insurance Commissioners, the National Conference of Insurance Legislators or through the admittedly unusual practice of judicial deference to majority rules even where the court thinks a slightly better case could be made for some alternative or minority doctrine.

Fourth, most forcefully in a case where the doctrine is implied rather than explicitly stated in the reinsurance contract, courts ought to be extremely wary of applying the follow the fortunes doctrine in cases where the reinsurance policy is not concurrent with that of the primary policy and the insureds settlement of the case arguably implicates matters within the scope of the primary policy but excluded (via exclusion, definition or otherwise) from the reinsurance policy. As courts have noted, see *Travelers Cas. & Sur. Co. v. Certain Underwriters at Lloyds of London*, 96 N.Y.2d

583, 597 (2001), a rule to the contrary lets an implied rule swallow up potentially negotiated and significant provisions of the reinsurance policy.

Fifth, courts ought to engage in a little honest introspection about their enthusiasm for the follow the fortunes doctrine. It used to be the case that reinsurance disputes were almost universally arbitrated. Over the past few decades, that tradition has broken down and courts are now being asked to resolve cases in an area that few consider terribly sexy. On the one hand, an expansive follow the fortunes doctrine, coupled with a decline in arbitration, prevents sophisticated parties from developing incredibly complex contracts (such as many modern insurance and reinsurance policies) and then externalizing many of the resulting high dispute resolution costs onto the public through the judicial system. On the other hand, an expansive follow the fortunes doctrine permits disputes to be resolved by parties who are, at least potentially, in no way unbiased. And when that doctrine is coupled with unusual limitations on discovery, such as that imposed in the *Hartford* decision, it prevents exposure of the bias and self-interest the current system permits. Sooner or later, courts will need to confront the problems created by prevailing notions of the follow the fortunes doctrine or reinsurers will relieve them of that burden by (a) going back to a system of arbitration or (b) writing explicit clauses that limit the scope of the doctrine.

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n1 The disarray is particularly troubling given the international nature of the reinsurance market and the fact that reinsurance law in the United States is, like many forms of insurance law, state-based, with resolution thus often depending on the interplay of hazy choice of forum and choice of law rules. Thus, many disputes that would ultimately be about the content of follow the fortunes law become compounded by difficult and often expensive antecedent disputes.

n2 Perhaps not coincidentally, the courts were thus spared an intensely factual and likely tedious coverage dispute.

n3 The court engages in an apparently approving citation, however, of *Hartford Accident & Indem. Co. v. Columbia Cas. Co.*, 98 F. Supp. 2d 251, 259 (D. Conn. 2000)

in which a district court declined automatic application of the follow the fortunes doctrine where the cedents allocation may have reflected an effort to maximize the amount of reinsurance collected. The citation of this opinion is mysterious because it appears that the sort of deliberate computation engaged in by the insurer in the *Columbia Casualty* case is exactly what was done by the insurer in the *North River* case. The court discusses, for example, North Rivers (laudatory) use of computer models and decision-tree software to quantify the effect of various settlement scenarios on the insurers responsibility. Although it is nowhere stated in the opinion, that modeling would be surprisingly deficient if it did not also examine the effect of various allocation formulae on the responsibilities of the various layers of insurance.

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Morrison Mahoney LLP on Peraza v. Robles

2008 Emerging Issues 2736

Morrison Mahoney LLP on Peraza v. Robles: Florida Courts Tightens the Rule on Time Limited Policy Limits Settlement Demands

By Michael F. Aylward

August 20, 2008

SUMMARY: A recent Florida opinion highlights the acute peril that time limited policy limits settlement demands present for insurers in the Sunshine State.

PDF LINK: [Click Here for Enhanced PDF of Commentary](#)

ARTICLE: A recent Florida opinion highlights the acute peril that time limited policy limits settlement demands present for insurers in the Sunshine State. For those who may be unfamiliar with such claims, time limited policy limits demands differ from conventional negligent failure to settle actions in that the goal of the third party claimant is not to extract the limits of coverage but rather to set aside what are typically relatively low limits of coverage to expose a deeper pocket of recovery to satisfy the plaintiffs injuries. To be blunt, a time limited policy limits demand is mainly a trap whereby a liability insurer can lose the protection of its policy limit if it insists on taking the time to undertake a reasonable investigation of the claims against its insured before agreeing to settle.

As liability insurers have discovered to their misfortune in the past, time limited policy limits demands in Florida create significant perils for an insurer that insists on interviewing witnesses, obtaining policy files, or otherwise undertaking the sort of reasonable investigation that most insurers would require before deciding whether to accept liability or pay a loss. Thus, in *Berges v. Infinity Ins. Co.* 896 So.2d 665 (Fla. 2004), upheld a finding of bad faith against an insurer, despite evidence that the insurer had made good faith efforts to pay its limits within the time granted but that its check had been sent to the wrong address. As a result, most insurers doing business in Florida have in recent years instituted safeguards and procedures to ensure that such demands are promptly and properly replied to. Unfortunately, as the recent opinion of the Florida District Court of Appeal in *Peraza v. Robles*, No. 3DO6-725 (Fla. DCA3 2008) illustrates, even a prompt response may not be enough.

Shortly after suffering injuries in an auto accident, Peraza engaged counsel who sent a demand letter to the other motorists insurer (MGA Insurance Company) demanding that it pay the \$10,000 policy limit within fifteen days. A day or two later, an MGA claims adjuster sent a check for \$10,000 to counsel. However, the letter made two crucial requests. First, MGA asked that it receive an authorization of settlement from the plaintiffs uninsured motorist carrier. Second, MGA asked for a waiver of any subrogation rights.

Plaintiffs counsel kept MGAs \$10,000 check but neither cashed it, nor agreed to MGAs terms. Instead, Peraza filed suit against Robles. Believing that the claims against its insured were resolved, MGA sought to have the case against dismissed and, indeed, the trial court granted the defendants motion to enforce the \$10,000 settlement agreement.

This finding was set aside by the Third District of the Florida Court of Appeals in a split decision. Two of the three justices declared that the insurers insistence on obtaining authorization from the uninsured motorist carrier and a waiver of subrogation rights changed the terms of the original settlement proposal such that MGAs response was in the nature of a counter-offer, not an acceptance of the original offer. As such, the court ruled that there was never a binding settlement agreement and that the plaintiff should be permitted to go forward with its bad faith action against MGA.

The third justice dissented, arguing that Florida precedents concerning time-limit agreements permitted the negotiation of the usual settlement documents even though they may not have been explicitly referenced in the original settlement offer. Justice Cope contended that the two additional proposals presented by MGA were in the nature of settlement documents that were customary and necessary to such cases and that its response was therefore an acceptance not a counter-offer.

To begin with, the dissent pointed out that when a plaintiff demands policy limits, the demand is necessarily subject to compliance with statutory and case law requirements. Judge Cope stated that it was his understanding that provisions for satisfaction of hospital liens and waiver of subrogation rights are customary in personal injury settlements and that it would have made little sense for a liability insurer to tender its policy limits if there remained a possibility that it could still be liable for further claims arising from the same incident. As such, the dissent found that MGAs requests were reasonable and customary and not an independent counter-offer.

In any event, the dissent argued that if there were questions with respect to the scope of the agreement, they should have been subject to a court hearing, not a judicial declaration that no binding agreement existed at all.

Judge Cope also took note of the fact that at oral argument plaintiffs counsel had candidly admitted that the entire controversy stemmed from a desire to set the stage for a bad faith suit against MGA. He commented (perhaps naively or wistfully) that but for this bad faith aspect, the matter would have been resolved long ago. We should adopt rules which encourage, and do not thwart settlements.

The District Court of Appeal had ruled in several cases that an insurers failure to meet an arbitrary deadline was not necessarily bad faith. *See DeLaune v. Liberty Mut. Ins. Co.*, 314 So.2d 601, 603 (Fla. DCA 4 1975)(Insurer did not act in bad faith where it missed by one business day an unreasonably short ten-day demand within which to tender its policy limits). Likewise, an insurer was held not to have acted in bad faith in *Clauss v. Fortune Ins. Co.*, 523 So.2d 1177, 1179 (Fla. DCA 5 1988), where it failed to accept a time-limit policy limits demand within the period prescribed because it was still investigating its insureds claimed liability but, once that investigation was concluded, tendered the limits only one day after the notice of bad faith was sent. However, the courts opinion in *Peraza*, coupled with the lingering after-effects of the state Supreme Courts opinion in *Berges* calls into question whether insurers still have any defenses to time limited policy limits demands in Florida.

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Morrison Mahoney LLP on Aurelius v. State Farm Fire & Cas. Co.

2008 Emerging Issues 2738

Morrison Mahoney LLP on Aurelius v. State Farm Fire & Cas. Co.: Illinois Court Upholds Intentional Act Exclusion Against Claims of Innocent Spouse

By Michael F. Aylward

August 20, 2008

SUMMARY: Many cases involve an innocent spouse who seeks coverage for first or third-party losses due to the intentional acts of their wife or husband. Many of these cases come down to a parsing of the perceived nuances among exclusions referring to "an" or "any" or "the" insured. Such was the case in the recent opinion of the Illinois Appellate Court in *Aurelius v. State Farm Fire & Cas. Co.*, No. 2-07-0266 (Ill. App. August 5, 2008).

PDF LINK: [Click Here for Enhanced PDF of Commentary](#)

ARTICLE: Many cases involve an innocent spouse who seeks coverage for first or third-party losses due to the intentional acts of their wife or husband. A husband whose wife intentionally burns down the family home may present a first party claim for the lost value of the house, whereas parents who are sued for preventing assaults by other household members may seek a defense under the liability provisions of their policies.

As sympathetic as the claimants are in such cases, courts have often refused to find coverage, whether due to the fact that the underlying loss is not fortuitous or as the result of exclusions or limitations barring coverage for losses intentionally caused by any insured. Indeed, many of these cases come down to a parsing of the perceived nuances among exclusions referring to an or any or the insured.

Such was the case in the recent opinion of the Illinois Appellate Court in *Aurelius v. State Farm Fire & Cas. Co.*, No. 2-07-0266 (Ill. App. August 5, 2008). Karen Aurelius had made a claim under her homeowners policy for the intentional destruction of their home by her husband. Following the fire, Aurelius and her husband had provided a recorded statement to State Farm claiming that the loss was accidental. However, after her husband was indicted and then convicted for the crime of arson in connection with the loss, State Farm denied coverage citing the intentional act limitation to coverage in its policy as well as conditions precluding coverage for misrepresented facts.

The intentional acts condition stated that the policy was void, If you or any person insured under this policy causes or procures a loss to property covered under this policy for the purpose of obtaining insurance benefits The concealment or fraud condition stated that, This policy is void as to you and any other insured, if you or any other insured under this policy has intentionally concealed or misrepresented any material fact or circumstance relating to this insurance either before or after a loss.

After a state trial court sustained State Farms contentions, Karen Aurelius appealed to the Second District of the Illinois Appellate Court. The principal thrust of Aurelius appellate argument was that the language in question could not survive the so-called innocent spouse doctrine under Illinois law.

In earlier cases, some Illinois appellate courts have upheld first party claims by insureds whose spouses intentionally destroyed property. In *Wasik v. Allstate Ins. Co.*, 351 Ill. App.3d 260 (2004), the Appellate Court had held that a homeowner was entitled to recover for the intentional destruction of their home by their stepson notwithstanding language in the policy stating that the insurer did not cover any loss or circumstance in which *any insured person has concealed or misrepresented any material fact or circumstance* nor did the policy cover intentional or criminal acts of or at the direction of any insured person The Appellate Court ruled that under long-standing principles of Illinois law, an insured should be entitled to recover for losses, even where committed by a co-insured under the policy, unless the policy expressly made clear that the intentional acts or misrepresentations of any insured precluded a claim by all insureds. The *Wasik* court declared that, It was reasonable for the husband and wife to have assumed that their rights were not dependent upon those of their children. Although these provisions could be read as the insurer proposed, the court found that they do not clearly state that the policy will be void or coverage will be excluded as to all insureds in the event of some improper behavior by any insured.

The *Aurelius* court contrasted the State Farm language with the policy provisions that Illinois courts had found wanting in cases such as *Wasik*. The court emphasized the repeated references to you or any other insured as precluding any suggestion that an innocent spouse was entitled to coverage for intentional losses or intentional misrepresentations of facts concerning a loss.

Thus, unlike the policy provisions at issue in *Salemi*, *Miceli*, and *Wasik*, the intentional acts provision her states not only that the policy is void due to an intentional act of any insured but also that in such event the insurer will not pay you or any other insured for this loss. Similarly, the concealment of fraud provision states not only that the policy is void due to concealment or fraud but further adds that in such event the policy is void as to you and any other insured. The additional language in these provisions distinguishes this case from *Wasik* and renders the innocent insured doctrine inapplicable.

The Appellate Court also rejected Aurelius effort to introduce ambiguity based on a claimed conflict between these policy wordings and related exclusionary terms in the liability provisions of the policy. In particular, the court pointed to language in Coverage L (Personal Liability) which stated that the policy did not apply to bodily injury or property damage which is expected or intended by the insured or which is the result of willful and malicious acts of the insured. The court also noted the severability of insurance language which required that the insurance apply separately to each insured. Aurelius argued that this language, which focused on the interests of separate insureds, was in conflict with the quoted provisions of the first party coverages.

Without addressing this issue directly, the Illinois Appellate Court declared that language with respect to third-party claims was entirely distinguishable and irrelevant to the scope of coverage for first party losses under the policy.

Although not directly addressed by the Illinois Appellate Court, similar issues have become a hot area of controversy with respect to liability insurance, particularly in cases where one insured under the policy has sexually abused or assaulted the plaintiff. In such cases, arguments have been raised that the other insured is legally liable for failing to prevent the abuse or assaults. Some courts have avoided the result by focusing specifically on the definition of occurrence and the requirement of accident holding that all claims of liability arising out of intentionally-caused injuries are necessarily precluded from coverage without considering independent theories of negligence based upon negligent supervision and the like. In many cases, however, courts have held that the severability of interests language requires that the interests of each insured be considered separately. See *Safeco Ins. Co. of America v. Robert S*, 26 Cal.4th 758 (Cal. 2001) and *Brumley v. Lee*, 963 P.2d 224, 228 (Kan. 1998).

In the face of such holdings, homeowners carriers have increasingly adopted more narrowly crafted intentional act exclusions. Even so, courts continue to reach conflicting conclusions with respect to coverage is required for innocent spouses where intentional act exclusions only speak to the conduct of the insured as opposed to an insured or any insured. *Compare Chacon v. American Family Mut. Ins. Co.*, 788 P.2d 748, 752 (Colo. 1990); *Oaks v. Dupuy*, 653 So.2d 165, 168 (La. App. 1995); *American Family Mutual Ins. Co. v. Copeland-Williams*, 941 S.W.2d 625, 629 (Mo. App. 1997)(no coverage for innocent insureds under any insured exclusion) with *American National Fire Insurance Company v. State of Fournelle*, 472 N.W.2d 292, 295 (Minn. 1991) and *Worcester Mutual Ins. Co. v. Marnell*, 496 N.E.2d 158, 161 (Miss. 1986)(finding coverage).

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Manning on Estate of Kathryn E. Spencer, et al. v. Daniel J. Gavin, Esq., et al.

2008 Emerging Issues 2735

Manning on Estate of Kathryn E. Spencer, et al. v. Daniel J. Gavin, Esq.,: Attorneys Legal Duty to Non-Clients in Legal Malpractice Cases

By Diana C. Manning

August 20, 2008

SUMMARY: Legal practitioners who practice individually, but work in close and interdependent business relationships with other lawyers, may have a legal duty to non-clients to report wrongdoing on the part of such other lawyers. The Appellate Division fashions a test for legal duty to non-clients in the legal malpractice context based on the actual knowledge of an attorney and his or her professional proximity to another lawyers business and clients.

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ARTICLE: The Appellate Division of the New Jersey Superior Court weighed in on the legal duty of attorneys to non-clients in legal malpractice cases in its recent opinion in *Estate of Kathryn E. Spencer, et al. v. Daniel J. Gavin, Esq., et al.*, 400 N.J. Super. 220, 946 A.2d 1051 (N.J. App. Div. 2008). The *Spencer* Court held that under certain circumstances an attorney may be liable to a non-client if he or she has actual knowledge of wrongdoing by another attorney that harms the non-client and fails to report it. Relying in part on New Jersey Rule of Professional Conduct (R.P.C.) 8.3, the Appellate Division reversed the trial courts order granting summary judgment to Dean Averna, Esq. and his firm Averna & Gardner, Esqs. and remanded the case for trial after determining that a reporting duty . . . is mandated by principles of legal ethics, tort law, and public policy, so long as the attorney is shown to have had actual knowledge of the other lawyers wrongdoing.

Dean Averna, Esq., his law firm, and several others were sued by the Estate of Kathryn E. Spencer and two other related estates after it was discovered that plaintiffs former executor, Daniel J. Gavin, Esq., misappropriated hundreds of thousands of dollars from the estates prior to his own death. Plaintiffs advanced two theories of liability against Averna and his firm: (1) that Averna had an attorney-client relationship with the plaintiffs as a matter of law because he performed per diem work at the request of the attorney-executor on estate matters, and (2) Averna had an independent duty to plaintiffs because of what plaintiffs described as his *de facto* partnership with the attorney-executor. The *Spencer* Court revisited some of the Appellate Divisions prior decisions by once again considering the factors that establish an attorney-client relationship in the estate law context, but broke new ground by deciding whether the Averna defendants owed a duty to plaintiffs that would subject them to civil liability if the duty was breached. While the former inquiry is fact-sensitive and often subject to a myriad of analytical approaches, the latter inquiry is a fairly simple legal analysis. As Judge Sabatino noted, the scope of a lawyers potential duty essentially has two facets: (1) the persons or entities to whom that duty is owed, and (2) the conduct required of the lawyer to fulfill that duty. It is this latter inquiry

in *Estate of Spencer* that is most instructive to practitioners in the legal malpractice context.

Attorneys Legal Duty to Non-Clients. Weighing the moral responsibility of an attorney to report wrongdoing by another attorney and the legal responsibility for said wrongdoing, the Appellate Division fashioned a holding in *Estate of Spencer* addressing the defendant attorneys knowledge of the malfeasance of a fellow attorney and his proximity to the wrongdoer. Citing the New Jersey Supreme Courts opinion in *Petrillo v. Bachenberg*, 139 N.J. 472, 655 A.2d 1354 (1995), the *Spencer* Court reiterated that an attorney may be liable to a non-client in certain situations where the attorney knows, or should know, that the non-client will rely upon the attorney. The Court found that plaintiffs implicitly relied upon Averna to be faithful to their best interests, and to not turn a blind eye if he learned that the executor was plundering estate funds. However, the Court stressed that the test for imposing a duty under these circumstances is actual knowledge of the wrongdoing.

The *Spencer* Court relied on two significant factors to determine that a reporting duty existed requiring Averna to report the attorney-executors malfeasance, one circumstantial and the other legal. First, the Court was persuaded by plaintiffs evidence of Avernas close and sustained nexus to Gavins law practice and found that imposing certain duties upon him as a consequence of that proximity was fair. Nevertheless, the Court rejected plaintiffs assertion that Averna and Gavin had entered into a *de facto* partnership finding that plaintiffs offered inadequate proof that Gavin and Averna exercised joint control over a common business. Second, while recognizing the Supreme Courts admonition in *Baxt v. Liloia*, 115 N.J. 190, 557 A.2d 1001 (1998), that violations of the R.P.C.s are not to be treated as *per se* grounds for an attorneys civil liability, the Court relied on R.P.C. 8.3(a), which states that [a] lawyer who knows that another lawyer has committed a violation of the Rules of Professional Conduct that raises a substantial question as to that lawyers honesty, trustworthiness or fitness as a lawyer in other respects, shall inform the appropriate professional authority. The Court emphasized that in accordance with R.P.C. 1.0(f), the term knowledge in R.P.C. 8.3(a) means actual knowledge, and therefore, Averna would have a professional obligation, owed not only to his clients but to the public at large, to bring Gavins thefts to light.

Recognizing the potential for this decision to be read too broadly or otherwise misapplied, the Appellate Division stressed that the *Estate of Spencer* decision does not stand for the proposition that a lawyer who receives a routine, arms-length referral from another lawyer automatically exposes himself or herself to civil liability if he or she fails to intercede after learning that the referring lawyer has somehow harmed a client. Rather, the decision stands for the proposition that an attorney . . . who has a close and interdependent business relationship with another lawyer, and who is performing legal work for a common client at that lawyers request, has a duty to report that lawyer if he or she develops actual knowledge that the lawyer has been stealing funds from their common client. It should be noted that the determination of whether a reporting duty exists under these circumstances did not turn on whether Averna performed legal services for the plaintiffs since the evidence established that he only performed legal services on behalf of one of the three plaintiffs. Rather, it was Avernas nexus to the wrongdoer that drove the *Spencer* Court to conclude that a jury should determine when, if ever, Averna developed actual knowledge that Gavin was stealing from the . . . estates.

While a true arms-length referral, one of the touchstones of private practice for attorneys, will not likely create the type of nexus necessary to establish a duty to a non-client as found in *Estate of Spencer*, as this decision makes clear, there is no brightline test for how close is too close. The *Estate of Spencer* decision serves as an important example of the judiciarys willingness to expand the legal duty between attorneys and non-clients, thereby establishing the prerequisite for a legal malpractice action. Legal practitioners sharing office space and/or clients should be mindful of the potential duty created by close, interdependent business relationships.

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Meckler Bulger Tilson Marick & Pearson on American Intl Specialty Lines Ins.

2008 Emerging Issues 2707

Meckler Bulger Tilson Marick & Pearson LLP on American International Specialty Lines Ins. Co. v. Res-Care, Inc.: The New Fifth Circuit Opinion Holding that it is Against Texas Public Policy to Insure Punitive Damages

By Robert Allen

August 19, 2008

SUMMARY: *American International Specialty Lines Ins. Co. v. Res-Care, Inc.*, 2008 U.S. App. LEXIS 11758 (5th Cir. June 2, 2008) involves whether the amount of a settlement allocated to punitive damages can be passed on to a Commercial Liability insurance carrier. Relying heavily on allegations contained in pleadings, the Fifth Circuit held that Texas public policy prohibited the insurability of punitive damages.

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ARTICLE: Background Facts

It took over three years after the oral argument for the Texas Supreme Court to issue its opinion in *Fairfield Ins. Co. v. Stephens Martin Paving*, 246 S.W.3d 653 (Tex 2008), (*Fairfield*) earlier this year. In a very limited holding, the Texas Supreme Court held that it was not against Texas public policy to insure punitive damages in the context of a workers compensation policy insuring an employer for gross negligence wrongful death cases. From that precedent, it took only four months for the Federal Fifth Circuit Court of Appeals to hold that it is against Texas public policy to insure punitive damages under a primary Commercial General Liability policy in *American International Specialty Lines Ins. Co. v. Res-Care, Inc.* 2008 U.S. App. LEXIS 11758 (5th Cir. June 2, 2008).

Underlying this coverage case was a particularly volatile wrongful death case brought by the family of Trenia Wright against Res-Care, its pertinent subsidiaries and several employees (*Wright v. Res-Care*). According to the pleadings, Trenia Wright was a 37 year old woman who suffered from cerebral palsy and other mental disabilities. She resided at a home, Applleridge, which was owned by Res-Care, that provided services to mentally disabled individuals. For the critical time period, Res-Care, its subsidiaries and employees were covered by primary and umbrella liability policies issued by American International Specialty Lines Insurance Co. (AISLIC).

The background facts of the events leading up to Ms. Wrights death are horrible and they are set out in detail in the Fifth Circuits opinion in *AISLIC v. Res-Care*. Suffice it to say, she died, in a most undignified way, from complications emanating from a fall four days earlier. The first employee who happened upon her after the fall was convicted of recklessly causing bodily injury to a disabled individual.

As the underlying *Wright v. Res-Care* case proceeded, Res-Care demanded AISLIC to settle the claims against it and AISLIC urged Res-Care to contribute to the settlement because it believed that the punitive damage exposure was not covered. Eventually, AISLIC and Res-Care executed a non-waiver agreement that allowed AISLIC to settle the *Wright v. Res-Care* litigation and then possess the right to proceed with a claim for recoupment from the Res-Care Defendants of all sums paid by [AISLIC] attributable to any claims not covered under the applicable Policies.

Eventually, AISLIC settled on behalf of Res-Care for \$9 million and then sued Res-Care for recoupment of the non-covered portion of the settlement.

In the instant recoupment litigation, AISLIC took the position that the actual damages in the *Wright v. Res-Care* settlement were between \$2 and \$3.5 million and that the remainder of the settlement was attributable to non-covered punitive damages. Res-Care posited that the entire \$9 million settlement was covered. The district court presided over a bench trial to apportion the non-covered and covered portions of the settlement pursuant to *Enserch Corporation v. Shand Morahan & Co.*, 952 F.2d 1485 (5th Cir. 1992).

The district court determined that the entire \$9 million settlement was attributable to the injuries emanating from the fall (even though other non-related incidents were also alleged in the suit). The district court apportioned the settlement as \$4 million for actual damages and \$5 million in punitive damages. The district court then rendered judgment that AISLIC recoup \$5 million from Res-Care.

Fifth Circuit Analysis

The Fifth Circuit's analysis of the legal issues arising from the underlying settlement involved waiver and estoppel, number of occurrences, trigger, burden of proof and whether Texas public policy precluded the insurability of the punitive damages aspect of the settlement. While all of these issues and the Fifth Circuit's treatment of them are noteworthy, this casenote will focus solely on the court's treatment of the insurability of punitive damages.

To begin with, it should be noted that the subject AISLIC umbrella policy specifically excluded coverage for punitive damages, so that policy was not in play for the punitive damages aspect of the settlement. The relevant AISLIC primary policy did not contain a punitive damages exclusion, so the Fifth Circuit analyzed whether it is against Texas public policy to insure the punitive damages aspect of the settlement under that policy in light of the specific facts of this case.

The Fifth Circuit followed the process for determining whether punitive damages are insurable as set out in the very recent Texas Supreme Court opinion in *Fairfield*. In *Fairfield*, the Texas Supreme Court held that a two-step process should be employed in determining whether punitive damages are recoverable. In this regard, the first step is whether the policy covers punitive damages. Since the only policy at issue was the primary policy that did not include a punitive damages exclusion, the Fifth Circuit held that as a threshold matter, punitive damages were covered.

The second step is whether Texas public policy precludes the insurability of punitive damages. To determine this, *Fairfield* requires the court to determine whether the Texas legislature has expressed an explicit public policy. If not, then, the court is free to consider general public policies.

With respect to the public policy issue, the Fifth Circuit quoted *Fairfield* for the proposition that the Texas legislature has been sensitive to the issue of insurance coverage for punitive damages and has made the policy decision to preclude such coverage in certain circumstances. *Fairfield*, 246 S.W.3d at 656. In this regard, the Fifth Circuit noted that the home in question, Appleridge, operated as an Intermediate Care Facility for the Mentally Retarded (ICF/MR) and that [t]he Texas legislature has not included ICF/MRs in the definition of health care providers found in the Texas Insurance Code. *American International Specialty Lines Ins. Co. v. Res-Care, Inc.*, 2008 U.S. App. LEXIS 11758 at 27-28 (5th Cir. June 2, 2008). This is important because health care providers have generally been prohibited from obtaining insurance coverage for punitive damages, *id.* at 26, although there are exceptions to this rule.

This allowed the Fifth Circuit to determine whether general public policy precludes the insurability of punitive damages in this instance. Under *Fairfield*, this requires a court to consider the interest of freedom of contract with whether enforcing the contract as written would frustrate important public policy. *Fairfield*, 246 S.W.3d at 663-64. All of this, bearing in mind, a strong public policy in favor of preserving freedom of contract. *Id.* at 664.

In determining whether general public policy precludes the insurability of punitive damages in this matter, the Fifth Circuit initially noted that the modern purpose of punitive damages is to punish the wrongdoer. *Fairfield* noted that in the corporate setting there may be some circumstances where it might be possible to insure punitive damages. In this regard, the *Fairfield* opinion states: [w]here other employees and management are not involved in or aware of an employees wrongful act, the purpose of exemplary damages may be achieved by permitting coverage so as not to penalize many for the wrongful act of one. *Id.* at 670.

Nonetheless, the Fifth Circuit rejected Res-Cares argument that as a corporation it should receive coverage for punitive damages. Interestingly, the Fifth Circuit relied heavily on the pleadings to note the allegations that all defendants, including Res-Care, were grossly negligent and that there were many allegations of gross negligence on the part of Res-Care. *Res-Care*, 2008 U.S. App. LEXIS 11758 at 31. Also, there were additional allegations, which supported the Fifth Circuits finding that the gross negligence allegations should not permit Res-Care to shift the responsibility for those actions on to AISLIC. For example, the pleadings alleged that a State of Texas report showed [that] Res-Care poorly operated other facilities, thereby establishing a course of conduct warranting exemplary damages . . . [and] [i]t therefore recommended that the Appleridge facility be closed. *Id.* at 33-34.

The Fifth Circuit then concluded that the circumstances:

were so extreme that the purposes of punishment and deterrence of conscious indifference outweigh the normally strong public policy of permitting the right to contract between insurer and insured. [citing *Fairfield*]. This case demonstrates the kind of avoidable conduct that causes injury where public policy is best served by requiring the insured to bear the costs of punitive damages. [citing *Fairfield*]. The district court did not err by failing to apportion any of the punitive damages to the primary policy.

Id. at 34.

Potential Impact

The *AISLIC v. Res-Care* opinion, then, will provide insurers with considerable leverage in negotiating settlements, not only with claimants, but their own corporate insureds. How this will actually materialize, however, is another story. This is because in light of *Texas Assn of Counties County Govt Risk Mgmt. Pool v. Matagorda County*, 52 S.W.3d 128, as more recently reaffirmed in *Excess Underwriters at Lloyds London v. Franks Casing Crew and Rental Tools, Inc.*, 246 S.W.3d 42 (Tex. 2008) an insurer can seek reimbursement from the insured only if it obtains the insureds clear and unequivocal consent to the settlement and the insurers right to seek reimbursement. *Matagorda County*, 52 S.W.3d at 135.

In the event that the insured does not provide such consent, an insurer could not settle a case with punitive damages exposure and then bring an action to recover from the insured for the amounts attributable to the punitive damages exposure. What effect an insureds refusal to either contribute to a settlement or agree to a subsequent reimbursement suit will bear on insurers in cases involving punitive damages exposure remains to be seen. For example, an insureds refusal to contribute to a settlement or agree to a reimbursement suit might motivate an insurer to reject a settlement offer and let the case go to trial. As a practical matter, if the case includes punitive damage exposure, a financially solvent insured might find it risky to be obstinate about contributing to a settlement or reject a request to consent to a reimbursement suit. This is because if such conduct prevents such a case to be settled, the insured might eventually be forced to pay for an uncovered punitive damage award that might far exceed its requested contribution to a settlement.

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Bullivant on Devonwood Condominium

2008 Emerging Issues 2705

Bullivant Houser Bailey PC on Devonwood Condominium Owners Assn v. Farmers Ins. Exchange, What Happens After The Appraisal?

By Samuel H. Ruby

August 15, 2008

SUMMARY: On several occasions, California courts have told us what an appraisal panel may or may not do. But what is a court supposed to do after the panels work is done? When, if at all, may an appraisal award be adjusted under the terms and conditions of the policy? This commentary, discusses the import and practical considerations of *Devonwood Condominium Owners Assn v. Farmers Ins. Exchange*, 162 Cal. App. 4th 1498 (2008).

PDF LINK: [Click Here for Enhanced PDF of Commentary](#)

ARTICLE: On several occasions, California courts have told us what an appraisal panel may or may not do. But what is a court supposed to do after the panels work is done? When, if at all, may an appraisal award be adjusted under the terms and conditions of the policy? These questions are answered in *Devonwood Condominium Owners Assn v. Farmers Ins. Exchange*, 162 Cal. App. 4th 1498 (2008).

I. Insurance Appraisals: The Substantive Case Law

Appraisal is process for resolving certain disputes under an insurance policy. California Insurance Code § 2071, which codifies the standard form of fire insurance policy for this state, requires that every fire insurance policy provide: In case the insured and this company shall fail to agree as to the actual cash value or the amount of loss, then, on the written request of either, each shall select a competent and disinterested appraiser. The appraisers must appraise the loss, stating separately the actual cash value and loss to each item. If the appraisers cannot agree, they must submit their differences to an umpire, and an award signed by the umpire and at least one appraiser shall determine the amount of actual cash value and loss.

On several occasions, California courts have held that the authority of an appraisal panel under *Insurance Code § 2071* is limited. For example, appraisers may not disregard the applicable formula for measuring actual cash value and substitute their own formula. *Jefferson Ins. Co. v. Superior Court*, 3 Cal. 3d 398 (1970). Also, in determining actual cash value of lost property, the appraisers must appraise the value of the property as the insured describes it and not make judgments as to whether the insureds claim is fraudulent. *Safeco Ins. Co. v. Sharma*, 160 Cal. App. 3d 1060 (1984). Furthermore, while appraisers are empowered to decide if a given article of property was damaged at all, they may not (absent a stipulation by the parties) make judgments about the

cause of the alleged damage. *Kacha v. Allstate Ins. Co.*, 140 Cal. App. 4th 1023 (2006).

II. Insurance Appraisals: The Procedural Case Law

The California Insurance Code provides no guidance on how the substantive right of appraisal is to be enforced. However, appraisal has been declared a species of arbitration. Code of Civil Procedure (CCP) § 1280(a). California's Arbitration Act provides a detailed set of procedural rules regarding the commencement, conduct, and enforcement of arbitrations. See CCP §§ 1280 et seq. By bringing appraisal under the umbrella of arbitration, California courts have applied those procedural rules to appraisals in several respects. See, e.g., *Louise Gardens of Encino Homeowners Assn. v. Truck Ins. Exchange, Inc.*, 82 Cal. App. 4th 648 (2000) (applying Arbitration Acts time limit to insureds challenge to appraisal award).

The Arbitration Act provides that a party may petition to a court for confirmation of an arbitration award. CCP § 1285. It further provides, If an award is confirmed, judgment shall be entered in conformity therewith. CCP § 1287.4. Until recently, few had thought to ask what application CCP § 1287.4 has to insurance appraisals. Given that the scope of insurance appraisal is limited, what sort of judgment--if any--should a court enter based on an appraisal award?

III. *Devonwood v. Farmers*--Substance and Procedure Collide

Devonwood, an association of condominium owners, made a claim to Farmers for property damage allegedly caused by a fire. When Devonwood and Farmers were unable to agree on what amount Farmers owed on the claim, they convened an appraisal. The appraisers were charged with determining the value of (1) the allegedly damaged floor, ceiling, and wall coverings; and separately, (2) the rest of the alleged damage (described as structure damage).

The coverings were segregated for a separate valuation because Farmers disputed coverage for them. However, consistent with *Sharma* and *Kacha*, the appraisers were not asked to decide whether the coverings were covered under the policy. The appraisers followed the rules and returned a unanimous award, which they said was without consideration of any deductible amount or any coverage or other provision of the policy which might affect the amount of the insurers liability thereunder. Devonwood petitioned a court to confirm the award, and Farmers apparently did not oppose confirmation.

However, relying on CCP § 1287.4, Devonwood further moved the court to enter a *monetary judgment* against Farmers--not only for the replacement cost of the structure damage, but also for the replacement cost of the coverings. Farmers objected that such a judgment would not be in conformity with the award, because the award did not constitute an adjudication of Farmers liability for the coverings. Nonetheless, the trial court entered the requested monetary judgment. Fortunately, that absurd result was reversed in a thoughtful opinion by the California Court of Appeal.

The appellate court agreed with Farmers that an insured is not entitled to a judgment under the California Arbitration Act that holds [an insurer] liable for the amount stated in an appraisal award, because the award itself does not determine this liability. The court noted that while arbitrators are frequently, by the terms of the agreement providing for arbitration . . . given broad powers . . . appraisers generally have more limited powers. The court reaffirmed that while a party to an appraisal has no jury trial right as regards the setting of the dollar amount of the loss, a party retains jury rights as to other issues.

Concluding that the trial courts judgment was not in conformity with the award as required by CCP § 1287.4, the appellate court reversed the judgment and remanded the case for entry of a new judgment.

IV. Implications

Although Devonwood stops short of dictating precisely what form a judgment based on an appraisal award should take, the implication is that a court should enter a *declaratory* judgment. The judgment should simply declare the property values and amounts of loss to be as stated in the confirmed award. The court should not declare whether the insurer is *liable* for the confirmed award. Indeed, the court should expressly *disavow* any implication that it is declaring the insurer liable.

When an award is confirmed and a judgment entered, the insurer has the right to adjust the award in accordance with policy provisions. The insurer is obligated only to pay the adjusted amount. If the insured does not accept the adjustments, then either party may then bring a lawsuit to resolve the dispute. *Practice Tip:* Where the parties anticipate factual issues beyond the value of the property or the amount of loss, they should consider stipulating to have those issues decided by the appraisal panel. Litigation is almost always slower and more expensive.

ABOUT THE AUTHOR(S):

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Bullivant Houser Bailey PC on Polygon Northwest Co. v. American Natl Ins. Co.

2008 Emerging Issues 2706

Bullivant Houser Bailey PC on Polygon Northwest Co. v. American Natl Ins. Co.: Attorney Fees Are Not Costs Taxed Under a Sophisticated Insureds Supplementary Payments Provision

By P. Jason Skuda

August 15, 2008

SUMMARY: Polygon Northwest provides a bright line delineating attorney fees from covered costs taxed under a common supplementary payments provision. But insurers should beware. The bright line could be blurred if challenged by a less sophisticated insured. This commentary discusses the import and practical considerations of a key holding in *Polygon Northwest Co. v. American Natl Ins. Co.*, 143 Wash. App. 753, 2008 Wash. App. LEXIS 773 (2008).

PDF LINK: [Click Here for Enhanced PDF of Commentary](#)

ARTICLE: 1. Supplementary Payments: Jurisdictions are divided concerning coverage for attorney fees

Commercial liability policies typically include a supplementary payments provision. A common example provides:

SUPPLEMENTARY PAYMENTS COVERAGES A AND B

We will pay, with respect to any claim we investigate or settle, or any suit against the insured we defend:

...

e. All costs taxed against the insured in the suit.

A division exists among U.S. jurisdictions concerning what costs taxed encompasses. Some courts hold the word costs means expenses incurred in litigation, thus bringing attorney fees awarded against the insured within the coverage for supplementary payments. *See, e.g., Mutual of Enumclaw v. Harvey*, 772 P.2d 216 (Idaho 1989). Insureds benefit from this interpretation, as supplementary payments coverage is not subject to the policy's indemnity limits. Other courts hold attorney fees do not constitute costs taxed since the term is typically used in statutes and other legal authority to indicate expenses other than attorney fees. *See, e.g., CIM Ins. Corp. v. Masamitsu*, 74 F. Supp. 2d 975 (D. Haw. 1999). *Polygon Northwest* is Washington's first appellate-level decision concerning whether attorney fees are recoverable under supplementary payment provisions.² *Polygon Northwest*: Attorney fees are not costs taxed, at least for some insureds

Polygon Northwest Co. (Polygon), a condominium developer, obtained insurance coverage from a number of companies, including a primary policy from Assurance Company of America (Assurance). Polygon was later sued by a homeowners association for allegedly defective work on one of Polygon's projects. Polygon tendered its defense to

Assurance and other liability insurers.

Polygon and the association eventually settled of the associations claims, funded by certain insurers which were also parties to the litigation. The settlement provided the association would receive \$6,314,000 allocated to payment of claims and \$1,486,000 allocated to litigation costs, primarily constituting attorney fees. *Id.* at 764-65. Assurance paid its \$1 million per occurrence limit under Polygons policy. In addition Assurance paid half of the litigation cost sum, characterizing its portion as supplemental payments coverage, and, therefore, outside of the liability limit.

Assurance later attempted to recoup the litigation costs it paid from the associations excess insurers, arguing those cost fell within Assurances indemnity obligations, which should not have exceeded \$1 million. The trial court disagreed, holding that the litigation cost amount properly fell under Assurances supplementary payments provision. Assurance appealed this holding.

Assurance argued on appeal that the litigation costs should be characterized as part of Polygons overall losses . . . and collectible only under [Assurances] general liability coverage. *Id.* at 784. Since Assurances portion of litigation costs payment exceeded its general liability limit, Assurance posited the full amount of the litigation costs should have been paid by Polygons excess insurers. More specifically, Assurance argued the supplementary payments provision in its policy obligating it to pay [a]ll **costs taxed** against the insured in the suit, has a specific meaning that does not necessarily include all legal fees or costs incurred by the insured in a lawsuit. *Id.* at 784-85 (emphasis added). The court of appeals agreed.

The court of appeals held the term costs taxed had a technical meaning under Washington legal authority. Under this authority, costs taxed excludes attorney fees. *Id.* at 788-89 (citing, *e.g.*, RCW 4.84.010; *Nordstrom, Inc. v. Tampourlos*, 107 Wash. 2d 735, 743, 733 P.2d 208 (1987)). Although Washington courts generally apply ordinary, not technical, definitions to insurance policy terms, the court noted: A technical legal or technical meaning will be applied to a term in an insurance policy if it is clear that the parties to the contract intended that the language have a [legal or] technical meaning. *Id.* at 786 (quoting *Thompson v. Ezzell*, 61 Wash. 2d 685, 688, 379 P. 2d 983 (1963)).

The court determined Polygon and Assurance intended costs taxed to have a technical meaning since costs taxed refer[s] to taxable costs as that term is commonly used in Washington legal parlance. *Id.* at 786. The court based this intent on a finding that Assurance and Polygon were both sophisticated business entities whose understanding of the term would not be divorced from its standard and well-established legal usage. *Id.*

The court specifically rejected an excess insurers argument that dictionary meanings for the individual words costs and taxed should apply in lieu of a technical meaning for the complete term. *Id.* Based on this argument all costs associated with the legal process, including attorney fees, would have fallen within the definition of costs taxed. The court held the term could not be parsed in this manner, as it was clearly defined under Washington law and contained in a policy provision specifically referring to the legal process in one way or the other. *Id.*

The court further rejected arguments that no mutual intent existed, as only Assurance would intend for costs taxed to have such a technical meaning. The court held Polygon also intended for the technical meaning to apply, as the text of the supplementary payments provision in combination with the context of . . . its creation demonstrated a mutual intent for a technical meaning. *Id.* at 787. The court did not elaborate on the nature of this context beyond the parties sophistication. The *Polygon Northwest* opinion was not appealed to the Washington Supreme Court.³ Implications

In light of *Polygon Northwests* focus on the insureds sophistication, it remains to be seen how Washington courts will interpret the scope of costs taxed where an insured has less business or legal savvy. The case also provides a basis for insurers to argue that other legal or technical definitions should apply to sophisticated insureds.

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Bullivant Houser Bailey PC is a business and litigation law firm with approximately 155 attorneys and six offices on the West Coast. The firm is headquartered in Portland, Oregon and maintains offices in Sacramento and San Francisco, California; Seattle and Vancouver, Washington; and Las Vegas, Nevada. In 2008, Multicultural Law magazine named Bullivant a Top 100 law firm for workplace diversity. Please visit bullivant.com to learn more about Bullivant Houser Bailey and its Insurance Industry Services Group.



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Insurance Recovery Grows on Trees: Decision Tree Analysis

2008 Emerging Issues 2700

The CapAnalysis Group, LLC on Insurance Recovery Grows on Trees: Decision Tree Analysis Improves Attorney-Client Communication and Results

By John S. Wyckoff, Evy M. Wild and Robert N. Martin

August 15, 2008

SUMMARY: Using decision trees to support insurance recovery allows attorneys and clients a greater understanding of the underlying variables, the effect of uncertainty, and what drives the outcome. Attorneys and clients can conduct what-if analyses and establish resolution targets. Attorneys and clients can better manage expectations and achieve better results through the use of decision trees.

PDF LINK: Core Emerging Issues Commentary (\$)

ARTICLE: Introduction

Clients involved in insurance recovery often ask their counsel several questions regarding: how will their claim costs be reviewed (and possibly discounted) by the insurance carriers; what are the potential claim hurdles with respect to coverage (exclusions, self-insured retentions, occurrence wording, etc.); and how will the different allocation theories impact recovery? To effectively analyze the potential recovery and communicate the impact of these issues, attorneys can use decision trees to depict the relationships between different choices or scenarios and their associated outcomes. More broadly, decision trees also assist attorneys in communicating to their clients a particular cases strengths and weaknesses, the chances that the client will prevail, and the range of possible outcomes. In this regard, decision trees are very helpful in insurance recovery litigation because they can be used to visually display: (1) the claim process involving pre-claim analysis, claim valuation, and claim allocation; and (2) the impacts on a claim process involving multi-parties (primary and excess carriers) and (3) settlement versus litigation end points.

Decision tree analysis is a valuable tool because it can be used in all three phases of the claim process as well as in litigation and settlement. This commentary reviews the concepts of decision tree analysis and presents a hypothetical tree that explains potential insurance allocation outcomes. While this commentary presents the use of a decision tree for the purposes of allocation, it is hoped that the reader will see the power of decision trees and how they can be used in the other claim process phases and throughout the dispute resolution process. Moreover, it is hoped that the reader will appreciate how decision trees can be used in other litigation contexts such as contract disputes, intellectual property disputes, antitrust cases, and environmental litigation.

Decision Tree Diagram -- A Picture Is Worth a Thousand Words

Simply put, decision trees graphically depict the relationships between decisions

or events and the outcomes that result from them. The best feature of decision trees is their *intuitive and visual nature*, which allows attorneys and clients to understand the (1) hierarchy or order of decisions that need to be made or the chronology of events, (2) the assumptions regarding the probabilities of decisions or events, and (3) the impacts of the decisions or events on the outcome. Importantly, the decision trees graphical depiction of the hierarchy/order of decisions or events allows the user to properly and efficiently define different scenarios (a set of related events) and show which factors are pertinent to a scenario and which are not.

Decision trees can be used to organize and relate all factors and scenarios into a single simple to understand and interpret diagram. It is quite possible to have many different scenarios with relatively few choices or options. For instance, in insurance recovery of environmental claims there are usually two allocation options (Pro Rata and All Sums), two cost discount options (discounted to reflect a common insurer position that some costs are unreasonable or inapplicable and not discounted), and at least two coverage discounts (pollution exclusions, occurrence wording, etc). Even in this simplified analysis there are eight possible outcomes ($2 \times 2 \times 2$). Here a decision tree neatly organizes and relates all these factors and provides an analysis tool for determining the value of the potential recovery.

As the name implies, decision trees are comprised of branches and the intersection of branches are known as nodes. Each branch extends from a node. A fork is defined by a node with two or more branches. There are two types of forks: (1) an act fork and (2) an event fork. An act fork is defined by a node and branches reflecting various choice (decision) options controlled and selected by the decision maker. Conversely, an event fork is defined by a node and branches that depict the possible uncertain outcomes associated with the node.

The rules associated with forks are quite simple: (1) The branches that comprise the fork must include all the possibilities (events or decisions) and (2) they must include each possibility only once. In other words branches stemming from a fork must consist of events or decisions that are collectively exhaustive and mutually exclusive.

Regardless of the type of fork, the layout or arrangement of forks that comprise a decision tree is such that the hierarchy or sequence of decisions/choices or events proceeds from left to right with base of the tree (or present time) at the left and the outcomes or tips of the tree (or future events/decisions) depicted at the right.

Figure 1 below is a hypothetical allocation decision tree. It shows the hierarchy/order of decisions from left to right and the application of discounts to cost and coverage and the impacts of different allocation theories (Pro-Rata vs. All Sums) on the outcome. The hierarchy/order of reading decisions from left to right is the convention that events to the right of node and that are connected directly via a branch or via a series of branches affect the value of that node.

Cutting the Tree Down Branch by Branch from the Tips to the Trunk

The branches of the tree (branches stemming from event forks) are weighted by probabilities assigned by the user. The branch probabilities reflect the users assumptions about whether or not cost discounts will be applied, whether or not coverage discounts will be applied, and the users thoughts regarding which allocation theory, Pro Rata or All Sums will be applied. At each end node or outcome, represented by triangles at the rightmost branch tree tips, the probability and associated outcome -- the recovered cost -- is shown for each of the different branches. The end nodes with the higher outcome probability imply that their associated recoveries are more likely to occur than those recoveries associated with lower probabilities. For example, the end node that has the highest overall probability of 37% has an associated recovery of \$5 million (see box surrounded by dashes in the upper right corner of Figure 1) and this outcome

is considered most likely. Similarly the second most likely outcome is the \$25 million with 20% probability. These recoveries reflect the application of discounts (cost and coverage) and the effect of different allocations. The \$5 million or lower recovery amount reflects the application of Pro Rata allocation theory versus the \$25 million All Sums allocation. Almost twice the probability was assigned to the Pro Rata allocation (65%) compared to the All Sums allocation (35%). This assumption favors the carriers position. If, on the other hand, the user felt that the All Sums was the allocation theory that would more likely prevail based for examples by previous positions taken by the court, then the All Sums branch could be assigned a higher probability and the Pro Rata allocation branch assigned a lower probability. Regardless, the probabilities assigned to the branches extending from a single node must add to 100%.

[Click on Core Emerging Issues Commentary at the end of this commentary to see Figure 1]

In this case, the dollar amounts at the branch tip are based on: (1) assumptions regarding discounts and their impact on both past and future defense and indemnity costs; (2) discounts for coverage defenses based on late notice, occurrence wording, pollution exclusion, missing policies, and insolvencies; and (3) allocation analysis using discounted and non-discounted costs and coverage inputs.

Each branch is connected to a node (shown as round circles on the chart) and at each node there is a dollar value which represents the expected value (EV) at that node. The expected value is the probability-weighted value for the node, i.e. the sum of the value of each branch multiplied by its probability. For example, the expected value for the branch with the highest probability is \$12 million (see box surrounded by dashes at the top in Figure 1). This is the probability-weighted value based on the cost at each branch multiplied by its assigned probability and summed. (E.g., $EV = (65\% \times \$5 \text{ million}) + (35\% \times \$25 \text{ million}) = \$12 \text{ million}$.) Using this same process and tracing each branch back to the trunk (i.e., to the left end or beginning of the chart) will produce the expected value for the entire tree of \$14.6 million (see box surrounded by dashes on the left side of Figure 1). This represents the value based on all the outcomes and associated probabilities. This provides a benchmark value based on all the assumptions the user has put into the decision tree.

Decision Trees Provide a Powerful, Dynamic Tool for Litigation and Settlement Negotiations

Using a Microsoft Excel add-in computer program, such as Palisades Decision

Analysis Software, allows the user to construct a decision tree (Precision Tree). In addition, the tree may be linked to Excel spreadsheets containing: (1) cost information (past and future indemnity and defense costs); (2) cost discount information, i.e. reasonableness of costs; (3) coverage defense discount; and (4) allocation models. Changes in the underlying costs, discounts, or allocation models can cascade via the spreadsheet links to the inputs on the tree branches. Similarly, the probabilities on the decision tree branches can be changed to reflect different scenarios. The linking of the cost, discount, and model inputs to the decision trees provides the user with the ability to conduct what if scenarios on the fly and see the results immediately. Attorneys and clients appreciate this functionality and it provides them with a dynamic model to analyze the underlying legal and cost variables, the effect of uncertainty, and what drives the outcome.

Lastly, the ability to define the most likely outcome (cost with the highest

probability), the least likely outcome (cost with the lowest probability) and the expected value (cost-probability weighted value) provides attorneys and clients with the ability to establish negotiation targets. These targets may include an amount to initiate settlement negotiations versus an amount which is considered the lowest target settlement amount. It would also be helpful to understand what would be considered a successful high settlement result versus a successful low settlement result so as to manage attorney-client expectations. Using the what-if-scenarios and the

outcome values defined above, attorneys and clients can hone their strategies and optimize the outcome.

References. Harvard Business School, A Note on Decision Diagrams 9-171-035, Rev. 7/71, Distributed by HBS Case Services, Harvard Business School, Boston, MA 02163. *See also* Chapter 23, *Settling Insurance Coverage Disputes* in New Appleman Insurance Law Practice Guide on valuing the coverage claim.

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When It Comes to Insurance Regulation, Is Uncle Sam the New Sheriff in Town?

2008 Emerging Issues 2696

Richmond on When It Comes to Insurance Regulation, Is Uncle Sam the New Sheriff in Town?

By Douglas R. Richmond

August 13, 2008

SUMMARY: The proposed federal Insurance Information Act of 2008 and Treasury Secretary Paulson's Blueprint for a Modernized Financial Regulatory Structure are the latest expressions of the need some perceive for federal insurance regulation. This commentary succinctly examines these potentially significant developments and expresses skepticism about the desirability of federal insurance regulation based on the rationales offered to date.

PDF LINK: [Click Here for Enhanced PDF of Commentary](#)

ARTICLE: Introduction

Insurance regulation has historically been left to the states. For that matter, states have been entrusted with insurance regulation going as far back as the late 1700s and early 1800s. In the 1860s, however, many insurers considered state regulation to be burdensome and inefficient, and they accordingly urged Congress to adopt standards that would make insurers federal institutions analogous to banks. ⁿ¹ That effort failed, and state regulation flourished anew. State regulation of insurance was seemingly cemented by the passage of the McCarran-Ferguson Act in the 1940s. Since then, there has been occasional noise about replacing state regulation of insurance with a federal system.

Proponents of a federal regulatory scheme argue that the insurance business is truly interstate in character, and therefore requires a coordinated national regulatory framework. Second, the financial requirements imposed by states on insurers are perceived to be too low. Third, requiring insurers to deal with 50 separate regulatory agencies is grossly inefficient. Fourth, federal regulation would be better than state regulation because state insurance departments have long been regarded as under-funded and under-staffed. Fifth, state legislators, theoretically lacking the support staff, sophistication, or time necessary to evaluate the subtleties of insurance are vulnerable to unhelpful pressures exerted by special interest groups. Sixth, state insurance regulators are unlikely to intercede on consumers' behalf when the need arises because doing so will make them unemployable in the insurance industry when their term expires or desire for public service diminishes, and they are unlikely to find other employment matching their experience. Thus, they are better off being industry lapdogs than watchdogs. ⁿ²

On the other hand, proponents of state regulation argue that the current system is necessarily preferable to a non-existent federal regulatory framework of uncertain structure and efficiency. Second, state regulation encourages innovation because regulatory experiments typically take place where their effect will be confined to individual states.

Third, the notion that a federal system would be more efficient is unfounded given the SEC's often impotent regulation of the securities markets, the federal government's inability to prevent or repair the subprime mortgage mess, the federal government's gross mishandling of Iraq's post-war reconstruction, the weak federal response to Hurricane Katrina, and so on. Fourth, the notion that state legislators are more vulnerable to special interest pressures than U.S. representatives or senators is infirm, given the several recent cases of improper influence involving Washington politicians, their staffers, and government officials. Fifth, it is doubtful that insurance issues will attract the amount of congressional oversight and attention by federal officials that they deserve. Sixth, there has been no showing that state regulation has failed in any material fashion. n3

In any event, the noise concerning possible federal regulation of insurance is building to a crescendo as a result of three recent developments. The first was the introduction in the Senate in 2007 of the National Insurance Act of 2007 (S. 40) by Sen. John Sununu, R-N.H. and Sen. Tim Johnson, D-S.D. The second is the introduction in the House of Representatives of H.R. 5840, the Insurance Information Act of 2008. This bill was introduced in April 2008 by Rep. Paul Kanjorski, D-Pa. The third is the Department of the Treasury's recent publication of proposed sweeping reforms of the financial services industry in its *Blueprint for a Modernized Financial Regulatory Structure*. n4 This commentary will principally focus on the latter two developments, the National Insurance Act of 2007 having been the subject of an Emerging Issues Commentary in January 2008. n5

The Insurance Information Act of 2008

H.R. 5840 proposes to establish within the Treasury Department an Office of Insurance Information. The office would be headed by a Deputy Assistant Secretary of the Treasury and would be a career position within the Senior Executive Service. The Deputy Assistant Secretary would be authorized to (a) receive, analyze, collect and disseminate publicly available data and information and issue reports on all lines of insurance except health insurance; (b) establish federal policy on international insurance matters and ensure that state insurance laws are consistent with agreements relating to such [f]ederal policy entered into by the United States or on its behalf by a designated representative . . . with a foreign government or regulatory entity; and (c) advise the Secretary of the Treasury on major domestic and international insurance issues affecting both consumers and insurers.

As proposed, the Act would preempt any state law or regulation to the extent that it is inconsistent with federal policy on international insurance matters set forth in an agreement entered into by the United States or its representative with a foreign government or regulatory entity. Any determination of preemption would be made by the Deputy Assistant Secretary. Any aggrieved state would have the right to appeal such a determination to the Secretary of the Treasury. Nothing in the Act, however, should be construed to establish any general supervisory or regulatory authority of the [new office] or of the Treasury [Department] over any insurer.

H.R. 5840 has received mixed reviews. The National Association of Professional Insurance Agents (the PIA) has condemned it as misguided. The PIA contends that the Act's innocuous title is grossly misleading. The PIA raises a valid point. The Act as it is now drafted has much more to do with enabling federal regulation of insurance than it does with, say, the collection and dissemination of insurance information. The National Association of Insurance Commissioners (NAIC) has tepidly approved the bill, conditioned upon some amendments and definitional tightening. n6 The NAIC seems to be principally concerned with the Act's reference to agreements, which the organization urges should be more tightly defined to ensure that [s]tate consumer and solvency protections are preserved and to clarify which entities have authority to negotiate international agreements under the proposed legislation. n7 The amendments that the NAIC favors would make the Act subject to the federal Administrative Procedures Act and Freedom of Information Act, and would clarify that the Office of Insurance information created by the legislation would have no regulatory authority over the business of insurance, in addition to having no regulatory power over any insurer. n8

The Blueprint

Readers may recall that the National Insurance Act of 2007 proposed that insurers operating in multiple states be allowed to be regulated at the federal level under an Optional Federal Charter (OFC). The National Insurance Act would establish a parallel federal regulatory scheme to the state regulatory regimes for life and property and casualty insurers similar to the current dual banking system. Insurers would be free to elect between federal and state charters, licenses and regulation. Under the National Insurance Act, insurers opting for federal regulation would be regulated by a new Office of National Insurance (ONI) within the Treasury Department. The American Insurance Association (AIA) applauded the bill's introduction as an attempt to modernize insurance regulation. The National Association of Mutual Insurance Companies (NAMIC), on the other hand, came out in opposition. NAMIC expressed the view that the bill would harm consumers and small- to medium-sized insurers, which make up the bulk of the industry. The PIA also opposed the bill, explaining that state insurance departments are optimally knowledgeable about issues affecting their citizen's concerns, contending that state regulation is favorable from a consumer protection standpoint, and reasoning that the state regulatory scheme is more streamlined and efficient overall. Regardless of whether one supports or opposes the OFC concept, it received a significant boost from the *Blueprint*, which the Treasury Department published in March 2008.

The *Blueprint* grew out of the Treasury Department's study of the capital markets regulatory structure, including a March 2007 conference on capital markets competitiveness hosted by the Department. n9 The underlying premise of the study was that our current regulatory structure, while functioning well, is not optimal for promoting a competitive financial services sector leading the world and supporting continued economic innovation at home and abroad. n10 Insurance, of course, is a major component of the financial services sector. In the *Blueprint*, the Treasury Department offers a number of short-term and intermediate-term recommendations for reforming the current United States financial services regulatory structure.

The *Blueprint* proceeds from the assumption that the insurance industry has a national focus within the current state-centric regulatory structure. The inherent nature of state-based regulation is said to make developing national insurance products costly and cumbersome, directly impairing domestic insurers' competitiveness. n11 This is true despite the NAIC's laudable efforts at coordinating state regulation, whether by promulgating model laws or through other measures. As things now stand, insurers operating on a national basis are subject to multiple licensing requirements and regulatory examinations, and operate pursuant to multiple different state laws. n12 With respect to global insurance operations, a state-based insurance regulatory scheme is thought to produce increasing tensions in the global marketplace, both in the ability of U.S.-based firms to compete abroad and in allowing greater participation of foreign firms in U.S. markets. n13

To address these issues in the short-term, the *Blueprint* expresses the Treasury Department's recommendation of an OFC for insurers within the current structure. An OFC would provide for a system of federal chartering, licensing, regulation and supervision of insurers, reinsurers, and insurance intermediaries (i.e., agents and brokers). Industry participants who decline national regulation would continue to be regulated at the state level. States would not have jurisdiction over insurers opting for a federal charter, except that insurers would still be subject to some state laws, such as state tax laws, and mandatory workers' compensation and automobile insurance requirements. Federally chartered insurers would still be required to participate in state insurance guaranty funds and other residual risk mechanisms. n14

An OFC would be issued to specify the lines of insurance that each national insurer would be allowed to underwrite and sell. An OFC for life insurance would be broad enough to permit the insurer to distribute annuities, disability insurance, long-term care coverage, and so on. An OFC for property and casualty insurance would presumably encompass liability insurance, various personal lines coverages, surety bonds, and the like. No OFC would permit an insurer to hold a license as both a life insurer and as a property and casualty insurer. n15

As reflected in the *Blueprint*, the Treasury Department also recommends the creation of an ONI within its walls to regulate those who engage in the business of insurance pursuant to an OFC. The ONI would be headed by a Commissioner of National Insurance, who would have specified regulatory, supervisory, enforcement, and rehabilitative powers with respect to national insurers. n16

Finally, the Treasury Department recommends that Congress establish an Office of Insurance Oversight (OIO) within the Department. The OIO would be statutorily empowered to address international insurance regulatory issues, such as reinsurance capital. The OIO would be the nation's leading regulatory voice in promoting international insurance regulatory policy. It would have the authority to ensure that the NAIC and state insurance regulators uniformly implement what the United States considers to be international insurance policy goals. The OIO would also advise the Secretary of the Treasury on major domestic and international insurance issues. Ultimately, the OIO would be incorporated into the OFC framework. n17

Analysis

The current push for federal regulation is curious. As the *Blueprint* notes at the outset, the current insurance regulatory scheme is functioning well. n18 The only problem is the perception of some that the system is not optimal. Perhaps the most interesting thing about this observation is that the people making this judgment have no obvious basis for it. Few, if any, of the participants in the 2007 capital markets conference that spawned the *Blueprint* have readily discernable insurance experience. n19 There is nothing apparent in their backgrounds that suggests they have the ability to responsibly judge the strengths or weaknesses of the existing insurance regulatory framework. What is perceived to be optimal or less than optimal in the abstract by bankers, economists, securities industry insiders, and political scientists (i.e., the people driving Treasury's push for national regulation) with respect to financial regulation as a whole does not necessarily translate to insurance.

Second, how will federal involvement in insurance optimize its regulation or competitiveness? What about the history of federal regulation of financial markets suggests that the Treasury Department's stated goals are achievable? No one can seriously argue that the mere act of federalizing anything necessarily makes it better. There are countless examples of federal regulatory failures in various segments of the financial services industry that inspire little confidence in the Treasury Department's ability to regulate the insurance industry.

Perhaps the most disturbing recent trend in federal regulation generally is the disregard for the senior executive service commonly shown by political appointees. What will happen to federal insurance regulation if decisions that should be entrusted to capable career staffers are co-opted or undermined by political appointees? Does anyone think that the tremendous damage done to, say, the Department of Justice by partisans like Monica Goodling and Kyle Sampson cannot be replicated at the Treasury Department? It is no answer to say that the same sort of thing can happen within state insurance departments because the point here is not that the state regulatory scheme is flawless, but that federal regulation is not necessarily an enhancement or improvement.

Legislatively speaking, are the United States House of Representatives and Senate truly equipped to do a better job of governing the insurance industry than are state legislatures? If the answer is yes, based on what evidence?

Third, the United States is arguably the world's most competitive insurance market. n20 What evidence is there that foreign insurers are unable to compete or participate effectively in the United States market? That surely would come as news to European powerhouses such as Aegon, Allianz, Swiss Re and Zurich, all of which have robust U.S. operations and are competing quite effectively here in various lines of insurance and reinsurance. And let's not forget the many Lloyd's of London underwriters that profitably insure United States risks. Similarly, how is it that the current regulatory structure is impairing domestic insurers' abilities to compete overseas? Where is the evidence of that? What data support Treasury's claims of increasing tensions in the global insurance marketplace attributable to the current regulatory scheme?

Fourth, insurance intermediaries will not be able to take advantage of the proposed OFC as vaguely outlined in the *Blueprint*. For insurance brokers, absent something more, licensure in multiple states will remain the norm. Admittedly, that something more may be coming in the form of H.R. 5611, the National Association of Registered Agents and Brokers Reform Act of 2008, sponsored by Rep. David Scott, D-Ga. This proposed legislation would amend the Graham-Leach-Bliley Act and would establish the National Association of Registered Agents and Brokers (NARAB) as

a not-for-profit corporation fostering the multi-state licensing and continuing education of insurance intermediaries. In other words, NARAB would promote the reciprocal licensing of producers, and eliminate the cumbersome and expensive multi-state licensing process employed today. As drafted, H.R. 5611 reserves to the states the right to license and discipline intermediaries, and to prescribe and enforce laws and regulations oriented towards consumer protection and unfair trade practices.

Fifth, the suggestion that the current regulatory framework is undesirable because insurers are subjected to the potentially inconsistent laws of 50 states is lame. National insurers operating under an OFC will still do business in various states and will be subject to tort, contract and various other common law claims in all of them. The tort and contract law principles applicable to insurers, while occasionally inconsistent, and sometimes unhelpfully so, are not so wildly disparate as to be disabling. Nationalizing insurance regulation solves potential legal confusion only if with an OFC comes the development of a federal common law of insurance, much as has developed in connection with ERISA. Note that the federal common law of ERISA has been a disaster for consumers, because it strongly favors insurers and plan administrators in many contexts.

Sixth, the OFC scheme risks regulatory arbitrage and gaps in oversight. n21

Seventh, how and at what level will the ONI be funded? Who will staff it?

To be sure, the current system of state insurance regulation is imperfect. Insurers are justifiably concerned about some states' rate-setting practices and about others' unwillingness to bless innovative policy forms. The current state-centered regulatory scheme means that adjusters and intermediaries must be licensed in numerous states, and insurance companies and brokers must devote significant resources to compliance. A national regulatory scheme would presumably simplify matters for insurers and brokers administratively, and would accordingly lower related costs. Insurers and brokers could, in turn, pass such cost savings along to consumers.

That said, there is nothing about the current structure that is so obviously flawed as to justify calls for a redundant federal regulatory regime in the form of an OFC and ONI. And, if, as the *Blueprint* asserts, the state regulatory scheme is functioning well, but just not optimally, why is the solution not simply the improvement of the state scheme? Long story short, if the Treasury Department or interested groups possess data or concrete examples of gross systemic inefficiencies demonstrating a need for federal insurance regulation, they should hold them up for analysis and study. Anecdotes, intuition and speculative economic theory--which are what the Treasury Department and supportive legislators have principally offered so far--ought to be insufficient to justify the radical paradigm shift roughly set forth in the *Blueprint*.

In fact, there may be data or information suggesting the wisdom of the OFC. Experts on the insurance industry may be able to well articulate the wisdom of the OFC concept where the Treasury Department has failed. For example, a 2007 study for the American Council of Life Insurers by two Georgia State University professors suggests that an OFC would substantially reduce insurers' compliance costs and, at least in the life insurance industry, create some competitive advantages. n22 More research along these lines is necessary and should be encouraged.

Conclusion

Insurance regulation has historically been left to the states. For many years, there has been occasional noise about replacing state regulation of insurance with a federal system. That noise is building to a crescendo as a result of the introduction in the Senate of the National Insurance Act of 2007, the introduction in the House of Representatives of the Insurance Information Act of 2008, and the Department of the Treasury's recent publication of proposed sweeping reforms of the financial services industry in its *Blueprint for a Modernized Financial Regulatory Structure*. The current push for federal regulation, however, appears to be incompletely considered.

Any move toward federal insurance regulation is not going to happen immediately. H.R. 5840 may never make it out of the House Financial Services Committee. Depending on what happens in the November 2008 elections, the Treasury Department's regulatory focus may shift significantly. Regardless, there is as yet no compelling reason to modify the existing state insurance regulatory scheme to accommodate a redundant federal one.

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n1 Robert H. Jerry, Jr. & Douglas R. Richmond, *Understanding Insurance Law* 65 (4th ed. 2007).

n2 Jerry & Richmond, note 1 above, at 105-06.

n3 See Jerry & Richmond, note 1 above, at 106 (recounting some of these arguments).

n4 Dep't of the Treasury, *The Department of the Treasury Blueprint for a Modernized Financial Regulatory Structure* (Mar. 2008) [hereinafter *Blueprint*].

n5 The Proposed National Insurance Act of 2007, *LexisNexis Emerging Issues Commentary* (Jan. 2008), *LexisNexis, 2008 Emerging Issues 9* (9 January 2008).

n6 Letter from Sandy Praeger, President, Nat'l Ass'n of Ins. Comm'rs, to Hon. Paul Kanjorski and Hon. Deborah Pryce (July 8, 2008) (available on the NAIC website) [hereinafter *Praeger Letter*].

n7 Praeger Letter, note 6 above, at 2.

n8 Praeger Letter, note 6 above, at 1.

n9 See U.S. Dep't of the Treasury, Press Release HP-304, Schedule for Treasury Conference on US Capital

Markets Competitiveness (Mar. 9, 2007).

n10 Blueprint, note 4 above, at 1.

n11 Blueprint, note 4 above, at 9.

n12 Blueprint, note 4 above, at 10.

n13 Blueprint, note 4 above, at 10.

n14 Blueprint, note 4 above, at 10.

n15 Blueprint, note 4 above, at 10.

n16 Blueprint, note 4 above, at 10-11.

n17 Blueprint, note 4 above, at 11.

n18 Blueprint, note 4 above, at 1.

n19 *See* Press Release, note 9 above (identifying conference speakers).

n20 Praeger Letter, note 6, at 2.

n21 Hervey P. Levin, *Excerpts from the Continuing Federal Charter Debate*, TortSource (Am. Bar Ass'n, Chicago, Ill.), Summer 2008, at 4, 4 (quoting New York Superintendent of Insurance Eric Dinallo).

n22 Martin F. Grace & Robert W. Klein, *The Effects of an Optional Federal Charter on Competition in the Life Insurance Industry* (2007) (available on the American Council of Life Insurers website).

RELATED LINKS: For analysis of the proposed National Insurance Act of 2007, see 2008 Emerging Issues 9
 ■ 2008 Emerging Issues 9

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Cope on City of Eastlake, et al., v. St. Paul Fire and Marine Ins. Co.

2008 Emerging Issues 2867

Cope on City of Eastlake, et al., v. St. Paul Fire and Marine Ins. Co., No. 07-1867, N.D. Ohio; 2008 U.S. Dist. LEXIS 4345: Insurers Intent Clear Despite Leaving Defense Obligation in Policy Exclusion

By Carrie Cope

August 4, 2008

SUMMARY: Insureds are very quick to accuse insurers of ambiguous policy wording in the face of a coverage denial especially when the denial is based on a coverage amendment. Eastlake is a decision in which the court unequivocally found the insurers policy amendments to be clear and unambiguous even though the insurer did not delete references to its defense obligation throughout the policy.

PDF LINK: [Click Here for Enhanced PDF of Commentary](#)

ARTICLE: Modifying pivotal terms of an insurance policy by endorsement sometimes involves a delicate balancing act between making succinct changes that clearly convey the insurers intent and a wholesale rewriting of the policy's terms to address every provision the potential change impacts. Insureds, if unhappy about the limiting effect of a particular endorsement on coverage, will invariably argue that the change to the policy wording created ambiguity by the choice of specific words or the failure to change crucial provisions in the policy. Indeed, a fall down the sometimes slippery slope of policy amendments can result in an unanticipated avalanche of exposure for insurers. That was not the case, however, in *City of Eastlake, et al., v. St. Paul Fire and Marine Ins. Co.*, No. 07-1867, N.D. Ohio; 2008 U.S. Dist. LEXIS 4345, in which an Ohio court unequivocally found that the insurers intent to delete its defense obligation was unambiguous even though references to the defense obligation had not been consistently deleted throughout the policy.

The City of Eastlake and several of its current and former city officials sought coverage under a public entity management liability policy for a lawsuit brought against them by Richard Fatur, a taxpayer and resident of Eastlake. Mr. Fatur alleged that Eastlake and its officials over-collected on a tax levy, made improper budget requests during specified years and failed to keep the tax levy distributions in a separate trust fund as required by Ohio law. Mr. Fatur sought various forms of injunctive relief as well as a declaration that Eastlake conducted a criminal enterprise that engaged in a pattern of corrupt activity in violation of Ohio's RICO statute. The insureds sought a defense and indemnity under the policy issued by St. Paul. St. Paul denied coverage on the grounds that 1) it had no defense obligation under the policy and 2) the policy excluded coverage for loss resulting from a) improper administration or collection of taxes; b) any criminal, dishonest, fraudulent, or intentionally wrongful act or omission; and c) any claim seeking declaratory, injunctive or other non-monetary relief.

In the policy form itself, St. Paul had both the right and duty to defend any protected person against a claim for a

covered loss. However, that provision was changed via a Self-Insured Retention Endorsement which gave the insurer the right to investigate or defend any claim or suit for covered loss and specifically stated that the insurer had no duty to defend any claim or suit or perform other acts or services. The court examined the plain and ordinary meaning of the language in the Endorsement and noted: [A]s a matter of law, a contract is unambiguous if it can be given a definite legal meaning. In finding the elimination of the insurers defense obligation in the Endorsement to be unambiguous, the court discussed the difference between a deductible and a self-insured retention and noted the significance of the insureds obligation to defend itself until the self-insured retention is exhausted. In other words, the change to the defense obligation was communicated by the very nature of the Endorsement itself.

The plaintiffs argued that the Self-Insured Retention Endorsement did not modify the policy's exclusion for criminal, dishonest, fraudulent or intentionally wrongful acts, which contained language expressly stating that the exclusion would not be applied to the insurers duty of defense until it has been determined by legal processes that such act or omission was committed by [an insured]. Essentially, the insureds were arguing that the omission of a change to the defense wording in the exclusion created an ambiguity in the policy which must be resolved in their favor under Ohio law. The insureds relied on, *Edmondson v. Motorists Mut. Ins. Co.*, 48 Ohio St. 2d 52, 356 N.E. 2d 722 (1976), in which the insured prevailed because certain critical terms were defined in one section of an insurance policy but not in another part of the policy. However, the court in *Eastlake* declined to apply *Edmondson* and determined that since the Endorsement's change to the defense obligation, construed in the plain, ordinary, and popular sense of the language and words used, was unambiguous, it effectively nullified the insurers defense obligation in the intentional act exclusion. In reaching its decision, the court considered two fundamental concepts of Ohio law: Even if a conflict existed between the general policy wording and that of the Endorsement, the terms of the Endorsement control under Ohio law. Moreover, under Ohio law, exclusionary clauses generally cannot be used to create coverage where none existed in the first instance.

Policy wording issues are often construed against the insurer as the drafter of the policy. This can be the case regardless of how much input the insured had in negotiating the coverage change or how soft the market is for the type of coverage being purchased. In *Eastlake*, while the court found the language of the Self-Insured Retention Endorsement to be clear and unambiguous, the fact that the claim was ultimately not covered based on the tax and injunctive relief exclusions likely influenced the court's decision even though it purportedly reached its decision notwithstanding the application of those exclusions. While insurers sometimes face a difficult challenge in balancing the need to make changes consistently throughout the policy without overwhelming the insured with excess verbiage that potentially exposes the insurer to allegations of ambiguity, *Eastlake* is a strong decision supported by fundamental principles of policy wording construction.

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Bullivant Houser Bailey PC on Rising Catastrophic Flood Loss & Insurer Response

2008 Emerging Issues 2691

Bullivant Houser Bailey PC on Rising Catastrophic Flood Losses and Insurer Response

By J. Douglas Durham and Erin Nelson

August 1, 2008

SUMMARY: Floods cause significant and largely unpredictable property and business interruption losses each year. This commentary discusses the coverage and adjustment issues presented by flood claims. In addition to analyzing property damage issues, the commentary also explores business interruption loss issues triggered by floods. Seminal court decisions are surveyed and practice insights for insurance coverage attorneys are imparted.

PDF LINK: Core Emerging Issues Commentary (\$)

ARTICLE: Introduction

Floods cause significant and largely unpredictable property and business interruption losses each year. From 1972 to 2006, flood catastrophes have caused national losses of \$94 billion, an average of over \$176 million per flood. n1 Hurricane-related floods account for \$973 million of those losses. n2 These losses trigger insurance claims under policies that provide various types of insurance coverage. Many of these claims involve property damage, interruption in business, and often additional expenses incurred as a result of these catastrophes.

Due to the vast impact of Hurricane Katrina and, more recently, the Midwest storms causing this years (2008s) floods along the Mississippi River, insurers are confronted with dramatically increasing disaster losses. n3 As they respond to these claims, insurers are working to minimize claims expenses and evaluating or implementing various risk-limiting strategies. n4

Frank Russo, of Aons Rapid Response Property and Casualty Unit reports that, mitigation of damages and having a plan in place when a catastrophe strikes is key[.] n5 By rapidly fielding personnel who not only help process claims, but also assist insureds taking steps to limit their losses, insurers can help limit the extent of individual insured losses while providing assistance when it is most needed.

Among risk-limiting strategies, underwriters for certain insurers have elected not to issue homeowners insurance for homes along substantial stretches of the East and Gulf coasts. n6 As recently as June of 2008, Joe Lattanzio of Aon Corp.s Rapid Response Program commented that, [s]ome facilities are so exposed and prone to flooding that they cant get flood insurance at all. n7 Rod Fisher of Factory Mutual Ins. Co. explained, with reference to a 100-year flood, It doesnt mean the site is prone to flooding once every 100 years, it means that the chance of flooding is one out of 100. In

any given year you can have two, 100-year flooding events. n8 Given this years extensive flooding along the Mississippi River and major tributaries, some insurers may elect to limit their risks by reducing or eliminating their underwriting in such areas, just as they have in coastal areas prone to hurricane-related flooding, by reducing available coverage limits, by increasing premiums, or some combination of these approaches.

Standard Homeowners Insurance; Wind Damage, Flood Damage, and Coverage Disputes Over Causation Most homeowners insurance policies include standard provisions excluding coverage for losses caused by flood. n9 However, the typical homeowners policy covers damage caused by wind. Insurance policy interpretation involving the interplay between these provisions came to the forefront in the aftermath of Hurricane Katrina because a significant number of claims turned on the question of whether property damage was due to wind or storm surge. n10

The Mississippi Insurance Commissioner confirmed that homeowners policies typically specifically exclude damages from flooding. n11 However, U.S. Representative Gene Taylor (D. Miss) said that the tidal surge was not a water-actuated event, but rather, caused by wind and as such should be covered under policies covering wind damage. n12

In *Buente v. Allstate Property & Cas. Ins. Co.*, n13 the insureds sued their insurer for property damage sustained in Hurricane Katrina, alleging that the damage to their home was partly due to wind and wind-driven rain. n14 The policy in *Buente* contained a flood exclusion which provided in relevant part, [w]e do not cover loss to the [insured] property consisting of or caused by: 1. Flood, including, but not limited to surface water, waves, tidal water or overflow of any body of water, or spray from any of these, whether or not driven by wind 4. Water or any other substance on . . . the surface of the ground regardless of its source. n15

In evaluating whether the flood exclusion applied, the court in *Buente* determined that water driven by Hurricane Katrina was a flood as the term is ordinarily understood, and thus the insureds damage was excluded under the policy terms quoted above. n16

Likewise, in *Leonard v. Nationwide Mut. Ins. Co.*, n17 the insureds sued under their homeowners insurance policy to recover for damage to their home caused by Hurricane Katrina. n18 The policy in *Leonard* excluded coverage for damage caused by rising water and weather conditions, but did not preclude coverage for losses due to wind. n19 Following a bench trial, the court held that the insureds could not recover for damage that was a result of a storm surge, but to the extent that their losses were due to wind-driven debris, recovery was allowed. n20

This result is consistent with the general trend that rejects application of the efficient proximate cause doctrine when evaluating coverage for claims arising out of damage caused by Hurricane Katrina.

Where Covered and Uncovered Losses Collide; Actual Versus Proximate Causation A majority of states have adopted the efficient proximate cause doctrine when more than one causes result in damage to the insureds property. The doctrine, in a nutshell, holds that for insurance purposes the cause that sets the other causes in motion is deemed the efficient cause of the loss, even if the other causes follow and operate more immediately in producing the property damage. n21 Thus, if a covered peril such as wind creates a condition permitting natural forces such as water to cause damage which would not have resulted but for the condition created by the wind, coverage exists because the wind is deemed the efficient proximate cause. n22

The efficient proximate cause doctrine does not apply where separate causes, some covered and some not covered, cause divisible or different property damage. n23 Instead, the insurer is liable only to the extent of damage caused by the covered peril. n24

For example, in *Napoletano v. Standard Fire Ins. Co.*, n25 the insured sued to recover under a windstorm policy. n26 The court held that the question of whether the insureds loss was caused by the windstorm or flooding by the subsequent tidal wave was a question for the jury and that the insured could recover under the policy only to the extent that the damages were caused by the covered peril of wind as opposed to the non-covered peril, flooding due to tidal

wave. n27 Similarly, in *Hanover Fire Ins. Co. v. Ivey*, n28 the court affirmed judgment in favor of the insured holding that the insured had sufficiently established the extent of recoverable damages. n29

Where losses resulting from covered perils cannot be distinguished from those resulting from uncovered perils, recovery has not been allowed. n30 In one case, the insureds grain elevator was damaged in an explosion. The Missouri Supreme Court determined that the jury had to decide the question of whether the explosion resulted from built up pressure in grains soaked by flood waters, or by expansion of wet grains that caused dislocation of the hopper bottoms of the elevators. n31 The court reasoned that the insured could not recover the cost of repairing the elevators where the insured could not establish that the losses were due to explosion (a covered cause of loss) as opposed to flood (an excluded cause of loss). n32 Similarly, in *Niagara Fire Ins. Co. v. Muhle*, n33 the court remanded a case for a new trial based on an absence of evidence distinguishing losses caused by a tornado from those caused by water. n34

Thus, failure to distinguish covered losses from uncovered losses may have dire consequences for both the insurer and the insured. Since the insured bears the initial burden of establishing coverage, a practitioner may better serve a clients interests by focusing on the cause of each divisible item of damage rather than risking all coverage by failing to make this distinction.

Practice Insight: In evaluating an insureds losses focus on the cause or causes of each element of damages. Those that can be attributed solely to a covered cause of loss are least likely to result in a dispute with the insurer. If more than one cause combines to produce a particular element of damage, coverage is more likely to be disputed and the efficient proximate cause issue is likely to be a jury question.

Business Interruption Losses Present a Variety of Coverage Issues, Challenging Adjusters and Counsel for Insurers to Carefully Evaluate Their Recommendations

Of course, flooding losses are not limited to private homes. Flooding affects entire communities, and businesses sustain losses that may be covered under their business insurance. A business insurance policy that includes a flood exclusion should be reviewed to determine whether the exclusion applies to business interruption coverage provided under a separate insuring agreement.

Business losses triggered by floods frequently result in one or more of three major types of coverage disputes. First, business interruption coverage customarily includes provisions that control benefits due during the period of restoration. Generally, the covered period of restoration is a theoretical period, measured by the time reasonably necessary to accomplish the physical repair of the premises. n35

Nevertheless, the reasonableness of the period of restoration in light of the time necessary for repair or rebuilding may be disputed following a flood, for a variety of reasons. These may include the availability of materials, labor, or required infrastructure. Valuation issues regarding the cost to repair or rebuild can also be the subjects of dispute, and may also impact the restoration period. Following Hurricane Katrina, issues regarding proof of loss for estimates of cost of repair and replacement damage gave rise to litigation. n36 Best practices include early identification of these potential points of disagreement with an effort to reach agreement on how they will affect the restoration period before the impact becomes critical.

Second, business interruption coverage extends to income that the business would have received but for the catastrophe. The purpose of business interruption coverage is to do for the insured what, but for the interruption, the business itself would have done. n37 Business interruption coverage is intended to protect profit which the insured would have earned but for the interruption in its normal business activities due to a covered cause of loss. n38 Some policies provide coverage for net profit that would have been earned as well as continuing normal operating expenses. n39 Others provide coverage for the sum of net income that would have been earned minus the continuing normal operating expenses incurred during the interruption. n40 Business interruption coverage is not intended to place the

insured in a better position than it would have been in had there been no interruption of operations. n41

The formula a particular policy uses to determine the extent of business interruption coverage should be reviewed to determine what sort of information the insured must present to establish a valid claim. This is particularly true where some required information may not be available due to the effects of the catastrophe. For instance, electronic records may not be available until a hard drive or other storage system is recovered and accessed to provide data that establishes normal operating expenses, past revenues for seasonal businesses during the same time of year, and similar information. Again, because the disaster may introduce extraordinary problems in obtaining information required to process a claim, early identification of those problems can permit the insured and insurer to agree on how to address them, as well as whether an interim arrangement is required, thereby minimizing dispute and delay.

Finally, contingent business interruption coverage and extra expense coverage have been held to extend to ancillary expenses, including raw materials and increased transportation costs incurred as a result of a catastrophic event. n42 In preparing to present a claim for business interruption coverage, the best practice is to identify all forms of coverage purchased by the insured that potentially could be triggered by the insureds claim, including contingent business interruption and extra expense coverages. Even though these coverages may not be immediately triggered, claims may arise under them during the restoration period. Similarly, the effects of a natural disaster on an insured that has no direct property losses could result in a claim.

Practice Insight: Counsel should consider that contingent business interruption coverage may be triggered even where no damage to the subject property is caused by flood if a supplier is affected, resulting in decreased revenue.

The practitioner must be cautioned that a policyholders inability to prove that its market is still economically viable may affect its ability to recover business interruption losses. n43 Many policies contain an exclusion barring coverage where a policyholder loses its market. n44 This can pose a particular problem in geographic regions where the population has been forced to evacuate due to extensive flood damage and profitability is uncertain. n45

Catastrophic natural disasters typically disrupt normal daily activities of individuals and businesses over a wide geographic area. The effects can be long lasting depending on the area affected and the nature of the damage, as well as the availability of materials and resources to restore or repair damaged property. The type of disaster can determine the kinds of insurance coverage issues that arise. In an event such as a hurricane, a variety of perils may cause property damage, raising significant coverage issues. Some familiarity with the types of issues likely to exist, the facts likely to be determinative of those issues, and the law controlling them can help a practitioner effectively represent his or her client in coping with the aftermath of the disaster. n46

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n1 Stanley A. Changnon, *Assessment of Flood Losses in the United States*, Journal of Contemporary Water Research & Education, April 2008, at 38-44.

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n4 *Id.* at 2-4.

n5 Jeff Casale, *Floods Soak Midwest*, Business Insurance, June 23, 2008, at 2.

n6 Peter G. Gosselin, *Insurers Saw Record Gains in Year of Catastrophic Loss*, Los Angeles Times, April 5, 2006, at 2.

n7 Jeff Casale, *Floods Soak Midwest*, Business Insurance, June 23, 2008, at 2.

n8 *Id.*

n9 Peter G. Gosselin, *Insurers Saw Record Gains in Year of Catastrophic Loss*, Los Angeles Times, April 05, 2006, at 2-3.

n10 See David P. Rossmiller, *Interpretation and Enforcement of Anti-Concurrent Policy Language in Hurricane Katrina and Beyond*, New Appleman on Insurance: Current Critical Issues in Insurance Law (Oct. 2007).

n11 Peter G. Gosselin, *Insurers Saw Record Gains in Year of Catastrophic Loss*, Los Angeles Times, April 5, 2006, at 2-3.

n12 Becky Gillette, *Legal fights expected over insurance claims from Katrina*, The Mississippi Business Journal, Sept. 12, 2005, at 1.

n13 2006 U.S. Dist. LEXIS 23742 (S.D. Miss. April 11, 2006).

n14 *Id.* at *2.

n15 *Id.*

n16 *Id.* at *3-4.

n17 438 F. Supp. 2d 684 (S.D. Miss. 2006).

n18 *See id.*

n19 *Id.* at 688-699.

n20 *Id.* at 696; *see also Northrop Grumman Corp. v. Factory Mut. Ins. Co.*, 2007 U.S. Dist. LEXIS 60730 (C.D. Cal. Aug. 16, 2007) (plain language of flood exclusion does not include storm surge or wind driven water).

n21 *Gavey v. State Farm Fire & Casualty Co.* 48 Cal. 3d 395 (1989).

n22 *Gillis v. Sun Ins. Office, Limited* 238 Cal. App. 2d 408 (1965).

n23 32 Appleman on Ins. 2d § 192.03[D].

n24 32 Appleman on Ins. 2d § 192.03; *Grace v. Lititz Mut. Ins. Co.*, 257 So. 2d 217 (Miss. 1972) (insured may recover portion of loss he can prove is result of covered peril, wind); *see also Lititz Mut. Ins. Co. v. Boatner*, 254 So. 2d 765 (Miss. 1971) (insured can recover that portion of loss he can prove was caused by wind).

n25 102 R.I. 604, 232 A.2d 278 (1967).

n26 *See id.*

n27 *Id.* at 608-609.

n28 250 F.2d 110 (4th Cir. 1957).

n29 *See id.*

n30 *See Hart-Bartlett-Sturtevant Grain Co. v. Aetna Ins. Co.*, 365 Mo. 1134, 293 S.W.2d 913 (1956).

n31 *Id.* at 1156-1158.

n32 *Id.*

n33 208 F.2d 191 (8th Cir. 1954).

n34 *Id.* at 196; *See also Jacobs Press Inc. v. Hartford Steam Boiler and Inspection Ins. Co.*, 107 F.3d 886 (4th Cir. 1997) (insured must offer proof that allows jury to allocate amount of loss caused by the insured peril).

n35 See *Beautytuft, Inc. v. Factory Ins. Assn*, 431 F.2d 1122 (6th Cir. 1970); *Lakewood Mgg. Co. v. Home Ins. co. of New York*, 422 F.2d 796 (6th Cir. 1970); *DiLeo v. United States Fidelity & Guaranty Co.*, 248 N.E.2d 669 (Ill. App. Ct. 1969).

n36 Becky Gillette, *Legal fights expected over insurance claims from Katrina*, The Mississippi Business Journal, Sept. 12, 2005, at 2.

n37 4 John Alan Appleman and Jean Appleman, *Appleman Ins. Law and Practice* § 2329.

n38 *Firemans Fund Ins. Co. v. Holland American Line-Westours, Inc.*, 25 Fed. Appx. 602, 603, 2002 U.S. App. LEXIS 244, at *4 (9th Cir. 2002).

n39 *Continental Ins. Co. v. DNE Corp.*, 834 S.W.2d 930, 931 (Tenn. 1992).

n40 *Firemans Fund*, 25 Fed. Appx. at 603.

n41 *Id.*

n42 See, *Archer-Daniels-Midland Co. v. Phoenix Assur. Co. of N.Y.*, 936 F. Supp. 534 (S.D. Ill. 1997).

n43 Yourlawyer.com, *Business Interruption Claims*, http://www.yourlawyer.com/topics/overview/Business_Interruption_Claims, (last visited July 9, 2008).

n44 *Id.*

n45 *Dictiomatic, Inc. v. U.S. Fid. Guar. Co.*, 958 F. Supp. 594, 604 (S.D. Fla. 1997) (insured not entitled to recover business interruption proceeds because business would have been unprofitable even without the business interruption).

n46 See 32 Appleman on Insurance 2d ch. 192 (Insurance Coverage Issues Involving Hurricanes).

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Bullivant Houser Bailey PC is a business and litigation law firm with approximately 155 attorneys and six offices on the West Coast. The firm is headquartered in Portland, Oregon and maintains offices in Sacramento and San Francisco, California; Seattle and Vancouver, Washington; and Las Vegas, Nevada. In 2008, Multicultural Law magazine named Bullivant a Top 100 law firm for workplace diversity. Please visit bullivant.com to learn more about Bullivant Houser Bailey and its Insurance Industry Services Group.



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Gerber and Kingsley on Cal. Joint Powers Ins. v. Munich Reinsurance America

2008 Emerging Issues 2616

Daniel W. Gerber and Jeffrey L. Kingsley on California Joint Powers Insurance Authority v. Munich Reinsurance America, Inc. : Whether A Reinsurer Can Be Exposed To Tort Damages For Bad Faith

By Daniel W. Gerber and Jeffrey L. Kingsley

July 31, 2008

SUMMARY: In a case of first impression, a California District Court in California Joint Powers Insurance Authority v. Munich Reinsurance America, Inc. concluded that reinsureds cannot allege tort damages for a perceived breach of the reinsurers implied covenant of good faith and fair dealing. In rendering this decision, the California District Court took a first and important step in shaping the scope of liability in a reinsurance context.

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ARTICLE: The reinsurance industry and market is premised, in part, on risk allocation. That is, the reinsurer assists the reinsured, typically an insurance company, in their business by sharing in the indemnification risk. In turn, and unlike a reinsurance contract, a more traditional insurance contract is premised on one party undertaking the task of indemnifying another against a loss concerning an unknown event. Therefore, given that there are some fundamental differences between the reinsurance and insurance markets, there have been unresolved issues as to whether a reinsurer can be sued by a reinsured for tort actions. The California District Court in *California Joint Powers Insurance Authority v. Munich Reinsurance America, Inc.* 2008 U.S. Dist. LEXIS 56654 (C.D. Cal. Apr. 21, 2008) took an important step in separating the reinsurance and insurance markets. Are there more to follow?

Until recently, the reinsurance market was unsettled as to whether a reinsured could commence a claim against a reinsurer for tort damages, such as a breach of the implied covenant of good faith and fair dealing as there was little caselaw on the subject. The insurance market has allowed independent tort causes of action to be asserted against an insurer for failing to perform its contractual obligations. See e.g. *Panasia Estates v. Hudson Insurance Company* 10 N.Y.3d 200 (Court of Appeals in New York expanded the scope of an insureds ability to assert extra-contractual and tort-like damages arising when the insurers alleged breach arose out of its failure to properly investigate loss).

In *California Joint Powers Insurance Authority v. Munich Reinsurance America, Inc.*, the reinsured was a self-insured retention pool consisting of numerous public agencies. As such, the reinsured provided general liability and special liability coverage to its members for amounts in excess of \$1,000,000. *Id.* One of the reinsured members was the City of Rancho Palos Verdes.

In 1978, the City of Rancho Palos Verdes issued a moratorium on development in certain parts of its city because

of concerns regarding landslides. In 2002, certain developers in the City commenced a lawsuit against extending the moratorium claiming that it was unfair. The City, being part of the self-insured retention pool, informed the California Joint Powers Insurance Authority, who in turn notified its reinsurer, Munich Reinsurance America, Inc and sought a defense and indemnity. The lawsuit between the developers and the City of Rancho Palos Verdes ultimately settled for 4.25 million dollars.

Munich disclaimed coverage to California Joint Powers Insurance Authority claiming that the City of Rancho Palos Verdes claims were not covered by its reinsured and therefore, it would be entitled to any reinsured reimbursement. The California Joint Powers Insurance Authority filed a lawsuit against Munich for (1) breach of contract; (2) breach of implied covenant of good faith and fair dealing; (3) declaratory relief. In the complaint, the Authority stated that Munich tortuously breached the implied covenant of good faith and fair dealing and sought punitive damages.

In moving to dismiss the tortious breach of the implied covenant of good faith and fair dealing, Munich claimed that such claim does not exist in the reinsurance context. The District Court, in issuing its opinion, examined the scope of imposing tort damages in the insurance contract generally:

Because the covenant of good faith and fair dealing essentially is a contract term that aims to effectuate the contractual intentions of the parties, compensation for its breach has almost always been limited to contract rather than tort remedies. [citation omitted] The exception is when the actions that constitute the breach violate a social policy that merits the imposition of tort remedies. California courts have found that an insurers breach of the covenant of good faith and fair dealing violates social policy, justifying tort damages.

Tort remedies for breach of the implied covenant are permitted in the insurance policy setting for policy reasons pertaining to the distinctive nature of such contracts and the relationship between the contracting parties. They are considered appropriate because such contracts are characterized by elements of adhesion and unequal bargaining power, public interest and fiduciary relationship. [citation omitted]. The relationship between reinsurer and reinsured does not implicate the same policy concerns.

As such, given the Court found the reinsurance contract to be defined by statute as a contract for indemnity made for the benefit of the liability insurer, it has no relevance in the underlying tort action brought against an insured under a policy of liability insurance. *Id.* The Court concluded that due to the fact that a reinsurance contract was executed by two sophisticated business entities, there is no unequal bargaining power and that the agreements seek to allow a reinsured the ability to write more policies as opposed to give it peace of mind and security in the event of an accident. Finally, the Court also distinguished the fiduciary relationship in the reinsurance context from the traditional insurance context. The Court concluded that given the arms-length transaction, the reinsurer does not have a fiduciary relationship with its reinsured. Therefore, the District Court dismissed the Breach of Implied Covenant of Good Faith and Fair Dealing against Munich.

The District Court in this powerful decision outlined the stark differences between the reinsurance and traditional insurance contracts. As such, the Court found that because of these great differences, tort remedies arising out of the reinsured contract are not recoverable. Given that this is a case of first impression in California, it will be interesting to see if the other jurisdictions seem to adopt this stark contrast approach between the reinsurance and insurance markets or is this decision simply an aberration and that tort remedies will be allowed in certain contexts. Unfortunately, the impact of the Courts decision has not be fully realized until other courts in different jurisdictions weigh in on the scope of a reinsurers liability concerning traditional insurance causes of action.

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Poolman on NCOIL viatical settlements model

2008 Emerging Issues 2633

Former North Dakota Insurance Commissioner Jim Poolman on Viatical Settlements: a discussion on the National Conference of Insurance Legislators Life Settlements Model Act, and NCOIL's attempts to attack the Stranger Originated Life Insurance" market

By Jim Poolman

July 30, 2008

SUMMARY: Former N.D. Insurance Commissioner Jim Poolman discusses the parameters of the National Conference of Insurance Legislators Life Settlements Model Act. Poolman compares the NCOIL model to the National Association of Insurance Commissioners model act, and pays particular attention to each organizations approach to waiting periods, free-look provisions, disclosure requirements and other consumer protections.

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Weighing in on a Controversial Issue. As the debate heats up regarding further regulation of the viatical settlement marketplace the NCOIL has weighed in with legislation of its own. NCOIL is an organization comprised of legislators with an interest in insurance issues, and some members serve on the insurance committees in their respective legislatures.

The NCOIL organization took an interest in addressing Stranger Owned or Stranger Originated Life Insurance--sometimes referred to as STOLI--after the National Association of Insurance Commissioners started their own debate on separate legislation. NCOIL had a viatical settlement model that was about to expire, and instead of having that model expire, NCOIL members decided to revise their model to address the changing issues in the viatical settlement marketplace. Viatical settlement (more commonly known as life settlement) companies and their brokers were unhappy with the direction state insurance regulators were heading with aggressive consumer protection changes made to their model, and they took their case to NCOIL members.

Stoli Served Shaken, Not Stirred. Regulators were concerned that Stranger Originated Life Insurance policies were becoming more pervasive and that consumers were being abused in the secondary life insurance market. STOLI policies are produced when an investor will have a consumer take out a life insurance policy on his or her life, typically financed with a non-recourse premium finance loan whereby the policy is secured as the collateral. The terms of the

loan are so outrageous that the policy is never intended to be held by the consumer because the loan will default, and the policy will have to be forfeited to the investors. In many cases the consumer will be induced into taking the policy with a cash payment, which will normally be a small percentage of the death benefit of the policy. After the two-year incontestability period has concluded, the ownership of that policy is immediately transferred to the investor. The investor will hold the policy and continue to pay the premium until the consumer dies, so the investor may collect the full death benefit.

The model put forth by NCOIL attacks STOLI very differently than the model put forth by the NAIC. The NAIC put forth a solution to stop the typical STOLI transaction by forcing the investor to wait for a longer period of time (five years) before taking the ownership of a policy. This five-year waiting period was narrowly crafted to only apply to policies that were completely financed, not unlike the transaction previously described. The new waiting period under the NAIC model also included several exceptions to the new waiting period, in case the consumer whose STOLI policy was taken out on his or her life could complete the settlement part of the transaction and give the ownership of the policy to the investor after the standard two-year incontestability period. Viatical settlement companies derided this proposal as anti-settlement, even though the waiting period only covered those policies where the consumer put none of their own resources to purchase the policy.

Seeing the settlement companies dissatisfaction with this approach, NCOIL tried to put STOLI back in the bottle a different way. Instead of regulating the transaction itself, legislators put together a STOLI definition whereby it would be a violation of law to participate in a transaction that met the STOLI definition.

The NCOIL model defines STOLI in Section 2, Subsection Y as follows:

Stranger-Originated Life Insurance or STOLI is a practice or plan to initiate a life insurance policy for the benefit of a third party investor who, at the time of policy origination, has no insurable interest in the insured. STOLI practices include but are not limited to cases in which life insurance is purchased with resources or guarantees from or through a person, or entity, who, at the time of policy inception, could not lawfully initiate the policy himself or itself, and where, at the time of inception, there is an arrangement or agreement, whether verbal or written, to directly or indirectly transfer the ownership of the policy and/or the policy benefits to a third party. Trusts, that are created to give the appearance of insurable interest, and are used to initiate policies for investors, violate insurable interest laws and the prohibition against wagering on life. STOLI arrangements do not include those practices set forth in Section 2L(2) of this Act.

This attempt at banning STOLI transactions is an important step forward in consumer protection. It is important to note that some life settlement interests have gone to state legislatures where this definition has been introduced to weaken this definition. Although this is a different approach to solve the problem of STOLI and arguably less restrictive than legislation put forth by regulators, this provision combined with other consumer protection pieces advances the ball. This approach, of course, is preferred by the life settlement companies because it is seen as friendlier and less aggressive in terms of regulating their business.

One specific piece important in this definition is the language about trusts. There are cases around the country, specifically the *Life Product Clearing LLC v. Linda Angel*, 2008 U.S. Dist. LEXIS 4233 case pending in New York court. In *Angel*, investors shrouded the insurable interest in the transfer of the policy to a trust mechanism, even after the policyholder had been paid up front for the policy. Investors still received the death benefit after the policyholders demise. This provision is not addressed in the regulators version of life settlement/STOLI legislation.

Consumer Protection: Hit and Miss. NCOIL members scored a goal for consumer protection when drafting their disclosure requirements. These requirements are very similar to what NAIC regulators put together in their draft. The NCOIL requirements force settlement brokers to fully disclose their compensation to the consumer. This stems from

lawsuits pending in New York court against Coventry First, one of the nations largest life settlement companies. *The People of the State of New York by Andrew M. Cuomo, Attorney General of the State of New York v. Coventry First, LLC*, 2008 NY Slip Op 5548; 2008 N.Y. App. Div. LEXIS 5460, alleges that those brokering life policies for consumers in some cases were making more on the transaction than the consumer who sold the policy.

Section 9C of the NCOIL Model lists disclosures that a broker must make to the owner of a policy as follows:

(3) A full, complete and accurate description of all the offers, counter-offers, acceptances and rejections relating to the proposed Life Settlement Contract;

(5) A complete reconciliation of the gross offer or bid by the Provider to the net amount of proceeds or value to be received by the Owner. For the purpose of this section, gross offer or bid shall mean the total amount or value offered by the Provider for the purchase of one or more life insurance policies, inclusive of commissions and fees;

The Life Insurance Settlement Association has traditionally opposed these types of disclosures. They are of the opinion that brokers should not have to tell the consumer what they are earning from the transaction, even though it absolutely affects the bottom line of what the consumer receives from their policy. They are at odds with the Institutional Life Markets Association, which believes this type of disclosure cleans up the business. Investors on Wall Street will be entirely more comfortable with putting money in this type of business if there is more transparency. This is a definite win for consumers and a smart move for legislators.

NCOIL legislators had an opportunity to march forward with consumer protection when giving consumers an opportunity to change their mind about a transaction, but failed to do so. Consumers under the NAIC Model have a longer time period to change their mind about selling their policy. For example, when a consumer purchases a long term care policy or a Medicare supplement policy they will typically have a 30 day free look period on that policy in which they can change their mind. Regulators thought that when consumers (typically seniors) are making the very important decision to sell their life insurance policy to a group of investors, they should have at least the amount of time they get when buying a long term care or Medicare supplement policy. NCOIL legislators in Section 11 of their bill included a 15-day period in which to rescind. Regulators included a provision in Section 10C that allows the consumer to rescind before the earlier of 60 days after the contract has been executed or 30 days after the proceeds from the settlement have been delivered to the consumer. This is an important distinction for consumers because consumers will want a longer period in which to change their mind about a very important transaction that sells their life insurance policy and in some cases for a significant amount of money.

Conclusion: Moving the Ball Forward for Consumers. The NCOIL model may not fill all the gaps in regulating an ever changing viatical settlement industry, but this legislation represents a large step forward with respect to protecting consumers around the country. Essential elements like full disclosure of compensation in settlement transactions and an attempt at going after STOLI transactions are important consumer protections. Those in the settlement industry prefer this legislation to the model regulators have put forward because they believe it is less aggressive and easier to work around by creating transactions that may not completely meet the definition of STOLI.

The NCOIL legislation does give the regulator power to conduct examinations of settlement companies, which is incredibly important to keep the industry in check. There are very legitimate players in the settlement industry who want to give maximum value to those that want to sell their policies in the secondary market. Regulation needs to be designed to protect consumers from the less legitimate companies that design their marketing practices, compensation schemes and transaction details for the purpose of using consumers to front policies where there is minimal benefit to the consumer and enormous benefit to the investor.

As legislators continue to debate these issues around the country, consumer protection should be the key. Legislators should not decide these issues based on who has drafted the bill, or what industry participants are involved.

There will be life insurance companies on one side and settlement companies on another. This is because there are billions of profits at stake for settlement companies, and life insurance companies believe their products are being abused. If decisions are made on what is best for the consumers, legislation and regulations based on those consumer-oriented decisions will promote the strongest consumer protections possible to give consumers the necessary selling power in this growing and changing marketplace. The NCOIL model may not be the strongest piece of legislation out there, but it is a step in the right direction.

ABOUT THE AUTHOR(S):

Jim Poolman. was elected North Dakota Insurance Commissioner in 2000, and overwhelmingly reelected in 2004. While Insurance Commissioner, he was an outspoken leader at the National Association of Insurance Commissioners, serving as their Vice-President, Chairman of the Midwestern Zone, Chairman of the Life Insurance and Annuities Committee, Executive Committee on Principles Based Reserving, Chairman of the Producer Licensing Working Group; amongst a host of other leadership posts. In North Dakota he was instrumental in preserving a competitive marketplace while passing very important consumer protections ranging in areas from privacy of consumers medical and financial information, suitability in annuity sales, restrictions on the use of claims information, insurance fraud and life settlements, amongst others. Mr. Poolman has been a sought after speaker on numerous insurance topics around the country. In August of 2007, Mr. Poolman resigned his post in North Dakota to start an independent regulatory consulting practice based in Bismarck, North Dakota. Mr. Poolman received his bachelors of Business Administration degree from the University of North Dakota in 1992. Mr. Poolman also served four terms in the North Dakota House of Representatives before being elected Insurance Commissioner.

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Levine on Florida and Connecticut Suitability Laws

2008 Emerging Issues 2637

Levine on Suitability in Annuity Transactions: a Comparison of the 2008 Amendments to the Suitability Laws in Florida and Connecticut

By A. Kenneth Levine

July 30, 2008

SUMMARY: Florida and Connecticut adopted NAICs narrowly drafted Suitability in Annuity Transactions Model in 2004. When NAIC returned to a wide-reaching standard in 2006, Florida declined to adopt the NAIC model. Connecticut amended its enabling legislation to adopt the new model. This commentary describes the bases for these changes, the trend these changes illustrate, and the manner in which producers, agents, and insurers may comply with this trend.

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During September 2003, the National Association of Insurance Commissioners adopted the Suitability in Annuity Transactions Model Regulation (Suitability Model) to establish uniform standards and procedures for ensuring that annuity purchases and exchanges were suitable to the insurance needs and financial objectives of senior citizens. Prior drafts of the Suitability Model addressed purchases and exchanges of annuities by persons of all ages. The final version of the Suitability Model recommended a narrow model that addressed the area of most concern to regulators--the sale of annuities to seniors . . . [b]ecause of the lack of support for a wide-reaching standard, and because none had existed before in most states. NAIC Model Laws, Regns & Guidelines 275-1, 2003 NAIC Proc. 3rd Qtr 28, Legis. History (2007). In 2004, the Florida Legislature enacted the Suitability Model as statutory text, while the Connecticut Assembly passed legislation authorizing the Connecticut Insurance Department (CID) to adopt the Suitability Model by rulemaking. With an effective date of August 4, 2005, the CID promulgated rules to enact the Suitability Model.

During June 2006, the NAIC returned to the wide-reaching standard draft of the Suitability Model and amended it to make it applicable to purchases and exchanges involving annuity consumers of all ages. During Floridas regular 2008 legislative session, Florida lawmakers reviewed Floridas version of the Suitability Model. Ultimately, they declined to adopt the NAICs amendments. Rather, the Florida Legislature significantly enhanced the existing standards by which an agent must determine the suitability of annuity transactions with seniors, converted a subjective measure to an objective standard for determining whether the agent properly applied these standards, required that the agents suitability analysis be documented, and invoked various other procedures. Meanwhile, Connecticut lawmakers amended that states

authorizing legislation to enable the CID to match the agency's suitability regulations with the NAIC's broadened version of the Suitability Model. Florida would travel by alternate legislative and administrative means to expand suitability analysis into product sales to other segments of Florida's population. Despite the differing issues addressed by the legislation in these states, producers, agents, and insurers are bestowed significant additional responsibility for ensuring compliance with a substantial increase in enforcement authority over the suitability of annuity transactions.

This commentary will describe the purported bases for these changes, the trend which these changes illustrate, and the manner in which producers, agents, and insurers may endeavor to comply with this trend.

Florida. In 2004, Florida codified the NAIC's Suitability Model to require that an insurance agent or, in direct sales, the insurer make reasonable efforts to obtain information concerning the senior consumer's financial status, tax status, and investment objectives and such other information used or considered to be reasonable by the [agent or insurer] in making the recommendation. Fla. Stat. § 627.4554(4)(b) (2007). Over the next four years, these criteria eluded a precise template for the Florida Department of Financial Services (FDFS) to determine the standard information which an agent was to glean from a senior consumer in conducting suitability analysis and making a recommendation. The FDFS suggested that a more accurate assessment of suitability required that the agent determine the consumer's investment goals and strategies, debt, assets and liabilities, health status, and any need for liquidity, and a host of other factors not specifically tied to age. The FDFS further advised that its role in reviewing an agent's suitability analysis often alluded to evidentiary support as the law lacked any verification requirement to demonstrate that a consumer, in fact, had been asked for the information to determine suitability and that the consumer actually provided or refused to provide the information. With annuity exchanges in particular, seniors complained to the FDFS that they were not fully informed of any possible disadvantages of the transactions, such as steep surrender charges.

To complicate the FDFS enforcement efforts further, the 2004 law prescribed, as the standard for determining the propriety of an agent's suitability recommendation, that the agent shall have reasonable grounds for believing that the recommendation is suitable for the senior consumer on the basis of the facts disclosed by the senior consumer as to his or her investments and other products and as to his or her financial situation and needs. Fla. Stat. § 627.4554(4)(a) (2004). Under Florida law, this reasonable grounds for believing standard required a subjective inquiry into whether the agent *believed* that a particular transaction was suitable regardless of whether the transaction was actually suitable on an objective basis. This subjective standard required that the FDFS prove the negative by clear and convincing evidence: that the agent did not believe that a particular transaction was suitable for a particular applicant. *See Ferris v. Turlington*, 510 So. 2d at 294-95 (Fla. 1987) (holding that agency may only discipline a license upon clear and convincing proof). To the FDFS, [t]his burden is largely unachievable, given that the suitability determination is solely within the discretion of the agent. Roxanne Rehm, *Florida Department of Financial Services 2008 White Paper on Annuities* 7 (Mar. 5, 2008) (*FDFS White Paper*). Meanwhile, during fiscal year 2006-07, the FDFS opened 351 investigations related to annuity transactions, a 41% increase over the prior fiscal year. The FDFS opened 260 annuity-related investigations during the first 8 months of fiscal year 2007-08, trending to a 58% increase over the prior fiscal year. Of these investigations, the FDFS trended a 20% increase per year in annuity cases involving seniors. *Id.* at 8.

The FDFS found that many of these cases involved agent misrepresentation or material omission designed to conceal the unsuitable nature of a sale. With an eye on possible systemic activity, the FDFS determined to review the adequacy of insurer efforts to supervise the agents which the insurer appointed. In practice, though, the FDFS found the 2004 law unclear as to whether ultimate responsibility for addressing suitability lay with the agent or with the insurer.

The Florida Legislature responded to these concerns with Senate Bill 2082, known as the John and Patricia Siebel Act, which passed both legislative chambers with unanimous approval. The bill was named for a Venice, Florida couple in their 80s who were sold \$600,000 worth of annuities that could not be touched for 15 years without large penalties. Jennifer Liberto, *State CFO Wants Tougher Rules on Annuities*, St. Petersburg Times, April 18, 2008.

Floridas new legislation amended the states 2004 suitability law, effective on January 1, 2009. The amended statute retained some standard information from the 2004 legislation and clarified or added new information which the agent, or insurer in direct sales, must obtain from the consumer to analyze suitability. For example, the agent must continue to determine the applicants tax status, investment objectives, and such other information used or to be considered *relevant* by the agent (with the term relevant replacing the term reasonable in this latter criterion). The bill clarified the financial status inquiry, by replacing that term with an examination of the applicants annual income; existing assets, including investment holdings; liquid net worth and liquidity needs; and, financial situation and needs. Further, SB 2082 added several new criteria, not found in the amended Suitability Model: personal information, including the age and sex of the parties to the annuity and the ages and number of any dependents; the source of the funds to purchase the annuity; the applicants intended use of the annuity; and, the applicants risk tolerance. 2008 Fla. Laws ch. 237, §§ 9 and 13. These new criteria appear to have been culled from the Financial Industry Regulatory Authoritys (FINRA) new suitability standards for variable annuities, adopted by way of FINRA Rule 2821(1)(B)(2), effective May 5, 2008, as to all registered representatives.

This information must now be transcribed onto an FDFS-adopted form, signed by the agent and the applicant; and, within 10 days of execution, forwarded on to the insurer or any third-party contracted by the insurer to supervise the agents suitability compliance. The consumers refusal to provide this information must also be documented on an FDFS-adopted form. Also on an FDFS-adopted form, before consummating an annuity exchange, the agent must indicate the differences between the consumers current and proposed annuity contracts.

The Florida Legislature also furnished the FDFS with an objective standard for determining the propriety of an agents suitability recommendation. The agent must now have an objectively reasonable basis for believing that the recommendation is suitable based on the facts disclosed by the consumer. This objective basis, coupled with the revised consumer information criteria for the agents analysis of suitability, arguably will enable the FDFS to apply an objective measure against the agents conduct.

Despite Floridas commitment to the 2004 version of the Suitability Model, focusing on the states senior population, Florida has endeavored by other means to address suitability in annuity transactions with other segments of the state. For example, by rule effective July 28, 2008, Florida seeks to ensure suitability in the sale of any annuity product by an [insurance producer or] insurer to an active duty service member of the United States Armed Forces. Fla. Admin. Code rr. 69B-240.001(2) (2008) (applicability as to producers) and 69O-142.200(2) (2008) (applicability as to insurers). For legislative authority to promulgate this rule, the FDFS drew from its broad grant of rulemaking authority under Floridas Unfair Insurance Trade Practices Act, Fla. Stat. §§ 626.9541(1) and 626.9611 (2007). Under this new rule, sale of an annuity to an enrollee of the Servicemembers Group Life Insurance (SGLI) program is deemed unsuitable unless, after a needs assessment, the producer and/or insurer demonstrate(s) that the applicants SGLI death benefit, together with any other military survivor benefits, savings and investments, survivor income, and other life insurance are insufficient to meet the applicants needs. Fla. Admin. Code rr. 69B-240.001(6)(v) and 69O-142.200(6)(v) (2008); *see also* Fla. Admin. Code rr. 69B-240.001(4)(f) and 69O-142.200(4)(h) (2008) (defining life insurance as including annuities, concerning regulation of producers and insurers, respectively).

A second example may be found in another statutory section amended by SB 2082. Section 626.99(4)(a), Fla. Stat., was amended to require that all annuity contracts, regardless of the purchasers age, provide an unconditional refund for a period of at least 14 days. 2008 Fla. Laws ch. 237, §8. A prior version of this bill limited this free look period to purchasers of annuities who were 75 years or older. This expanded free look period is intended to provide all annuity consumers adequate time after the transaction to review the suitability of their purchase. A third example may be found in a new requirement for agent continuing education. SB 2082 requires that, regardless of the age of any consumer to whom an agent intends to market an annuity, persons holding a life license in Florida must complete at least 3 hours of FDFS-approved continuing education coursework on the subject of suitability in annuity and life insurance transactions. *Id.* at § 3 (amending Fla. Stat. 626.2815(3)(k)).

These examples signal Floridas expanding application of suitability analysis beyond the confines of the states

senior constituency. While Floridas senior population is expected to grow by a staggering 176 percent by the year 2030, *FDFS White Paper* at p. 1, Florida lawmakers and regulators clearly do not intend to withhold suitability analysis from the balance of the population in the meantime.

Connecticut. Effective June 2, 2005, Connecticut enacted legislation authorizing the Insurance Commissioner to adopt regulations to establish standards for the sale or exchange of annuities to seniors, and procedures for making recommendations to seniors regarding the sale or exchange of annuities. Conn. Gen Stat. § 38a-432a (2007). Effective August 4, 2005, the CID adopted regulations addressing Senior Protection in Annuity Transactions. *See* Conn. Agencies Regs. § 38a-432a-1, *et seq.* The CID designed these regulations to set forth standards and procedures for recommendations to seniors in transactions involving annuities so that the insurance needs and financial objectives of senior consumers known at the time of the recommendation were appropriately addressed. Conn. Agencies Regs. § 38a-432a-1.

By 2008, in keeping with the NAICs revision of the Suitability Model, the CID determined to broaden the scope of these regulations to address the suitability of recommendations to any annuity consumer regardless of age. The statutory authority for the CIDs rules, though, specifically limited the scope of regulation to seniors. To address this qualification, the CID proposed legislation to remove the term seniors from Section 38a-432a of the Connecticut General Statutes. Such a simple statutory revision could not escape the political intervention inherent to the legislative process. One voice of intervention came in the form of Senate Bill 155, on February 14, 2008, which would altogether prohibit the sale of variable annuity contracts to seniors. By March 6, 2008, Senate Bill 155 died in committee for lack of sufficient favorable support.

Under separate cover, House Bill 5158 was reported favorably out of another committee, passed the General Assembly on May 7, 2008. This bill repealed Section 38a-432a and re-enacted the same language less any reference to seniors. On June 17, 2008, the CID formally published for adoption the agencys rules on Suitability in Annuity Transactions, indicating the agencys intent to remove all references to seniors. The 30-day comment period following publication passed without the CID receiving any comment. The CIDs suitability rule thus sets forth the standards and procedures for producer recommendations, commencing July 17, 2008, to all consumers that result in a transaction involving annuities.

The Connecticut rules retain the same suitability standards as the 2004 Florida law and the amended Suitability Model. In contrast to Florida, the Connecticut rules require that producers ensure the suitability of, *e.g.* fixed annuities with deferred payouts, when recommended to younger consumers who may need ready access to funds.

Insurer Culpability. Under the Florida, Connecticut, and Suitability Model amendments, insurers remain administratively culpable for suitability transgressions in annuity sales and exchanges which involve no producer or agent. The three regulatory schemes also require that the insurer ensure the establishment of a system to supervise recommendations that is reasonably designed to achieve compliance with each states suitability standards. Ensuring the establishment of such a system, versus adopting a straightforward requirement that the insurer establish a system to supervise, recognizes the different distribution methods by which an insurer may transact annuities. As indicated, the FDFS found it difficult to determine where ultimate responsibility lay for ensuring the suitability of a purchase or exchange of an annuity. SB 2082 included a couple of amendments which suggest that the insurer retains ultimate responsibility for the actions of parties which it appoints, but leaves this question somewhat unanswered with regard to parties transacting the insurers products either without proper authorization or in contravention of the supervisory system the establishment of which the insurer ensured.

First, SB 2082 now specifically authorizes the Florida Office of Insurance Regulation (FOIR) to order the insurer to rescind the contract and either fully refund all premium paid on the contract or the accumulation value, whichever is greater. The fact that this penalty is directed at the insurer, without reference to the agent, suggests the insurers administrative exposure for harm to a senior by violation of the Florida suitability law, whether caused by the insurer or the agent. Second, in an apparent effort to temper this administrative penalty, SB 2082 amends the law to indicate that

nothing in the amended statute shall subject an insurer to criminal or civil liability for the acts of independent individuals not affiliated with that insurer for selling its products, when such sales are made in a way not authorized by the insurer. Presumably, a way not authorized signals that the insurer can avoid evidence of a violation of Florida's suitability statute in a civil or criminal proceeding if the agent either lacked due authorization to represent the insurer by appointment, failed to adhere to the supervisory system enabled by the insurer, or otherwise exceeded the authority delegated to the agent by way of other agreement or authorization. Insurers, thus, should endeavor to assure that a specific and clear supervisory system is established and followed, that business may only be produced by duly-authorized agents, and that the parameters of an agent's authority are clearly delineated.

Conclusion. A vague legal standard often makes for a flexible allegation against an insurer or agent. On the other hand, violation of a standard which defies measurement is often difficult to prove. Insurers can sidestep their direct involvement in such time-consuming, costly, and public allegations by developing suitability standards which match or exceed the most rigorous and expansive of state requirements. Florida now appears to provide such a heightened level of scrutiny. Connecticut now reflects the breadth of annuity consumers intended for protection by the NAIC. Insurers can reduce litigation and reputation cost by routinely monitoring the application of these standards to ensure that authorized agents only sell annuities which can provide real value and security for each consumer's financial needs.

FL 2004 Statute

FL 2008 Amendments

CT Rule

NAIC Model Regulation

personal information, including the age and sex of the parties to the annuity and the ages and number of any dependents

financial status

annual income; existing assets, including investment holdings; liquid net worth and liquidity needs; financial situation and needs

financial status

financial status

source of the funds to be used to purchase the annuity

tax status

tax status

tax status

tax status

investment objectives

investment objectives

investment

objectives

investment

objectives

intended use of the

annuity

risk tolerance

such other information used or considered to be reasonable by the agent or insurer

such other information used or considered to be relevant by the agent or insurer in making recommendations to the consumer

such other information used or considered to be reasonable by the producer or insurer

such other information used or considered to be reasonable by the producer or insurer

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Ken Levine is widely regarded as one of the nations premier insurance and warranty regulatory lawyers. With almost two decades of regulatory and administrative experience, Mr. Levine has represented purchasers in some of Floridas largest mergers and acquisitions, and represented several of the countrys largest trade associations in administrative proceedings, bid protests, rule challenges, and negotiated solutions, before numerous agencies of the State. He serves as the managing partner of The Levine Law Group and focuses his practice primarily on Insurance and Financial Services. During the early 90s, Mr. Levine served in various legal capacities at the Florida Department of Insurance (now the Florida Department of Financial Services), including serving as senior counsel in the Chief of Staffs office, and as lead trial attorney, then as Hearing Officer, in dozens of formal and informal administrative hearings. He also led the Departments prosecutions of unauthorized insurers in federal courts from Florida to California.

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Zalma on Steele v. Insurance Company of North America

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Zalma on Steele v. Life Insurance Company of North America: No Conviction Necessary to Enforce Felony Exclusion

By Barry Zalma

July 30, 2008

SUMMARY: Some courts ignore an insurers right to select risks and find coverage for widows where none exists. Other courts apply the wording of a policy as written--even if the result is harsh. Barry Zalma discusses Steele v. Life Ins. Co. of North America and applauds the 7th Circuit for upholding a felony exclusion where an insured died while committing his third DUI, even though the decision deprived a widow of a \$500,000 accidental death benefit.

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Insurance is not a right. It is a contract purchased to spread the risk of loss between an insurer and the person seeking insurance. The contract, whether negotiated or a contract of adhesion, expresses in writing the intent of the parties. The insurer describes the risks it is willing to take and those it refuses to take. No insurance policy covers every risk faced by its insureds. Some do not fit within the insuring agreements and others are excluded from the grant of coverage.

[An insurance company] has the unquestioned right to select those whom it will insure and to rely upon him who would be insured for such information as it desires as a basis for its determination to the end that a wise discrimination may be exercised in selecting its risks. (*Robinson v. Occidental Life Ins. Co. (1955) 131 Cal.App.2d at 586.*) (Emphasis added)

Some courts are willing to ignore this general rule and find coverage for widows and orphans even if they are not entitled to coverage. Others, as they should, apply insurance policy wording as written if that wording is clear and unambiguous.

The decision handed down by the Seventh Circuit Court of Appeals in *Steele v. Life Insurance Company of North America*, 507 F.3d 593; 2007 U.S. App. LEXIS 25857; 43 Employee Benefits Cas. (BNA) 1078 (7th Cir. 2007) is a perfect example of a court willing to apply the clear and unambiguous language of an insurance policy to deprive a widow of a \$500,000 accidental death benefit because her husband was killed in the process of committing a felony.

William Steele died after crashing his car while under the influence of alcohol. His widow, Laura Steele, filed a claim for benefits with Life Insurance Company of North America, the underwriter of William's accidental death and dismemberment policy. LINA denied the claim because William's death resulted from his commission of a felony, a class of conduct the insurance policy excluded from coverage. Litigation ensued. The district court granted LINA's motion for summary judgment, and Mrs. Steele appealed unsuccessfully. n1

Before his death Steele worked for CSX Corporation as a railroad maintenance worker. William enrolled in the CSX Corporation Optional Personal Accident Insurance Plan policy and paid 100% of the premiums through payroll deductions. The policy provided a death benefit of \$500,000, which William's wife, Laura Steele, would receive in the event of his "accidental death."

William Steele's fatal drunk-driving accident was his third driving-under-the-influence offense. Illinois punishes third-offense DUI as a felony. Mrs. Steele argued that a third episode of drunk driving becomes a felony only upon conviction.

The policy at issue in *Steele* stated:

We agree to insure those Eligible Person [sic] who are within the covered classes listed in the Organization's application (each herein called the Insured) for whom the required premium is paid and an application made. We will insure the dependent(s) of an Insured provided the correct premium is paid and the eligibility requirements are met. We agree to pay benefits for loss from bodily injuries:

- (a) caused by an accident which happens while an insured is covered by this policy; and
- (b) which, directly and from no other causes, result in a covered loss. (See the Description of Coverage.)

We will not pay benefits if the loss was caused by:

- (a) sickness, disease, or bodily infirmity; or
- (b) any of the Exclusions listed on page 2.

One of the listed exclusions states: "No benefits will be paid for loss resulting from: . . . *commission of a felony by the Insured.*"

In November 2002 the Steeles attended a wedding reception in Georgetown, Illinois. William consumed too much alcohol and then got into his car to drive home. While he was en route, a Vermillion County Sheriff's Deputy pursued his vehicle for speeding. William sped up in an effort to evade the police and struck the rear of a pick-up truck. He was taken to the hospital and died shortly thereafter. Both the police and toxicology reports pertaining to the accident indicate William's blood-alcohol level was .255 (more than three times the legal limit), and Mrs. Steele does not dispute that her husband was legally intoxicated. He was convicted of two misdemeanor DUI offenses, one in Tennessee and one in Indiana, before the fatal collision.

In January 2003 Mrs. Steele filed a claim with LINA for benefits under William's accident policy. LINA denied her claim based on the policy's felony exclusion, stating that "Mr. Steele was committing a felony at the time of his death, namely driving while intoxicated, while on a suspended license with two prior DUI's. His driving while intoxicated, coupled with driving at a high rate of speed in order to avoid police intervention, resulted in the accident that caused his death." Under Illinois law, first and second DUI offenses are misdemeanors, but a third such offense is a felony.

The Seventh Circuit concluded that under Illinois law, "[t]he term 'felony' denotes an action that renders one liable to a certain amount of punishment. . . . Illinois does not define 'felony' with any reference to whether there has been a

'conviction.'" n2 Since William Steele's death occurred during his commission of an act that was punishable as a felony, that is all the policy exclusion requires to defeat Mrs. Steeles right to recover under the policy.

The law in Illinois is clear: if the insured's conduct is punishable as a felony, the insured's commission of that conduct is enough to come within the language of the policy's felony exclusion regardless of whether a felony conviction is actually sought or obtained.

Practice Pointers. The felony language is unusual in most insurance policies. Usually, exclusions deal with intentional acts, criminal acts and the like. Therefore, before taking a stand like that taken by the Life Insurance Company of North America, the insurer and its counsel must:

- . Determine the exact wording of the policy.
- . Determine if the exclusion is construed as clear and unambiguous in the jurisdiction where the loss occurred.
- . Determine the facts of the incident by a thorough and fair investigation.
- . Compare the facts determined to the policy wording as that wording has been interpreted by the courts in the jurisdiction where the loss occurred.
- . Look for other defenses, like:
 - o Other exclusions
 - o Misrepresentation or concealment at the time the policy was acquired
 - o Failure to comply with conditions
 - o Breach of warranty in the policy

Prudent insurers and their counsel cannot afford to be cavalier--they must be certain of the facts and how courts apply those facts to the law in a particular jurisdiction before denying a claim on grounds that the loss occurred while the insured was committing a felony.

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n1 . *Steele v. Life Insurance Company of North America*, No. 06-1331 (7th Cir. 11/07/2007)

n2 . *Berg v. Bd. of Trs., Local 705 Int'l Bhd. of Teamsters Health & Welfare Fund*, 725 F.2d at 70 (7th Cir. 1984)

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Zalma on Vigilant Ins. Co. v. Bear Stearns

2008 Emerging Issues 2639

Zalma on Vigilant Ins. Co. V. Bear Stearns: Insureds Settle at their own Peril

By Barry Zalma

July 30, 2008

SUMMARY: Insurance Coverage lawyer, consultant and expert witness, Barry Zalma, analyzes the matter of Vigilant Insurance Company v. Bear Stearns and discusses how a major investment bank made a \$70 million gift to its professional liability insurers by a garden variety breach of contract.

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ARTICLE: Cite as: Zalma, Barry. *Vigilant Insurance Co. v. Bear Stearns Companies, Inc.*: Insureds Settle at Their Peril. LexisNexis Expert Commentary, (*Insert date you accessed the document online*).

In New York, when an insured acquires a policy of insurance that requires it to obtain the consent of its liability carriers before settling claims in excess of \$5 million, failure to comply breaches the insurance contract and prevents the insurer from obtaining indemnity in any amount. *Vigilant Insurance Co. v. Bear Stearns Companies, Inc.*, 2008 NY Slip Op 2080; 10 N.Y.3d 170; 884 N.E.2d 1044; 855 N.Y.S.2d 45; 2008 N.Y. LEXIS 542 (2008).

As if Bear Stearns Companies, Inc. did not have enough troubles with its finances it insured its primary professional liability, and then--by its own actions--destroyed its ability to obtain indemnity from a policy issued by Vigilant Insurance Company that provided coverage for losses resulting from claims made against the insured for its wrongful acts. The Vigilant policy afforded \$10 million in coverage after Bear exhausted a \$10 million self-insured retention. Plaintiffs Federal Insurance Company and Gulf Insurance Company further provided Bear an additional \$40 million in coverage under follow-form excess liability policies. Pursuant to the terms of these insurance contracts, Bear agreed not to settle any claim in excess of \$5 million without first obtaining the consent of its insurers. In addition, the policies excluded coverage for claims arising from investment banking work undertaken by Bear.

In early 2002, the U.S. Securities and Exchange Commission, National Association of Securities Dealers, and New York Stock Exchange, along with state Attorneys General, initiated a joint investigation into the practices of research analysts working at financial services firms and the potential conflicts that could arise from the relationship between research functions and investment banking objectives. The investigation focused on allegations that research analysts employed at ten major financial institutions, including Bear, were improperly influenced by investment banking concerns. Toward the end of 2002, the regulators met separately with each of the investigated firms to discuss a global settlement.

On December 20, 2002, Bear signed a settlement-in-principle document, acknowledging that each regulator would commence an action or administrative proceeding against it and that Bear would subsequently "consent to the action and the relief sought without admitting or denying the allegations." Bear further agreed to pay \$50 million in retrospective relief, plus \$25 million to fund independent research and \$5 million for investor education. The document indicated that the terms of the settlement were subject to approval by the SEC and other regulators. Also taking place on December 20, 2002, the regulators issued a press release announcing they had achieved an industry-wide settlement with the 10 financial institutions that would result in payments of more than \$1.4 billion in penalties, restitution and education funds. A few months later, Bear executed a consent agreement in which it acceded to the entry of a final judgment in the SEC's federal lawsuit against Bear in the United States District Court for the Southern District of New York.

Three days after executing the settlement agreement, Bear Stearns sent letters to its insurers requesting their consent to the settlement. The insurers disclaimed coverage and commenced this declaratory judgment action seeking a declaration that the \$45 million sought by Bear Stearns (after depletion of the \$10 million self-insured retention) was not covered by the policies.

In October 2003 the federal district court found the Bear settlement to be "fair, adequate, and in the public interest," and entered a final judgment ordering Bear to pay the agreed-upon sum of \$80 million. Shortly thereafter, the insurers moved for summary judgment in this declaratory judgment action.

The court stated: The insurers raise a number of objections to the Appellate Division order, but we find it necessary to address only one of them. The insurers contend that the Bear settlement is not recoverable because Bear breached the policy provision obligating it to obtain their consent prior to settling the regulator lawsuits. Specifically, the insurers claim that Bear resolved and finalized the settlement of the case when it executed the settlement-in-principle in December 2002 or, at the latest, when it signed the consent agreement in April 2003 without advising the insurers. Bear counters that the courts below properly found a triable issue of fact as to whether its execution of these two documents constituted a breach of the policy provision. *Id.* at 177.

The court highlighted as relevant the following provision of the primary insurance policy at issue in the case, which read:

"The Insured agrees not to settle any Claim, incur any Defense Costs or otherwise assume any contractual obligation or admit any liability with respect to any Claim in excess of a settlement authority threshold of \$5,000,000 without the Insurer's consent, which shall not be unreasonably withheld. . . The insurer shall not be liable for any settlement, Defense Costs, assumed obligation or admission to which it has not consented."

In addressing this policy provision the court specifically noted that "unambiguous provisions of an insurance contract must be given their plain and ordinary meaning, and the interpretation of such provisions is a question of law for the court." *White v Continental Cas. Co.*, 9 NY3d at 267 [2007] [citation omitted].

Bear expressly agreed that the insurers would "not be liable" for any settlement in excess of \$5 million entered into without their consent and was, as the court notes, aware of this contingency in the policies . . . Bear nevertheless elected to finalize all outstanding settlement issues and executed a consent agreement before informing its carriers of the terms of the settlement.

The court also pointed to the absence from the settlement agreement of any provision subjecting that settlement to the insurers' approval as required by the policy. Having signed the consent agreement, Bear was not free to walk away from it before entry of a final judgment. As a sophisticated business entity, Small wonder then that Bear Stearns--clearly marked by the court as a sophisticated business entity, could not recover the settlement proceeds from its insurers.

That Bear Stearns--with its armies of financial and legal consultants--actually made such a costly mistake may explain why the company failed recently and sold its assets for a mere peppercorn. Instead of giving its insurers, as it

had promised, notice of a proposed settlement for which it intended to make claim under the policy, Bear proceeded unilaterally, without obtaining its insurers consent to the settlement, and imposed an \$80 million loss on its stockholders, instead of the \$10 million it would have been required to pay if it had complied with the conditions its insurance contract.

This sophisticated bank stupidly, and with the advice of counsel, threw away at least \$70 million. Their lawyers, if they advised the settlement without first obtaining permission of the insurer, should consider reporting a potential claim to their errors and omissions carriers.

Practice Pointers. When asked to advise a defendant about a potential settlement counsel should always:

1. Obtain all insurance policies that may potentially provide coverage for some or all of the amounts claimed.
2. Read each policy of insurance carefully to enable counsel to advise the insured defendant of the coverages available and the defendants obligations under the terms and conditions of the policy.
- 2.
3. Consider retaining the services of an insurance coverage lawyer to read, review and provide advice concerning the terms, conditions and limitations of the policy and the duties that the insured defendant must fulfill to collect the benefits of the policy.
4. Immediately involve the insurer in the negotiations even if there is no condition requiring prior consent.
5. Ascertain that all of the insurance policy terms and conditions have been complied with by the insured before effecting settlement or make the settlement conditional upon receiving the approval of the insurer.
6. If the client/insured insists on settling without giving notice to the insurer with a condition like the one in the Bear Stearns policy, counsel must:
 - a. advise the client, in writing, of the conditions of the policy
 - b. advise the client of the dangers of settlement to the availability of coverage
 - c. refuse to effect the settlement without first obtaining a release and hold harmless agreement from the client, or withdraw from the representation of the client

ABOUT THE AUTHOR(S):

Barry Zalma, Esq., CFE, is an insurance coverage attorney. He is the founder of Barry Zalma, Inc., a California law firm whose practice emphasizes the representation of insurers and those in the business of insurance. He is also the founder and chief consultant with Zalma Insurance Consultants who consult with insurers, plaintiffs' counsel and defense concerning insurance bad faith, insurance coverage and insurance claims handling matters and, if needed, often serves as an expert witness at trial. Mr. Zalma is recognized as an expert on insurance claims handling, insurance bad faith, and insurance fraud. He is the author of several books relating to insurance, insurance coverage, insurance claims handling and insurance regulations including Chapters 12 and 13 of the New Appleman Insurance Law Practice Guide, November 2007, Matthew Bender & Company, Inc., a member of the LexisNexis Group. Details and his CV are available at [<http://www.zalma.com> & <http://www.zic.bz>]and Mr. Zalma can be reached at zalma@zalma.com.

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Poolman on changes to the NAIC's Viatical Settlements Model Act

2008 Emerging Issues 2624

Poolman on the NAIC's Viatical Settlements Model Act: a discussion about the NAIC's newly crafted changes to the regulation of the viatical settlement business

By Jim Poolman

July 29, 2008

SUMMARY: Former North Dakota Insurance Commissioner Jim Poolman discusses the NAIC's recent changes to its Viatical Settlements Model Act. His commentary recaps events that caused the changes, addresses the pending New York case against Coventry First LLC, outlines the provisions enacted to put STOLI transactions on ice--such as the five-year incontestability period and the new disclosure rules--and describes other important consumer protections.

PDF LINK: [Click Here for Enhanced PDF of Commentary](#)

ARTICLE: The business of viatical settlements or life settlements as those in the business now like to refer to it, has grown immensely over the past few years. With that growth, some of those in the business see new and changing opportunities, and some of those business practices have raised the eyebrows of regulators, legislators and others in charge of protecting the public. Between the morphing of this business and pending litigation against life settlement companies, the National Association of Insurance Commissioners started to examine the life settlement marketplace and passed comprehensive changes to their existing Viatical Settlements Model Act being debated around the country.

What Caused the Changes? Throughout 2005 and early 2006 insurance regulators around the country heard about a new phenomena within the viatical settlement industry. Some called it STOLI, which is an acronym for Stranger Originated or Stranger Owned Life Insurance. Others got even craftier and started using SPINLIFE, or Speculator Initiated Life Insurance. No matter what you call it, it wasn't the standard practice commonly known in the viatical settlement industry. Previous to this morphing of the business, a settlement company would purchase a life insurance policy on a terminally ill insured, so that the insured could cover final living expenses or treatments that were not covered under health insurance policies. We came to know about these transactions in the 1990s when the business of viatical settlements originally came onto the scene.

Viatical transactions were first geared to those who were afflicted with AIDS or terminal cancer. The policy owners were frequently forced to take experimental medications not covered under their health insurance plan, and the expensive treatments were paid for by the insured out of their own pockets. The practices then started to encompass policyholders who had owned their policies for a lengthy period of time, and decided that they didn't need those policies anymore. These policyholders instead found a way to realize an economic benefit out of those policies that could surpass the cash value that had built up inside the policy.

While the advances of medicine helped AIDS patients live longer and healthier lives, it also made that business far less attractive for settlement companies, as it became more and more difficult to analyze the mortality rate. With the impending difficulty of predicting death on these consumers, it certainly became more difficult to estimate a profit on those policies. In addition, there certainly is a finite pool of those consumers who want to give up their policies purchased to protect their families, plan estates, and transition businesses. So some settlement companies turned to the manufacturing of life settlements. These wet paper transactions, as they are commonly referred to, are ginned up policies with the sole intent to transfer the ownership of the policies to the investor at the time the policy is taken out. Typically the policies are sold as free insurance because the premiums are paid with a premium finance loan. These loans many times carry usurious interest rates, designed so that the insured would have to sign over the policy because they cannot pay back the loan to keep it.

These questionable transactions are different from legitimate premium financing mechanisms. Typically those who are planning estates, business succession or wealth transfer are offered competitive interest rates and those companies will not take an ownership interest in the policy.

In Addition to Stoli; Other Allegations of Bilking Seniors. In the midst of exploring STOLI transactions and how those transactions were affecting consumers, regulators discovery of potential unscrupulous activity in the settlement marketplace gave them momentum to promote new laws that govern other activity in settling a policy.

Former New York Attorney General Eliot Spitzer took aim at one of the largest life settlement carriers for potentially bilking seniors out of money on their policies. The alleged activity took place by Coventry First LLC Coventry, a Pennsylvania based life settlement company and brokerage firm. The complaint against Coventry (*State of New York v. Coventry First LLC*) laid out a bid-rigging scheme in which Coventry paid off other life settlement companies and brokers to not bid on policies so that Coventry could pay the policyholders less for their policies, and therefore, increase the profit to the company. The suit also alleges there were conflicts of interest with the company and other co-brokers where the company may not have been acting in the best interest of the consumer interested in settling a policy.

The lawsuit is still pending in New York state court, but pieces of the suit have been dismissed because the policyholders were not New York residents.

New Regulations to Protect Those Who Settle Their Policies. The National Association of Insurance Commissioners approach to providing new protections for those that enter into life settlement arrangements was comprehensive. Regulators wanted to first provide a defense against those settlement companies who were entering into STOLI or wet ink transactions where the policy is sold entirely for the benefit of investors. Secondly, but equally as important, are new regulations that protect those consumers who want to enter into a legitimate settlement arrangement to gain an economic value with a policy that they may see no need in keeping.

One of the key elements in life insurance transactions is the two-year waiting period, the expiration of which prevents a policy from being contested. Many wet ink transactions are specifically constructed to get around this two-year incontestability period, to include agreements to transfer the ownership of a policy immediately after the period concludes. In testimony at NAIC hearings, all groups participating--including life insurance carriers, agents, settlement companies, their brokers and consumer groups--agreed that the transactions were inappropriate. Settlement companies told regulators either that the transactions weren't happening, or that none of the witnesses were participating in those transactions. Yet, it seemed when options were discussed to stop those transactions, settlement companies were hesitant to come up with a real fix.

Putting Stoli on Ice! In their effort to combat these types of STOLI transactions, insurance regulators crafted a narrow five-year period in which those policies could be contested. A five-year period is crafted narrowly to only capture those policies paid by a premium finance loan. The provision is obviously tailored to capture the wet ink transactions. Even with the narrowly crafted five-year moratorium, there are a number of extenuating circumstances

when that fully premium financed policy can still be settled and the insured may enter into a settlement transaction. These exceptions as identified in *Section 11 A (2)* of the revised NAIC model are:

- (a) The viator or insured is terminally or chronically ill
- (b) The viators spouse dies
- (c) The viator divorces his or her spouse
- (d) The viator retires from full time employment
- (e) The viator becomes physically or mentally disabled and a physician determines that the disability prevents the aviator from maintaining full-time employment
- (f) A final order, judgment or decree is entered by a court of competent jurisdiction, on the application of a creditor of the aviator, adjudicating the aviator bankrupt or insolvent, or approving a petition seeking reorganization of the viator or appointing a receiver, trustee or liquidator to all or a substantial part of the aviators assets

These broad based exemptions allow for the consumer to continue the ability to sell their life insurance policy in a STOLI arrangement inside of this five-year window. Yet settlement companies rallied against this provision because they felt it reduced the property rights of the consumer, when really it diminished their economic interest in selling these inappropriate STOLI arrangements. Settlement companies were FAR less willing to have an arrangement where they would have to finance the premiums for five years before they could take the ownership of the policy, when currently they only have to wait for two years. If the policyholder died BEFORE the five-year period was completed, the *full death benefits would go to the policyholders beneficiary, NOT the investor*. This is an important benefit of the five-year waiting period for the consumer, to the detriment of the investor that is wagering on the life of the insured.

Disclosure is Good For Everyone! One of the allegations in the *New York State v. Coventry* case states that Coventry was taking exorbitant profits off of consumers who were settling their policies. In fact, according to the complaint, in some cases the settlement brokers were receiving more in compensation on the settled policy than the consumer selling the policy on their life. This is in addition to the complaint of bid rigging whereby Coventry was alleged to pay off other companies/brokers to make sure they could obtain the settled policy for lower compensation to the consumer.

Regulators are very concerned that consumers are being taken advantage of regularly in this marketplace. To combat this, the NAIC model requires two very important features:

Section 8. Disclosure to Viator

C. (2) A full, complete and accurate description of all offers, counteroffers, acceptances and rejections relating to the proposed viatical settlement contract

(4) The amount and method of calculating the brokers compensation, which term compensation includes anything of value paid or given to the viatical settlement broker for the placement of the policy.

It should come as no surprise that the Life Insurance Settlement Association vociferously opposed these two provisions, as there is certainly a motive to protect the secrecy of the compensation paid to the brokers in these transactions. Regulators felt very strongly that these important consumer protection provisions needed to remain.

Other Important Consumer Protection Provisions. There are a host of other consumer protections included in the NAIC Viatical Settlements Model Act. Some of these include a longer period during which a person who sells a life insurance policy has the ability to change their mind. Many states have free look periods on different types of insurance policies, especially when buying a Medicare supplement or long term care policy. Regulators felt that there should at

least be an equal free look period to allow someone to change their mind when selling a life insurance policy to a group of investors. Regulators increased the time to sixty (60) calendar days after the date upon which the viatical settlement contract is executed by all parties or thirty (30) calendar days after the viatical settlement proceeds have been paid to the viator.

The NAIC viatical settlement act also provides bonding requirements for viatical settlement brokers in case there are issues of fraud. This will allow the regulator to hold the settlement broker accountable and try to recoup any assets for the consumer if there are any instances of fraud.

Consumer Protection is Key. In a market that has changed immensely from the days of buying life insurance policies on the terminally ill, it is incumbent upon regulators and lawmakers to keep up with the pace of this change. Regulators who have drafted the NAIC model kept in mind the ultimate goal of protecting consumers as the bill was advanced. It is important to note, not all parties agreed to every piece of this Model. The Life Insurance Industry wanted stricter regulation, as they perceive STOLI and other life settlement transactions as a perversion of their products. The life settlement industry wanted very little or no regulation, even though their rhetoric is that they advocate for responsible regulation of their industry. It was up to regulators to balance all of these opinions and serve what they perceived as the best interests of consumers and the marketplace.

One thing is for sure, the NAIC action has spurred legislators, regulators and the public to have a discussion about investors owning a life insurance policy on someone they don't even know. It has created a debate about the proper consumer protections, the moral hazards of such a practice, and how this marketplace changes the face of the life insurance industry. I am confident this will not be the end of the debate as settlement companies will come up with new and creative ways to market their products, and consumers will need to continue to be protected from new schemes.

ABOUT THE AUTHOR(S):

Jim Poolman was elected North Dakota Insurance Commissioner in 2000, and overwhelmingly reelected in 2004. While Insurance Commissioner, he was an outspoken leader at the National Association of Insurance Commissioners, serving as their Vice-President, Chairman of the Midwestern Zone, Chairman of the Life Insurance and Annuities Committee, Executive Committee on Principles Based Reserving, Chairman of the Producer Licensing Working Group; amongst a host of other leadership posts. In North Dakota he was instrumental in preserving a competitive marketplace while passing very important consumer protections ranging in areas from privacy of consumers medical and financial information, suitability in annuity sales, restrictions on the use of claims information, insurance fraud and life settlements, amongst others. Mr. Poolman has been a sought after speaker on numerous insurance topics around the country. In August of 2007, Mr. Poolman resigned his post in North Dakota to start an independent regulatory consulting practice based in Bismarck, North Dakota. Mr. Poolman received his bachelors of Business Administration degree from the University of North Dakota in 1992. Mr. Poolman also served four terms in the North Dakota House of Representatives before being elected Insurance Commissioner.

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Poolman on Principles-Based Reserves: FL regs on new split mortality tables

2008 Emerging Issues 2632

Poolman on Principles-Based Reserves: a discussion of the Florida regulatory provisions in FAC 69O-162.203 relating to the use of new split mortality tables in calculating reserves

By Jim Poolman

July 29, 2008

SUMMARY: Former N.D. Insurance Commissioner Jim Poolman discusses Principles-Based Reserves by examining FAC 69O-162.203, the recent Florida regulatory provisions relating to the use of new split mortality tables in calculating reserves. Considered an interim step in providing companies that sell term life insurance relief from redundant reserves, the new regulations are a sign of future reform toward a more principles-based approach.

PDF LINK: [Click Here for Enhanced PDF of Commentary](#)

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Floridas Temporary Approach for Principles-Based Reserving. In an effort to modernize the state system of regulating the solvency of life insurance companies, Florida Insurance Commissioner Kevin McCarty proposed new rules that will eventually provide changes in how companies calculate the reserves they are required to hold to pay out future claims.

Part of a National Effort for Reform. Insurance regulators at the National Association of Insurance Commissioners have been discussing overhauling the system of how companies determine the amount of funds to hold in reserves for different life insurance products. The NAIC has been pushing changes that will create a more principles-based system of reserving rather than the current rules-based approach. In other words, companies would be given more freedom to use their own experiences in setting their reserves based on general reserving principles rather than using formulas that may not be applicable. Formulas have traditionally been one size fits all rather than taking into account different product variables and risks. Those variables can change based on a companys product design.

Generic formulas used in the current system of determining necessary reserve levels can sometimes lead to over conservative reserves for some products and lead to inadequate reserves for other products. Inadequate reserves, of course, can lead to solvency problems for both companies and the regulators in charge of protecting the consumers against a companys inability to pay future claims.

In the generic term life insurance business, insurers have demonstrated that the reserves they are forced to carry under a formulaic approach are far higher for many companies than the amount actually needed to pay future claims. Those redundant reserves can cause added expense to the consumer because of an inefficient use of capital by the company. For example, to meet the needed higher reserves, companies may need to charge extra premium to the consumer, purchase necessary reinsurance, secure letters of credit, or use other securitization measures to add the reserves to the balance sheet. All of these options add cost to the company, which in turn is reflected in the price of term life insurance. In many cases these extra reserves that are necessary under the formulas provided by regulation do not add any solvency protection for consumers, but will just necessitate extra cost to the company.

Redundant reserves became more of a problem when regulators at the NAIC passed regulation XXX or Triple X. Triple X affected how companies reserved for their products and drastically affected the term life insurance business, in many cases drastically raising the reserving levels required for the product. Studies by the industry showed that by moving to a more principles-based approach, some companies could be able to reduce their reserves by almost half, still have an appropriate reserve to pay claims, and not have any solvency risk to the company. This again allows companies to price their products more competitively, and better utilize the capital in their company.

Specific Change in Florida. The changes to *FAC 690-162.203*, which were proposed in May of 2007, are designed to address the problem found specifically in the term life insurance business. The new regulations will allow the use of revisions to the 2001 CSO mortality table that will reflect differences between a standard risk and a preferred risk of potential policyholders when rating and pricing their policy. The current mortality table only allows for one non-smoker table for males and females and one smoker table for male and females. The change will allow for a further segmentation of the policyholders to more adequately reflect the risk of the policyholders, thus allowing companies to adjust their reserves accordingly.

The changes to the Florida rules are based on one of the pieces of a package of regulations created and blessed by the NAIC in September of 2006. Regulators were specifically looking for an interim step to provide more accurate reserving measures for companies while moving toward a more principles-based approach for all life products. The life insurance industry and regulators identified the largest problem of disparate reserves that were potentially too conservative or not conservative enough with two specific products. The products identified were term life insurance and universal life policies that had secondary guaranties built in them. Regulators worked quickly to set out a plan to correct the reserve levels so companies would set reserves at a more appropriate level, and came up with the interim approach before wholesale change would take place. It is predicted that it will take much longer for the larger changes to be vetted at the NAIC--much less implemented in the states--and therefore the implementation of interim steps in large-market states like Florida is of key importance.

Conclusion: Win For Companies, Win For Consumers. The changes provided by Florida will be advantageous for insurers writing term life business in Florida. They will be able to more accurately measure the risks in their term life business by further segmenting the risks and charging the appropriate premium for those risks. By using the new split mortality tables provided in the changes to the reserving regulations, they will be able to better adjust the reserves needed to pay future claims. For those companies holding redundant reserves that are not necessary to pay future claims, they will be able to reduce them. This can result in lower cost to the company and potentially lower cost of insurance to consumers. In an era where insurance costs seem to only continue to rise, regulators and companies are responding in ways that will likely have positive effects across the board.

ABOUT THE AUTHOR(S):

Jim Poolman was elected North Dakota Insurance Commissioner in 2000, and overwhelmingly reelected in 2004. While Insurance Commissioner, he was an outspoken leader at the National Association of Insurance Commissioners, serving as their Vice-President, Chairman of the Midwestern Zone, Chairman of the Life Insurance and Annuities Committee, Executive Committee on Principles Based Reserving, Chairman of the Producer Licensing Working Group;

amongst a host of other leadership posts. In North Dakota he was instrumental in preserving a competitive marketplace while passing very important consumer protections ranging in areas from privacy of consumers medical and financial information, suitability in annuity sales, restrictions on the use of claims information, insurance fraud and life settlements, amongst others. Mr. Poolman has been a sought after speaker on numerous insurance topics around the country. In August of 2007, Mr. Poolman resigned his post in North Dakota to start an independent regulatory consulting practice based in Bismarck, North Dakota. Mr. Poolman received his bachelors of Business Administration degree from the University of North Dakota in 1992. Mr. Poolman also served four terms in the North Dakota House of Representatives before being elected Insurance Commissioner.

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Zalma on Regulating Insurers to Avoid Fraud in Catastrophe Claims

2008 Emerging Issues 2634

Zalma on Regulating Insurers to Avoid Fraud in Catastrophe Claims

By Barry Zalma

July 29, 2008

SUMMARY: Barry Zalma discusses why it should be the duty of every insurance regulatory agency to implement catastrophe regulations that require insurers and their claims personnel, as well as independent and public insurance adjusters to be licensed, competent and well trained on insurance, insurance claims handling, fraud recognition techniques, and enough of the law of the state to correctly adjust claims and recognize attempted fraud.

PDF LINK: [Click Here for Enhanced PDF of Commentary](#)

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After a catastrophe insurance regulators must be certain that insureds who suffer loss receive the indemnity to which they are entitled. Insurance regulators must control the insurers and their catastrophe teams while dealing with the fraud they know will be rampant after the catastrophe. For example, while the wild fires of October 2007 were still burning, California authorized insurers to bring in unlicensed adjusters from out of state to serve the thousands of victims and created a fraud task force to hold down fraud. After Katrina, Louisiana allowed unlicensed adjusters and public adjusters to enter the state to assist homeowners.

The California regulators, unlike those in Louisiana, recognized that after a catastrophe billions of dollars of insurance money floods into the location to indemnify insureds. Insurers send in teams of insurance adjusters to help those whose property has been damaged or destroyed. Even more rapidly fraud perpetrators send in teams of criminals to milk as much of the money as possible from the insurers and those they insure.

Insurance regulators are charged by their states to protect the public. This obligation is amplified when a catastrophe occurs. Regulators must be prepared to deal with the inability of insurers to adequately serve the public. During a catastrophe a high volume of claims for which the insurer is not staffed will flow to the insurer. Regulators must approve adjusters who are not licensed in the state, police inadequate or incompetent insurance claims adjusters and public insurance adjusters who attempt to take advantage of insureds. Simultaneously regulators must protect the insurers from insurance fraud which history teaches will consume between ten and 30% of the claims paid in a catastrophe.

When fires swept through Southern California in October 2007 the vast majority of those persons watching the horrors on television were thinking about the people, the homes, the tragedy. Those closer to the insurance industry were working to adequately staff their claims operation in Southern California and considering how to have the catastrophe teams think about arson, crime, and fraud while providing immediate relief to the honest victims of the fires.

The entire concept of insurance, the spreading of the risk of loss, is a mystery to the public. The public does not understand that potential loss probability, computed on astronomical amounts of data, means that insurers are seldom surprised on long term projections. Part of the great mystery is that insurance companies are essentially money managers, spreading the losses of a few over the ability of the many to pay.

Over the past few decades fraud has become an ever escalating problem. It is part of the cost of doing business equation and is passed on to the insurance buying public. When a catastrophe hits everyone suffers. Not only the victims of the catastrophe suffer but the insurers whose staff has not been adequately trained to discover fraud suffers the loss of millions of dollars not owed under the contracts of insurance.

Every person and every entity involved in a catastrophe will make a choice as it relates to the honesty of the overall process. The perception much of the public has is that insurance fraud is a victimless crime. Individuals do not have to pay. It is the trillion-dollar insurance pool that is designed to avoid payment that is tapped.

It is not just in a catastrophe that insurance fraud occurs. In fact, fraud by insureds is often pervasive throughout every layer of the insurance marketplace. It can involve, at a minimum:

1. Underwriting Fraud the insured lies when the policy is acquired.
2. Rating Fraud the insured lies about the location of the property to decrease the premium the insured will owe.
3. Premium Fraud the insured does not accurately report all employees to the workers compensation insurer.
4. Nondisclosure Fraud the insurance agent or broker sells a policy or annuity to someone who does not need it like life insurance to a 90-year-old.
5. Claims Fraud Paper accidents, inflated claims, owner give ups, kickback schemes, arson-for-profit, doctors/lawyers, conspiracies or staged accidents.
6. Identity Fraud.

If the insurance industry either desires, or is forced, to eliminate or reduce the extent of fraud the single answer is education. Every individual entrusted with the duty and/or privilege of working in or for the insurance industry must be educated in both the process and the products.

To be certain that the public receives the indemnity to which they are entitled and to be certain that fraud fails insurance regulatory agencies must, and many do, ascertain the abilities of the insurers who do business in their jurisdiction to properly indemnify their insureds and compel those who are not to train their personnel up to competence.

It should be the duty of every insurance regulatory agency to require insurers, their claims personnel, independent insurance adjusters and public insurance adjusters, to be licensed, competent and well trained on insurance, insurance claims handling, fraud recognition techniques, and enough of the law of the state to competently adjust claims and recognize fraud when it is attempted.

Insurance regulators should require that each person involved in the claims process from the clerk who takes in the first notice of loss to the executive who has the final say on the largest claim paid, be trained, and knowledgeable, about

the following:

1. Insurance, its history and modern application
2. The Fair Claims Settlement Practices laws and regulations imposed to enforce the law by the states where insurance claims may occur
3. How to read, understand and interpret insurance contracts
4. Investigation techniques including, but not limited to
 - a. Interviewing
 - b. Photography of loss scenes
 - c. Use of independent experts
 - d. Use of private investigators
 - e. Use of claims counsel
5. What is necessary to prove insurance fraud
6. Fraud recognition
7. The operation and use of the Special Investigative Unit (SIU) and reporting to the Fraud Bureau or Fraud Division
8. The SIU unit laws and the regulations enacted to enforce them
9. The law of contracts and torts needed by claims professionals to competently adjust claims

Compliance with the training requirements should involve more than mere attendance at training sessions. Training provisions should require that training session attendees actually understand what they are required to learn. The obligation to train need not be onerous or even take the claims person away from work for an extensive period of time. Modern computer-based training programs can be taken incrementally by the student while drinking his or her first cup of coffee in the morning. The computer-based training (CBT) can also test the student on what is learned without the student leaving his or her desk.

Insurers and their regulators can receive a record of the time spent by the insurance personnel on the training and the results of the tests electronically. Insurance personnel who use CBT training 3 minutes a day, 5 days a week, 50 weeks a year will receive 12.5 hours of training, while the claims person who spends 6 minutes a day will receive 25 hours of training.

Training is not a panacea. It will not staff catastrophe teams. It will not resolve all claims problems nor will it eliminate fraud. It is a beginning. Regulators must audit and enforce the requirement that claims personnel are adequately trained and are capable of applying that training to provide the indemnity promised by the policy of insurance.

If regulations are put in place across the country and insurers are forced to hire, train and maintain competent staff the public will be better served, the insurers will pay only what they owe, fraud will be reduced and insurance regulators will receive a lesser number of complaints.

Practice Pointers

When litigating on behalf of or against insurers it is essential that counsel determine:

The regulations imposed by the state to control claims handling

The regulations imposed by the state to control fraud investigations

Armed with this regulatory knowledge, counsel should concentrate investigation and discovery to prove or disprove compliance with those regulations.

Counsel for the state should work to put into effect sufficient training regulations to protect the public if not already in place.

ABOUT THE AUTHOR(S):

Barry Zalma, Esq., CFE, is an insurance coverage attorney. He is the founder of Barry Zalma, Inc., a California law firm whose practice emphasizes the representation of insurers and those in the business of insurance. He is also the founder and chief consultant with Zalma Insurance Consultants who consult with insurers, plaintiffs' counsel and defense concerning insurance bad faith, insurance coverage and insurance claims handling matters and, if needed, often serves as an expert witness at trial. Mr. Zalma is recognized as an expert on insurance claims handling, insurance bad faith, and insurance fraud. He is the author of several books relating to insurance, insurance coverage, insurance claims handling and insurance regulations including Chapters 12 and 13 of the New Appleman Insurance Law Practice Guide, November 2007, Matthew Bender & Company, Inc., a member of the LexisNexis Group. Details and his CV are available at [<http://www.zalma.com> & <http://www.zic.bz>]and Mr. Zalma can be reached at zalma@zalma.com.

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Title I of the Genetic Information Nondiscrimination Act of 2008

2008 Emerging Issues 471

Chandler on Title I of the Genetic Information Nondiscrimination Act of 2008

By Prof. Seth Chandler

July 24, 2008

SUMMARY: Many have hailed the newly enacted Genetic Information Nondiscrimination Act of 2008 (GINA) as the first major piece of civil rights legislation of the 21st Century that will foster medical treatment based on genetics by prohibiting genetic discrimination on the part of insurers and employers. Professor Seth Chandler untangles the complex path by which the bill, through interaction with existing provisions of ERISA, the Public Health Service Act, the Internal Revenue Code and the Social Security Act, alters the law of insurance underwriting. He finds that, while GINA will, as touted, severely restrict use of genetic information as a basis for health insurance underwriting, the understandable failure of the bill to address life, disability and long-term care insurance, the existing state limitations on use of genetic tests in health insurance, and the fact that few health insurers were using genetic tests, means that GINA has changed the dilemma faced by the choice confronting most patients and medical practitioners in only a marginal way. Professor Chandler suggests the sort of litigation, regulatory and legislative controversies likely to be created by GINA. These include litigation over alleged use of family history information by insurers, actions against medical practitioners when patients rely to their insurance detriment on overstatements about the insulating effects of GINA, the backlash faced by regulators in obeying GINA's requirement that genetic information be given the same limited HIPAA privacy protections as other forms of medical information, and perhaps most importantly, legislative debate over in Congress and state legislatures as to whether the genetic exceptionalism premise behind GINA can withstand the statute's limitation of anti-discrimination provisions to just the health insurance industry.

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ARTICLE: Chandler on GINAs Challenge: An Exposition of Title I of the Genetic Information Nondiscrimination Act of 2008 and the Issues Likely to Arise

By Seth J. Chandler Introduction

On May 21, 2008, President George W. Bush signed into law the Genetic Information Nondiscrimination Act of 2008 (GINA), Pub. L. No. 110-233, 122 Stat. 881 (2008), following favorable votes of 414-1 in the House of Representatives and 95-0 in the Senate. This act, hailed by some as the first major piece of civil rights legislation of the 21st Century, restricts in Title I the collection and use of genetic information for underwriting by health insurers starting in May 2009 and in Title II limits the ability of employers to use genetic information in hiring and other employment-related decisions starting in November 2009. This commentary examines Title I of GINA: what it does,

what it does not do, and the litigation and legislative challenges likely to follow in its wake.

The BackgroundLegal background. GINA cannot be well understood without an appreciation of the legal and factual background against which it was enacted. Legally, the federal government, which retained authority under the McCarran-Ferguson Act, 159 Stat. 33, ch. 20, 15 U.S.C. § 1011 et seq., to regulate the business of insurance provided it did so explicitly, had already restricted somewhat the use of genetic information in health insurance. Under Title I of the 1996 Health Insurance Portability and Accountability Act (HIPAA), Pub. L. No. 104-191, 110 Stat. 1936, 42 U.S.C. § 201 note, group health insurers serving the employment market pursuant to the Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 829, 29 U.S.C. § 1001 et seq., were prohibited from taking genetic information into account in determining eligibility for membership in the group (42 U.S.C. § 1182) and could not treat genetic information that had not yet manifested as a disease as a pre-existing condition whose coverage could potentially be limited for up to 12 months. No such restrictions existed, however, with respect to individuals seeking health insurance outside the employment context or, critically, with respect to other forms of insurance such as life insurance, disability insurance, Medicare supplemental policies (Medigap) and long-term care insurance where genetic information might well be relevant to the risk transferred to the insurer. The Americans with Disabilities Act, Pub. L. No. 101-336, 104 Stat. 327, 42 U.S.C. § 12101 et seq., although not entirely clear on the matter, was generally thought to provide little if any protection against discrimination by insurers based on genetic information.

Various states had provided additional protection against use of genetic information in health insurance underwriting. See Shannyn C. Riba, *The Use of Genetic Information in Health Insurance: Who will be Helped, Who Will be Harmed And Possible Long-Term Effects*, 16 S. Cal. Rev. L. & Soc. Just. 469 (2007). Most states prohibited health insurers from basing eligibility decisions on genetic information or for risk classification. Susan M. Wolf & Jeffrey P. Kahn, *Genetic Testing and the Future of Disability Insurance: Ethics, Law & Policy*, 35 J. L. Med. & Ethics 6 (2007). About half the states prohibited health insurers from requiring genetic tests. See Genetics and Health Insurance State Anti-Discrimination Laws, at <http://www.ncsl.org/programs/health/genetics/ndishlth.htm> (last visited July 14, 2008).

With respect to other forms of insurance, the picture was even more mixed. Only a handful of states prohibited use of genetic information in disability insurance (Susan M. Wolf & Jeffrey P. Kahn, *Genetic Testing and the Future of Disability Insurance: Ethics, Law & Policy*, 35 J. L. Med. & Ethics 6 (2007)) or long-term care insurance (Robyn Nicoll, *Long-Term Care Insurance and Genetic Discrimination Get It While You're Young and Ignorant: An Examination of Current Discriminatory Problems in Long Term Care Insurance Through the Use of Genetic Information*, 13 Alb. L.J. Sci. & Tech 751 (2003)), although several others created procedural restrictions on their use and on genetic testing. Genetics and Life, Disability and Long-term Care Insurance, at <http://www.ncsl.org/programs/health/genetics/ndislife.htm> (last visited July 14, 2008). As summarized by the National Conference of State Legislatures, Seven states prohibit genetic discrimination in life insurance without actuarial justification. Of these seven, Arizona, Maine, and New Jersey also prohibit genetic discrimination in disability insurance without actuarial justification, and Massachusetts, Montana and New Mexico extend their prohibitions to disability and long-term care insurance. Of the three lines of insurance, Idaho prohibits genetic discrimination in disability insurance only. Colorado, Massachusetts, Oregon and Vermont prohibit insurers from requiring applicants to undergo genetic testing for long-term care insurance but permit the use of test results. Some states mention life, disability or long-term care as exclusions to their genetic nondiscrimination legislation. Factual background. Whether because of the legal restrictions constrained in HIPAA, the various state law prohibitions, the current costs of genetic testing relative to the useful information likely to be obtained thereby, or fear of adverse public reaction, few if any health insurers were actually requiring genetic tests as part of the underwriting process or asking explicitly for the results of any genetic tests. Mark A. Hall & Stephen S. Rich, *Laws Restricting Health Insurers Use of Genetic Information: Impact on Genetic Discrimination*, 66 Am. J. Hum. Genet. 293 (2000). In the individual health insurance market, where HIPAA's restrictions did not apply, and in life, disability and long-term care insurance, genetic information could be and frequently was obtained indirectly through the relatively inexpensive process of requesting information on family history in the insurance application and the collection of medical records, privacy to which was

waived by the applicant as a condition of obtaining insurance. *See generally* Genetics and Life Insurance: Medical Underwriting and Social Policy (Mark Rothstein ed., 2004); Krupa Subramanian, et al., *Estimating Adverse Selection Costs From Genetic Testing for Breast and Ovarian Cancer: The Case of Life Insurance*, 66 J. Risk & Ins. 531 (1999) (discussing questionable use of family history as proxy for genetic information while barring use of more accurate genetic testing). The law of misrepresentation provided an incentive for applicants to be truthful in this process. Insurers were free to make a Bayesian inference, see E.S. Iverson, et al., *Validating Bayesian Prediction Models: a Case Study in Genetic Susceptibility to Breast Cancer*, in *Case Studies in Bayesian Statistics*, IV (C. Gatsonis et al. eds.) 321 (1998), that those whose near relatives suffered a heritable medical condition were at heightened risk of having that heritable proclivity manifest itself as expensive diseases while the insurer was on the risk. Summary. Until the passage of GINA, most insurers in most states who found such information relevant to their underwriting decisions could obtain genetic information either directly, through a medical test, or indirectly, through medical records or questions of the applicant. If, for example, an individual had already taken a genetic test that found the presence of a BRCA1 gene, or the individual knew that their mother had died of breast cancer, an insurer could obtain that information through the application process and then make underwriting decisions on life insurance, disability insurance, or long-term care insurance based on that information. To protect against difficult-to-detect mistakes (fraud) by the applicant, these insurers could purchase or otherwise collect genetic information from various repositories, including other insurers. Alternatively or in supplementation, most of these insurers could -- at least if they surmounted procedural requirements existing in some states -- theoretically request or require an applicant for insurance to take a genetic test, although instances of such requests were rare. The insurer could make underwriting decisions based on the results, or, if the individual refused to take the test, assume the worst. The exceptions to this regime were in group health insurance provided through employment, in which even HIPAA and some state laws made use of genetic information difficult and individual health insurance, where many but not all states tightly restricted use of genetic information. What the Bill Does

In General. GINA greatly restricts the ability of most health insurers, whether acting in the employment context or otherwise, to use any of several current routes to discover genetic information about the individual and base certain underwriting decisions thereon. It does so primarily by amending four federal statutes: (1) ERISA; (2) the Public Health Service Act (PHSA), the Internal Revenue Code (IRC), and (4) the Social Security Act (SSA). Prohibition on Use of Genetic Information by Insurers. Sections 101(a)(2) and 102(a) of GINA respectively amend section 702(b) of ERISA, 29 U.S.C. § 1182, and section 2702(b) of PHSA, 42 U.S.C. § 300gg-1(b), to prohibit group health plans or health insurance issuers offering group health insurance coverage in connection with a group health plan (ERISA insurers) from adjusting premiums or contribution amounts on the basis of genetic information. Section 102(b) of GINA adds section 2753 to PHSA to prohibit health insurance issuers offering health insurance coverage in the individual market (individual insurers) from several underwriting practices on the basis of genetic information: establishing rules for eligibility, adjusting premium or contribution amounts, and imposing a pre-existing condition limitation. Section 104 of GINA amends section 1882(s)(2) of SSA (42 U.S.C. § 1395ss(s)(2) to create similar requirements with respect to Medicare supplemental policies (Medigap insurance). These policies, purchased in a tightly regulated private market, permit Medicare beneficiaries to purchase insurance for expenses not covered by Medicare or whose coverage is significantly limited by Medicare.

Definitions are critical to an understanding of the scope of GINA's prohibitions. GINA amends section 733(d) of ERISA, 29 U.S.C. § 1191b(d), section 2791(d) of PHSA, 42 U.S.C. § 300gg-91(d), and section 1882 of SSA, 42 U.S.C. § 1395ss, to define genetic information about an individual to include three possibilities: (1) information about such individual's genetic tests; (2) information about the genetic tests of family members of such individual; and (3) information about the manifestation of a disease or disorder in family members of such individual.

The term genetic test on which the definition of genetic information largely depends, is in turn defined broadly to include not only analysis of human DNA to detect genotype, mutation or chromosomal changes but also analyses of RNA and chromosomes that permit similar detection. GINA §§ 101(d), 102(a)(3), 103(d), 104(b). Analysis of protein and metabolites is also considered a genetic test unless that test does not detect genotypes, mutations or chromosomal

changes or if it is directly related to a *manifested* disease. *Id.* Thus, if an insurer based premium decisions for a group on the existence of elevated white blood cell counts for many of the group members, that would not be treated as a genetic test by GINA because the presence of these proteins would not be probative as to the genetic makeup of the individuals. Similarly, if an insurer based premiums after learning the nature of an individual's CFTR protein, that would not likely be treated as a genetic test or genetic information by GINA because, even though information on the protein did provide information on the genetic makeup of the individual the location, amount and nature of the protein is highly correlated with the existence of cystic fibrosis the manifestation of the disease through symptoms such as thick mucus production rather than the protein test basically provided the genetic information.

The term family member on which the definition of genetic information likewise depends is also defined broadly. It includes any dependent of the individual (through marriage, birth, adoption or placement for adoption) as well as any first, second, third, or fourth degree relative of the individual or of their dependent. Thus, an insurer subject to GINA could not use genetic information about an individual's first cousin or their great uncle because those persons would be the individual's fourth degree relative under the frequently used civil law system of kinship or a yet closer relative under alternative kinship systems. Genetic information derived from a fetus is essentially treated as if it were genetic information from the woman inside whom it is present; genetic information derived from an embryo that results from assisted reproduction is essentially treated as if it were genetic information from the persons who legally hold the embryo. GINA § 101(c) (modifying ERISA § 733); GINA § 102(a)(3) (modifying PHSA § 2702); GINA § 103(c) (modifying IRC § 9802); GINA § 104(b) (modifying SSA § 1882). Limitations on Collection of Genetic Information. Some insurers might worry that insureds would forget or make a mistake with respect to genetic information in their possession and that the insurers would have difficulty proving fraud to the requisite standard. Alternatively, some insurers might want to attempt to collect genetic information on the likely members of a group to determine whether they wanted to offer insurance to the group or the terms on which such insurance would be offered. GINA prohibits insurers, however, from requesting, requiring, or purchasing genetic information for underwriting purposes. GINA § 101(b) (modifying ERISA § 702 codified at 29 U.S.C. § 1182); GINA § 102(a)(2) (modifying PHSA § 2702(b), codified at 42 U.S.C. § 300gg-1(b)); GINA § 103(b) (modifying IRC § 9802); GINA § 104(b) (modifying SSA § 1882, codified at 42 U.S.C. § 1395ss). Underwriting purposes is defined more broadly than mere eligibility but includes computation of premiums, application of pre-existing conditions, exclusions or other activities related to the creation, renewal or replacement of a contract of health insurance or health benefits. GINA § 101(d) (modifying ERISA § 733(d), codified at 29 U.S.C. § 1191b(d)); GINA § 102(a)(4) (modifying PHSA § 2702, codified at 42 U.S.C. § 300gg-1); GINA § 102(b) (referencing PHSA 2791(d), codified at 42 U.S.C. 300gg-91(d)); GINA § 103(d) (modifying IRC § 9832(d)); GINA § 104(b) (modifying SSA § 1882, codified at 42 U.S.C. § 1395ss). An exception is made, however, if the insurer acquires the information incidental to the collection of non-genetic information. As discussed below, this exception is likely to breed litigation. Limitations on Genetic Testing by Insurers. GINA also prohibits ERISA insurers, individual insurers and Medigap insurers from requesting or requiring an individual or family member to undergo a genetic test for the purposes of underwriting. (GINA §§ 101(b), 102(a)(2), 102(b)(1), 104(b)). These insurers may order genetic tests, however, for the purposes of making coverage and payment determinations and may request that individuals volunteer for genetic tests in connection with federally authorized research. Extension of HIPAA Privacy Rules. Section 105 of GINA requires the Secretary of Health and Human Services to enact (without prior public comment) regulations that accord genetic information largely the same privacy status as conventional medical information under current HIPAA privacy regulations. Violations of the regulations enacted as a result are to be punished in the same way as are HIPAA privacy violations with respect to more traditional medical information. Preemption of State Law. Unlike Title II of GINA which contains a new and specific provision addressing preemption of state law, Title I of GINA appears to be silent on the preemption issue. The silence is somewhat misleading, however, since GINA would appear simply to piggyback on existing preemption provisions contained in ERISA and part B of Title XXVII of the PHSA, which it amends.

With respect to ERISA insurers, the most reasonable assumption in the face of Congressional silence is that Congress wanted to leave the murky and contentious state of ERISA preemption untouched for now. And, although that very murk makes prediction in this field difficult, one would therefore assume that ERISA will in fact preempt any

private right of action against ERISA plans or ERISA insurers that might exist under state law for genetic discrimination in health insurance akin to that addressed by Title I of GINA. *See Alessi v. Raybestos-Manhattan Inc.*, 451 U.S. 504 (1981); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987). Claims for such violations should in general be properly removable to federal court. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 209 (2004). Permitting such causes of action would, it will be said, disrupt the uniformity created by GINA with respect to genetic nondiscrimination in health insurance and would undercut the remedial scheme such as it is created by ERISA § 502. *Id.*

With respect to individual insurers, GINA leaves considerable scope for state law. This freedom exists because the relevant part of GINA amends Part B of Title XXVII of PHSA. Under section 2762 of PHSA, nothing in Part B shall be construed to prevent a state from establishing, implementing, or continuing in effect standards and requirements unless such standards and requirements prevent the application of a requirement of [Part B]. Thus, while a state could not permit an individual insurer to take an action prohibited by GINA, it would appear free to enact laws that were more stringent than GINA relating to genetic discrimination or even laws that were less stringent but that provided different remedies. Thus, the current peculiarity of protection against insurer malfeasance in the individual insurance market being greater than that against insurer malfeasance in the employer group market is likely to be perpetuated by GINA. The extent to which GINA will succeed in creating the desired uniformity will depend in part on whether the standard it sets with respect to the rights of individuals as to their genetic information ends up being sufficiently high in practice that the costs of enacting yet stricter state laws, including the costs of disuniformity and the possible perils of adverse selection, outweigh the perceived benefits of broader rights.

Enforcement. In examining a piece of legislation, it is always critical to examine how it is enforced. There are four basic modes of enforcement under GINA: (1) imposition of a civil penalty by the Secretary of Labor, (2) imposition of an excise tax under the Internal Revenue Code, (3) under some circumstances a private right of action, and (4) potential criminal liability for knowing release of individually identifiable genetic information.

Section 101(e) of GINA amends ERISA § 502 (codified at 29 U.S.C. 1132) and section 102(a)(5) of GINA amends PHSA § 2722(b) (codified at 42 U.S.C. 300gg-22(b)) to permit the Secretary of Labor to impose a \$100 per day per participant/beneficiary penalty for violations of GINA's prohibitions on insurer use of genetic information, subject to a minimum penalty of \$2,500 if de minimis violations are not corrected after receiving notice from the Secretary or a minimum penalty of \$15,000 if more than de minimis violations are not corrected after receiving notice from the Secretary. Two caps exist on potential penalties. First, there is an aggregate cap of the lesser of \$500,000 or 10% of the amount paid by the plan sponsor during the preceding taxable year. Second, the penalty is reduced to zero if the GINA violations were due to reasonable cause and not to willful neglect and were corrected within 30 days of the time that the person otherwise liable knew or should have known of the violation. Moreover, the Secretary has discretion to reduce the penalty if it would be excessive relative to the failure involved. There are similar provisions with respect to enforcement of GINA's substantive provisions that relate to the individual insurance market.

Under section 103(e) of GINA, employers that violate GINA can also face an excise tax of up to \$100 per day per participant in much the same way that they previously could for violation of HIPAA or for violations of COBRA. The minimum excise tax and the limitations on the tax are virtually identical to those placed on the civil penalties that the Secretary of Labor can impose.

It is not entirely clear from a reading of GINA whether the Secretary of Labor can impose civil penalties and the Internal Revenue Service can impose an excise tax for the same violations. Section 106 of GINA states, however, the Secretary of Health and Human Services, the Secretary of Labor and the Secretary of the Treasury shall insure through the execution of an interagency memorandum that their regulations regarding the statute are administered so as to have the same effect that to coordinate enforcement in order to avoid duplication of enforcement efforts and assign priorities in enforcement. Also, with respect to individual insurers, states have primary responsibility for seeing that GINA's requirements are met. GINA § 102(b)(2) (modifying PHSA § 2753).

There is also the possibility of private enforcement through injunctive action of at least parts of Title I of GINA.

Private enforcement with respect to ERISA insurers will be done through ERISA. Section 502(a)(3) of ERISA, 29 U.S.C. § 1132(a)(3), gives an ERISA participant or beneficiary the right to enjoin any act or practice which violates any provision of this subchapter [Subchapter I of ERISA]. Subchapter I spans ERISA § 2 through ERISA § 734 (29 U.S.C. § 1001 through 29 U.S.C. § 1191c) and includes ERISA § 702 (29 U.S.C. § 1182) and ERISA § 733 (29 U.S.C. § 1191b), which are the main provisions GINA modifies. It would thus appear that injunctive relief would be appropriate in the event that an ERISA plan refused eligibility to a dependent of a participant based on the fact that a family member had a genetic medical condition or if the ERISA plan was collecting genetic information for improper underwriting purposes. Federal courts will have exclusive subject matter jurisdiction over these actions for injunctive relief. *See* ERISA § 502(e)(1), 29 U.S.C. § 1132(e)(1).

Obtaining a private *damage* remedy against ERISA insurers will be more difficult because section 502(a)(1) of ERISA, which is the main provision that provides a damage remedy, applies only to recover under an ERISA plan or to enforce an ERISA plan. It does not expressly include a right to recover for violations of the statute itself. The participant or beneficiary allegedly damaged by a violation of GINA will thus have to pursue the ambitious argument that GINA's requirements are implicitly incorporated into an ERISA plan and that the participant or beneficiary therefore has a right *under the plan* that has been violated.

With respect to individual insurers, private enforcement would appear to be available under state law. These remedies exist because, as set forth above, section 2762 of GINA permits state law regulating genetic discrimination to continue as long as it does not directly conflict with GINA. Thus, if a state has a law barring genetic discrimination and provides a private right of action to enforce it against individual insurers, nothing in GINA would appear to preclude the continued use of that private right of action. And this would be true whether the law was less stringent, as stringent, or more stringent than GINA.

There would appear to be no federal private right of action, however, even for injunctive relief, for victims of the same sort of Title I GINA violations in the individual health insurance market. GINA creates no explicit private right of action and courts have ruled that no federal private right of action should be implied for violations of the closest related statute, part B of Title I of HIPAA. *See O'Donnell v. Blue Cross Blue Shield of Wyo.*, 173 F. Supp. 2d 1176 (D. Wyo. 2001). Victims and prospective victims of these types of GINA violations will have to hope that private enforcement via state law, public enforcement or the threat of public enforcement by the Secretary of Labor or the IRS proves an adequate deterrent.

There is also criminal liability for violation of portions of GINA. Section 105(a) of GINA makes clear that a knowing and intentional release of individually identifiable genetic information by certain health insurers will be treated the same as a knowing and intentional release of individually identifiable conventional health information. As such, under SSA § 1177, which is expressly referenced by GINA, violators can face penalties in the worst cases of a \$250,000 fine and 10 years in prison.

What the Bill Does Not Do

As to Other Forms of Insurance. GINA leaves untouched the use of genetic information by insurers other than health insurers. It does not violate GINA, for example, for a life insurer to use genetic information to set premiums or determine coverage. If an individual has a gene statistically correlated with breast cancer, for instance, GINA does not bar the insurer from refusing to write the policy or charging a higher premium. Similarly, it does not violate GINA for a long-term care insurer to use genetic information to set premiums. A family history of Alzheimers, for example, may reveal the existence of genes in an individual that make it more susceptible to that illness. While, in light of GINA, neither an individual nor a group insurer could take that family history into account in underwriting a health insurance policy on, say, a 58-year-old applicant, nothing in GINA would preclude a long-term care insurer from taking that same information and basing underwriting decisions on it. The same inconsistency applies with respect to disability insurance as well. The same proclivity to cancer that raises the expected costs of insuring an individual against health expenses raises the expected costs of insuring that individual against the loss of income resulting from inability to work. While

GINA precludes the health insurer from raising premiums or making other underwriting decisions as a result of the genetic information, nothing in GINA precludes the disability insurer from doing so.

The failure of GINA to prohibit underwriting decisions by life insurers, disability insurers and long-term care insurers is a crucial decision by Congress. Thus, contrary perhaps to the exhortations of those in the medical and research communities who, for various altruistic and economic motivations would like to see heightened use of genetic tests, a medical practitioner can still not truthfully tell patients that the results of a genetic test will have no impact on their future insurability. Indeed, attorneys for such practitioners would do well to counsel their clients not to incur potential liability by accepting overstatements of GINAs scope and thus advising their patients that the discovery of genetic information was without potential insurance implications.

As to Certain Forms of Health Insurance. Also untouched by GINA are certain types of health insurance that are termed excepted benefits. The most notable of these are specific disease insurance policies that provide independent coverage, for example, only against cancer. This exception exists with respect to ERISA insurers because ERISA § 733(c)(3)(A) (29 U.S.C. § 1191b(c)(3)(A)) includes "[c]overage only for a specified disease or illness" as an "excepted benefit" and ERISA § 732(c)(2) (29 U.S.C. § 1191a(c)(2)) states that the requirements of Part 7 of Subtitle B of ERISA, which is a part modified by GINA, generally do not apply to excepted benefits. This exception exists with respect to individual insurers because GINA modified part B of Title XXVII of the PHSA and PHSA § 2763 (codified at 42 U.S.C. § 300gg-63) states that the requirements of Part B, including the new prohibitions against various forms of genetic discrimination, do not apply to excepted benefits defined in PHSA § 2791(c)(3) (codified at 42 U.S.C. § 300gg-91(c)(3) and because that provision describes coverage only for a specified disease or illness.

As to All Forms of Genetic Information. GINA also does not protect all forms of genetic information even with respect to health insurance. Gender, for example, which correlates (in different directions) with various forms of health expense risks, is generally determined by the presence of a Y chromosome in the individual. Sections 101(d), 102(a)(4), 103(d) and 104(b) of GINA make clear, however, that an insurer may use information about sex in setting underwriting. And, while sex is conventionally determined readily without the need for genetic information, nothing in GINA would appear to prohibit a health insurer from resolving sex in ambiguous cases through genetic testing. An insurer who wanted to test for gender in the case of someone representing themselves as a woman but who had symptoms, for example, of complete androgen insensitivity syndrome (infertility, delayed menstruation) would likely not be hindered by GINA in taking the existence of a Y chromosome into account in an underwriting decision. The lack of perfect clarity of GINA, however, with respect to inter-sexed individuals may become an area of potential litigation.

As to Manifest Diseases. Genetic information can be revealed in a number of ways. For much of the 20th Century and continuing into the present, family history, coupled with a knowledge of genetics and deduction, provided useful information on the genetic makeup of the individual. More recently, genetic information can often be obtained directly through direct tests for the presence of a given gene or allele. As noted above, GINA would appear to prohibit use of these methodologies in obtaining information about the genetic makeup of an individual, predicting the individuals statistical health trajectory, and making underwriting decisions. This is so because GINA prohibits various underwriting decisions based on genetic information (section 101(a)(2), 102(a)(1)(B), 103(a)(2)), which, as noted above, is in turn defined by reference to genetic tests.

There are, however, other methods of obtaining genetic information about an individual. One is the presence of various diseases. In some cases, such as the manifestation of sickle cell anemia or Huntingtons disease, it is believed that the presence of the disease determines with virtual certainty the existence of a certain allele in the individual. In other instances, such as breast cancer or diabetes, the presence of the disease makes the presence of an allele or set of alleles more likely but not certain. The manifestation of disease is more frequently based on poly-genetic or epigenetic characteristics coupled with the environment encountered by the individual over their lifetime. GINA does not prohibit the use of genetic information discovered in this fashion. The exception likely exists because, while genetic information will be uncovered, clinical manifestations have basically mooted out their importance in making underwriting decisions. Information about which baseball team has a higher batting average has zero marginal predictive value with respect to

the outcome of the World Series if you already know the outcome of the World Series. Likely Litigation Issues

Family History Litigation. One fertile source for litigation is likely to arise from the realms of genetic information contained in current medical records as a result of medical practitioners routine use and recording of family history information. Individual insurers, who routinely request medical record information for underwriting purposes, will thus routinely gain knowledge of individuals genetic information. When these individuals are turned down for insurance or face higher-than-expected premiums, which will occur frequently, some may be willing to sue on a theory that there must be a causal relationship between the genetic information and the underwriting decision. Insurers will no doubt defend on grounds that (a) other factors caused the underwriting decision and (b) that the genetic information collected was incidental, as permitted by GINA.

Although insurers may end up winning many of these lawsuits, at least until clear precedents are established, the result is likely to be a significant amount of litigation that will be difficult to resolve without significant and expensive discovery. The very possibility of these lawsuits may, in fact, end up being an argument to give GINA broad preemptive scope.

Practitioner Liability. One form of litigation created by GINA is likely not actions to enforce the statute itself but to create liability on the part of medical practitioners for misrepresenting the scope of the statute in an effort to persuade individuals to undergo genetic testing. At present, the research community appears to be celebrating the passage of GINA as removing the barriers to genetic testing and research. What happens, however, when the patient who does not recall hearing the physicians caveats about the statutes restriction to health insurance ends up being turned down for life insurance or long-term care insurance following an adverse result on the test?

Definition Issues. There are also likely to be issues arising directly under GINA, particularly with regard to definitions. One issue is the scope of the excepted benefits exclusion from the definition of health insurance coverage. If genetic testing becomes cheaper and more accurate or GINA starts creating significant adverse selection issues in the individual health insurance market, one could expect to see more health insurers recasting themselves as specific disease insurers, providing a long list of diseases or a package of policies against a list of diseases. The extent to which courts will permit such packages to qualify as an excepted benefit may depend in part on the success of an economic argument. Insurers of this sort should be able to argue credibly that, as a matter of economics, disease specific insurance, such as insurance against cancer, should not be subject to the new law. GINA, they will say, showed sensitivity to the countervailing concern of adverse selection by declining to include life insurance, disability insurance and other forms of health related insurance within its prohibitions. Legislators did so, in part, because these forms of insurance are more subject to adverse selection effects: people can stoke up on life insurance, for example, in a way that is not possible with health insurance. Adverse selection risk, these insurers may well be able to show, is considerably higher with respect to discretionary specific disease insurance than for broader, traditional health insurance.

Issues might also arise about the meaning of family member because GINA fails to specify which of the several kinship degree systems are to be used in determining the degree of relationship between an individual and another. By way of example, if the collateral degree system is used, a twice removed second cousin is a third degree relative and thus a prohibited subject of genetic testing. If, however, the civil degree system is used, a twice removed second cousin is an eighth degree relative and thus a permissible scope of genetic testing. (An excellent discussion of kinship degrees may be found at <http://www.umanitoba.ca/faculties/arts/anthropology/tutor/descent/cognatic/degree.html>). The courts may be saved from excessive litigation on this point, however, by the improbability that an insurer would be able to glean much useful genetic information from testing on relatives that were distant under any computation of kinship degree.

Issues Created by Scientific Developments. In certain instances, the text of GINA appears wedded (perhaps too closely) to the specifics of current genetic science. Issues under GINA could arise in the future, for example, if genetic content can be determined or at least narrowed through means other than direct analysis, protein/metabolite analysis, or family history. Already, for example, there are theories that finger-length ratio correlates with homosexuality. See

Terrance J. Williams, *Finger-length ratios and sexual orientation*, 404 *Nature* 455 (2000). Thus, to the extent that homosexuality has a genetic component and creates different health risks than heterosexuality, one can imagine the aggressive insurer of the future engaged in GINA litigation when they attempt to deduce the presence of genes for homosexuality by using rulers on the digits of an applicants hand. The current definition of genetic test would not appear to encompass alternative methods such as analysis of human morphology or behavior.

Moreover, the statutes definition of genetic information with its focus on DNA, RNA and chromosomes is wedded to an approximation of current sciences best understanding of genetics. It may well turn out, however, that other molecules found inside the body play a role in human development and in epigenetics, the process whereby identical genes express themselves differently depending on environmental or chemical factors, including those affected by the expression of other genes. It is thus not entirely clear whether GINA would prohibit insurers from testing for the presence of various chemicals such as DES or other epigenetic carcinogens that are not themselves any of the prohibited test subjects described in GINA yet work by modifying the expression of at least some genetic material.

Finally, if science permits more complex forms of reproduction in which at least some individuals may have more (or less) than two genetic parents, the computation of kinship degree required by GINA may become more complex. Even now, a child produced through certain forms of surrogacy may have the nuclear DNA of the genetic father, the nuclear DNA of the mother, but the mitochondrial DNA of the surrogate. Who exactly counts as the resulting child's fourth degree relative?

Likely Regulatory Issues

Although the fleshing out of Title II of GINA is likely to require far more regulatory work, the agencies charged with administration of GINA are still likely to have some work in the coming year to implement Title I. The Secretary of Health and Human Services will have to determine how to conform HIPAA privacy provisions to accommodate genetic information and to obey GINA's section 105 command that genetic information must be treated as health information. Because existing regulations permit substantial sharing of medical information for treatment, payment and operations, regulators are likely to face controversy from those who regard genetic information as being more sensitive perhaps akin to psychotherapy notes than information about an ear infection and who will thus wish regulations to provide genetic information with still heightened privacy protections. *See Congress Inadvertently Legalizes Sharing of Genetic Information Without Patient Consent*, Reuters, May 6, 2008. Whether an immediate official forum for the expression of such controversy will exist is hardly clear: section 105(c) of GINA states that revisions to the HIPAA privacy rules will take effect 60 days after publication in the Federal Register without opportunity for any prior public comment. Public comment will be permitted to suggest revisions of the regulations after they are first promulgated.

A second focus of regulatory effort will involve the research exception to the prohibition otherwise existing in GINA against insurers (group, individual or Medigap) from requesting genetic tests of applicants or potential applicants (such as existing insureds eligible for renewal). Various sections of GINA permit insurers to request (but not require) such genetic tests provided a host of procedural protections are followed, including requirements that the research conform to the usual human subjects research requirements, that it be clear that compliance with the request is voluntary, and that the results of the research not be used in any way for group or individual underwriting. In addition, however, the statute authorizes the relevant regulatory authorities to promulgate additional regulations that restrict health insurers in genetic testing for research purposes.

A third regulatory effort will involve the development of memoranda of understanding among the various agencies charged with GINA enforcement as to regulatory priorities. *See* GINA § 106.

Likely Legislative Follow Up

GINA is likely to provoke considerable legislative debate and reconsideration. This is so because it rests on the

dubious intellectual idea of genetic exceptionalism. As critics from the (moderate) left such as Professor Mark Rothstein (see *Is GINA Worth the Wait?*, 36 *J.L. Med. & Ethics* 174 (2008)), and critics on the right such as Professor Eric Posner (see

<http://www.slate.com/blogs/blogs/convictions/archive/2008/05/04/the-puzzling-consensus-in-favor-of-the-genetic-information-nondiscrimi>

have noted, there is something very peculiar about saying that a persons risk for a future condition cannot be used in insurance underwriting while a persons manifestation of a condition can be. In property insurance, for example, would one be willing to say that an insurer should not be able to take the proximity of a property to a seismic fault line into account in underwriting simply because the possible earthquake might never occur but permit an insurer to decline to insure a house that has already suffered earthquake damage because the damage suggests proximity to a fault line? And, if it be objected that property insurance is different than medical insurance, consider why an insurer may decline to insure someone who has suffered cancer but is in remission yet may not decline to insure someone who has a genetic predisposition to cancer? And if it be objected that an individuals genetic make up is not their fault and this differentiates the genetic situation from that of the homeowner who chooses to purchase property near a seismic fault line, consider the individual who has future health risks as a result of an accident that was not her fault. Why should the insurer be able to make underwriting decisions based on an individuals risk of future medical expense following, say, a shooting in which he was the faultless victim, but not be able to make underwriting decisions based on an individuals risk of future medical expenses following, say, a genetic mutation in which he was the faultless victim?

To critics on the left, the difficulty in satisfactorily answering these questions shows the need for greater restrictions on private insurance underwriting or greater dependence on public insurance schemes. To critics on the right, the difficulty satisfactorily answering these questions shows why GINA is a bad idea to begin with and should be limited or repealed. GINA thus thrives only in an intellectual environment where the idea that genetic information is special so-called genetic exceptionalism can be taken seriously. See Deborah Hellman, *What Makes Genetic Discrimination Exceptional?*, 29 *Am. J. L. and Med.* 77 (2003).

The debate is most likely to crop up as advocates of genetic exceptionalism press a case either at the state or federal level to expand GINA to different forms of insurance. Preemption is unlikely to be a barrier given GINAs confinement to health insurance and the room for state insurance regulation created by the McCarran-Ferguson Act. If, after all, use of private genetic information is immoral or unfair, how can it be tolerated to permit life insurers, disability insurers and other insurers from using that same information? Or if the privacy of genetic information is essential to the success of personalized medicine, pharmacogenomics, and medical research, how can it be permitted to let concerns about life insurance, disability insurance and other forms of insurance where genetic information is relevant to the risk, sabotage vital medical treatment or research? If the fact that our genes are not our fault, but just the result of random or pseudo-random forces, suggests that genetic information should not be used by insurers, how can we permit any insurer to use the information?

The answer to these questions, or at least the partial answer to these questions, is that GINA is a balancing act and that all the right does not lie on the side of restricting insurer access to genetic information. Health insurance is almost certainly more vital to most individuals than life insurance; underwriting of health insurance should thus be subject to tougher regulation. Adverse selection that results from asymmetric information coupled with optional insurance purchasing is almost certain to be far stronger in the case of life insurance than in the case of broad health insurance and likely to be stronger in the cases of disability insurance and long-term care insurance than in the case of health insurance. The health insurance market can likely tolerate asymmetric information about genetic risk to a greater extent than the life insurance market or other insurance markets. See Seth J. Chandler, *Visualizing Adverse Selection*, 8 *Conn. Ins. L.J.* 435 (2002). But, if GINA fosters the norm shared by many now that genetic information is special, and that it is just bad for insurers to use it, particularly if doing so invades the privacy of the individual, one may see serious pressure, particularly at the state level for an expanded scope of protection against insurer use of genetic information.

The Marginal Choice Made by a Potential User of Genetic Tests

Prior to GINA, individuals seeking genetic information sometimes had a difficult choice. On the one hand, genetic

information might enable them to plan better for the future even if the condition it revealed was not presently amenable to treatment. Probable lifespan and probable health trajectories might make rational individuals make different choices about, for example, the deferral of pleasure. The person who knew he had the gene for Huntingtons disease might, for example, resist forms of lengthy education whose benefits were more economic than philosophical. Moreover, in some instances, genetic information could be used to make better medical decisions. A woman who discovered she (or even a close relative) contained a BRCA1 or BRCA2 gene heightening the risk of breast or ovarian cancer, might decide to conceive children earlier in life or undergo prophylactic surgeries to remove the presently benign homes of future cancers. But, in a market system in which insurance involving medical risk is often written on a short-term basis or often not obtained until later in life, such an individual could rationally fear that the discovery of such genetic information could be used by those to whom he would ordinarily transfer medical risk, such as his health insurer, life insurer, disability income insurer or long-term care insurer. Indeed, there could be a rational fear that the very discovery of information making treatment prudent would eliminate their economic ability to treat the discovered condition. And, while the failure of the insurance industry to engage in aggressive genetic testing might have rendered such fears somewhat exaggerated in many instances, it was still a risk faced by many and that could not be entirely discounted.

GINA does not eliminate the difficult choice faced by those wanting genetic information about themselves, but it does make the choice easier in many instances. If the chief fear of individuals was that they would not be able to pay for medical treatment after a health insurer declined coverage (one way or another) following an adverse genetic test result, GINA should make the decision to undergo testing much easier. There is now a federal guarantee that genetic information will generally not be used in health insurance. Thus, individuals need not rely on the laws of the state in which they currently reside to protect them from this possibility. If, however, individuals also have substantial fears about an inability to protect their family from the risk of premature death through life insurance, through the depletion of their financial resources through longterm care or from the familys loss of wealth through disability, GINA may not be enough to persuade them to abandon the state of deliberate ignorance in which they now exist.

The Big Picture

GINA is a piece of wedge legislation important perhaps more for the incoherence it introduces in our previous assumptions about insurance regulation than for its practical importance. As noted above, many states already prohibited most of the practices barred by GINA and, whether because of the law, social norms, the economics of testing or even altruism, virtually no health insurers were engaged in the practices GINA now clearly prohibits. Thus, as a practical matter, except perhaps for creating additional administrative costs related to HIPAA privacy compliance, creating litigation over incidental use of genetic information by insurers in the individual market, or for making it clearer to potential consumers of genetic tests the limited consequences of an adverse result, GINA is likely to have little impact in the short term. In the long run, however, GINA is important for at least three reasons.

First, while genetic testing is now sufficiently expensive and sufficiently unlikely to yield determinative information about the health trajectory of most individuals for the duration of most private insurance policies that few health insurers would routinely engage in it even if permitted, the time may come when science changes this calculus and GINA has a practical bite. By this time, however, the letter and spirit of GINA will have existed for sufficiently long that a norm of non-discrimination will have evolved. Indeed, this fostering of a norm before the problem arises may be the chief contribution of GINA. Thus, even though Title I of GINA may have only modest practical importance at present, it may prove a powerful force when the problem of adverse selection potentially created by private and widespread genetic testing arises.

Second, the intellectual frailty of genetic exceptionalism will ultimately force legislators to consider whether insurers should be able to take other causes of risk into account in making underwriting decisions. Both Mark Rothstein from the left and Eric Posner from the right and still others from across the political spectrum are correct in noting the incoherence of prohibiting insurers from taking the existence of genetic information into account in making

underwriting decisions yet permitting them to do so in the case of information (the presence of manifest disease, for example, or the presence of epigenetic co-factors) that are equally probative of unmanifested future risk. Indeed, though successful search is easy in political discourse, it is hard to find, at least in the academic community, persons who have studied the matter and who vigilantly support traditional justifications for genetic exceptionalism. See, e.g., Deborah Heller, *What Makes Genetic Discrimination Exceptional?*, 29 *Am.J.L. and Med.* 77 (2003) (debunking traditional arguments for genetic exceptionalism though developing new arguments in support).

Third, GINA disrupts yet again whatever notions remain that the spirit of the McCarran Ferguson Act should cause Congress to leave regulation of health insurance to the states. To an increasing extent, health insurance is being treated by the federal government as just another form of interstate commerce as to which the benefits of uniformity and the supposed deficiencies of state regulation call for greater federal intervention. It will be interesting to see over the coming decade if believers in either federalism or a less regulated insurance market are able to hold the line at GINA.

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The Evolving Role of Custom and Usage in Reinsurance Contracts

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Foley & Lardner LLP on the Evolving Role of Custom and Usage in Reinsurance Contracts

By Glen Kanwit, Andrew Oberdick and Yana Bondar

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SUMMARY: Traditionally, reinsurance contracts have been treated as creatures of custom and usage in the industry. In the last decade, however, courts have increasingly relegated custom and usage to the same shelf as other contracts, to be taken out only where appropriate. The implications for reinsurance law are significant. Both litigants and drafters of reinsurance contracts need to understand and apply this convergence between normal commercial law and reinsurance law. As this commentary points out, [L]itigants cannot assume that reinsurance contracts will be treated as special and unique, with a favored place for trade usage. Drafters of reinsurance contracts should not assume that brevity of expression will be cured either by mutual good will of the contracting parties or by the wisdom of a court delving into trade usage in the reinsurance industry.

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ARTICLE: The Evolving Role of Custom and Usage in Reinsurance Contracts

By Glen H. Kanwit, Andrew Oberdeck and Yana Bondar

Introduction

Economic forces within the reinsurance industry have pushed parties away from informal expressions of their agreements, and toward more complete writings associated with normal commercial practice. As courts give recognition to this convergence, parties who rely on outmoded notions of custom or usage for terms to be included in their contracts are likely to be disappointed. This article explores the role of custom and usage in normal commercial contracts, the place custom and usage has had in reinsurance contracts, and finally, developments in the last decade which confirm the growing convergence of reinsurance law and commercial law with respect to custom and usage.

Custom and Usage in Commercial Contracts

Commercial contracts are often peppered with specialized vocabulary, referencing or incorporating particular customs of conducting business. These customs, termed usage or usage of trade, are defined in the Uniform Commercial Code as practice or method of dealing having such regularity of observance in place, vocation or trade as to justify the expectation that it will be observed with respect to the transaction in question. Uniform Commercial Code § 1-205(2) (1977).

There are two major areas in which trade usage has been employed in commercial contracts: as an aid to interpret terms of a contract, and to supply a term when a contract is silent on a particular issue. Restatement (Second) of Contracts § 221 (1981); Uniform Commercial Code § 1-205(3).

Provide Meaning to an Existing Term. When a contract term is ambiguous, or capable of more than one reasonable meaning, courts turn to usage to determine its meaning in the context in which the term is used. *Bonnie & Co. Fashions, Inc. v. Bankers Trust Co.*, 945 F. Supp. 693 (S.D.N.Y. 1996).

Often terms that seemingly have a clear meaning in a contract have a different meaning in the context of specific industry practices. In these instances, courts may enforce the specific industry definition in order to honor the true understanding of the parties as determined by actual usage and custom. Restatement (Second), § 212, cmt. b.

Even such an apparently clear expression as one thousand may be shown by trade usage to have a different meaning in a specific industry. In the bricklaying trade, a contract which fixed the bricklayers compensation at \$5.25 a thousand did not obligate him actually to lay 1,000 bricks to earn \$5.25, but instead, required that he build a wall of a certain size. While the number one thousand was not ambiguous in itself, the court allowed evidence of its meaning in the industry-specific context to show that a thousand is estimated according to the cubic feet of masonry of laid brick, rather than by the actual number of bricks laid. *Brunold v. Glasser*, 25 Misc. 285, 53 N.Y.S. 1021, 1022 (N.Y. County Ct. 1898).

Contracting parties are presumed to have intended to use terms as they are used and understood in the industry, even if those terms vary from their commonly understood meaning in other contexts. *Hardware Specialties, Inc. v. Mishara Constr. Co.*, 2 Mass. App. Ct. 277, 280 (1974) (stating that [v]alid usages known to contracting parties, respecting the subject matter of an agreement, are by implication incorporated therein, unless expressly or impliedly excluded by its terms, and are admissible to aid in its interpretation, not as tending in any respect to contradict or vary a contract, but upon the theory that the usage forms a part of the contract.); *SI Communications, Inc. v. Nielsen Media Research*, 181 F. Supp. 2d 404, 409 (S.D.N.Y. 2002) (finding that under Illinois law, customs and usages of trade are presumed to form part of contract where the contract contains no provision to the contrary); *Trent Partners and Associates, Inc. v. Digital Equipment Corp.*, 120 F. Supp. 2d 84 (D. Mass. 1999) (stating that under Massachusetts law, evidence of industry custom and usage is relevant to contract interpretation, even in the absence of ambiguity); *see also* Restatement (Second) of Contracts § 223 cmt. b (There is no requirement that an agreement be ambiguous before evidence of a course of dealing can be shown); 3 Arthur Corbin on Contracts 555 (1960) (It is not necessary that words should be unusual words or words that are ambiguous on their face in order to admit evidence of special usage).

The circumstances under which trade usage is admissible as an aid to contract interpretation may depend upon which law governs. A minority of courts, including those in New York, will not allow trade usage evidence to interpret contractual terms that contain no ambiguity. *Milonas v. Public Employment Relations Bd.*, 225 A.D.2d 57, 648 N.Y.S.2d 779 (1996) (stating that custom or usage may be admissible only if the agreement is found to be ambiguous). The courts determine whether ambiguity exists by looking within the four corners of the document, not to outside sources. *Kaas v. Kaas*, 91 N.Y.2d 554, 556 (1998) (noting that in deciding whether an agreement is ambiguous, courts should examine the entire contract and consider the relation of the parties and the circumstances under which it was executed. Particular words should be considered, not as if isolated from the context, but in the light of the obligation as a whole and the intention of the parties as manifested thereby).

Add Omitted Terms to a Contract. Evidence of usage may be also introduced to add terms to the agreement where the contract is silent as to a particular issue, particularly where the term is essential to the agreement. *4-County Elec. Power Assn v. Tennessee Valley Authority*, 930 F. Supp. 1132 (S.D. Miss. 1996).

For example, trade usage was used to supplement a distributorship agreement where the agreement was silent as to its duration. *VistaTech Enterprises, Ltd. v. Brother Intl Corp.*, 677 F. Supp. 178 (S.D.N.Y. 1988). In this case, the agreement between a supplier of consumer electronics and its distributor did not have any time limitation or a termination clause. The court considered a common practice among distributors in New York to quote prices to the trade for a two-month period. Based on the quotation custom, the court construed the agreement between distributor and supplier to have a two-month term.

In *Point Adams Packing Co. v. Daubenspeck*, trade usage in the fishing industry was admitted to supplement an agreement between an owner of a fishing vessel and a processor of seafood. The agreement was silent on which party was responsible for paying the fishing resource raw material tax. The court admitted the evidence of a well-established trade custom in Alaska, according to which the processor was responsible for the payment of the tax, but in turn had to be reimbursed by the owner of the processed fish. *Point Adams Packing Co. v. Daubenspeck*, 584 P.2d 479 (Wash. Ct. App. 1978).

In *Cooper v. Kane*, where a contract for the excavation of lots was silent as to the ownership of sand and other materials that were excavated, the court admitted trade usage evidence that such material belonged to the excavator instead of the owner. *Cooper v. Kane*, 19 Wend. 386 (N.Y. Sup. Ct. 1838).

The Role of Custom and Usage in Reinsurance Contracts

Given the informal nature of insurance and reinsurance contracts for much of the late eighteenth and nineteenth centuries, courts generally held that such contracts must be interpreted in light of the parties course of performance and usage when determining the meaning of an agreement. See, e.g., *Yeaton v. Fry*, 9 U.S. 335 (1809); *Maryland Ins. Co. v. Woods*, 3 L.Ed. 143 (1810); *Palmer v. Warren Ins. Co.*, 1 Story 360 (C.C. Mass. 1840); *Dutcher v. Brooklyn Life Ins. Co.*, 8 F. Cas. 147, 3 Dill. 87 (C.C. Mo. 1874); *Wilkins v. Tobacco Ins. Co.*, 30 Ohio St. 317, 335 (1876); *Blummer v. Phoenix Ins. Co.*, 45 Wis. 622 (1878).

The prominent role of custom and practice in the insurance industry was explained in a derogatory characterization of a marine insurance policy in an eighteenth century English case, *Brough v. Whitmore*. Graydon Staring, *The Law of Reinsurance* § 12:8 (2008) (citing *Brough v. Whitmore*, 4 Term Rep. 206, 210, 100 Eng. Rep. 976, 978 (K.B. 1791)). In that case, Mr. Justice Buller wrote that a marine insurance policy, has at all times been considered in Courts of law as an absurd, incoherent instrument: but it is founded on usage, and must be governed by usage. *Id.*

Nearly two decades later, Chief Justice Marshall of the United States Supreme Court took a similar approach in *Yeaton v. Fry*, writing: Policies of insurance are generally the most informal instruments which are brought into courts of justice; and there are no instruments which are more liberally construed, in order to effect the real intention of the parties, if that intention can be clearly ascertained. *Id.* (citing *Yeaton*, 9 U.S. 335 (1809)).

The courts liberal use of evidence of trade usage during this era was often made necessary by the contracting parties frequent use of blanks instead of negotiated reinsurance contracts. Courts recognized that such blanks did not, and were never intended to, embody the intentions of the contracting parties. See, e.g., *Philadelphia Life Ins. Co. v. American Life & Health Ins. Co.*, 23 Pa. 65 (1854) (using evidence of reinsurance trade practice where the parties use of a printed blank supplied no relevant contract terms); *Manufacturers' F. & M. Ins. Co. v. Western Assurance Co.*, 145 Mass. 419, 424, 14 N.E. 632, 633-34 (Mass. 1888) (noting that [w]henver words are found in a contract which can have no proper application to the subject to which it relates, they cannot be regarded; and not infrequently the careless use of printed blanks compels recognition of this rule).

As reinsurance agreements became more complex and embodied the intentions of the contracting parties, courts began to limit evidence of trade usage. As early as 1903, in the case of *Ocean S.S. Co. v. Aetna Ins. Co.*, 121 F. 882, 886 (S.D. Ga. 1903), the court noted that more complete and complex agreements should be interpreted by reference to their clearly stated terms rather than by reference to trade custom and usage applied in informal settings. Applying this standard to the disputed reinsurance contract, the court rejected the reinsurers argument that custom and usage called for its liability to be shared pro rata with the ceding insurer, citing the clear language in the policy stating that the reinsurer agree[s] to pay the assured in full all claims for such losses arising from perils enumerated in the [underlying] policy as the assured may, in their judgment, settle for with the owners or other parties interested in the merchandise as aforesaid . *Id.* at 866.

Similarly, in *American Guaranty Co. v. American Fidelity Co.*, the court rejected a reinsurers argument that custom and usage imported a retention requirement into reinsurance contracts. 260 F. 897, 900 (6th Cir. 1919), *cert. denied*, 251 U.S. 559 (1920). The reinsurance contract at issue did not contain a retention clause, and the reinsurer claimed that the lack of any retention clause rendered the contract unintelligible such that extrinsic evidence of custom and usage could be presented to explain the contract. *Id.* Accordingly, the reinsurer sought to apply evidence of custom and usage to imply a retention requirement in the following clause:

Any loss hereunder shall be payable by the reinsurer pro rata with the reinsured; that is to say, in the proportion which the amount of this reinsurance bears to the amount of the reinsureds total liability, and under the same conditions by the reinsurer as the reinsured shall pay

Id. The court found this pro rata clause to be unambiguous and held that, even if the reinsurer could prove a contrary custom or usage, it could not change or avoid the terms of a clear, definite and unambiguous contract. *Id.*

At the same time, courts began to limit the circumstances under which usage was admissible with respect to reinsurance contracts to circumstances applicable to normal commercial contracts. *French Mut. General Society of Mutual Ins. Against Theft v. United States Fidelity & Guar. Co of Baltimore City*, 203 F. 558 (D. Md. 1914), *rev'd on other grounds*, 212 F. 620 (4th Cir. 1914) (holding that where contracting parties have not expressed their intentions plainly, general terms and phrases must be construed in light of the circumstances surrounding the parties); *Union Ins. Co. of City of San Francisco v. American Fire Ins. Co. of City of New York*, 107 Cal. 327, 333 (1895) (holding that in reinsurance contracts, as in other contracts, where there is a known usage of trade, persons carrying on that trade are held to have contracted in reference to the usage, *unless the contrary appears*, and the usage forms a part of the contract).

In *Christiana Gen. Ins. Corp. of N.Y. v. Great American Ins. Co.*, 979 F.2d 268, 274 (2d Cir. 1992), the court allowed extrinsic evidence of industry custom and practice to be considered only after finding that the term prompt notice in a reinsurance contract was ambiguous. The court ultimately determined that an issue of material fact existed as to whether applicable industry custom and practice dictated that a reasonable insurer in the ceding insurers position would have given its reinsurer prompt notice of the occurrence at issue. *Id.* at 278. *See also United Fire & Cas. Co. v. Arkwright Mut. Ins. Co.*, 53 F. Supp. 2d 632, 640 (S.D.N.Y. 1999) (holding that when a contract is in any respect uncertain or equivocal in meaning, all the circumstances leading to its execution may be shown for the purpose of clarifying, but not contradicting or changing its terms but that the parties course of performance of a contract is relevant to understanding the contract even if the contract is unambiguous); *Unigard Sec. Ins. Co. v. North River Ins. Co.*, 4 F.3d 1049, 1071 (2d Cir. 1993) (refusing to allow evidence of the parties course of dealing to override a standard limit of liability provision in the reinsurance contract, holding that the efficiency of the reinsurance industry would not be enhanced by giving different meanings to identical standard contract provisions depending upon idiosyncratic factors in particular lawsuits).

The special place of custom and usage in the reinsurance business has tended to linger, however, in spite of cases that have announced that reinsurance contracts are like all other contracts. A treatise authored in 1996 stated that The special and unique nature of the reinsurance arrangements makes it imperative that a court consider industry custom and

practice in interpreting reinsurance contracts. The typical reinsurance agreement is relatively short and concise, using terms of art rather than lengthy, legalistic explications to define the obligations of the parties. Barry R. Ostrager and Mary Kay Vyskocil, *Modern Reinsurance Law and Practice* § 5.03 (1996).

In isolated instances, some courts have continued to imply terms in reinsurance contracts on the ground that, by usage, such terms are deemed to part of every reinsurance agreement. Perhaps the most prominent of these instances is the follow the fortunes doctrine, under which a reinsurer is precluded from questioning a cedents good faith claim decision.

The leading case in support of the view that a follow the fortunes clause is implied in every reinsurance contract is *International Surplus Lines Ins. Co. v. Certain Underwriters & Underwriting Syndicates at Lloyds of London*, 868 F. Supp. 917 (S.D. Ohio 1994). [See also *Mentor Ins. Co. Ltd. v. Norges Brannkasse*, 996 F.2d 506 (2d Cir. 1993); *National American Ins. Co. of California v. Certain Underwriters at Lloyds London*, No. CV 91-4021-MRP (C.D. Cal. Aug. 26, 1993), *revd*, 93 F.3d 529 (9th Cir. 1996).] In that case, the court held that even in the absence of any contractual language to support the implied follow the fortunes clause, such a clause was implied because the doctrine applies to all reinsurance contracts. 868 F. Supp. at 920; see also William Hoffman, *On the Use and Abuse of Custom and Usage in Reinsurance Contracts*, Tort & Ins. L.J., Vol. 33, No. 1, at 60, 72 (1997) (providing a thorough analysis of the courts approaches in *International Surplus Lines Ins. Co.* to evidence of reinsurance custom and usage concerning follow the fortunes clauses, and questioning the precedent and evidence relied upon which the court based its decision).

Other courts have been more skeptical, holding instead that whether reinsurance custom and practice dictates that a follow the fortunes is an implied term in every reinsurance contract is an issue of material fact, which must be established by appropriate evidence. See *Michigan Township Participating Plan v. Federal Ins. Co.*, 233 Mich.App. 422, 430, 592 N.W.2d 760, 765 (1999); *Natl Am. Ins. Co. of Cal. v. Certain Underwriters at Lloyds London*, 93 F.3d 529, 537 (9th Cir. 1996). Instances such as this have left parties to reinsurance contracts unclear whether they are like all other commercial contracts, or whether trade custom and usage still occupy a special place in interpreting reinsurance contracts.

Recent Cases Confirm the Trend Towards Treating Reinsurance Contracts Like Other Commercial Contracts

In the last decade, courts have consistently said that they treat reinsurance contracts like any other commercial contract. As these pronouncements accumulate, they create a body of law that has its own momentum and a weight that makes it increasingly difficult for a litigant to argue that reinsurance contracts should have their own specialized interpretation rules.

For example, in *Employers Reinsurance Corp. v. Mid-Continent Cas. Co.*, 358 F.3d 757, 764-768 (10 Cir. 2004), the court faced the issue of whether attorneys fees and expenses that the insurer was required to pay to its insured as a result of declaratory judgment actions on coverage issues were required to be reimbursed by the reinsurer as compensatory damages under the reinsurance agreement. Applying Oklahoma law, the court noted that the court interprets an insurance contract in accordance with principles applicable to all contracts. *Id.* at 764. The court examined the plain language of the reinsurance agreement, and after it found that the language was susceptible of two possible meanings, held that extrinsic evidence of circumstances surrounding the contract formation and execution as well as evidence of trade usage should be considered. *Id.* at 768.

In *Commercial Union Ins. Co. v. Seven Provinces Ins. Co.*, 217 F.3d 33, 38-39 (1st Cir. 2000), the reinsurer argued that the cedent had violated the net retention provision of the contract by ceding part of its share of the potential exposure to another reinsurer under a quota share treaty. The court found that the contract was ambiguous on this point, and that extrinsic evidence was appropriate. Because the contract was several decades old, extrinsic evidence of the intent of the parties was unavailable. General evidence of usage in the industry at the time of execution of the contract was supplied by conflicting expert affidavits. The court resolved the issue by determining the relative credibility of the

experts opinions. The *Commercial Union* case provides a graphic illustration of how seemingly straightforward contract interpretation principles become difficult to apply when evidence of the parties intent is lost by the passage of time.

In the past decade, it has become increasingly difficult for parties to reinsurance contracts to import understandings that they claim they had into their written agreements. In *ReliaStar Life Ins. Co. v. IOA Re, Inc.*, 303 F.3d 874, 879-881 (8th Cir. 2002), the reinsurer sued its retrocessionaires for failure to pay certain losses. The retrocessionaires claimed, among other things, that their obligations were limited by an underlying reinsurance contract which required strict proof of coverage and would thus defeat application of the follow the fortunes doctrine. Supporting affidavits averred that the understanding of the retrocessionaires was that the underlying contract was part of the retrocessional agreement. *Id.* at 880.

The court rejected this argument, holding that under commercial contract principles, the understanding expressed in the affidavits was insufficient to create an ambiguity in the contract, and without such an ambiguity, the understanding could not become part of the written contract. *Id.* at 880-881. If the retrocessionaires had thought that it was unnecessary to include the underlying agreement as an express part of their retrocessional agreement, relying on informal custom and practice in the reinsurance industry, they were quite mistaken. If a party to any reinsurance contract believes that it need not completely set forth the agreement between the parties, it runs exactly the same risk.

While courts in the past decade have consistently applied commercial contract interpretation rules to reinsurance contracts, the prominent role played by usage in the reinsurance industry continues to be a focus of controversy. In *British Intl Ins. Co. Ltd. v. Seguros LA Republica, S.A.*, 342 F.3d 78, 82 (2d Cir. 2003), the cedent argued that its reinsurer had an obligation of pro rata reimbursement under facultative reinsurance certificates for declaratory judgment expenses incurred in coverage disputes with its insureds. Following New York law, the court held that the intent of the parties was to be gleaned from within the four corners of the contract, and not from extrinsic evidence. Only if an ambiguity was apparent within the terms of the document would extrinsic evidence be permitted to resolve the ambiguity. The court did not find any such ambiguity in the contract.

As a fallback position, the cedent argued that--even if there was no ambiguity in the contracts--reinsurance industry custom and practice could be used to supplement the terms of the contract, to include such an obligation in the agreement between the parties. 342 F.2d at 83-84. In rejecting this contention, the court turned to normal commercial contract rules applicable where a party seeks to import a term into a contract on the basis of trade usage. The burden is on the party seeking to establish such a custom and practice; that party must prove that the party to be bound was either aware of the custom or that it was so notorious that the party to be bound should have been aware of it. *Id.* While the court held that this burden had not been met, it should be noted that the cedent was able to obtain affidavits from members of the reinsurance industry that such a trade usage existed in the 1970s and early 1980s. Thus, even in the absence of any contractual term obligating the reinsurer to share in declaratory judgment expenses, the persistence of the view that trade usage in the reinsurance industry could supply terms to supplement reinsurance agreements has continued.

The battle also continues over whether the follow the fortunes doctrine is inherent in every reinsurance contract. In *North River Ins. Co. v. Employers Reinsurance Corp.*, 197 F. Supp. 2d 972 (S.D. Ohio 2002), the court held that this issue could not be decided as a matter of law, because it could not be said that the practice of implying such a clause is so widespread and accepted in the industry as to be beyond all factual and legal dispute. *Id.* at 986. The court then turned to evidence in the form of competing expert affidavits as to whether there was a custom or usage in New Jersey, the jurisdiction whose law governed, at the time that the contract was made. In a subsequent opinion, *North River Ins. Co. v. Employers Reinsurance Corp.*, 2002 U.S. Dist. LEXIS 11711 at *8-24 (S.D. Ohio 2002), the court held that the expert affidavits were of little weight because they lacked factual support. *Id.* at *18. The case was decided on the plain language of the contract, once the court concluded that the cedent had not proved a custom and practice for reinsurers to honor a reinsureds good faith settlement of claims involving disputed coverage.

Parties who invoke the follow the fortunes doctrine can no longer count on the support of courts absent proof that

the doctrine is an accepted usage in the governing jurisdiction. In *American Employers Ins. Co. v. Swiss Reinsurance America Corp.*, 275 F. Supp. 2d 29, 36-37 (D. Mass. 2003), *revd on other grounds*, 413 F.3d 129, the U.S. District Court in Massachusetts noted that the favored view is that follow the fortunes and follow the settlements are an industry custom, and apply even in the absence of express language to that effect. The Second Circuit is firmly of the same view, as discussed in *Travelers Casualty & Surety Company v. Gerling Global Reinsurance Corp. of America*, 419 F.3d 181, 189-90 (2d Cir. 2005). But in *American Motorists Ins. Co. v. American Reinsurance Co.*, No. C 05-5202 CW (N.D. Cal. May 29, 2007), the U.S. District Court for the Northern District of California held that follow the settlement doctrine is not inherent in every reinsurance contract. Since the insurer had failed to provide evidence of trade usage, the court declined to imply a follow-the settlement provision in a reinsurance agreement that did not expressly include such a provision. And in *Affiliated F.M. Insurance Co. v. Employers Reinsurance Co.*, 369 F. Supp. 2d 217, 227 (D.R.I. 2005), the court expressed a high degree of skepticism about whether it would be appropriate to read follow the fortunes into a contract given the divergence of precedent on the issue.

Conclusion

In summary, there has been a clean convergence between normal commercial practice and reinsurance law with respect to trade usage that has accelerated in the last decade. The trend has several implications. First, litigants need to understand the rules that are applied in normal commercial settings when trade usage is at issue in a reinsurance contract case. Second, litigants cannot assume that reinsurance contracts will be treated as special and unique, with a favored place for trade usage. And finally, drafters of reinsurance contracts should not assume that brevity of expression will be cured either by mutual good will of the contracting parties or by the wisdom of a court delving into trade usage in the reinsurance industry. As in normal commercial practice, there is no substitute for careful and comprehensive draftsmanship.

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HRDLICK AND RICHTER ON MIDWEST FLOODING

2008 Emerging Issues 2548

HRDLICK AND RICHTER ON RESPONSE TO RECENT MIDWEST FLOODING BY STATE INSURANCE DEPARTMENTS

By Thomas R. Hrdlick and A. John Richter

July 19, 2008

SUMMARY: Following the devastation wrought on several Midwestern states by recent floods, the insurance departments of Illinois, Indiana, Iowa and Wisconsin issued bulletins requesting, imposing, or reminding insurers of certain protections for insureds in their states. These bulletins are summarized below. Several important questions about the applicability of the bulletins remain.

PDF LINK: [Click Here for Enhanced PDF of Commentary](#)

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The torrential rains of June 2008, and the flooding that ensued, will not soon be forgotten. For days, surging floodwaters threatened the lives and property of many Midwestern families and businesses. As the immediate threat began to recede with the floodwaters, worries set in of a different kind. Worries about starting over, rebuilding homes, minimizing damage from polluted water. Insurance factored heavily into all of these concerns, and that spurred action from the insurance departments of Illinois, Indiana, Iowa and Wisconsin. The insurance departments of these four states issued bulletins requesting, imposing, or reminding insurers of certain protections for insureds relative to the payment of premiums and the cancellation or non-renewal of policies. While certainly well-intentioned, these bulletins do raise some questions about their intended applicability and scope. In the paragraphs below, we provide analysis of the bulletins and some of the legal issues they present.

Regulatory Action in Affected States

Illinois

For Illinois policyholders affected by the flooding, the Illinois Division of Insurance has issued a bulletin to all insurers licensed or authorized to transact business in Illinois. With respect to the bulletins provisions, affected policyholders include, but are not limited to, those residing in state or presidential declared disaster areas. The bulletin

includes (among other things) the directives described below and also requires insurers to post all actions taken to implement these directives on their websites.

The principal directive Illinois imposed is a 60-day moratorium, beginning on June 18, 2008 and retroactive to June 10, 2008, on policy cancellations and non-renewals. Thus, any cancellation or non-renewal issued on or after June 10, 2008 must be withdrawn and the policy reinstated with no lapse in coverage. In addition, no new cancellations or non-renewals will be allowed for affected policyholders until August 18, 2008, or a later time, if reasonable, given an individual's circumstance.

The bulletin also imposes other insurance-related time extensions. Insurers must extend any deadlines for action by an insured (e.g. submission of claim of loss or bills, reporting of information, or payment of funds) at least 60 days beyond the last date allowed in the contract. Finally, insurers must not cancel or refuse to renew policies respecting affected property due to an increase in the risk originally accepted or the geographical location of the risk.

The complete Illinois bulletin is available at <http://www.idfpr.com/DOI/General/CB200804ExceptionsforConsumersinDisasterareasDOI.pdf>.

Indiana

To protect Indiana policyholders in the impacted areas, the Indiana Department of Insurance has issued a bulletin to all insurance companies. The Indiana impacted areas are limited to those designated as disaster areas by state executive order or presidential declaration.

The Indiana directives include (among other things) a 60-day moratorium for cancellation of any insurance policy in effect for any policyholder residing within the impacted areas. The 60-day period begins on June 17, 2008, but the moratorium is retroactive to May 30, 2008. The moratorium applies only to cancellations/non-renewals for failure to pay premiums during the 60-day period. Cancellations/non-renewals for other reasons may still be made pursuant to statutory notice requirements; however, the Department of Insurance requests that insurers take into consideration that persons in impacted areas may not be able to receive notice of a cancellation/non-renewal due to evacuation or delayed postal service.

Also, penalties attaching to late payment of premiums within the moratorium period are suspended. Indiana stresses that the moratorium is not a waiver, it is only an extension of the grace period in which to pay the premium. Thus, after 60 days, Indiana has requested that insurers work with policyholders to develop a repayment plan for premiums that would have become due during the moratorium period.

The complete Indiana bulletin is available at http://www.state.in.us/idoi/files/Bulletin_163.pdf.

Iowa

The Iowa Insurance Division has *requested* that all insurance companies authorized to transact business in Iowa, regardless of the line of insurance, implement the extensions described below with regard to their insureds who have been affected by the recent flooding. This request is applicable to insureds residing in or property insured in Iowa counties declared state or presidential disaster areas.

Iowa requests that insurers provide each insured an optional 60-day interest-free deferral for all premium payments due in the month of June. In addition, insurers are asked to provide a 60-day extension on contractually defined time

limits with respect to various required actions of the insured (such as submitting follow-up documentation on an existing claim). The start date for relief consideration is May 25, 2008, and, as of this time, deferrals and extensions are not required for July due dates. In a Frequently Asked Questions notice issued in response to the bulletin, Iowa clarified that the insurer should grant relief if the insurer knows that an insured is impacted either by a known, community-wide disaster or by a consumer's self-reported impact. Also, in the Frequently Asked Questions notice, Iowa urges insurance companies not to deduct deferred June premiums from claim payments being made in July.

While Iowa has only requested insurance company cooperation, any insurer who was unable or unwilling to comply with the request needed to notify the Iowa Insurance Division within five working days from the receipt of the bulletin (issued on June 16, 2008).

The complete Iowa bulletin is available at <http://www.iid.state.ia.us/docs/bull0809.pdf>.

A list of Frequently Asked Questions in response to the bulletin is available at <http://www.iid.state.ia.us/docs/Q&Aforbulletin0809.pdf>.

The list of Iowa counties declared state or presidential disaster areas is available at <http://flood2008.iowa.gov/index.php?topic=disaster>.

Wisconsin

While Wisconsin has yet to issue any type of moratorium on cancellation or non-renewal of insurance policies, the Wisconsin Commissioner of Insurance has issued a stern and detailed reminder of the statutory notice requirements for non-renewal or renewal with altered terms. This perhaps signals that the Commissioner of Insurance will closely scrutinize post-flood renewals and strictly enforce the statutory notice requirements.

The complete Wisconsin bulletin is available at <http://oci.wi.gov/bulletin/0608renew.htm>.

General Points

Viewed collectively, the actions taken by the Illinois, Indiana, Iowa and Wisconsin insurance authorities reveal a shared concern that insureds may be unable to make their required premium payments (whether due to logistical or financial reasons) and/or that insurers may take action to cancel or non-renew coverage because of new concerns over the nature and location of the risk. The following are some general points to consider when evaluating the impact of the bulletins on an insurer's operations.

1. P&C vs Life/Health Insurers. Nothing in the directives or bulletins draws a distinction between property/casualty and life/health insurers. Indeed, concern about the logistic or financial ability to make premium payments would be equally applicable in all contexts, and the bulletins should be noted and/or adhered to by all insurers regardless of lines of business.

2. Licensed vs Unlicensed Insurers. There is perhaps some ambiguity as to whether the bulletins and directives apply to only licensed insurers transacting business in these states. Illinois asserts that its directive applies to entities licensed or authorized to transact insurance business in the state. Such language suggests that Illinois intends to draw a distinction between licensed insurers and authorized insurers for purposes of the bulletin, and thus the bulletin may arguably apply to surplus lines insurers and perhaps even reinsurers. Indiana states that its directive applies to all insurance companies, drawing no distinction between licensed and unlicensed entities doing business in Indiana. Iowa states that its bulletin pertains to all insurance companies authorized to transact business in the state. This typically

would be interpreted to mean all licensed companies, but query whether this is the Iowa departments intention. The issue is not addressed by Iowas FAQ noted above.

3. Commercial vs Personal Lines. It appears from the language of these bulletins that they are intended to apply to both commercial and personal lines insurers. While this is clear in the bulletins issued by Indiana, Iowa, and Wisconsin, it is perhaps less clear in Illinois, where the bulletins protections are said to benefit insurance consumers. Some may read this as Illinois intent to target individual, personal lines consumers as opposed to commercial lines consumers. However, the principal concerns of these departments (i.e., the insureds inability to pay premiums and/or policy cancellation due to the nature and location of the risk) are equally applicable in both the personal lines and the commercial lines setting, and thus it one presumes Illinois intends for its bulletin to apply to both absent a clear and express direction to the contrary.

4. Constitutional Validity. Finally, some may argue that a state government acting to alter or interfere with the contractual terms of existing insurance policies raises legal issues under the Contract Clause of the United States Constitution, which provides that [n]o State shall pass any ex post fact Law, or Law impairing the Obligation of Contracts. The principal question would be whether the bulletins result in an unconstitutional impairment of private contractual rights. U.S. Const. art. I, § 10, cl. 1. Research reveals that the Contract Clause does not impede a states power to protect the general welfare of its citizens under its police power. In fact, the United States Supreme Court has recognized the importance of a states power to alter private contracts in an emergency, stating that the Contract Clause does not prevent limited and temporary interpositions with respect to the enforcement of contracts if made necessary by a great public calamity such as fire, flood, or earthquake. *Home Building & Loan Assn v. Blaisdell*, 290 U.S. 398, 439-40 (1934). In *Blaisdell*, the Court upheld a Minnesota law granting a moratorium on mortgage foreclosures during the Great Depression because of the emergency situation and the temporary nature of the modification. The recent floods arguably present a similar emergency situation and the bulletins issued in response represent a temporary modification. Thus, it is unlikely that a constitutional challenge of the state bulletins at issue under the federal Contract Clause would succeed.

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New Developments Regarding Limitations on Discovery of Reinsurance Information

2008 Emerging Issues 452

Wiley Rein LLP on New Developments Regarding Limitations on Discovery of Reinsurance Information

By Sandra Stevens

July 18, 2008

SUMMARY: In her analysis of New Developments Regarding Limitations on Discovery of Reinsurance Information, Wiley Rein, LLP litigation partner, Sandra Tvarian Stevens, Esq., discusses appropriate limitations on the production of reinsurance information and provides practical advice for insurers and reinsurers on topics such as: -- The Nature of the Reinsurance Relationship;- The Role of Utmost Good Faith;- The Purpose of Access to Records and Cooperation Clauses; -- Policyholder and Underlying Claimants Demands for Discovery of Reinsurance Information; and -- Privilege and Work Product Considerations. The commentary explores why insurers and their policyholders continue to grapple with the question of whether reinsurance information has any relevance to the issues raised in coverage disputes. The commentary features an analysis of current and past decisions addressing demands for production of reinsurance information and examines why courts have refused to order production in some cases, while allowing it in others.

PDF LINK: Premium Emerging Issues Commentary (\$)

ARTICLE: Wiley Rein LLP on New Developments Regarding

Limitations on Discovery of Reinsurance Information

By Sandra Tvarian Stevens

Introduction

Over the years, insurers and their policyholders have grappled with the question of whether reinsurance information has any relevance to the issues raised in a coverage dispute to which the reinsurer is not a party. A number of recent decisions concerning the scope of discovery of reinsurance information demonstrate that this topic continues to have significance for insurers and policyholders alike. As discussed below, these decisions also provide practical guidance

for insurers and reinsurers with respect to responding to demands for discovery of reinsurance information from policyholders, as well as from other third parties.

The Nature of the Reinsurance Relationship

In order to understand the arguments propounded both, in favor of, and against the use of reinsurance information in a coverage dispute, it is helpful to review the nature of the reinsurance relationship. In its most basic form, reinsurance has been described as insurance of an insurer. *See, e.g., Reinsurance Claims* 41 (Hammesfahr 2004). The reinsurance relationship allows the insurer (also referred to as the ceding company or cedent) to transfer or cede some or all of its risk to a reinsurer, in exchange for payment of a premium. *Id.* at 39 (internal citations omitted). *See also Catholic Mutual Relief Society et al., v. Superior Court of Los Angeles County*, 42 Cal. 4th 358, 368, 165 P.3d 154, 160, 64 Cal. Rptr. 3d 434, 440 (2007) (Reinsurance is 'a special form of insurance obtained by insurance companies to help spread the burden of indemnification.'). The reinsurer does not underwrite the policyholders risk. Nor does it investigate or adjust any of the policyholders claims under the direct insurance contract. Rather, the responsibilities for administering and paying the policyholders claims are left to the insurer, and the reinsurers role is limited to indemnifying the ceding insurer.

Because a policyholder is not a party to the reinsurance contract, it does not enjoy privity of contract with the reinsurer, and may not enforce any rights under the reinsurance contract. *See, e.g., In re Bennet Funding Group, Inc. Sec. Litig.*, 270 B.R. 126 (S.D.N.Y. 2001), *aff'd*, 60 Fed. Appx. 863 (2d Cir. 2003) (rejecting direct action suit brought by policyholder against reinsurer). *Cf. World Omni Fin. Corp. v. Ace Capital Re, Inc.*, No. 02 Civ. 0476 (RO), 2002 U.S. Dist. LEXIS 16870, at *6 (S.D.N.Y. Sept. 6, 2002) ([W]here the insured consistently deals directly with its insurer's reinsurer . . . the reinsurer may become directly liable to the insured"). As one court succinctly explained, [a] reinsurance contract operates solely between the reinsurer and the ceding company. It confers no rights on the insured. *See, e.g., Unigard Sec. Ins. Co. v. North River Ins. Co.*, 594 N.E.2d 571, 574 (N.Y. 1992).

The Role of Utmost Good Faith

All aspects of the reinsurance relationship between cedent and reinsurer are governed by the age-old concept of *uberrimae fidei*, or utmost good faith. As the Supreme Court first explained more than a century ago, the duty of utmost good faith requires communication and disclosure of all material facts by the ceding company. *Sun Mut. Ins. Co. v. Ocean Ins. Co.*, 107 U.S. 485, 510 (1883) (finding that the need for information may be greater in a case of reinsurance than as between the parties to an original insurance.). *See also AXA Corp. Solutions v. Underwriters Reinsurance Co.*, No. 02 C 3016, 2004 U.S. Dist. LEXIS 22609, at *50 (N.D. Ill. Nov. 9, 2004) (This tradition of utmost good faith in the reinsurance context was the result, in part, of the understanding between the reinsurer and the ceding insurer that they would conduct themselves in a manner of trust and full disclosure that led to long term relationships and repeat transactions.).

Some contemporary decisions have suggested that the duty of utmost good faith applies principally in the context of underwriting and require[s] the reinsured to disclose to the reinsurer all facts that materially affect the risk of which it is aware and of which the reinsurer itself has no reason to be aware. *Christiania Gen. Ins. Co. v. Great Am. Ins. Co.*, 979 F.2d 268, 278 (2d Cir. 1992) (citation omitted). Other courts, however, have acknowledged that the duty of utmost good faith extends to the reinsurance claims relationship as well because a reinsurance companys ability to respond to a reinsurance claim relies to a large extent on the information that the ceding company provides to the reinsurer. *See, e.g., United Fire & Cas. Co. v. Arkwright Mut. Ins. Co.*, 53 F. Supp. 2d 632, 633 (S.D.N.Y. 1999) (the duty of utmost good faith falls principally upon the ceding insurer, because it is the ceding company, not the reinsurer who controls the settlement of claims and access to the facts regarding those claims); *Allendale Mut. Ins. Co. v. Excess Ins. Co.*, 992 F. Supp. 278, 282 (S.D.N.Y. 1998) (accord). Courts have also found that the ceding companys duty of utmost good faith is broader for treaty reinsurance -- which reinsures an entire book of business that may cover different claims and losses --

than for facultative reinsurance -- which applies to specific risks and policies -- because more information may be required for treaty reinsurance. *See, e.g., In re Matter of the Liquidation of Union Indem. Ins. Co.*, 674 N.E.2d 313 (N.Y. 1996).

A handful of decisions have also implied that the strict standard of utmost good faith has eroded, and that the parties to reinsurance contracts should be subject only to the general standard of good faith which, under the law of many states, applies to all contractual relationships. *See, e.g., Unigard Sec. Ins. Co. v. North River Ins. Co.*, 4 F.3d 1049, 1066 (2d Cir. 1993) ([U]tmost good faith does not accurately describe the modern relationship of sophisticated insurers bargaining at arms length.) (Citation omitted.). *See also AXA Corp. Solutions*, 2004 U.S. Dist. LEXIS 22609. As the AXA Court explained:

Times have changed, however, and [t]he reinsurance market today does not have the same profitable long term relationships that outweigh any single loss, repeat transactions, or dependent on reputation. Instead, whereas utmost good faith once promoted an efficient reinsurance market by allowing the reinsurer to rely on the ceding insurers disclosure without monitoring, these sophisticated parties must now bargain for adequate protection.

2004 U.S. Dist. LEXIS 22609, at *50 (citation omitted). *But see Nichols v. Am. Risk Mgmt.*, No. 89 Civ. 2999 (JSM), 2002 U.S. Dist. LEXIS 22221, at *4 (Sept. 14, 2002) (duty of utmost good faith encompasses basic obligation of a reinsured to disclose to potential reinsurers all material facts regarding the original risk of loss and finding that reinsurer was entitled to rescind reinsurance contracts where insurer knew of and was required to advise others of its insolvency well before the date of the reinsurance agreements at issue, but failed to do so). Thus, there continues to be some expectation that the reinsurer and insurer should conduct their business in good faith.

The Purpose of Access to Records and Cooperation Clauses

Consistent with the duty of utmost good faith and the need for information sharing between insurer and reinsurer, many reinsurance contracts contain access to records or cooperation clauses. Both access to records and cooperation clauses are intended to facilitate the exchange of information between cedent and reinsurer in the ordinary course of their business dealings with one another.

Access to records clauses generally provide that the reinsurer may examine all books and documents relating to the business transacted under the reinsurance treaty and permit the reinsurer to request copies of insurance policies, claim documents, and the like from the ceding insurer. A typical access to records clause may state as follows:

The reinsurer or its duly accredited representatives shall have the right to inspect the books and records of the reinsured at all reasonable times for the purpose of obtaining information concerning this agreement or the subject matter thereof.

See Hammesfahr at 255.

Cooperation clauses, as the name implies, require the reinsured to cooperate with the reinsurer. *See, e.g. id.* at 258-260. A cooperation clause may require the cedent to report claim developments to the reinsurer automatically:

The Reinsured shall keep the Reinsurer informed of all developments likely to affect the cost of any claims hereunder and undertakes in so far as is reasonably possible to cooperate with the Reinsurer or its representative in the conduct and settlement of such claim or claims and in the estimating of claims reserves.

Id. at 258. Certain other cooperation clauses require the reinsurer to affirmatively invoke the cooperation clause before a cedents reporting obligation is triggered:

When so requested in writing, the Company shall afford the Reinsurer or its representatives an opportunity to be associated with the Company, at the expense of the Reinsurer, in the defense of any claim, suit or proceeding involving this reinsurance, and the Company and the Reinsurer shall cooperate in every respect in the defense of such claim, suit or proceeding.

Id. Thus, both access to records and cooperation clauses recognize that a reinsurer is dependent on information provided to it by the ceding insurer.

Policyholders Demands for Reinsurance Information

The circumstances under which an insurer shares information with its reinsurer during the course of a typical reinsurance relationship are very different from situations in which a policyholder demands that reinsurance information be produced during discovery in a coverage dispute involving the policyholder and insurer. Policyholders demands that the insurer produce reinsurance contracts and communications with its reinsurers, or even policyholder subpoenas to reinsurers are not new. Policyholders routinely argue that an insurers presentation of the facts of a claim to its reinsurer may have bearing on the insurers analysis of coverage for the policyholders claim, and that therefore, the policyholder is entitled to such reinsurance communications.

Most courts that have addressed this issue have concluded that discovery of reinsurance information is not relevant to the issues in a coverage dispute. *See, e.g., Rhone-Poulenc Rorer Inc. v. Home Indem. Co.*, 139 F.R.D. 609, 613 (E.D. Pa. 1991) (denying request for reinsurance information where vague and limited monetary demands are insufficient to bring the reinsurance agreements within the scope of discovery); *Green Constr. Co. v. Kansas Power & Light Co.*, 732 F. Supp. 1550, 1554 (D. Kan. 1990) (finding request for the production of reinsurance file was not relevant to the present litigation and finding that reinsurance materials did not need to be produced); *Leksi, Inc. v. Fed. Ins. Co.*, 129 F.R.D. 99, 106 (D.N.J. 1989) (denying motion to compel reinsurance information because its relevance is very tenuous and is not related to questions of policy interpretation). The decisions finding that reinsurance information is not relevant to issues raised in a coverage dispute involving a policyholder and insurer recognize the fact that a policyholder is not a party to a reinsurance contract and does not have any rights under that reinsurance contract.

Even those courts that have permitted discovery of reinsurance information have typically ruled that the information is only discoverable under limited conditions, such as when the coverage dispute involves a rescission claim, a late notice defense, or lost policy issues. *See, e.g., Medmarc Cas. Ins. Co. v. Arrow Int'l, Inc.*, No. 01-cv-2394, 2002 U.S. Dist. LEXIS 15082, at *10 (E.D. Pa. July 29, 2002) ([C]ourts appear reluctant to permit discovery of communications between cedents and their reinsurers for the purpose of establishing the proper interpretation of an unambiguous insurance policy, but are more willing to permit discovery for other purposes, such as defending against an insurer's effort to rescind a policy; to deny claims for late notice; to reconstruct a lost policy; or as extrinsic evidence of an ambiguous policy provision.); *Turnell Corp. v. U.S. Fid. & Guar. Co.*, No. 4:07-cv-1169, slip op. at 1-2 (E.D. Mo. Oct. 19, 2007) (denying policyholders demand for reinsurance agreement where insurer had not notified the reinsurer of the claim at issue); *United States Fire Ins. Co. v. Bunge North Am.*, No. 05-2192-JWL-DJW, 2007 U.S. Dist. LEXIS 38754, at *27 (D. Kan. May 25, 2007) (finding reinsurance was relevant for purposes of rebutting the Insurers defense of late notice, for purposes of establishing [the policyholders] claims of bad faith and improper handling, and for purposes of reconstructing the terms of any lost policies).

One of the most recent decisions addressing whether or not reinsurance information is discoverable, *Heights at Issaquah Ridge Owners Ass'n v. Steadfast Ins. Co.*, No. C07-1045 RSM, 2007 U.S. Dist. LEXIS 95213 (W.D. Wash. Dec. 13, 2007), drew a distinction between production of the reinsurance contracts themselves which the court found were discoverable and reinsurance communications which the court found to be irrelevant. In *Issaquah*, the policyholder

argued that the reinsurance agreements and communications between insurer and reinsurer were relevant to its bad faith claim. The court explained this distinction as follows:

With respect to reinsurance, the policies themselves are discoverable under rule 26(a)(1)(D). . . . The rule does not, however, extend to communications between insured and reinsurer regarding the reinsurance policies . . . To obtain discovery of those communications, plaintiff must demonstrate their relevance to the bad faith claim.

The court then found that reinsurance matters are rarely relevant to a claim of bad faith and denied the request for production of reinsurance communications. *Id.* See also *Fireman's Fund Ins. Co. v. Superior Court*, 233 Cal. App. 3d 1138, 1141, 286 Cal. Rptr. 50 (1991) (refusing to allow discovery of reinsurance information even though reinsurer was direct party to bad faith action).

As the *Issaquah* decision demonstrates, policyholders demands for production of reinsurance information can be quite broad, and often encompass requests for reinsurance communications between the insurer and its reinsurer in addition to requests for copies of the reinsurance agreements themselves. However, there are a number of steps insurers and reinsurers can take to seek to impose reasonable limits on the production of reinsurance information. For example, if the insurer is faced with a demand for discovery for reinsurance information from the policyholder, it can assert relevancy objections and/or oppose the production of reinsurance information by motion. The reinsurer can make similar arguments, where appropriate, in order to respond to, or quash, a subpoena seeking production of reinsurance information, if the reinsurer is a non-party to the litigation.

As the California Supreme Court recently made clear, [a]n essential feature of reinsurance is that it does *not* alter the terms, conditions or provisions of the contract of liability insurance between the direct liability insurer and its insured (the tort defendant). See *Catholic Mutual Relief Society*, 42 Cal. 4th at 369, 165 P.3d at 160, 64 Cal. Rptr. at 440. Thus, insurers (and reinsurers) may argue that discovery concerning reinsurance agreements or reinsurance communications to which policyholders are not parties will not assist the court in determining the scope of coverage under separate insurance contracts between the insurer and its policyholder that may have different terms and conditions. Moreover, even in those jurisdictions where courts have required production of reinsurance information, insurers should emphasize that many of those decisions do not allow for the whole-sale production of reinsurance information, but rather impose limitations on the scope of reinsurance information produced. Finally, insurers and reinsurers should assert objections based upon the attorney-client privilege and protected work product where appropriate.

Underlying Claimants Demands for Discovery of Reinsurance Information

Policyholders, however, are not the only third parties that may demand production of reinsurance information. Two recent decisions *Kadlec Medical Center v. Lakeview Anesthesia Assocs.*, 527 F.3d 412 (5th Cir. 2008) and *Catholic Mutual Relief Society et al., v. Superior Court of Los Angeles County*,

42 Cal. 4th 358, 165 P.3d 154, 64 Cal. Rptr. 3d 434 (2007) appear to be representative of a growing number of cases in which the issue to be decided is not whether reinsurance information is relevant to the coverage dispute between an insurer and its policyholder, but rather, whether it is relevant in an underlying tort action involving the policyholder.

In *Kadlec Medical Center*, an anesthesiologist under the influence of narcotics improperly anesthetized a patient, causing her to enter into a permanent vegetative state. 527 F.3d at 417. The medical center and its insurer settled a claim brought by the patients family and then brought suit against the anesthesiologists prior employer, Lakeview, alleging that Lakeview had failed to disclose the anesthesiologists drug use in a referral letter it had sent on his behalf. *Id.* at 417-18. At trial, Lakeview sought unsuccessfully to introduce evidence of the fact that the reinsurer had paid a portion of the settled claim. *Id.* at 425. The court on appeal agreed that evidence of the reinsurance payment had been excluded properly under Louisianas collateral source rule, finding that allowing the reinsurance information to be

introduced would effectively penalize [the insurer] for having the foresight to obtain reinsurance. *Id.* at 426. The court further explained that the policy driving the [collateral source] rule is the belief that a tortfeasor should not benefit because a plaintiff had the foresight to obtain insurance. *Id.* at 425. Thus, *Kadlec* presents the not so typical situation in which insurer and policyholder can both agree that reinsurance information is not relevant.

Unlike *Kadlec*, which appears to have been decided primarily on public policy grounds, *Catholic Mutual Relief Society* involved a question of statutory construction. 42 Cal. 4th at 363. In *Catholic Mutual*, victims of alleged abuse sought discovery of financial information from the Church's insurer. *Id.* at 363-64. The insurer, who was not a party to the litigation against the Church, moved to quash the subpoenas. *Id.* at 365. The lower court denied the motion. *Id.* The Court of Appeal concluded that the reinsurance documents and information sought were not discoverable under a California statutory provision authorizing limited discovery of insurance information as a matter of right. *Id.* The California Supreme Court granted review and held that the statute did not authorize pretrial discovery of a nonparty liability insurer's reinsurance agreements for purposes of facilitating a pretrial settlement of underlying tort claims. *Id.* at 374. In so doing, the Court emphasized that reinsurance contracts are irrelevant to underlying tort actions:

Because a contract of reinsurance is defined by statute as a contract of indemnity made for the benefit of the liability insurer, as a general matter it has no relevance in an underlying tort action brought against an insured under the policy of liability insurance. Indeed, the insurance code expressly provides that "[t]he original insured has no interest in a contract of reinsurance." (*Ins. Code*, § 623, italics added.)

Id. at 368. Thus, both *Kadlec* and *Catholic Mutual* demonstrate that insurers and reinsurers have sound arguments available to them in objecting to the relevance of reinsurance information in underlying tort actions, including arguments based upon public policy and/or statute.

Privilege and Work Product Considerations

Given that demands for production of reinsurance information from third parties have become fairly common, insurers and reinsurers also need to be sensitive to privilege and work product issues. In that regard, a recurring issue has been whether disclosure of information in the ordinary course of the reinsurance relationship will be found to operate as a waiver of privilege or work product protection as to third parties if a portion of the information disclosed consists of privileged communications or attorney work product.

The purpose of the attorney-client privilege is to encourage full and frank communication between attorneys and their clients. *Upjohn Co. v. United States*, 449 U.S. 383, 389 (1983). Waiver of attorney-client privilege occurs whenever disclosure of privileged communications to a third party is inconsistent with maintaining confidentiality *per se*. *Bank of America v. Terra Nova Ins. Co.*, 211 F. Supp. 2d 493, 496 (S.D.N.Y. 2002). In turn, the work product privilege protects materials prepared in anticipation of litigation, and affords special consideration to materials that would reveal mental impressions, conclusions, opinions or theories concerning the litigation. *United States v. Adlman*, 134 F.3d 1194, 1195 (2d Cir. 1998) (materials are prepared in anticipation of litigation if they would not have been prepared but for the prospect of litigation).

A number of courts have held that the disclosure of privileged communications to reinsurers, such as pursuant to an access to records clause contained in a reinsurance contract, does not waive privilege or work product protection *per se*. See, e.g., *Gulf Ins. Co. v. Transatlantic Reinsurance Co.*, 788 N.Y.S.2d 44, 45-46 (N.Y. App. Div. 2004) (Access to records provisions in standard reinsurance agreements, no matter how broadly phrased, are not intended to act as a *per se* waiver of the attorney-client or attorney work product privileges); *North River Ins. Co. v. Philadelphia Reinsurance Corp.*, 797 F. Supp. 363, 369 (D.N.J. 1992) (Although a reinsured may contractually be bound to provide its reinsurer with all documents or information in its possession that may be relevant to the underlying claim . . . it does not through a cooperation clause give up wholesale its right to preserve the confidentiality of any consultation it may have with its attorney concerning the underlying claim and its coverage determination.).

Similarly, courts have generally held that a cedent does not waive work-product privilege protection by providing documents to its reinsurers. *See, e.g., Trustmark Ins. Co. v. Gen. & Cologne Life Re of Am.*, No. 00 C 1926, 2000 U.S. Dist. LEXIS 18917, at *12-13 (N.D. Ill. Dec. 19, 2000) (work product protection is waived when disclosure is inconsistent with protecting information from adversaries); *Minn. Sch. Boards Assoc. Ins. Trust v. Employers Ins. Co.* 183 F.R.D. 627, 631-32 (N.D. Ill. 1999) (insurer did not waive work product protection by sharing documents with its reinsurer because waiver of work product occurs only when disclosure . . . to a third party is inconsistent with the maintenance of secrecy from the disclosing party's adversary and insurer always intended and expected that [its communications with its reinsurer] would remain confidential); *United States Fire Ins. Co. v. General Reinsurance Corp.*, No. 88 Civ. 6457 (JFK), 1989 U.S. Dist. LEXIS 8280, at *7 (S.D.N.Y. July 19, 1989) (finding no waiver of work product protection where insurer and its reinsurers remain[ed] in a community of interest regarding this lawsuit).

Courts have tended to be less consistent, however, when a waiver of attorney client privilege is alleged, and their analysis has turned in large part on whether or not a common interest exists between cedent and reinsurer. The common interest doctrine is a limited exception to the rule that privilege is waived when a protected communication is disclosed to a third party. *SR Intl Bus. Ins. Co. v. World Trade Ctr. Props.LLC*, No. 01 Civ. 9291, 2003 U.S. Dist. LEXIS 1106 at *2 (S.D.N.Y. Jan. 29, 2003); *see also Allendale Mut. Ins. Co. v. Bull Data Sys., Inc.*, 152 F.R.D. 132, 139-40 (N.D. Ill. 1993). The common interest doctrine provides that a party does not waive privilege when it shares privileged communications with another party having a mutual legal interest against a common adversary. *SR Intl*, 2003 U.S. Dist. LEXIS 1106 at *2; *Allendale*, 152 F.R.D. at 140.

Generally speaking, the mere fact that a reinsurance relationship exists between the cedent and its reinsurer, standing alone, is not enough for a common interest to exist. *See, e.g., Reliance Ins. Co. vs. Am. Lintex Corp.*, No. 00 Civ. 5568 WHP KNF, 2001 U.S. Dist. LEXIS 7140 (S.D.N.Y. May 31, 2001). *See also Aetna Cas. & Sur. Co. v. Certain Underwriters at Lloyds London*, 676 N.Y.S.2d 727 (Sup. Ct. N.Y. 1998). As the *Aetna* Court explained:

any common interest privilege must be limited to communication between counsel and parties with respect to legal advice in pending or reasonably anticipated litigation in which the joint consulting parties have a common legal interest. . . . [It] may not be used to protect communications that are business oriented or are of a personal nature.

Applying this analysis, a number of courts have held that insurers and reinsurers do share common interests sufficient to protect the attorney-client privilege. *See, e.g., Great Am. Surplus Lines Ins. Co. v. Ace Oil Co.*, 120 F.R.D. 533 (E.D. Cal. 1988) (rejecting policyholders argument that privilege had been waived when the insurer transmitted certain privileged documents to its reinsurer and finding that under California law, reinsurers business interest in the claim was sufficient to prevent waiver); *Hartford Steam Boiler Inspection & Ins. Co. v. Stauffer Chem. Co.*, No. 701223, 1991 Conn. Super. LEXIS 2527, at *4-5 (Conn. Super. Ct. Nov. 4, 1991). As the *Stauffer* Court explained in denying a motion to compel privileged reinsurance communications:

The Insureds contend that [the insurer] has waived the attorney-client privilege because it disclosed the communications to a third party. The Court disagrees. The legal and economic interest of [the insurer] and [the reinsurer] in the EIL insurance claims and lawsuits are inextricably linked by the reinsurance treaty. The fact that [the reinsurer] is not a party defendant in those lawsuits is of little significance because [the reinsurer] will automatically share in any liability suffered by [the insurer] . . . The Court holds, under all of these circumstances, that the privilege is not waived but rather continues to protect the confidentiality of the communications.

Id., at *4. *But see North River Ins. Co. v. Columbia Cas. Co.*, No. 90 Civ 2518, 1995 U.S. Dist. LEXIS 53, at *8 (S.D.N.Y. Jan. 5, 1995) (addressing dispute between cedent and reinsurer).

North River involved a dispute between a cedent and its reinsurer in which North River sued to recover defense costs it alleged were due to it under a reinsurance contract. *Id.*, at *1. When Columbia Casualty, the reinsurer, requested that North River produce certain alternative dispute resolution (ADR) documents and other memoranda, North River moved for a protective order, arguing that the various documents were immune from disclosure under the

attorney-client privilege and work product doctrine. *Id.*, at *3. The reinsurer argued that the ADR documents should be produced because it and North River shared a common interest. *Id.* In rejecting that argument, the court explained that the interests of the ceding insurer and the reinsurer may be antagonistic in some respects and compatible in others, and that therefore, a common interest cannot be assumed merely on the basis of the status of the parties. *Id.*, at *12. In reaching this decision regarding the ADR documents, the court found the following facts persuasive:

[the parties] were not represented by the same counsel, and Columbia Casualty did not contribute to North River's legal expenses nor exercise any control over its conduct of the proceedings. Nor is there any evidence that the two coordinated litigation strategy in any way. While their commercial interests coincided to some extent, their legal interests sometimes diverged, as demonstrated by the instant litigation. In short, Columbia Casualty's only argument for finding a common interest is that the two parties stand in the relation of reinsurer to ceding insurer, and that is insufficient.

Id. at *15. However, the court found that North River had waived the privilege with respect to the other memoranda since it had provided them to another third party. The court explained, [h]aving waived the privilege as to one third-party, North River cannot now resurrect it as a barrier to discovery by Columbia Casualty. *Id.* at *23.

These various decisions implicitly recognize that there is an inherent tension between the insurers obligation to provide information to its reinsurer under the terms of the reinsurance agreement on the one hand, and on the other, its need to protect privileged communications from disclosure to third parties. While the extent to which an insurer will share information with its reinsurer depends on the terms of the applicable reinsurance contract and on the facts of a particular case, there are some general considerations that insurers should keep in mind with respect to privilege issues.

First, because courts have reached different conclusions as to whether an insurers sharing of privileged communications with its reinsurer will waive the privilege, it is important to assess the potentially applicable case law regarding waiver of privilege. In that regard, it may be advisable for the insurer to discuss waiver concerns with in-house or outside counsel.

Second, insurers should weigh the pros and cons of entering into a confidentiality agreement with their reinsurer(s). The typical confidentiality agreement may require all information exchanged between the parties to the agreement, including attorney client communications and work product, to be kept confidential, subject to specific exceptions-such as disclosures to courts, auditors, and federal and state regulators-or where the information is already publicly available. While it has become common practice for insurers and reinsurers to enter into confidentiality agreements in an effort to protect their communications from disclosure to third parties, such agreements generally are only binding on the parties to that agreement, and not on third parties. In fact, at least one court has expressed a reluctance to limit discovery of reinsurance information on the grounds that reinsurance information is confidential. *See, e.g., U.S. Fire Ins. Co. v. Bunge North America, Inc.*, 244 F.R.D. 638 (D. Kan. 2007) (affirming order requiring production of reinsurance materials and finding *inter alia* that [t]he Insurers have not shown how an agreement's confidentiality may overcome Rule 26(a)(1)(D)). Thus, it may be useful for the insurer to consult with counsel prior to entering into a confidentiality agreement.

Conclusion

It is highly likely that courts will continue to address demands for production of reinsurance information from policyholders and other third party strangers to the reinsurance contract. In responding to these demands, insurers and reinsurers should remember that they have available a number of arguments to seek to impose appropriate limitations on any such discovery.

* For additional information about discovery issues of particular interest to insurers, see Sandra Tvarian Stevens, *Trends in E-Discovery One Year After the Amendment of the Federal Rules of Civil Procedure*, published in LexisNexis Emerging Issues Commentaries (December 2007); Sandra Tvarian Stevens, *E-Discovery: Competing Considerations*

for Insurers and Policyholders, published in *Coverage, LexisNexis*, Vol. 17, No. 4 (March/April 2007).

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Godes on Princeton University v. National Union Fire Insurance Co.

2008 Emerging Issues 2564

Scott N. Godes on Trustees of Princeton University v. National Union Fire Insurance Co. of Pittsburgh, Pa.

By Scott N. Godes

July 17, 2008

SUMMARY: In *Trustees of Princeton University v. National Union Fire Insurance Co. of Pittsburgh, Pa.*, the New York Supreme Court and the Appellate Division, First Department, rejected National Union and AIGs arguments that under a D&O policy, the insured versus insured exclusion bars coverage for all derivative-type claims and that a sublimit applies to all costs relating to an occurrence that involved mixed (covered and non-covered claims).

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In *Trustees of Princeton University v. National Union Fire Insurance Co. of Pittsburgh, Pa.*, 15 Misc. 3d 1118A; 839 N.Y.S.2d 437; 2007 N.Y. Misc. LEXIS 2350; 237 N.Y.L.J. 90 (N.Y. Sup. Ct. Apr. 10, 2007), *affd*, 2008 N.Y. App. Div. LEXIS 4849 (App. Dept 1st Div. June 5, 2008) (*Trustees of Princeton*), an insurance coverage dispute, AIG, through its insurer National Union, tried to escape from providing directors and officers insurance coverage for direct and derivative claims under its D&O policy.

National Union and AIG relied on two primary arguments in its efforts to refuse to pay. First, they argued that the insured versus insured exclusion bars coverage for all derivative-type claims. *See* 2007 N.Y. Misc. LEXIS 2350, at *4. Second, they argued that a sublimit of coverage, which offered 1/3 the aggregate limit of the full policy limit, applies to all costs relating to an occurrence that involved mixed (covered and non-covered) claims. *See id.* at *4-5. The court, in a decision that was affirmed by the Appellate Division, First Department, rejected National Unions arguments. n1 This commentary, written by Scott N. Godes, counsel at Dickstein Shapiro LLP, who represents policyholders in insurance coverage disputes, discusses the implications of the *Trustees of Princeton* decision for policyholders facing coverage disputes under directors and officers insurance policies. The views and opinions expressed in this article are solely those of the author and not necessarily those of his current or former law firms and/or clients.

The Court Decided Properly That the Insured Versus Insured Exclusion Did Not Preclude Coverage. The underlying dispute involved direct and derivative claims. *Id.* at *3. National Union and AIG argued that the policy

provided no coverage for the derivative claims, which were brought against the officers (who were individual insureds under the policy) on behalf of the organization (which was the named insured), due to the insured versus insured exclusion. See *id.* at *3-4.

The so-called insured versus insured exclusion in the relevant policy stated:

The Insurer shall not be liable to make any payment for Loss in connection with a Claim made against an Insured...

(f) which is brought by or on behalf of the Organization against any Individual Insured; provided however, this exclusion shall not apply to any derivative Claim made on behalf of the Organization by a member or any other such representative party if such action is brought and maintained independently of and without the solicitation of or assistance of, or active participation of or intervention of any Individual Insured or the Organization or any Affiliate thereof.

Id. at *4.

The trial court denied National Union and AIGs argument. Had the court adopted the insurers position, it could have gutted D&O coverage for derivative claims in general, potentially wiping out unfathomable amounts of insurance protection. In support of its ruling, the trial court noted that [t]he purpose of the insured versus insured exclusion is to prevent collusive lawsuits that corporations bring against their officers and directors to recoup consequences of business mistakes, effectively transforming liability insurance into business loss insurance. *Id.* at *5 (citing *Bodewes v. Ulico Cas. Co.*, 336 F. Supp. 2d 263, 272-277 (W.D.N.Y. 2004)). The trial court refused to extend the exclusion as broadly as National Union and AIG requested that is, to exclude coverage for all claims that it deemed to be derivative in nature. *Id.* at *6.

The trial courts decision was eminently correct in light of the second argument that National Union and AIG advanced: that *all* costs arising from an occurrence some of which were subject to policy limitations and some not are subject to the policy limitations. Had the trial court accepted National Union and AIGs arguments in full, they likely would have asserted in other cases that coverage is excluded for *all* claims that involve *any* underlying derivative-based causes of action.

The Appellate Division affirmed the trial court on this point, reject[ing] the contention that the policy's insured versus insured exclusion applies to claims brought against the insured entities by individual insureds acting in their individual capacities. 2008 N.Y. App. Div. LEXIS 4849, at *2.

The trial court also explained that its ruling was supported by the rule that unless National Union and AIG could determine which costs were due specifically to non-covered claims, they had to pay defense costs in full, and could not apportion claims at the expense of the insureds defense of the underlying action. 2007 N.Y. Misc. LEXIS 2350 at *6. This is in line with New York law that, to defeat its duty to defend, an insurer has a heavy burden of showing that no claim is possibly covered. See, e.g., *Frontier Insulation Contractors, Inc. v. Merchants Mut. Ins. Co.*, 91 N.Y.2d 169, 175 (1997); *Tortso v. MetLife Auto & Home Ins. Co.*, 21 A.D.3d 27, 278, 799 N.Y.S.2d 506, 508 (App. Div. 1st Dept 2005).

The Court Decided Properly That the \$5 Million Sublimit Did Not Apply to All Claims. National Union n2 also sought to limit its obligations by arguing that a sublimit of coverage applied. The policy had a \$15 million aggregate limit; a separate sublimit, however, provided that for Claims that involve multiple allegations, the \$ 5,000,000 sublimit will only apply to the portion of the Claim which is related to the equitable or injunctive relief allegations. *Trustees of Princeton*, 2007 N.Y. Misc. LEXIS 2350, at *7.

National Union argued that the limitation was so expansive that it applied to all defense costs, without an allocation, because the claims in the underlying action are equitable in nature. *Id.* at *6. National Unions position would have subjected all costs to the sublimit, rather than allocating certain costs that fell within the \$5 million sublimit, and

paying the rest of the costs out of the full \$15 million overall limit.

Again, the trial court rejected National Union and AIGs position. The court struck a middle ground, holding that AIG could allocate between claims seeking equitable relief and claims seeking monetary relief if apportionment is feasible. *Id.* at *7. On appeal, the Appellate Division, First Department, rejected National Unions similar arguments: that the \$5 million sublimit for claims that seek equitable relief applies also to claims arising from the same underlying occurrence that seek legal relief based on tort and contract law principles. 2008 N.Y. App. Div. LEXIS 4849, at *2. The appellate court explained that National Unions argument relie[d] on a strained construction of the terms of the policy. *Id.*

National Union and AIGs arguments were wrong. At a minimum, if there is a duty to defend any part of a claim, an insurer generally is obligated to defend the entire claim. *See, e.g., Frontier Insulation Contractors, Inc.*, 91 N.Y. at 177-78. Moreover, because National Union and AIG attempted to apply a sublimit a limitation on coverage National Union and AIG bore the burden of proving that the sublimit applied. *See, e.g., Gaetan v. Firemans Ins. Co.*, 264 A.D.2d 806, 807, 695 N.Y.S.2d 608, 609 (2d Dept 1999) (insurer bore the burden of proving that lower coverage limit for a certain type of claim applied); *accord, e.g., Am. Employers Ins. Co. v. Eagle, Inc.*, No. Civ. A. 03-0048, slip op. at 2-3, available at 18-22 Mealey's Litig. Rep. Asb. 19 (2003) (E.D. La. Nov. 12, 2003) (Plaintiffs [insurers] must prove that the products/completed operations aggregate limits have been exhausted by their proper allocation of each and every claim.), *affd on other grounds*, 122 F. Appx 700, 2004 U.S. App. LEXIS 25014 (5th Cir. Dec. 6, 2004).

The Insurer Had to Advance Defense Costs, Without an Allocation, Until the Underlying Litigation Was Completed. A final significant point in the Appellate Divisions decision is that National Union had to advance defense costs, in full, until the underlying litigation was resolved. *See Trustees of Princeton*, 2008 N.Y. App. Div. LEXIS 4849, at *2. That decision is critical, as it allows the insured to recover its defense costs, without being forced to allocate between covered costs and those that the insurer believes are not covered. Indeed, it is not appropriate for a court to address the question of allocation of defense expenses while the underlying claims are pending. *See id.*

Conclusion. The *Trustees of Princeton* decisions correctly rejected National Union and AIGs attempts to have limited exclusions and limitations apply to coverage and defense costs for all claims, without, at a minimum, an allocation to determine whether the claims were covered or not. Moreover, the appellate court explained that the insured may recover its defense costs, in full, without an allocation between covered and uncovered claims, while the underlying actions are pending. As AIG is one of the largest insurers issuing directors and officers insurance (often through its insurer, National Union), it is not unlikely that National Union and AIG will raise similar arguments in other cases, and these decisions are instructive as to why such arguments should be rejected.

Return to Text

n1 . Unlike the trial court, the Appellate Division, First Department, attributed arguments to National Union only.

n2

[2]. The trial court attributed this argument to National Union only.

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Scott N. Godes is an attorney in the Washington, DC office of Dickstein Shapiro LLP. Mr. Godes represents corporate policyholders in insurance coverage disputes. He is an experienced trial lawyer who has litigated complex insurance coverage disputes, including class actions, in state, federal, bankruptcy, and appellate courts, as well as in commercial arbitrations. Mr. Godes has a wide-ranging coverage practice, pursuing insurance in disputes relating to directors and officers claims for alleged securities violations; allegations of damaged computer data, hardware, and software; mass tort liabilities, including asbestos; environmental property damage; flood claims; allegations of improper alcohol advertising; and class actions. Recently, Mr. Godes was lead counsel in *Continental Casualty Co. v. Employers Insurance Co. of Wausau*, a landmark case decided by the New York Supreme Court that ruled there are millions of dollars of coverage for thousands of asbestos claims, even after the insurers claimed to have paid their full aggregate limits of coverage. Mr. Godes received his B.A., cum laude, from Middlebury College, and his J.D., with honors, from the George Washington University Law School.

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Bullivant Houser Bailey PC on Goddard v. Farmers Ins. Co. of Oregon

2008 Emerging Issues 2549

Bullivant Houser Bailey PC on Goddard v. Farmers Ins. Co. of Oregon: Oregon Supreme Courts Most Recent Interpretation of the Constitutional Limits on Punitive Damages Awards

By Nicholas L. Dazer

July 17, 2008

SUMMARY: In cases that do not involve personal injuries and involve only economic damages, the Oregon Supreme Court in *Goddard* holds that a punitive damages award is unconstitutionally excessive if it exceeds four times the amount of compensatory damages.

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ARTICLE: Cite as: Dazer, Nicholas L. *Goddard v. Farmers Ins. Co. of Oregon*: Oregon Supreme Courts Most Recent Interpretation of the Constitutional Limits on Punitive Damages Awards. LexisNexis Expert Commentary, (*Insert date you accessed the document online*).

On March 6, 2008, the Oregon Supreme Court released another case examining the constitutionality of a large punitive damages award. In *Goddard v. Farmers Ins. Co. of Oregon*, 344 Or. 232, 179 P.3d 645 (2008), the court holds that the jury's approximately \$20 million award was unconstitutionally excessive. In the portion of the opinion that makes new law in Oregon, the court holds that the maximum constitutional award in the case would be an amount four times the amount of the compensatory damages award. That analysis is interesting because it marks the first time the court has specifically articulated how much is constitutional in a case where the amount awarded by the jury was deemed unconstitutional. The court's decision is the most recent opinion in a long-running appeal arising from an auto accident 20 years ago.

In the underlying case, Farmers insured, John Munson, was sued for causing an automobile accident that killed Marc Goddard, while Munson was under the influence of alcohol. Farmers undertook Munson's defense but failed to settle within policy limits. A jury returned a verdict of \$863,274 against Munson, who then assigned his bad faith claim against Farmers for unreasonably failing to settle within policy limits to the plaintiff. That action resulted in a verdict against Farmers for approximately \$1.2 million in compensatory damages and approximately \$20 million in punitive damages.

The Court of Appeals reduced the punitive damages award, and then the Oregon Supreme Court took review to analyze the constitutionality of the punitive damages.

In a unanimous opinion, the court holds that a punitive damages award of four times the amount of compensatory damages is the maximum award permitted by the constitution under the circumstances of this case. Most of the decision is a revisitation of the familiar rules and principles from *BMW of North America, Inc. v. Gore*, 517 US 559 (1996), and *State Farm Mut. Ins. Co. v. Campbell*, 538 US 408 (2003). Applying the "guideposts" from those cases, the court concluded that the \$20 million award was unconstitutional. Then the court turns to the next question: If \$20 million is too much, what is a permissible number?

The court holds that the ratio guidepost is the most helpful in making that determination, and notes that the US Supreme Court has occasionally opined that a four-to-one ratio between compensatory damages and punitive damages is at the outer boundary of constitutionality. The court also notes that the US Supreme Court has indicated that cases involving only economic loss do not warrant punitive damages as substantial as cases involving physical harm. Applying these and other considerations, the court holds that the maximum permissible punitive damages award is four times the compensatory award.

The Supreme Court affirms as modified the Court of Appeals, vacates the judgment of the trial court, and grants defendants motion for new trial on punitive damages, unless plaintiff agrees to remittitur of punitive damages to four times the compensatory award.

Practice Tip. The practitioner should be aware that, under Oregon law, the prevailing party receives 40% of any award for punitive damages, and 60% is paid to the Criminal Injuries Compensation Account of the Department of Justice Crime Victims Assistance Section, pursuant to ORS 31.735.

Practice Tip. While the Oregon Supreme Court has not yet established a firm limit on punitive damages in cases involving physical harm, the Oregon Court of Appeals has found a seven to one compensatory to punitive damages ratio constitutionally permissible in a case brought by an injured patient against a physician who prescribed theophylline-based medication and the drugs manufacturer in *Bocci v. Key Pharmaceuticals, Inc.*, 190 Or. App. 407, 79 P.3d 908 (2003).

For information on the due process limitations imposed by the Fourteenth Amendment, see Constitutional Law §778 (LexisNexis Matthew Bender).

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Nicholas L. Dazer is a shareholder in the Portland, Oregon office of Bullivant Houser Bailey PC. He is a trial attorney who focuses much of his practice on multi-state insurance coverage disputes, and representing both plaintiffs and defendants in complex commercial matters. His significant litigation experience includes a wide range of cases involving bad faith, first party coverage, reinsurance, construction defect, arson, business interruption, fraudulent claims, Fair Credit Reporting Act, and complex business litigation. Mr. Dazer has tried a number of jury trials to verdict and has successfully argued in the Oregon Supreme Court. Mr. Dazer's most recent victory was a defense verdict for a national trucking company in a multi-million dollar catastrophic personal injury case. Mr. Dazer serves on the firm's hiring committee, the firm's e-discovery task force, and is past editor of Bullivant Insurance Coverage News.

About Bullivant Houser Bailey PC. Bullivant Houser Bailey PC is a business and litigation law firm with six offices and more than 160 attorneys on the Pacific Rim and West Coast of the U.S. Headquartered in Portland, Oregon, the firm maintains offices in Sacramento and San Francisco, California; Seattle and Vancouver, Washington; and Las Vegas, Nevada. In 2008, Multicultural Law magazine again named Bullivant a Top 100 law firm for workplace diversity. Learn more at www.bullivant.com.

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Mark Vespole on Villa v. Short

2008 Emerging Issues 2571

Mark Vespole on Villa v. Short: Has the New Jersey Supreme Court Swung to a More Insurer-Friendly Judicial Philosophy?

By Mark R. Vespole

July 17, 2008

SUMMARY: By virtue of its decision and opinion in *Villa v. Short*, decided on June 5, 2008, the New Jersey Supreme Court has given insurers reason to believe that the pendulum may be swinging in their favor. In upholding a disclaimer of coverage based upon its rather conservative analysis of the frequently-litigated intentional act exclusion, the Court may have presaged a change in judicial philosophy regarding the interpretation of insurance policies.

PDF LINK: [Click Here for Enhanced PDF of Commentary](#)

ARTICLE: Cite as: Vespole, Mark. *Villa v. Short: Has the New Jersey Supreme Court Swung to a More Insurer-Friendly Judicial Philosophy?* LexisNexis Expert Commentary, (*Insert date you accessed the document online*).

In *Villa v. Short*, 195 N.J. 15 (N.J. 2008), the Court considered whether a homeowner's insurance policy excludes coverage for all insureds if any insured under the policy commits an intentional or criminal act. The insureds, Joseph and Elsie Short, had homeowners' insurance with Allstate. The couple had two children, an older, married daughter and a son, John, who was diagnosed as mildly mentally retarded when he was six years old. John received special education and vocational training which enabled him to obtain employment at a nursing home. John lived with his parents as a young adult and relied upon them to help manage the money he earned.

On various occasions starting in 1983 when John was 21, he began sexually molesting his five-year-old niece. This occurred on family vacations and at the Shorts' home during a span of approximately five years. In 1990, the victim advised her mother of the abuse, which was acknowledged by John. John's parents knew that their son was familiar with sex, because they were with him when he purchased sexually explicit magazines. John's niece alleged that he showed her those magazines.

Just before her 20th birthday, the abused niece filed a complaint against her uncle for sexual molestation and her grandparents for negligent supervision of their son in failing to prevent the sexual assaults. Allstate disclaimed coverage under its homeowners' policies based upon exclusions for intentional or criminal acts. A declaratory judgment lawsuit by the policyholders seeking coverage ensued.

Because the sexual molestation occurred over several years, there were two different policy forms used by Allstate.

The two policy provisions at issue were the intentional act exclusion, which was the same in both policies, and a severability clause, which was different. The intentional act exclusion of the policies provided:

We do not cover any bodily injury or property damage which may reasonably be expected to result from the intentional or criminal acts of an insured person or which is in fact intended by an insured person.

The severability or "Our Limits of Liability" clause of the earlier policies began with the sentence:

This insurance applies separately to each insured person.

The later version of Allstate's policies removed this first sentence from the severability clause and added "joint obligation" language, whereby the acts or omissions of one insured person under the policy are deemed to be binding upon another insured person.

The Appellate Division held there was no coverage because the molester was "an insured person" under the policy, and losses arose from his intentional or criminal acts. The grandparents argued that the policy was ambiguous because the term "an insured" could be interpreted to mean "each" insured, so that coverage should only be denied for the insured committing the intentional act.

Against this backdrop, the Court addressed three principal issues:

1. Whether or not the molester could be charged with intentional conduct in light of his mental disability.
2. Whether or not the intentional acts exclusion clearly excludes coverage for all insureds based upon the intentional acts of one insured.
3. Whether based upon the changes in the severability clauses of the policies, the conduct of each insured [the victims uncle and grandparents] is assessed separately for the purpose of the intentional act exclusion.

Conclusion

1. In cases involving undisputed criminal acts which require proof of intent, intent is usually inferred unless the wrongdoer is incapable of distinguishing between right and wrong because of mental illness or incapacity. *Ruvolo v. American Casualty Co.*, 39 N. J. at 497 (1963). However, in *Villa*, the Appellate Division found and the Supreme Court apparently agreed that, based upon the limited record regarding John's mild mental retardation, it was impossible to determine whether or not his level of reduced mental capacity "would render the [intentional acts] exclusion ineffective." It is entirely possible that the policyholder's counsel knew more about John's mental condition than was found in the record, which may have weighed against the argument that his diminished mental capacity made him incapable of forming the requisite intent, thereby vitiating the exclusion. However, policyholders with a diminished mental capacity seeking coverage for an intentional act which would otherwise be excluded under the terms of the policy would probably be well served by retaining a medical expert to provide an opinion as to whether their mental incapacity impacts the ability to act intentionally. If a policyholder is incapable of acting intentionally, the exclusion will not apply, and there will be coverage.

2. In upholding Allstate's disclaimer of coverage, the Court held that the term "an insured" in the intentional acts exclusion was not ambiguous. In doing so, the Court relied upon a similar interpretation in two Appellate Division cases, *Argent v. Brady*, 386 N. J. Super. at 349-50 (App. Div. 2006) and *J.C. v. N. B.*, 335 N. J. Super. at 506-509 (App. Div. 2000) cert. denied, 168 N. J. 294 (2001). The Court found that while the use of the term "the insured" is inherently ambiguous because "the" is a definite article, the use of the indefinite article "an" clearly equates "an insured" with "any insured. Consequently, if an insured or any insured commits an intentional or criminal act that falls within the exclusion, the exclusion will apply to all insureds under the policy.

Given that the Supreme Court was merely following two well reasoned Appellate Division decisions, which represent the majority position nationwide, perhaps the Court's opinion is not particularly startling to some. However, the Court's opinion was by a 4-2 margin, with Justice Albin, who unequivocally would have sided with the dissent, not participating. Therefore, it is clear that the Court was fairly closely divided on this insurance coverage issue, a conclusion aptly illustrated by Justice Long's cogent dissent.

Justice Long cited to the Court's own opinions in *Auto Lenders Acceptance Corp. v. Gentillini Ford, Inc.*, 181 N. J. at 270 (2004) and *Zacarias v. Allstate In. Co.* 168 N. J. at 595 (2001) for the proposition that if language in an insurance policy is open to more than one interpretation or could have been stated more precisely, the Court should choose the interpretation that comports with the reasonable expectations of the insured. Justice Long points out that both the United States Court of Appeals for the Fifth Circuit and the Kansas Supreme Court have held that the phrase "an insured" in a liability insurance policy is inherently ambiguous. Because the term "an insured" is capable of more than one reasonable interpretation, Justice Long concluded that the plaintiffs insured grandparents plainly had a reasonable expectation that they would be covered for their negligent supervision of their son.

The phrase "an insured" is used in numerous provisions of a typical commercial general liability insurance policy. Based upon the majority opinion of Court that "an insured" essentially means "any insured", that interpretation could be controlling whenever the policy refers to "an insured".

3. The policyholders argued that notwithstanding the interpretation of "an insured", that phrase nonetheless became ambiguous when read in conjunction with the first sentence of the severability clause of the earlier policy form. The Court's analysis of the severability clause begins by pointing out that it is situated in a different part of the policy than the coverages and exclusions. Even though the severability clause starts with the premise that the insurance applies separately to each insured, the Court held that the first sentence must be interpreted in the context of the entire clause. Because the remainder of the severability clause deals with limits of liability, the Court interpreted the first sentence to mean simply that each insured is entitled to coverage up to the limits of the policy. The Court further held that the severability clause did not in any way impact the "unambiguous exclusion for intentional or criminal acts of an insured."

In her dissent, Justice Long interpreted the severability clause to mean that each insured under the policy is entitled to his own separate coverage determination. Justice Long viewed Allstate's removal of the "separation" language and addition of the joint obligations language in its later policies as a tacit acknowledgment that earlier policy was ambiguous.

It will probably take a few more insurance coverage opinions from the New Jersey Supreme Court to determine whether this subtle shift in judicial philosophy is simply a one or two case aberration or the beginning of a trend. Stay tuned.

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Wiley Rein LLP on New York Insurance Late Notice Legislation

2008 Emerging Issues 2533

Wiley Rein LLP on New Yorks Longstanding Late Notice Insurance Law Facing Imminent Change

By Laura A. Foggan and Benjamin Theisman

July 16, 2008

SUMMARY: New York's longstanding "no prejudice" rule, strictly enforcing the notice conditions of liability policies, faces a major change. The New York legislature has sent a bill to the Governor that would modify New York's late notice law.

PDF LINK: [Click Here for Enhanced PDF of Commentary](#)

ARTICLE: On Wednesday, July 23, 2008, New York Governor David A. Paterson signed legislation changing New Yorks longstanding no prejudice rule, which for decades has strictly enforced the notice conditions of liability policies. The law takes effect in 180 days and will govern policies issued or delivered in New York, and any action maintained under such a policy, after its effective date. By amending NY CLS Ins § 3420, the new law will prohibit a liability insurer from denying coverage based on the policyholders failure to provide timely notice unless the insurer has been prejudiced by the late notice. Additionally, under certain conditions, the law will permit claimants in suits arising out of death or personal injury to maintain an action directly against an insurer in which the sole question is the insurers disclaimer or denial based on the failure to provide timely notice.

New Yorks consistent adherence to the no prejudice rule has been targeted by policyholders and claimants alike, in an effort to expand the available coverage and circumvent one of the strongest coverage defenses available to insurers in New York. This is the second time in the last two years that the New York legislature has sought to change New Yorks late notice jurisprudence and permit certain direct actions by claimants against insurers. Moreover, for many years, policyholder advocates have fought strenuously (although unsuccessfully) to overturn the no prejudice rule in the courts.

Recognizing that insurance policies are contracts that must be applied according to their plain language, New York courts historically applied liability policies plain and unambiguous notice provisions. Indeed, New York courts found that notice provisions are matters of vital concern and allow an insurer to protect the interests of the policyholder and the public, as well as itself. *Unigard Sec. Ins. Co., Inc. v. North River Ins. Co.*, 79 N.Y.2d at 583 (1992). Longstanding New York law has, with minor exceptions, applied notice requirements in liability policies without reference to a prejudice doctrine. This result was confirmed by the New York Court of Appeals as recently as 2005:

A liability insurer, which has a duty to indemnify and often also to defend, requires timely notice of lawsuit in order

to be able to take an active, early role in the litigation process and in any settlement discussions and to set adequate reserves. Late notice of lawsuit in the liability insurance context is so likely to be prejudicial to these concerns as to justify the application of the no prejudice rule.

Argo Corp. v. Greater New York Mutual Insurance Co., 4 N.Y.3d at 340 (2005).

Similarly, for decades New York courts have refused to allow a claimant to pursue an insurer prior to obtaining a judgment against the policyholder. See *Coster v. Coster*, 289 N.Y. at 443 (1943) (Under our law, the mere fact that the defendant was to be indemnified for damages awarded against him for accidental injury to a person establishes no right of action in favor of the latter.); *McKenzie v. N.J. Transit Rail Operations, Inc.*, 772 F. Supp. at 149 (S.D.N.Y. 1991) (New York law bars suit by a stranger to an insurance contract who has not secured a judgment against the insured).

This settled precedent is altered under the new law, which passed the legislature quickly at the end of the legislative session, being introduced on June 18, 2008 and passed on June 23, 2008. The law does contain some limitations. It will have prospective effect only, providing explicitly that it shall take effect on the one hundred eightieth day after it shall have become a law, and shall apply to policies issued or delivered in this state on or after such date and to any action maintained under such a policy. Additionally, the law only applies to insurance policies providing coverage against liability for injury to person . . . or against liability for injury to, or destruction of, property. . . . Further, the law does not change New York law with respect to notice under claims-made policies, specifying that these policies can require that a claim be made during the policy period or any extended reporting period.

Where it is applicable, the law signals a sea change in the approach to late notice under New York law. Under the provisions of the law, under newly-issued policies, a liability insurer cannot deny coverage for late notice unless the failure to provide timely notice has prejudiced the insurer. . . . The law further states that the insurers rights shall not be deemed prejudiced unless the late notice materially impairs the ability of the insurer to investigate or defend the claim. Moreover, if notice is less than two years late, the insurer will bear the burden of establishing prejudice. Only if notice is more than two years late will the policyholder bear the burden of showing the absence of prejudice, such prejudice being presumed. However, an irrebuttable presumption of prejudice applies if, prior to notice, the insureds liability has been determined by a court ruling or arbitration or if the insured resolved the claim by settlement or compromise.

As to the direct action right, the law specifies that with respect to a claim arising out of death or bodily injury . . . if the insurer disclaims liability or denies coverage based upon the failure to provide timely notice, then the injured person or other claimant may maintain an action directly against such insurer, in which the sole question is the insurers disclaimer or denial based on the failure to provide timely notice. . . . The law does provide that no such cause of action is permitted if the insurer or policyholder initiates a declaratory judgment action naming the injured person or claimant as a party within 60 days following a disclaimer based on late notice. The purpose of the new direct action provision is to allow a claimant to determine whether coverage may be available for a personal injury or wrongful death suit before pursuing what may be protracted litigation against the insured to establish liability and damages. As noted, prior New York law allowed a direct action against the insurer only if a claimant obtained a judgment against the policyholder which remained unsatisfied after 30 days.

A further provision in the law creates a process under which, upon written request with sufficient identifying information from a claimant, an insurer must within 60 days confirm whether the policyholder had a liability policy in effect on the date of the alleged occurrence and specify the limits of liability under any such policy. This provision appears to be geared toward enabling a claimant to determine whether there is a basis for a coverage claim and direct action against the insurer.

Proponents of the new law argued that New York has been in the minority of the states in requiring no showing of prejudice for an insurer to deny coverage based on late notice and that this permitted insurers to deny coverage based on what they deemed an inconsequential technicality while collecting billions of dollars annually in premiums. However, insurance policy provisions that require policyholders to provide timely notice both of any lawsuit and initial notice of

the occurrence or accident upon which the suit is based are fundamental to the efficient and predictable administration of insurance contracts. Prompt notice provides the insurer with an opportunity to investigate both coverage and the accident to prepare for potential claims, set up a defense where appropriate, engage in early settlement negotiations, to set appropriate premiums and establish adequate reserves, which benefits accrue to the policyholder and the insurer alike.

Both the insurer and the insured have an interest in an early investigation before memories fade and conditions change, and/or evidence is lost. It is imperative that an insurer is provided with notice while evidence is still available in order for the insurer to investigate both coverage and the accident to prepare for potential claims, set up a defense where appropriate, and detect and prevent potential fraud. Prompt notice of a claim also facilitates the opportunity to settle a claim early, which may limit the insurer's exposure and may protect the insured from a judgment in excess of the policy coverage.

In addition to prompt notice of the "occurrence" or claim, notice of suit is critical because it informs the insurance carrier of the existence of an actual court proceeding. The existence of a suit increases the probability of exposure for the insurer and may prompt further scrutiny and investigation. Until a complaint is actually filed, an insurer will not be able to know the identity of all of the plaintiffs or whether there will be any other defendants, nor to know the causes of action being pursued or the amount of alleged damages. All of this information is critical for assessing the strength of the case against the policyholder, the potential exposure for the insurer and even whether or not coverage is available under the policy. Moreover, under New York and many other states law, an insurer's duty to defend generally arises when the allegations in a complaint state a cause of action that gives rise to the reasonable possibility of recovery under the policy. An insurer can only make an informed decision regarding whether the four corners of the complaint potentially give rise to a covered claim if it is able to review the complaint. In order to do so, the insurer must receive timely notice of the complaint from its insured.

The New York law will remove incentives for policyholders to provide prompt notice, thereby undermining the important goals served by strict enforcement of notice requirements. Further, there is the inherent difficulty in proving prejudice from late notice. It is hard to show what the outcome would have been had timely notice been given or the extent to which proper notice would have had an impact on the insurer from whom coverage is sought. It is, for instance, difficult or impossible to prove the prejudice from not locating a witness who could have been found if timely notice were given. Similarly, it is difficult to prove how much lower a settlement might have been if the insurer had been able to negotiate a settlement immediately after the case was filed. Although this uncertainty is the result of the failure of the insured to meet notice requirements, the New York law places the burden of proving prejudice on the insurer if notice is given within two years of the time required under the policy. This allocation of the burden of proof undercuts important policy considerations underlying notice requirements in liability insurance policies.

Although New York has now altered its late notice law, a number of jurisdictions throughout the United States continue to adhere to the well-established "no prejudice" rule and enforce notice provisions without requiring prejudice to be shown. E.g., *State Farm Fire & Casualty Co. v. Walton*, 244 Va. 498, 423 S.E.2d 188, 191 (1992); *Greycoat Hanover F St. Ltd. P'ship v. Liberty Mut. Ins. Co.*, 657 A.2d 764 (D.C. 1995); *Haston v. Transamerica Ins. Servs.*, 662 So. 2d 1138 (Ala. 1995); *Granite State Ins. Co. v. Nord Bitumi U.S., Inc.*, 262 Ga. 502, 422 S.E.2d 191 (1992); *Las Vegas Star Taxi, Inc. v. St. Paul Fire & Marine Ins. Co.*, 102 Nev. 11, 714 P.2d 562 (1986). It will be interesting to monitor the effect of the proposed changes in New York law, as well as the case law giving further definition to the meaning of prejudice affecting the ability of the insurer to investigate or defend the claim. This law signals a significant shift in how notice requirements will be applied to future liability policies issued or delivered in New York.

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Leventhal on Nat. Council on Compensation Ins. v. American International Group

2008 Emerging Issues 2526

Leventhal on National Council on Compensation Insurance, Inc. v. American International Group, Inc.: The Discovery Obligations of Reinsurance Pool Participants When Is A Non-Party Treated Like A Party

By Robert C. Levanthal

July 14, 2008

SUMMARY: A recent federal trial court decision required a reinsurance pool and its attorney in fact to produce documents that were in the possession of approximately 500 pool members in response to a FRCP Rule 34(a) request for production of documents. If other courts adopt this rationale, it would place an immense obligation on reinsurance pools and their attorneys to insure the preservation and production of documents that are not in their possession.

PDF LINK: [Click Here for Enhanced PDF of Commentary](#)

ARTICLE: Cite as: Leventhal, Robert C. *Compensation Insurance, Inc. v. American International Group, Inc.*: The Discovery Obligations of Reinsurance Pool Participants When Is A Non-Party Treated Like A Party. LexisNexis Expert Commentary, (*Insert date you accessed the document online*).

In *National Council On Compensation Insurance, Inc. v. American International Group, Inc.*, 2007 U.S. Dist. LEXIS 91518 (N.D. Ill. Dec. 11, 2007), the National Council on Compensation Insurance Inc., (NCCI) acting solely as the attorney in fact for the National Workers Compensation Insurance Pool (NWCIP), sued pool member American International Group (AIG) alleging that AIG engaged in a fraudulent scheme to avoid its proportional share of pool obligations. AIG served a Rule 34(a) request for production of documents on NCCI seeking documents in the possession of NCCI, NWCIP, and each of the approximately 500 pool members. NCCI claimed that it should only have to produce documents in its own possession because it was the only named plaintiff. The court rejected this argument and held that NWCIP was the real party in the case because NCCI was suing solely as its attorney in fact.

The court acknowledged that the individual pool members were not parties to the case and could not be required to respond to discovery procedures that were only applicable to parties. n1 However, the court went on to hold that NCCI and NWCIP had control over documents in the possession of each of the pool members and were required to preserve and produce relevant documents that were in each pool members possession (including electronic files). Thus, the court concluded that while AIG could not serve Rule 34(a) document requests on individual pool members, it could obtain documents in the possession of pool members merely by serving the Rule 34(a) requests on NCCI and NWCIP. Further, the court held that NCCI and NWCIP were required to include information in the possession of each pool member when responding to interrogatories and requests for production of documents. (*Id.* at 24 -25.)

The court based its decision primarily on a provision of the pools Articles of Agreement which provided in relevant part that [u]pon direction of the Board of Governors, the Administrator is empowered to act as attorney in fact for each participating company to prosecute, to defend, to submit to arbitration, to settle, and to propose or accept a compromise with respect to any claim existing in favor of, or against, such participating company based on or involving any matter relating to this Agreement or to intervene in any action or proceeding related thereto. (Id. at 11 12.) The court reasoned that [b]y authorizing this litigation on behalf of the participating members of the pool, the Board of Governors has exhibited that it has practical and managerial control over the pool [and that] the control necessarily extends to obtaining from the participating members documents relevant to the litigation. (Id. at 12.)

In reaching its decision, the court also relied on its determination that the pool appears to be in substance an unincorporated association. Although there are not many cases addressing the discovery obligations of members of unincorporated associations, there is at least one case that can be interpreted as holding that an association is not obligated to produce documents and information in the possession of each of its members and which therefore could support an argument that *NCCI* was wrongly decided.

In *University of Texas v. Vratil*, 96 F.3d 1337, 1996 U.S. App. LEXIS 24451, 1996-2 Trade Cas. (CCH) P71,573, 35 Fed. R. Serv. 3d (Callaghan) 1527, the Tenth Circuit issued a writ overturning a district court opinion that held that members of an unincorporated association are real parties in interest and are required to respond to the opposing parties interrogatories and sanctioned them for failing to respond. The Tenth Circuit rejected this holding and stated where [a] party is an association, Rule 33(a) allows it to select an officer or agent to respond on its behalf. 96 F. 3d at 1340. The court made no mention of any obligation that the association had to provide all responsive information that was in the possession of its members and the decision therefore appears to imply that no such obligation exists. See also Moores Federal Practice Civil 33.20 at n. 48; Manual for Complex Litigation (Fourth) at § 33.20, n. 48.

In any event, given the paucity of cases addressing the discovery obligations of reinsurance pool members (and the fact that many disputes involving reinsurance pools are addressed in confidential arbitrations) it is difficult to determine whether the reasoning of *NCCI* is likely to be adopted by other courts (or arbitration panels). However, the *NCCI* decision is important because it creates serious potential pitfalls for lawyers representing reinsurance pools. n2

For example, the *NCCI* court held that the Pool is responsible for ensuring that relevant information held by the participating companies is preserved and produced as required. (Id. at 24 25, n. 3, emphasis added.) Failure to preserve discoverable information within the possession of a pool member could give rise to serious discovery sanctions against the pool. In order to meet this obligation, counsel would have to make sure that each of the approximately 500 pool members took appropriate steps to preserve potentially discoverable information (including electronically stored information) and to search for, and produce, requested documents. (For a discussion of electronic document preservation requirements see, Moores Federal Practice, Civil §§ 37A.10.)

Further, Pool members would likely have to be consulted when framing answers to interrogatories and requests for admission, because information that is within their possession would be considered to be within the control of the Pool. Given the potential scope of these obligations, counsel for a pool should communicate with Pool members prior to filing suit and should inform them of their potential discovery obligations and put in place necessary procedures to ensure that potentially discoverable information is preserved.

There are also steps that counsel can take to minimize the scope of potential discovery of pool members. A complaint that raises issues about the knowledge of pool members is more likely to lead to broad discovery against pool members than a complaint that raises no such issues. Allegations that each pool member was defrauded may put the mental state of each pool member directly at issue, thereby increasing the potential scope of discovery. Narrower allegations could result in more limited discovery of pool members.

There are also steps that can be taken when drafting pool agreements that can assist in dealing with potential discovery issues. For example, pool agreements often include arbitration clauses requiring disputes between the pool and its members to be resolved by way of binding arbitration. Arbitration panels are likely to limit discovery more than a court would, and provide greater protection of confidential information. The arbitration clause can expressly limit the scope of discovery available, provided that it does so in a way that is compatible with due process requirements. n3 See, *Schacht v. Hartford Fire Ins. Co.*, 1991 US Dist. Lexis 16430 [*12].

Finally, a pool agreement could be drafted to specifically address each pool members obligation to cooperate with the pools counsel in the event of litigation and could require pool members to preserve information for use in litigation. The problem with such language is that it almost certainly would be used against the pool in determining the scope of information that the pool is required to produce in discovery. A party seeking discovery would undoubtedly argue that such contractual provisions demonstrate that the pool has control over all information in each pool members possession and would make it difficult for the pool to convince a court that it should define the scope of discovery against the pool more narrowly.

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n1 . The court held that pool members who served on NWCIPs Board of Governors were NWCIPs managing agent and could be served with notices of deposition under Rule 30, without the need for a Rule 45 subpoena.

n2 . It is good practice to attempt to raise and resolve the scope of discovery that may be had against the pool at the early stages on any litigation or arbitration to which a pool is a party.

n3 . It is a common practice to include arbitration clauses in reinsurance agreements between pools and their reinsureds.

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California Healthcare Reform Continues: Legislation in 2008

2008 Emerging Issues 434

Harbage, Haycock and Odeh on California Healthcare Reform: Legislation in 2008

By Peter Harbage, Hilary Haycock and Michael Odeh

July 12, 2008

SUMMARY: With comprehensive healthcare reform failing a key legislative vote in January 2008 [see *2008 Emerging Issues 199*], California policymakers are now energized to achieve specific healthcare reform goals in 2008, despite also struggling with a significant state budget deficit. In this commentary, Peter Harbage and colleagues identify and discuss the major healthcare reform bills currently moving through the California Legislature as of this writing in July 2008, including what they provide, the support and opposition they have garnered, and their projected fiscal impact.

PDF LINK: [Click Here for Enhanced PDF of Commentary](#)

ARTICLE: Harbage, Haycock and Odeh on California Healthcare Reform Continues: Legislation in 2008

INTRODUCTION

California policymakers spent much of 2007 debating comprehensive healthcare reform, engaging and energizing a variety of stakeholders across the state [see *2008 Emerging Issues 199*]. Despite strong support for reform from Republican Governor Arnold Schwarzenegger, many Democratic legislators, and key stakeholders, comprehensive healthcare reform ultimately did not pass the legislature.

However, healthcare reform has remained a priority for legislators and the governor alike. Several reform concepts have been resurrected from the ashes of last years debate and introduced as bills in the current session by a number of state legislators in hopes of achieving specific reform goals.

Many of the bills are aimed at strengthening regulation of the individual health insurance market, where insurer actions have been so egregious that both sides of the aisle are getting fed up with them, according to California State Senator Sheila Kuehl. n1 In fact, many pieces of legislation are receiving support from Republicans despite the opposition of their otherwise long-time allies in the insurance industry.

However, with a \$15 billion state budget shortfall, these efforts have been complicated by significant efforts to

reduce state spending, especially spending on healthcare. Even with bipartisan support, legislation with *any* associated state fiscal costs faces this added challenge of an extremely tight state budget. Thus, much of the reform legislation that is achieving success shifts costs not onto government, but onto insurance companies, healthcare providers and, most likely, consumers.

The Governors Office has begun public discussions around a two-year approach for achieving healthcare reform, building on the policy compromises achieved in 2007. The first year focuses on budget-neutral reforms to lay the groundwork for comprehensive reform. Reforms to expand coverage and which require financing must wait until 2009, when the state hopes to have a stronger budget outlook.

The Legislature is already considering a number of piecemeal reform proposals, including many which address the governors year one goals. This commentary consists of an analysis of the legislation currently under debate that fall into the three broad categories the governor has laid out as a priority this year:

- . Consumer Protections;
- . Cost Containment; and
- . Prevention.

ANALYSIS

California legislators have introduced a broad range of healthcare reform legislation in the 2008 session. Our analysis is limited to those bills which generally align with the priorities being discussed by Governor Schwarzeneggers office, such as being budget neutral to the state. Thus, legislation such as the reintroduced SB 840, Senator Kuehls single-payer universal coverage bill, and other efforts to expand coverage that require significant new state funding are not included.

Thus far in the 2008 Session, Democratic lawmakers have provided most leadership in authoring bills, but in many cases have been able to build bipartisan support even in the face of business and industry opposition. Many of these bills are likely to undergo amendment in the coming months as the Governors office releases specific legislative proposals and reaches out to legislators to build compromises.

Descriptions below are based on the most recent bill information and relevant analyses from Legislative Committees unless otherwise noted. n2

Consumer Protection Reforms. Much of the health reform legislation has been focused on protecting consumers in purchasing and using health insurance. These protections fall into three categories:

- Protecting consumers in the purchase of coverage;
- Protecting consumers against rescission; and
- Protecting consumers through benefits packages.

While many of these bills track the governors first-year vision for reform, a number of them go further to regulate the insurance market than the governor has indicated that he might be comfortable allowing. See Appendix A below for a list of these bills, their status as of this writing in July 2008 and their fiscal impact.

Protecting consumers in the purchase of coverage. Legislation that addresses the consumer purchase of health insurance coverage has done so through regulation of and standards for insurance companies. As such, these bills are generally supported by consumer groups but opposed by insurers.

- **SB 1522** (Steinberg, D) would help consumers better understand and shop for insurance on the individual market by

requiring the Department of Managed Health Care and the Department of Insurance to develop a system that places individual insurance plans into five categories based on costs and benefits. Health insurers offering a plan in one category would be required to offer plans in all categories. In addition, this bill would impose a limit on maximum out-of-pocket costs for consumers and create a standard benefit package for individual plans.

This bill is supported by many consumer, advocacy, medical and labor groups, but is opposed by most insurers who argue that this approach will eliminate affordable coverage options on the individual market by destroying their flexibility in benefit design. All Republican senators voted against this bill and it only passed the Senate based on the Democratic majority. This approach is similar to a proposal from Governor Schwarzenegger to create five tiers of health insurance options, but goes further than the governors proposal by limiting costs for consumers. n3

- **AB 1554** (Jones, D) would allow the state to regulate the rates insurers can charge. Under this bill, insurance plans are required to justify rate increases and obtain approval from the appropriate state regulatory agency. The bill is supported by many labor and consumer groups for attempting to address the growing cost of coverage, however the bill is strongly opposed by most health insurers as well as the California Medical and Hospital Associations based on their stated concerns about creating a new bureaucratic and regulatory structure that may inhibit innovation in the marketplace.

Protecting consumers against rescission. State-led investigations, and related media coverage, have drawn attention to insurer practices of unfairly dropping policyholders coverage, including via rescissions. n4 A rescission occurs when a policyholder is retroactively denied coverage, usually after a policyholder has submitted a claim for care. Rescissions are often based on research the insurance company conducts on policyholders medical records to find preexisting conditions or technical errors on insurance applications. The following legislative proposals reflect how high a priority this issue is for both Democrats and Republicans.

- **AB 1945** (De La Torre, D) would require state approval for health plan rescissions of an insured individual, and establish a third-party review panel. It would also create a standardized insurance application for consumers in the individual market. This bill is supported by a diverse set of medical, consumer, and labor groups. However, concerns have been raised primarily by attorney groups that this bill will limit the legal recourse patients have against health plans by relying on the review panel. Twelve of the 32 Republican members of the Assembly joined Democrats to pass the bill. Governor Schwarzenegger has expressed a desire to protect consumers who did not intentionally mislead their insurer on their application from rescissions. n5

- **AB 1150** (Lieu, D) would prohibit insurance companies from offering employees financial incentives, including bonuses, for rescinding policies or denying claims. Consumer, labor, and healthcare provider organizations including the California Medical Association have all come out in support. The California Association of Health Plans has the bill on their list of legislation to watch. n6 This bill passed out of the Assembly with overwhelming bipartisan support, and has received unanimous approval from the Senate Health Committee. Governor Schwarzenegger has also endorsed this concept.

- **SB 1168** (Runner, R), one of the only health bills to be introduced by a Republican, would prohibit insurers that cover dependent children who are full-time secondary or post-secondary students from dropping coverage if the dependent takes a medical leave of absence from school. This bill would have negligible state costs and passed the Senate without opposition. In fact, this bill has received support from insurers and underwriters (including Americas Health Insurance Plans), medical associations, consumer advocacy groups, and professional associations, and has faced

no opponents.

■ **SB 1525** (Kuehl, D) would require insurers to report their process for determining medical necessity, report the number of claim denials based on medical necessity, and report the medical qualifications of the individuals who make those decisions. This was passed out of the Senate with bipartisan support despite opposition by the insurance industry. The legislation had the support of provider organizations, including the California Medical Association and California Nurses Association, as well as consumer groups. Opponents argued the bill duplicated regulations and would unnecessarily raise administrative costs for insurers.

Protecting consumers through benefits packages. The governor has indicated he would consider legislation that would require insurers to either cover or offer coverage of certain services for policyholders. However, many of these benefit mandates are likely to increase policy costs for individuals and families, as well as significantly increase state costs for Medi-Cal (Californias Medicaid program) and CalPERS (the California Public Employees Retirement System), which may trigger opposition from the governor. Higher program costs and general opposition to market mandates could lead to opposition from Republican legislators. Reforms which require insurers to offer additional coverage for specific services for an additional charge, including SB 1198 below, have been more successful in building bipartisan support.

■ **AB 1887** (Beall, D) would require insurance plans to cover any disorder identified in the *Diagnostic and Statistical Manual of Mental Disorders IV*, however Medi-Cal and CalPERS plans are exempt. There would be some state costs associated with this bill, which is supported by medical, advocacy, and labor groups, but strongly opposed by insurance and some business groups.

■ **AB 1962** (De La Torre, D) would require most private insurance plans to cover specified maternity benefits. This bill has a wide variety of supporters and no state cost, but the California Association of Health Underwriters, Anthem Blue Cross, and the Association of California Life and Health Insurance Companies have opposed the bill claiming adverse effects on competition and decreased consumer choice.

■ **SB 1198** (Kuehl, D) would require private group insurance plans to offer policyholders the option to purchase additional coverage for durable medical equipment with annual and lifetime benefit maximums, and maximum out-of-pocket costs. This bill passed out of the Senate with support from both Democrats and Republicans despite opposition from insurers and health plans.

■ **SB 1634** (Steinberg, D) would require insurance plans to cover services that are medically necessary for the treatment of cleft palate. This bill is supported by dental and plastic surgeon groups but opposed by insurance and business groups. Despite industry opposition, this measure passed the Senate with significant Republican support, including a Republican co-author, and with 12 out of the 15 Republican Senators voting for it.

■ **AB 1894** (Krekorian, D) would require insurance plans to cover HIV antibodies and AIDS tests, regardless of whether the testing is related to a primary diagnosis. This bill is opposed by insurers and business groups, but supported by the Center for AIDS Research, Education and Services, as well as the California Medical Association.

■ **AB 1774** (Lieber, D) would require insurance plans to cover screening procedures for gynecological cancers when ordered by physicians and consistent with national guidelines; and **AB 2234** (Portantino, D) would require insurance

plans to cover screening and testing procedures to diagnose breast cancer, consistent with national guidelines. Both bills are estimated to have significant state costs for compliance in Medi-Cal and CalPERS plans.

Cost Containment Reforms. The governors recent reform outline calls for an expanded approach to cost containment, including increasing the use of health information technology, increasing the use of low-cost healthcare providers such as retail clinics, and improving the Workers Compensations system. The cost containment reforms proposed thus far in the 2008 session can be grouped into three categories: insurance regulation, increasing transparency, and provider oversight. See Appendix B below for a list of these bills, their status as of July 2008 and their fiscal impact.

Cost containment through insurance regulation. It has been estimated by some that 30 percent of premium dollars on the individual market go to administrative costs and profits for insurance companies. n7 A key part of 2008 reform efforts has been an effort to revive legislation which would limit this profit margin for insurers.

- **SB 1440** (Kuehl, D) would require healthcare plans and health insurers to spend at least 85 percent of premiums on healthcare benefits, or, in other words, cap insurance company profits at 15 percent. Medical, advocacy, and labor groups argue this bill is necessary to refocus healthcare spending and control spiraling healthcare costs. Healthcare plans disagree with the measures identified in the legislation and argue that administrative costs are a misleading indicator.

Cost containment through transparency. Improving transparency in cost and quality has been shown to both prompt underperforming providers to improve, and allow healthcare payers to reward or encourage high performance. n8 Provider groups have opposed such legislation, arguing that the new data collection and reporting requirements will be burdensome for them and may undercut competition.

- **AB 2967** (Lieber, D) would establish the development of a statewide healthcare cost and quality transparency plan designed to provide public reporting of healthcare safety, quality, and cost information. While this bill would not immediately change current provider reporting requirements, this bill has received fierce opposition from provider groups but strong support from consumer and labor groups. Governor Schwarzenegger has indicated his support for this legislation. n9

- **SB 1300** (Corbett, D) would prohibit confidentiality clauses between healthcare plans and providers that restrict the ability of healthcare plans to supply information on the cost of procedures to plan enrollees. This bill is opposed by insurers and providers but supported by consumer groups.

Cost containment through provider oversight. Legislators have also attempted to contain costs through greater oversight of provider practices that create inefficiencies in the healthcare system.

- **AB 2146** (Feuer, D) would restrict providers from billing patients or public health coverage programs, Medi-Cal and Healthy Families (Californias State Childrens Health Insurance Program), for never events medical errors that should never occur, such as hospital-acquired conditions. This will both save the state money, and encourage overall system savings by preventing medical errors. The legislation passed out of the Assembly mostly along party lines. The bill was opposed by provider organizations, including the California Medical Association and other specialty groups. It is supported by consumer organizations such as Health Access, Insure the Uninsured Project, and AARP, as well as SEIU. Governor Schwarzenegger has called for stricter reimbursement policies for never events, although his exact position on this bill has not been announced. n10

■ **AB 2942** (Ma, D) would standardize the community benefit requirements that non-profit hospitals must meet to maintain their tax-free status. This could lower costs by encouraging hospitals to promote public health and disease prevention, as well as by strengthening the safety net. The bill has the support of labor unions and consumer groups, and is opposed by the California Hospital Association and individual hospitals and hospital systems. The bill was passed out of the Assembly, largely along party lines.

Prevention Reforms. Prevention has long been a central focus of the governors healthcare reform plan, and the issue gained traction over the course of the debate in 2007. Given the long-term nature of a prevention strategy, it is not central to the current reform debate in the Legislature, but activity will likely increase as the governor renews focus.

CONCLUSION

Throughout 2008, California lawmakers have been finding bipartisan support for slices of the failed comprehensive reform plan. Given the significant state budget shortfall, however, policymakers have been unable to focus key reform concepts, such as expanding coverage. Instead, policymakers have introduced legislation to protect consumers and to contain costs. Many of these efforts would result in increased regulation, transparency, and oversight of the insurance market. Despite strong political support for many of these bills, however, those reforms with significant state costs face the additional challenge of securing financing during tight fiscal times.

Adding to the activity in the Legislature and restating its commitment to healthcare reform, the Schwarzenegger Administration is gearing up to release a detailed two-year plan. The governors plan aims to achieve healthcare reform by first building on the legislative efforts to create a solid foundation for comprehensive reform before embarking on a major coverage expansion and financing overhaul. Given this strong leadership from Governor Schwarzenegger, California continues to have the opportunity to achieve healthcare reform through the bills described in this commentary, which could help build momentum for additional efforts.

Appendix A: Consumer Protection Legislation

Protecting Consumers in the Purchase of Coverage

Bill Number

Short Description

Introduced

Status

Fiscal Impact

SB 1522

Changes rules governing individual insurance market by creating categories and minimum standards

Steinberg (D) on 2/22/2008

Passed Senate (22 to 16) on 5/27/08; re-referred to Assembly Committee on Appropriations on 6/18/08

\$500,000 in 2008-09 in administrative costs

AB 1554

Requires insurers to obtain approval from state for rate increases

Jones (D) on 2/23/07

Passed Assembly (42 to 33) on 6/7/07; re-referred to Senate Committee on Health on 6/18/08

Annual special fund costs of more than \$10 million

Protecting Consumers Against the Loss of Coverage

Bill Number

Short Description

Introduced

Status

Fiscal Impact

AB 1945

Requires review and approval of insurance rescissions

De La Torre (D) on 2/13/08

Passed Assembly (59 to 16) on 5/27/08; re-referred to Senate Committee on the Appropriations on 7/2/08

One-time fee-supported special fund cost of \$150,000 and annual fee-supported special fund costs of \$400,000

AB 1150

Prohibits insurers from setting goals, quotas, or compensation based on rescissions or cancellations

Lieu (D) on 2/23/07

Passed Assembly (76 to 0) on 1/29/08 and Senate (36 to 0) on 7/3/08

Negligible state costs

SB 1168

Prohibits insurers from dropping dependent coverage if student takes medical leave of absence from school

Runner (R) on 2/7/08

Passed Senate (38 to 0) on 4/23/08; sent to Assembly Consent Calendar on 6/23/08

Negligible state costs

SB 1525

Requires insurers to report their process for determining medical necessity

Kuehl (D) on 2/22/08

Passed Senate (26 to 9) on 5/12/08; re-referred to Assembly Committee on Appropriations on 6/18/08

Approximately \$60,000 in 2008-09

Protecting Consumers in Benefits Packages

Bill Number

Short Description

Introduced

Status

Fiscal Impact

AB 1887

Requires insurers to provide parity for coverage of mental health benefits

Beall (D) on 2/7/08

Passed Assembly (46 to 30) on 5/27/08; re-referred to Senate Committee on Appropriations on 6/25/08

Annual costs to Healthy Families and Medi-Cal of \$160,000, 33% to 50% from the General Fund

AB 1962

Requires private health insurance plans to cover specified maternity benefits

De La Torre (D) on 2/13/08

Passed Assembly (44 to 31) on 5/27/08; re-referred to Senate Committee on Appropriations on 6/19/08

No direct state impact

SB 1198

Requires private group plans to offer parity for coverage of durable medical equipment

Kuehl (D) on 2/13/08

Passed Senate (27 to 8) on 5/12/08; re-referred to Assembly Committee on Appropriations on 6/25/08

Unknown

SB 1634

Requires insurance plans to cover medically necessary services for treatment of cleft palate

Steinberg (D) on 2/22/08

Passed Senate (37 to 2) on 5/22/08; referred to Assembly Committee on Appropriations on 6/25/08

Approximately \$41,000 in state expenditures for CalPERS members who are state employees

AB 1894

Requires insurance plans to cover HIV and AIDS testing

Krekorian (D) on 2/7/08

Passed Assembly (47 to 28) on 5/27/08; re-referred to Senate Committee on Appropriations on 6/24/08

Negligible costs to CalPERS for compliance

AB 1774

Requires insurance plans to cover screening of gynecological cancers

Lieber (D) on 1/14/08

Held under submission in Assembly Committee on Appropriations on 5/22/08

Annual increased costs of \$39 million (50% from General Fund) to the Medi-Cal program and \$27 million from General Fund to CalPERS

AB 2234

Requires insurance plans to cover screening procedures to diagnose breast cancer

Portantino (D) on 2/20/08

Held under submission in Assembly Committee on Appropriations on 5/22/08

Annual increased costs of \$22 million (50% from General Fund) to the Medi-Cal program and \$3.8 million from General Fund to CalPERS

Appendix B: Cost Containment Legislation

Cost Containment Through Insurance Regulation

Bill Number

Short Description

Introduced

Status

Fiscal Impact

SB 1440

Require insurers to spend at least 85% of premiums on benefits, not administrative costs

Kuehl (D) on 2/21/08

Passed Senate (22 to 16) on 5/27/08; re-referred to Assembly Committee on Appropriations on 7/1/08

\$233,000 in 2008-09

Cost Containment Through Transparency

Bill Number

Short Description

Introduced

Status

Fiscal Impact

AB 2967

Establishes a transparency plan to provide public reporting of

health care safety, quality, and cost information

Lieber (D) on 2/22/08

Passed Assembly (41 to 32) on 5/27/08; re-referred to Senate Committee on Appropriations on 6/25/08

One-time, fee-supported special fund costs of \$300,000 and annual fee-supported special fund costs of \$500,000 to \$1 million

SB 1300

Prohibits cost confidentiality clauses between health plans and providers

Corbett (D) on 2/20/08

Passed Senate (22 to 12) on 5/15/08; re-referred to Assembly Committee on Appropriations on 6/26/08

Negligible state costs

Cost Containment Through Provider Oversight

Bill Number

Short Description

Introduced

Status

Fiscal Impact

AB 2146

Restrict providers from billing patients or public insurers for never events.

Feuer (D) on 2/20/08

Passed Assembly (48 to 29) on 5/28/08; re-referred to Senate Committee on Appropriations on 7/2/08

One-time General Fund cost of \$900,000

AB 2942

Revises hospital requirements for community needs assessments and community benefit plans

Ma (D) on 2/22/08

Passed Assembly (43 to 35) on 5/28/08; re-referred to Senate Committee on Appropriations on 6/26/08

Annual start-up costs of \$2 million for public hospitals and annual fee-supported special fund costs of \$900,000 through 2010-11

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n1 [i] Jordan Rau, *California legislators revive plans to expand healthcare insurance*, Los Angeles Times, June 3, 2008.

n2 [ii] All bills under consideration by the California Legislature are accompanied by a formal staff analysis. These are available at <http://www.leginfo.ca.gov/>.

n3 [iii] Insure the Uninsured Project, *Health Care Reform Update*, May 22, 2008.

n4 [iv] Lisa Girion, *Health Net ordered to pay \$9 million after canceling cancer patients policy*, Los Angeles Times, Feb. 23, 2009; Lisa Girion, *Healthcare insurance probe grows*, Los Angeles Times, March 5, 2008; Lisa Girion, *Anthem Blue Cross sued over rescissions*, Los Angeles Times, April 17, 2008.

n5 [v] Insure the Uninsured Project, Health Care Reform Update, May 22, 2008.

n6 [vi] California Association of Health Plans, CAHP Legislative Update, available at <http://ct2k2.capitoltrack.com/report.asp?rptid=U20120>, accessed July 7, 2008.

n7 [vii] S. Woolhandler et al. *Costs of Health Care Administration in the United States and Canada*, 349 *New Eng. J. Med.* 768-75 (Aug. 21, 2003).

n8 [viii] M.N. Marshall, P.G. Shekelle, S. Leatherman and R.H. Brook, *The Public Release of Performance*

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n9 [ix] Jordan Rau, *California legislators revive plans to expand healthcare insurance*, Los Angeles Times, June 3, 2008.

n10 [x] Insure the Uninsured Project, *Health Care Reform Update*, May 22, 2008.

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Cope on In re Zoran Corp. Derivative Litigation

2008 Emerging Issues 2464

Cope on In re Zoran Corp. Derivative Litigation: Raising Concerns About Collusion, Court Rejects Proposed Backdating Settlement and Suggests that Shareholders Would Be Better Off Going to Trial

By Carrie Cope

July 3, 2008

SUMMARY: In re Zoran Corp. Derivative Litig., is a decision in which the United States District Court for the Northern District of California refused to approve a low-end settlement proposal for a shareholder derivative suit after ferreting out several components of the settlement which it felt were not in the corporations best interest and were not appropriately disclosed by the parties attorneys in their presentation to the court.

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ARTICLE: Cite as: Cope, Carrie. *In re Zoran Corp. Derivative Litigation: Raising Concerns About Collusion, Court Rejects Proposed Backdating Settlement and Suggests that Shareholders Would Be Better Off Going to Trial.* LexisNexis Expert Commentary, (*Insert date you accessed the document online*).

When allegations first came to light that directors and officers in hundreds of companies had backdated options garnering, in many cases, huge financial gains, without following the requisite accounting rules or disclosure requirements, one may have expected decades of litigation resulting in multimillion settlements. Although the backdating scandal only rose to the forefront of public attention in 2005, many such cases have been resolved fairly quickly without substantial contributions by the individual defendants. However, a decision issued by a California court in April of this year raises significant questions about the expeditious path the settlements of many such cases have followed and the parties intent in settling them on terms that did not unduly burden the defendants. *In re Zoran Corp. Derivative Litig.*, 2008 U.S. Dist. LEXIS 48246 (N.D. Cal. Apr. 7, 2008), the United States District Court for the Northern District of California refused to approve what it evaluated as a low-end settlement proposal for a shareholder derivative suit after ferreting out several components of the settlement which it felt were not in the corporations best interest and were not appropriately disclosed by the parties attorneys in their presentation to the court.

The suit was filed against several of Zorans current and former officers and directors and alleged violations of securities laws, breaches of fiduciary duty, unjust enrichment, constructive fraud, abuse of control, corporate waste, gross mismanagement, and rescission. In particular, the plaintiffs alleged that the defendant board members knowingly ratified or participated in granting backdated stock options to each other as well as rank-and-file employees. All of the defendants were alleged to have contributed to the dissemination of false statements in financial statements, proxy statements, and other SEC filings.

On February 26, 2008, the parties executed a stipulated settlement, which provided that the plaintiffs attorneys would receive \$1.2 million in fees and costs and certain options owned by some of the defendants would be cancelled, while other options were repriced. The cancellation and repricing concessions were represented to the court to have a value of \$1.65 million. The settlement also provided for certain corporate governance reforms and a broad release of all claims. Absent from the stipulated settlement was any cash recovery for the corporation.

In determining whether to approve the settlement, the court addressed the key features of the proposal, beginning with the cancelled options. First, the court noted that it was highly improbable that the cancelled options would ever be exercised. The cancelled options had exercise prices ranging from \$24.78 to \$38.74, but the closing market price of the stock on March 3, 2008, the date of the hearing for preliminary approval of the settlement, was \$13.99. While the court acknowledged there was a chance the stock price would rebound, it disagreed with the parties valuation of the options. Each party used the Black-Scholes method, a mathematical algorithm, to determine the value of the cancelled options. This method uses five input variables for evaluation: (1) the exercise price of the option; (2) the current stock price; (3) the time to expiration of the option; (4) the volatility of the stock price; and (5) the risk-free interest rate. When presenting the proposed settlement to the court, both parties chose December 3, 2007 as the date of valuation of the stock, to arrive at a stock price of \$21.99. Using that price, the plaintiffs calculated the cancelled options value at \$1.57 million while the defendants calculated the value to be \$1.05 million. The court took issue with the valuation date of the stock price because it ignored the sharp decline in the price following December. By the time the stipulation of settlement was filed on February 26, 2008, the stock price had already dropped to \$14.30, and by March 3, the price was \$13.99. Using the defendants conservative valuation method, but substituting the stock valuation date of March 3, the Court determined the value of the cancelled options to be \$216,955.

The court commented that the discrepancy between the valuations was due to different input variables being used for the time to expiration, the risk-free interest rate and volatility. The court noted that the only consistent numbers that were used by both sides were the exercise price of the options and the stock price on the valuation date, both of which were predefined. The court explained that while the date of valuation chosen by the parties, December 3, 2007, was fundamentally important, the reason for counsels choice of the date was unclear. At the hearing, the attorneys gave the court the impression that the date was chosen because it marked the date the parties signed the memorandum of understanding on that date. However, that did not appear to be correct, after further investigation, the court concluded that counsel simply went back and selected a favorable date in order to make the proposal look better than it really is and then were not entirely forthcoming in disclosing the full timeline.

The court also addressed the value of the repriced options and held they could not be counted as consideration for the settlement. The parties had led the court to believe that the repricing occurred as part of the negotiations leading to the proposal, but the court later discovered that the options were repriced in December 2006, over a year before the settlement was proposed to the court, and even before the plaintiff filed its consolidated complaint. The court admonished the parties for failing to disclose that the defendants were attempting to settle based on old concessions instead of new consideration. Additionally, the court found that if a meaningful valuation date was used, the value of the repriced options was zero.

Moreover, the court characterized many of the corporate governance reforms as purely cosmetic, and was further troubled that five of the reforms listed in the settlement had been adopted by Zorans board before the parties entered settlement negotiations. Pointing out that the reforms did not compensate the company for the damage it suffered as a result of the backdated options, the court found the reforms to be a poor substitute in lieu of some substantial portion of the \$16 million in damages asserted by plaintiffs expert.

Not limiting its review to the settlements value, the court also determined that the scope the release was overbroad as it should only include claims made in the complaint and those closely related thereto. However, the release included claims that had not been asserted in the complaint, and it included all claims relating to all stock options granted and issued regardless of whether they [were] alleged to be backdated when there could be many alternative causes of action relating to Zorans stock options.

In sum, the court found the proposed settlement to be far too modest, noting [t]he corporation would recover no cash, all the cash going to counsel. The court acknowledged that while a district judge should give considerable deference to the plaintiff counsel's view of whether the proposed settlement is satisfactory in light of the risks of continued litigation, the plaintiff's counsel had not justified why such a low-end settlement should be approved given the strong allegations of wrongdoing in the complaint; nor had she addressed difficult proof problems with regard to liability. The court noted that to justify the proposed settlement, the record would have had to show that the plaintiff had no chance of success at trial. However, that had not been shown and the shareholders would be far better off to take their chances at trial—even at the risk of total loss—than to accept the proposal.

The court ended its opinion with a lesson on the duty of candor, stating that because of the risk of collusive settlements at the expense of the absent shareholders . . . counsel have an enhanced duty of candor to lay out the weaknesses as well as the strengths. It is unfair to try to slip a weak or collusive settlement past the judge, hoping he or she will simply sign off or will not stumble upon the right questions.

The impact of this decision on pending and future backdating settlements remains to be seen. However, at a minimum, the court's concerns about the reasonableness of the proposed settlement could encourage closer scrutiny of the parties' rationale for valuation of backdating settlements. The case also provides additional leverage for asking individuals who are defendants in backdating cases to contribute out of their own pockets under certain factual scenarios. While some legal commentators have suggested that insurers may have to put in more money to settle such cases, this decision should not be used successfully as leverage by defendants to obtain additional funds from their insurers to the extent such settlements comprise amounts that are not covered by insurance, as they often do. However, the serious concerns raised by the Court in *Zoran* could impact an insurer in other ways given that, while insurers typically independently evaluate potential damages when faced with a settlement proposal, such decisions are made, to a large extent, in reliance on the information presented by the parties' counsel as well as defense counsel's settlement recommendation.

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Wiley Rein LLP on Exxon Shipping and State Punitive Damages

2008 Emerging Issues 2469

Wiley Rein LLP on Exxon Shipping and State Punitive Damages

By Thomas W. Kirby

July 3, 2008

SUMMARY: The U.S. Supreme Courts ongoing effort to limit excessive punitive damages takes a different twist in *Exxon Shipping Co. v. Baker*. Rather than relying on due process, the Court uses its common law power over federal maritime law to hold that punitive damages in maritime cases must not exceed compensatory damages, adopting a 1:1 ratio as the cap.

PDF LINK: [Click Here for Enhanced PDF of Commentary](#)

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The Supreme Courts latest punitive damages case, *Exxon Shipping Co. v. Baker*, 2008 U.S. LEXIS 5263 (U.S. June 25, 2008), teaches us a great deal about challenging high punitive damages in state law cases, but we must take care not to learn too much. In contrast to the recent line of Supreme Court punitive damages cases exemplified by *BMW of North America, Inc. v. Gore*, 517 U.S. at 582 (1996), *Exxon Shipping* explicitly disavows any reliance on constitutional due process. Instead, the Court exercises its federal maritime common law authority to craft its view of an ideal punitive damages standard.

The upper limit set by the Court a ratio of 1:1 between punitive and compensatory damages is one many defendants would welcome. However, the lack of a constitutional foundation means that no state law or court is compelled to adopt that ratio. Instead, the opinion provides a thoughtful and potentially persuasive model for how state courts could exercise their common law authority to set similar caps under their own laws. Also, the general thrust of the decision strongly reinforces the due process cases, and it identifies themes and reasoning that may prove effective in shaping future due process decisions that restrict the size of punitive damage awards.

Background. The ink already spilled telling the story of the *Exxon Valdez* seems to approach the volume of oil the ship spilled off the Alaskan coast. Suffice it to say, the jury found that the captains intoxication while his ship transited treacherous waters caused a massive oil spill deemed to warrant a compensatory award of \$507.5 million for injuries to tens of thousands of Alaskans. For good measure, the jury also awarded \$5 billion in punitive damages against the ships owner, Exxon Shipping, which allegedly knew the captain had relapsed into heavy drinking and took no protective measures. After a long struggle, the Ninth Circuit cut the punitive award to \$2.5 billion on due process grounds. The

Supreme Court then granted certiorari to consider whether the punitive award was excessive *as a matter of federal maritime law* (not due process).

The Courts Common Law Approach. The Court stresses that federal maritime law is one of a few areas in which it is free to decide in the manner of a common law court. It takes a very broad view of the law-making powers of a common law court, saying such courts have established many generally applicable numerical standards such as the 21-year period in the rule against perpetuities [which] was a judicial innovation, as were various exact limitations periods for civil actions and age cut-offs. It recognizes that such rules are subject to the authority of Congress to legislate otherwise if it disagrees, but it declines to regard Congressional inaction as a barrier to fulfilling its traditional judicial role.

Of course, most state Supreme Courts claim broad common law powers with respect to many cases that come before them, particularly in crafting remedies. Thus, *Exxon Shipping* may be urged as a model that state courts can follow in setting punitive damage standards for a wide range of state causes of action. On the other hand, because state courts so commonly exercise common law powers, they may face considerable relevant precedent, while the U.S. Supreme Court addressed the issue as one of first impression, giving it maximum freedom to craft the rule it thinks best. The extent to which state courts can and should re-think previously decided cases will be a major battleground when *Exxon Shipping* is relied upon in state litigation. In such cases counsel must use the decision to *persuade*; it simply does not coerce state compliance.

The Limited Purposes Of Punitive Damages. The *Exxon Shipping* opinion begins its excessiveness analysis by reviewing the history of punitive damages, from common law origins in England through developments in America. The Court identifies three commonly asserted justifications for such damages: punishment, deterrence, and compensation for ephemeral or hard-to-quantify losses. It concludes, however, that modern punitive damages have no compensatory purpose, but serve only to punish and deter in cases of enormity where a defendants conduct is outrageous owing to gross negligence, willful, wanton, and reckless indifference for the rights of others, or behavior even more deplorable.

The Court holds that, in fairness, such essentially punitive awards should be reasonably uniform and predictable in severity, noting the trend in criminal law has been to reduce broad sentencing discretion. The Court opines that even a bad man should have some ability to know what the stakes are, and when the bad mans counterparts turn up, they should face a fair probability of suffering in like degree.

The Selection of a 1:1 Ratio Of Punitive to Compensatory Damages. Reviewing a wide range of data concerning punitive damages in American courts, *Exxon Shipping* does not detect mass-produced runaway awards. To the contrary, the Court perceives overall restraint in punitive awards. However, it also perceives a real problem [in] the stark unpredictability of punitive awards. It concludes that, although the frequency and median amount of punitive awards is not shocking, the wide spread in amount and occasional massive outlier award are troubling. Accordingly, the Court decides to craft a limit that will allow adequate room for substantial punishment while constraining outliers.

The Court identifies three possible means to that end. First, it considers a verbal solution, drafting more specific and concrete criteria to be used either in jury instructions or in a more rigorous judicial review than the traditional shock the conscience test. However, based on its view of the results of such an approach in several states, the Court concludes such a verbal approach was unlikely to succeed.

Second, the Court considers imposing a hard dollar cap on punitive damages. It decides, however, that there is no standard tort or contract injury that would permit setting a dollar cap. Also, a court is not well positioned to monitor such a cap, adjust it for inflation, and revise it as information develops. Thus, the Court finds that such a cap requires active involvement of a legislature.

The third option, and the one selected by the Court, is pegging punitive to compensatory damages using a ratio or

maximum multiple. It says this approach will tend to automatically adjust for inflation and other relevant factors, e.g. severity.

In seeking guidance as to a proper multiple, the Court considers state and federal statutes providing for enhanced awards, but finds they vary too much to be useful. Instead, it settles on guidance drawn from statistics about American punitive awards. Making various assumptions, the Court identifies a median ratio of punitive to compensatory damages of about 0.65:1. Recognizing some cases call for higher awards than others, it decides a 1:1 ratio, which is above the median award, is a fair upper limit in maritime cases. Since the compensatory damages awarded against Exxon Shipping were \$507.5 million, it orders that the punitive award be remitted to an equal amount. Exxon Shippings counsel thus find themselves in an elite circle of advocates who can claim that losing their client only a billion dollars was a great victory.

Applying *Exxon Shipping* to State Common Law Cases. Most of the Courts reasoning readily can be adapted to arguing that state supreme courts should establish similar punitive damages caps. As noted above, most state supreme courts claim broad law making powers, particularly with respect to remedy. And the data relied upon by *Exxon Shipping* came mainly from state law cases. Still, the case must be employed with some sensitivity to differing facts, however. For example:

- . For historic reasons having to do with the inability of shipowners to control their captains, maritime law arguably has been less hospitable to punitive damages than other areas. Thus, it might be argued that a higher ratio should be adopted in other areas. However, it does not appear that *Exxon Shipping* gave this factor any weight in selection its 1:1 maximum ratio.

- . In a similar vein, it might be thought that maritime claims have sufficient uniformity, e.g. a ship collides with something, to permit a fairly narrow range of possible awards. If a state court is considering a maximum ratio for a wide range of torts, plaintiffs may argue that something higher than 1:1 is necessary to accommodate potential variability. On the other hand, the *Exxon Shipping* opinion makes no claim that maritime claims are uniform.

- . *Exxon Shipping* notes that heavier punitive awards traditionally have been thought appropriate for wrongs that are difficult to detect, or where the actual injury to a given plaintiff is low. In a field of law where such cases may arise, the question of exceptions may have to be addressed.

- . The Court also notes that some regulatory schemes provide by statute for multiple recovery in order to induce private litigation to supplement official enforcement. These and similar considerations may affect the application of *Exxon Shipping* to liability arising under some statutes, as well as to some tort theories that may have been adopted to advance statutory policies.

A Practice Pointer: Preserving Issues in the Trial Court. Finally, *Exxon Shipping* has a procedural twist that has no particular relevance to punitive damage limits, but that may be of interest to litigators. One argument had not been presented in a timely way to the district court, but the Ninth Circuit had exercised its discretion to consider it. Although the Court declined to find that the Ninth Circuit had abused its discretion, it made clear that the failure to raise issues properly in the trial court is a serious matter that usually should result in waiver. Quoting an opinion by Judge Boudin of the First Circuit, the Court said:

The reason for the rules is not that litigation is a game, like golf, with arbitrary rules to test the skill of the players. Rather, litigation is a winnowing process, and the procedures for preserving or waiving issues are part of the machinery by which courts narrow what remains to be decided.

The point that issues should be carefully preserved is a commonplace, but *Exxon Shipping* provides a particularly powerful statement of the reasons for waiver. Counsel who rely on *Exxon Shipping* unavoidably will alert their opponents to that statement. Accordingly, it will be particularly important for counsel who anticipate using *Exxon Shipping* to take care to present and preserve the issue and any essential predicates. This process should start in the

Answer, which should plead that any punitive damages must be limited both by due process and by the limits of substantive law. Care should be taken that jury instructions do not state principles inconsistent with proper limits, or that a proper objection and request for a correct instruction are timely made. The courts procedures for end-of-trial motions should be scrupulously followed.

Another Supreme Court Punitive Damages Case On the Horizon. Meanwhile, there will be another punitive damages case next term. The Supreme Court has agreed to decide whether the Oregon courts wrongfully sustained a massive award against a tobacco company based on injury to other persons. *Philip Morris USA v. Williams*, No. 67-1216.

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Thomas W. Kirby is a senior litigation partner at Wiley Rein LLP handling complex, policy-oriented trial and appellate matters nationwide. Counsel in more than 70 published cases, he focuses on copyright and trademark, First Amendment, Commerce Clause and election law, as well as class actions and commercial disputes. The notable verdicts he has secured for his clients include one of the largest copyright verdicts in U.S. history, an award recognized in the NLJ 100. In a successful First Amendment/Commerce Clause challenge to an Internet statute, a federal judge said of Mr. Kirby, There have been few attorneys before the court as accomplished, trained, experienced, intelligent and skilled. He is quite unique in his ability to combine the theoretical and the clinical. *PSINet v. Chapman* (W.D.Va.)

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Morrison Mahoney LLP on Boston Gas Co. v. Century Indemnity Co.

2008 Emerging Issues 2453

Morrison Mahoney LLP on Boston Gas Co. v. Century Indemnity Co.: New Developments in Massachusetts Allocation Disputes

By Michael F. Aylward

July 2, 2008

SUMMARY: After years of controversy and confusion, the Supreme Judicial Court of Massachusetts is finally destined to answer whether long-tail claims may be assigned to a single policy year or must be allocated on some other basis. This article explores the First Circuits June 10, 2008 opinion in *Boston Gas v. Century Indemnity* and its implications for pending and future pollution, asbestos and other long-tail claims in the Bay State.

PDF LINK: [Click Here for Enhanced PDF of Commentary](#)

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Be careful what you ask for. After a decade of conflicting and increasingly problematic lower court rulings, parties who have long complained about the lack of clear law on allocation issues in Massachusetts now face the prospect of a decisive ruling from the Supreme Judicial Court in Massachusetts.

Allocation issues have pervaded long tail disputes in Massachusetts since the SJC emphatically rejected a manifestation trigger fifteen years ago in *Trustees of Tufts University v. Commercial Union Ins Co.*, 415 Mass. 844, 616 N.E.2d 68 (1993). Once the door was open to spreading losses among multiple years, issues began to arise with respect to who bore responsibility for orphan shares attributable to years for which insurance was unavailable due to insolvencies, exclusions or missing policies. With larger insureds, issues were also presented by the pervasive use of self-insured retentions. Insureds evaded these problems by persuading courts to allow them to spike their claims under an all sums or joint and several liability theory that allowed them to assign their entire loss to any single policy that was triggered by part of the loss, a position that was endorsed by the Appeals Court in *Rubenstein v. Royal Ins. Co.*, 429 Mass. 355, 708 N.E.2d 639 (1999).

Although the Supreme Judicial Court agreed to hear Royals appeal in *Rubenstein* it declined to consider the allocation aspects of the Appeals Courts opinion. In the intervening decade, other efforts to get the issue of allocation before the SJC were declined by the SJC or lower courts that were asked to certify the issue to the Court. As recently as *A.W. Chesterton Co. v. Massachusetts Insurers Insolvency Fund*, 445 Mass. 802, 838 N.E.2d 1237 (2004), the SJC refused to consider an *amicus* brief submitted by Lloyds that asked them to address the issue in the context of asbestos.

Now the issue has been squarely framed for the SJC by the U.S. Court of Appeals for the First Circuit in a large pollution claim. In *Boston Gas Co. v. Century Indemnity Co.*, No. 07-1452 (1st Cir. June 10, 2008), a gas utility had sued various insurers, seeking coverage for the cost of cleaning up a former production facility in Everett, Massachusetts. Boston Gas proceeded to trial against Century Indemnity, whose predecessor had insured it between 1951 and 1969 under primary policies that each contained a self-insured retention of \$100,000 or more. At trial, the jury awarded Boston Gas \$6.1 million. Additionally, Judge Zobel issued a declaration that Century was liable for all future cleanup costs.

The First Circuit began its review by considering Century Indemnity's contention that the U.S. District Court had erred in refusing to allocate Boston Gas's liability among the various insurers that had provided coverage to it during the historical period of the site's operation (1908-1969). Century Indemnity contended that its liability should be no more than its proportionate share and that the district court had erred in applying an all sums approach. Century Indemnity also argued that Boston Gas should be liable for a separate \$100,000 self-insured retention for each of the policies that it had issued that were thereby triggered.

Despite the insureds urging that it follow the Appeals Court's ruling in *Rubenstein*, the First Circuit found that this was an issue that required resolution by the Supreme Judicial Court noting that the Appeals Court's analysis of this issue in *Rubenstein* was cursory. Nor was there a clear consensus among other states as to whether *pro rata* or all sums is the preferable approach. The First Circuit observed that, at first blush, it might seem illogical to hold a single insurer fully liable for environmental damage that occurred over the course of a century. The court pointed out, however, that the insurer could seek contribution from other carriers on the risk during the period of injury and that the alternative would be to require a policyholder to sue insurers in a single suit to avoid inconsistencies.

The First Circuit observed that joint and several and *pro rata* both employ legal fictions that do not accurately reflect the means by which environmental contamination occurs over the years at a given site. The court also observed that the two approaches had very different implications for the involvement of excess carriers and the insureds' obligation to pay SIRs.

Given these conflicting implications and the absence of any clear guidance from the Supreme Judicial Court and particularly in light of the large sum of money involved, the court ruled that certification was appropriate. The court also took note of the fact that the absence of law in Massachusetts could be contrasted with holdings in New York, New Hampshire and Connecticut that had adopted the *pro rata* approach. The court also observed that *Rubenstein* did not address other secondary implications of allocation such as whether the insured could stack multiple policies under an all sums approach or whether allocation should be done purely by the years of coverage or based on years and limits. Accordingly, the First Circuit certified the following questions to the Supreme Judicial Court:

1. Where an insured protected by standard CGL policy language incurs covered costs as a result of ongoing contamination occurring over more than one year and the insurer provided coverage for less than the full period of years in which contamination occurred, should the direct liability of the sued insurer be *pro rated* in some manner among all insurers on the risk limiting the direct liability of the sued insurer to its share but leaving the insured free to seek the balance from other such insurers?
2. If some sort of *pro rata* liability is called for in such circumstances, what allocation method or formula should be sued?
3. If a single insurer in such circumstances is subject to liability under more than one policy and each policy has a separate deductible or self-insured retention, should the insured be able to collect covered losses from a single policy subject only to that policy's deductible or self-insured retention or should liability be reduced by the sum of the applicable self-insured retention, effectively allocating total liability across the policies of that insurer in effect during the contamination period?

In addition to these certified questions, the First Circuit answered important issues concerning the effect of the owned property exclusion in such cases and the ability of an insured to obtain a declaration of coverage for future losses.

Like most states, Massachusetts follows the rule that the owned property exclusion does not preclude coverage for the cost of preventing the migration of pollution onto the property of others. In *Hakim v. Abington Mut. Fire Ins. Co.*, 424 Mass. 275, 675 A.2d 1161 (1997), the court left open the issue of whether or how clean up costs might be allocated where some portions of a clean up are solely related to damage to the insureds own property.

In the *Boston Gas* case, the District Court gave the jury an instruction on the owned property exclusion that suggested an all or nothing approach whereas Century Indemnity argued that the exclusion might apply to preclude coverage for certain costs even if some portions of the cleanup eliminate or avoid contamination of groundwater, property or adjacent property. The court observed that several million dollars in cleanup costs had been incurred to remove soils on the property that might have been found to be subject to the exclusion including the cost of removing contaminated soils and liquids from underground storage tanks. Century noted that much of this work had been done to give the successor owner a firm foundation for its own facilities and did not involve remediation or prevention of further off-site damage.

While noting the narrowness of the issue, the First Circuit observed that the amounts in dispute were not trivial and therefore remanded the case for a further trial on the issue of determining whether all the costs were necessary to prevent off-site contamination or whether some were merely for the purpose of mitigating on-site contamination. On the other hand, the court declined to enter judgment as a matter of law for Century Indemnity with respect to the \$1.6 million spent to remove contaminated soils from the property. The court also rejected Century Indemnitys contention that it should not owe coverage for removal costs that were incurred after its coverage ended given the fact that the ongoing occurrence had begun prior to its policy.

The other major issue addressed by the First Circuit was the ability of an insured to obtain a declaration of coverage for costs to be incurred in the future. Century Indemnity complained that Boston Gas might use the judgment to compel it to pay for cleaning up the Mystic River even though no issue related to the cleanup of the River had been presented at trial. The First Circuit observed that the entry of judgment for Boston Gas did not preclude its insurer from contesting the amount of the requested costs or whether the work undertaken was consistent with compensable remediation efforts. As a result, the court concluded that Century was free to dispute future claims as to issues that not already been decided but that it could not re-argue matters that had been decided. Nor could Boston Gas seek to recover for future costs spent purely to remediate its own property where no threat exists of contamination outside the site.

The court also reversed Judge Zobel's ruling that Boston Gas was entitled to pre-judgment interest from the date that the individual costs were incurred. Applying federal law, the court held that statutory interest runs from the date of breach or demand. In this case, Century Indemnity had been put on notice of these claims in 1995 but Boston Gas had never submitted actual bills to it, nor was there any date when there was a breach or demand prior to the filing of the lawsuit in 2002. Since there was never a refusal to pay any invoice, either specifically or categorically, prior to the filing of the coverage litigation in 2002, the court ruled that Boston Gas was only entitled to pre-judgment interest from that date forward. The court emphasized the fact that the insureds 1995 notice letter had only referenced potential claims and that Century Indemnity had never denied coverage up until the date it was sued, nor was it bound to make payments in the absence of a specific request to do so by its policyholder.

If, as seems extremely likely, the Supreme Judicial Court accepts review of *Boston Gas*, litigants in long-tail disputes can look forward by 2009 to finally having clear appellate authority in Massachusetts on the basic issue of whether an insured can assign its entire loss to a single policy or not. Even if the court rejects this proposition and requires some sort of allocation, however, numerous secondary and tertiary issues will remain to be worked out.

Of particular significance will be how the issue is framed to the SJC. Will the question be whether a long-tail loss

should be allocated among the years of available insurance or should it be allocated on a pure time on the risk basis so that an insurer would only bear responsibility for that fraction of a loss that corresponds to the years (or months) that its policies were in effect as a percentage of the overall period of injury or damage. In this case, as in *Consolidated Edison Co. of New York v. Allstate Ins. Co.*, 98 N.Y.2d 208, 774 N.E.2d 687, 746 N.Y.S.2d (2002), the period of available insurance and the size of the SIRs so large that the insured might lose either way.

An issue that may or may not be considered by the court is how allocation should be undertaken if it is to be done. Should it be calculated on a pure time on the risk basis or is a *Carter-Wallace* approach preferable that takes into account the limits of coverage?

Also, will the court adopt an availability limitation to allocation that eliminates from consideration periods of time for which the policyholder could not have purchased insurance, especially years after the mid-1980s when absolute pollution exclusions and exclusions for asbestos losses became a common feature of CGL policies?

These are issues of acute importance in dozens of cases now pending and that remain to be brought in the future. Much now hangs in the balance.

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Michael F. Aylward is a senior partner in the Boston office of Morrison Mahoney LLP where he chairs the firms complex insurance claims resolution group. For nearly 25 years, Mr. Aylward has represented insurers and reinsurers in coverage disputes around the country concerning the application of liability insurance policies to commercial claims involving intellectual property disputes, environmental and mass tort claims and construction defect litigation. He is a frequent lecturer on insurance issues and has authored portions of various insurance treatises and is a frequent contributor to scholarly publications on legal issues. Mr. Aylward has taken a leadership role in legal organizations including the Defense Research Institute (Board of Directors (2000-2003); past Chair, Insurance Law Committee and Law Institute (2004-2006); and the International Association of Defense Counsel (Chair, Reinsurance, Excess and Surplus Lines Committee, Board of Editors, Defense Counsel Journal). He presently serves as the chair of the Reinsurance, Excess and Surplus Lines Committee of the Federation of Defense and Corporate Counsel.

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Sonnenschein Nath & Rosenthal, LLP on Insurance Bad Faith in Iowa

2008 Emerging Issues 2419

Sonnenschein Nath & Rosenthal, LLP on *Buhmeyer v. Case New Holland, Inc.* and *Niver v. Travelers Indemnity Co.*: Punitive Damages for Insurance Bad Faith in Iowa

By William T. Barker and Robert C. Johnson

June 30, 2008

SUMMARY: Two Iowa federal district courts have expressed differing views on the level of culpability that must be demonstrated to submit a punitive damages claim to a jury in an insurance bad faith case. No Iowa case clearly resolves this dispute. This commentary argues that *Niver* is right and suggests how the standard should be more precisely defined.

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ARTICLE: Cite as: Barker, William T., and Johnson, Robert C. *Buhmeyer v. Case New Holland, Inc.* and *Niver v. Travelers Indemnity Co.*: Punitive Damages for Insurance Bad Faith in Iowa. LexisNexis Expert Commentary, (*Insert date you accessed the document online*).

Two Iowa federal district courts have expressed differing views on the level of culpability that must be demonstrated to submit a punitive damages claim to a jury in an insurance bad faith case. *Buhmeyer v. Case New Holland, Inc.* n1 said that any case where bad faith can be found necessarily also satisfies the requirements for punitive damages. *Niver v. Travelers Indemnity Co.*, n2 disagreed, and set aside a punitive damage verdict, but without clarifying exactly what is required. No Iowa case clearly resolves this dispute.

Under Iowa law, to establish an insurer's bad faith, the plaintiff must prove (1) that the insurer had no reasonable basis for denying the plaintiff's claim or for refusing to consent to settlement, and (2) that the insurer knew or had reason to know that its denial or refusal was without reasonable basis. n3 The first element is an objective one; the second element is subjective. n4 We submit that, contrary to *Buhmeyer*, punitive damages may not be awarded unless the evidence permits a jury to find that the insurer either knew that it lacked a reasonable basis for delay or denial of the claim or it recklessly disregarded that lack. n5

An Iowa statute requires that, to recover punitive damages on any cause of action, a plaintiff must establish, by a preponderance of clear, convincing, and satisfactory evidence, [that] the conduct of the defendant from which the claim arose constituted willful and wanton disregard of the rights or safety of another. n6 Case law establishes that where there is no showing of personal spite, hatred, or ill will, the statute requires a showing of legal malice. n7 Legal malice is shown by wrongful conduct committed or continued with a willful or reckless disregard for another's rights.

Necessarily, then, a claim for punitive damages must be supported by something more than merely negligent conduct.
n8

Another formulation of the legal malice standard is that the actor has intentionally done an act of unreasonable character in disregard of a known or obvious risk that was so great as to make it highly probable that harm would follow, and which thus is usually accompanied by a conscious indifference to the consequences. n9

Buhmeyer said that the latter formulation embraces any case meeting the requirements for bad faith liability. n10 We disagree.

It is true that denying a claim is an intentional act. If the denial was in bad faith, then there can have been no reasonable basis, meaning that the act was (in a sense) of an unreasonable character. But that is true of any intentional conduct that negligently disregards risks. To permit punitive damages requires a greater culpability than mere negligence. But bad faith does not require greater culpability: it requires only that the defendant *should have known* that there was no reasonable basis to deny the claim.

The second formulation of the punitive damages standard was developed in cases where the conduct endangered the safety of persons or property. That is significant, because everyone has a right to be free from unreasonable risks to safety; disregard of a known or obvious great risk is more culpable than mere negligence. n11 And there is no problem applying that formulation to cases where the elements of the relevant tort or the facts of the case show elevated culpability. n12 In contrast, an insurers duty of good faith does not depend on the consequences of denying the claim. A fairly debatable claim may be denied, and thereby debated, no matter how severe the consequences to the claimant. So, mere knowledge of consequences does not elevate the culpability of the denial. The focus of any culpability analysis depends on whether the lack of reasonable basis was known or obvious. Only then could one could fairly say that the denial was wrongful conduct committed or continued with a willful or reckless disregard for anothers rights. n13

The Eighth Circuit recognizes that, under Iowa law, submission of punitive damages to a jury requires proof of egregious conduct. n14 It has held that evidence sufficient to prove retaliatory discharge for pursuing a workers compensation claim was not enough to submit punitive damages to the jury. n15 We submit that it cannot be true that Iowa law permits punitive damages whenever insurance bad faith is proven. Only clear and convincing evidence that the insurer knew it lacked a reasonable basis or recklessly disregarded that lack can support punitive damages.

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n1 . *Buhmeyer v. Case New Holland, Inc.*, 446 F. Supp. 2d 1035, 1047 (S.D. Iowa 2006).

n2

[2]. *Niver v. Travelers Indem. Co.*, 430 F. Supp. 2d 852, 860 (N.D. Iowa 2006).

n3

[3]. *Bellville v. Farm Bureau Mut. Ins. Co.*, 702 N.W.2d 468, 472 (Iowa 2005).

n4

[4]. *Id.*

n5

[5]. We developed the analysis offered here as post-trial and appellate counsel in a case where punitive damages were awarded, but which settled prior to briefing of the appeal.

n6

[6]. Iowa Code § 668A.1(1)(a) (2006).

n7

[7]. *Gilbert v. ITT Hartford Ins. Co.*, 621 N.W.2d 388, 396 (Iowa 2001) (citations omitted).

n8

[8]. *Id.*

n9

[9]. *Id.* at 395 (citations omitted).

n10

[10]. *Buhmeyer v. Case New Holland, Inc.*, 446 F. Supp. 2d 1035, 1047 (S.D. Iowa 2006).

n11

[11]. One basis for that formulation was Restatement (Second) of Torts § 500 (1965). *Kuta v. Newberg*, 600 N.W.2d 280, 288-89 (Iowa 1999); *Vlotho v. Hardin County*, 509 N.W.2d 350, 356 (Iowa 1993). That section defines Reckless Disregard of Safety.

n12

[12]. *E.g.*, *Watkins v. Lundell*, 169 F.3d 540, 545-46 (8th Cir. 1999) (fraud by false promises and pattern of deceit); *Pulla v. Amoco Oil Co.*, 882 F. Supp. 836, 882 (S.D. Iowa 1994), *rev'd on other grounds*, 72 F.3d 648 (8th Cir. 1995) (intentional violation of employees privacy by obtaining credit card records, which manager recognized as wrongful but furthered the wrong by retaining records and placing them in employees personnel file); *Condon Auto Sales & Serv., Inc. v. Crick*, 604 N.W.2d 587, 594 (Iowa 1999) (employers knowing retention of money due to employer); *Revere Transducers, Inc. v. Deere & Co.*, 595 N.W.2d 751, 771 (Iowa 1999) (tortious interference with contract by inducing disclosure of confidential business information); *Jones v. Lake Park Care Ctr., Inc.*, 569 N.W.2d 369, 378 (Iowa 1997) (managers intentional interference with employees contract by causing her to be discharged for an improper purpose); *Wilson v. IBP, Inc.*, 558 N.W.2d 132, 142-44 (Iowa 1996) (company nurse, with fiduciary responsibility for injured workers medical care, lied to doctor to prevent referral to specialist; company intentionally invaded privacy by spying on worker at home; company intentionally punished employees who resisted companys planned medical treatment by assigning them to a light-duty job where they were subjected to an atrocious smell; company created climate of suspicion towards WC claims); *Hockenberg Equip. Co. v. Hockenbergs Equip. & Supply Co. of Des Moines, Inc.*, 510 N.W.2d 153, 156-57 (Iowa 1993) (intentional breach of contract and violation of injunction, amounting to tortious interference with prospective advantage).

n13

[13]. *Gibson*, 621 N.W.2d at 396 (citation and internal quotations omitted).

n14

[14]. *Frazier v. Iowa Beef Processors, Inc.*, 200 F.3d 1190, 1196 (8th Cir. 2000).

n15

[15]. *Id.* at 1192-96; *Webner v Titan Distribution, Inc.*, 267 F.3d 828, 838 (8th Cir. 2001) (the evidence does not reveal willful or reckless disregard for Webners rights).

ABOUT THE AUTHOR(S):

William T. Barker is a partner in the Chicago office of Sonnenschein Nath & Rosenthal, L.L.P., with a nationwide practice representing insurers in complex litigation, including matters relating to coverage, claims handling, sales practices, risk classification and selection, agent relationships, and regulatory matters. He is a member of the Editorial

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Sonnenschein Nath & Rosenthal, LLP regularly handles high-risk and complex matters for financial and insurance industry clients. Staffed with seasoned litigators and former insurance regulators, Sonnenschein lawyers are relentless advocates for its clients interests.

For more than 70 years, Sonnenschein has partnered with insurance companies to understand their business and legal needs. Recent confirmation of Sonnenschein's outstanding insurance industry qualifications came in Chambers USA: Americas Leading Lawyers for Business. The 2007 edition identifies Sonnenschein as one of the top firms in the country representing insurers on their most complex matters. The Chambers description speaks for itself:

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Stempel on Federal Insurance Co. v. American Hardware Mutual Ins. Co.

2008 Emerging Issues 2421

Stempel on Federal Insurance Co. v. American Hardware Mutual Ins. Co., The Nevada Supreme Court Gives Broad Construction to Commonly Used Additional Insured Endorsements

By Jeffrey W. Stempel

June 30, 2008

SUMMARY: In *Federal Insurance Co. v. American Hardware Mutual Ins. Co.*, 2008 Nev. LEXIS 38 (May 29, 2008), the Nevada Supreme Court unanimously aligned itself with the apparent emerging majority approach and held that the additional insured endorsement in question covered active negligence by the additional insured and provided coverage even if the additional insured was the only insured accused of fault.

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ARTICLE: Cite as: Stempel, Jeffrey W. *Federal Insurance Co. v. American Hardware Mutual Ins. Co.*, The Nevada Supreme Court Gives Broad Construction to Commonly Used Additional Insured Endorsements. LexisNexis Expert Commentary, (Insert date you accessed the document online).

The Problem and Its Background. Insurers and additional insureds have been locked in contests for some time over the scope of additional insured coverage, with insurers often contending that additional insureds (insureds added on to a policy purchased from the insurer at the request of the named policyholder who bought the policy) are covered only if sued for vicarious liability flowing from the conduct of the named policyholder. Insurers argue that an additional insured does not enjoy coverage under the named insureds policy in cases where the additional insured is sued because of its own active negligence or where the additional insured is the only allegedly negligent tortfeasor. Conversely, additional insureds argue that an-insured-is-an-insured-is-an-insured and that they enjoy the full range of coverage available to the named policyholder and are thus covered even where their conduct contributes to the injury, alone or in combination with that of the named policyholder.

In general, additional insureds appear to be winning these coverage battles. See Jeffrey W. Stempel, Stempel on Insurance Contracts § 25.06 at p. 25-87 (3d ed. 2006 & Supp. 2008)([M]ost courts have tended to give the arising under language of the various traditionally used additional insured endorsements a broad construction and have refused to limit additional insured coverage to only cases of vicarious liability.); Douglas R. Richmond, *The Additional Problems of Additional Insureds*, 33 *Tort & Ins. L.J.* 945, 958 (1998)(noting that liberal interpretation of the additional insured endorsement is fast becoming the majority rule). See, e.g., *National Union Fire Ins. Co. v. Lumbermens Mut. Cas. Co.*, 385 F.3d 47 (1st Cir. 2004)(applying Massachusetts law); *Marathon Ashland Pipe Line v. Maryland Cas. Co.*, 243 F.3d 1232, 1240 n. 5 (10th Cir. 2001)(applying Wyoming law); *Mid-Continent Cas. Co. v. Swift Energy Co.*, 206 F.2d 487,

498 (5th Cir. 2000)(applying Texas law); *McIntosh v. Scottsdale Ins. Co.*, 992 F.2d 251, 254-55 (10th Cir. 1993)(applying Kansas law); *Acceptance Ins. Co. v. Syufy*, 69 Cal. App. 4th 321, 81 Cal. Rptr. 2d 557, 562-63 (1999). But see also *BP Chemicals, Inc. v. First State Ins. Co.*, 226 F.3d 420, 425-26 (6th Cir. 2000)(applying Texas law)(restricting coverage to cases not involving additional insureds own negligence because the particular endorsement at issue explicitly barred coverage for any negligent acts committed by the additional insured.); *National Union Fire Ins. Co. v. Nationwide Ins.*, 69 Cal. App. 4th 709, 82 Cal. Rptr. 2d 16, 21-22 (1999)(same result in case involving similarly explicit limitation in additional insured endorsement).

The Federal v. American Hardware Case. In *Federal Insurance Co. v. American Hardware Mutual Ins. Co.*, 2008 Nev. LEXIS 38 (May 29, 2008), the case began in state court but was removed to federal court, only to have the federal trial court certify the following legal question to the Nevada Supreme Court: [w]hether, under Nevada law, an additional insured endorsement provides coverage for an injury caused by the sole independent negligence of an additional insured? The Court [a]nswer[ed] the question in the affirmative and conclude[d] that, unless the contrary intent is demonstrated by specific language excluding or limiting coverage for injuries caused by the additional insureds independent negligent acts, there is coverage. See 2008 Nev. LEXIS 38 at *1-*2.

The liability insurance policy in question was issued by American Hardware Mutual to Clark Lift West, Inc. Clark Lift provided maintenance and repair services at a facility for Southern Wine and Spirits of America, Inc. American Hardware willingly issued an endorsement naming Southern Wine as an additional insured under the Clark Lift policy. The endorsement stated that Southern Wine was an additional insured covered for liability but only with respect to liability arising out of [the named policyholders] ongoing operations performed for that [additional insured]. See *id.* At *2. Soon after, a Clark Lift employee was injured while providing services at Southern Wines facility. He sued Southern Wine seeking damages for Southern's alleged negligence. While repairing a conveyor belt drive, the belt unexpectedly began moving and that he slipped on loose cardboard that was negligently left on the floor, resulting in his hand being mangled in the conveyor belt mechanism. Upon receiving notice of the suit from the company, Southern Wine informed its CGL insurer, Federal Insurance. The two tendered the defense of the tort action to American Hardware, which refused the tender, arguing that the additional insured coverage accorded to Southern Wine under the Clark Lift policy applied only when the alleged negligence could be imputed to the additional insured thorough the named insureds operations, i.e., when the additional insured can be vicariously liable for the named insureds negligence. See *id.* At *3.

The Court had two primary bases for deciding in favor of coverage. First, it found the additional insured endorsement in the American Hardware policy to be ambiguous and hence construed it against American Hardware as the drafter. Second, the Court applied what it viewed as the majority rule and the Nevada rule that grants of coverage in an insurance policy should be interpreted broadly and restrictions on coverage need to be clear and explicit. See *id.* At *6-*13. Under Nevada law, an insurer wishing to restrict a policy's coverage should use language that clearly and distinctly communicates to the insured the nature of the limitation. See *id.* At *6, citing *National Union Fire Ins. V. Renos Exec. Air*, 100 Nev. 360, 364, 682 P.2d 1380, 1382 (Nev. 1984).

Here, American Hardware's endorsement contains no such distinctly limiting language. Indeed, this court as well as other jurisdictions has recognized that the scope of coverage provided by virtue of the phrase arising out of the [named insureds] operations is ambiguous, since it is unclear whose acts are covered. Specifically, under one reasonable interpretation, the endorsement limits coverage to circumstances in which the named insureds negligent acts or operations directly caused the plaintiffs injury, that is, circumstances in which the additional insured is held vicariously liable for the named insureds negligence. Under another reasonable interpretation, however, the endorsement covers the additional insureds direct negligence, so long as the plaintiffs injury has some connection to the work or operations that the named insured performed for the additional insured. Thus, in accordance with our precedent and consistent with persuasive authority from other jurisdictions, we conclude that the endorsement here, which covers the additional insured only with respect to liability arising out of the [the named insureds] ongoing operations performed for [the additional insured], is ambiguous, since it is reasonable to interpret that language both in favor of and against coverage for the additional insureds independent negligence.

See 2008 Nev. LEXIS 38 at *6-*8 (citations omitted, bracketed terms in original).

The Significance of *Federal v. American Hardware*. The *Federal v. American Hardware* case is significant for a number of reasons. First, it puts another state supreme court unanimously in the camp of giving broad construction to the scope of additional insured coverage and requiring insurers to do more than just argue the purported public policy benefits of restricting coverage to only derivative liability or merely asserting a generalized industry intent that additional insured coverage be narrower than coverage for the named insured.

Second, in a move that perhaps will give both policyholder and insurer counsel concerns in future Nevada cases, the Court stated that the construction of restrictive language in insurance policies will be assessed not only according to whether it is facially ambiguous and with reference to the general rule that restrictions on coverage must be clearly expressed but also with reference to the reasonable expectations of the insured and extrinsic information as to the parties specific intent or the custom and practice regarding the understanding of the scope of coverage afforded by a common policy term. See *id.* at *11-*15 (footnotes omitted). See also *Anuvi, LLC v. G.L. Dragon, LLC*, 163 P.3d 405, 407 (Nev. 2006) (indicating that party intent can be ascertained from the text of the contract document and from the surrounding circumstances even where specific extrinsic evidence of intent is not introduced or received).

Third, and perhaps most important, the Nevada Supreme Courts decision in *Federal v. American Hardware Mutual* not only adds another case to the list of additional insured victories but also expressly embraces the view that a broad construction of the typical additional insured endorsement is the dominant majority view of the courts. The articulated norm is that the additional insured is covered under the named insureds policy so long as the additional insured is being sued for something reasonably related to its operations involving the named insured. See 2008 Nev. LEXIS 38 at *18-*20 (citing cases). In other words, *Federal v. American Hardware* stands for the proposition that insurers using the traditional arising out of the named insureds operations additional insured endorsements must provide broad coverage to the additional insured and that there is little judicial debate on the point.

An Available Escape Hatch for Insurers But Reluctance to Use It. However, the decision also gives insurers a chance to avoid providing such broad coverage. [A]n insurer may limit the coverage provided to an additional insured [but] in order to do so, it must include in the endorsement explicit language that would exclude particular causes of losses suffered. Absent an express exclusion, we are bound to construe the insurance term broadly, in favor of coverage. See *id.* at *20-*21. This means that insurers are perfectly free to write more restrictive additional insured endorsements or to introduce evidence of party intent, expectation, or industry custom and practice in arguing for a narrower construction of an additional insured endorsement. Although *Federal v. American Hardware* and other cases in the majority trend create a default rule or presumption in favor of broad additional insured coverage, it is a default rule that can be avoided by contract and a presumption that can be rebutted by specific policy language or other indicia of contract meaning.

Ironically, however, most insurers appear to continue to be using the arising out of the named insureds operations endorsement or only slight variations even though the Insurance Services Office has made available to insurers a more favorable endorsement. In 2004, ISO issued form CG 20 10 07 04 which attempts to achieve a fault based coverage grant by eliminating the phrase arising out of your [named insureds] ongoing operations performed for that [additional] insured and instead linking potential coverage for the additional insured directly to the acts or omissions of the named insured. More specifically, ISO seeks to limit coverage for an additional insured to its vicarious or contributory negligence and negate any coverage for the additional insureds sole negligence. . . . See Randy J. Maniloff, *Additional Insured Endorsements*, FC& S Casualty & Surety Bulletin M. 23-1 (May 2004) at 23-3; Randy J. Maniloff, 19-22 *Additional Insured Endorsements: (ISOs Revisions): Adopting a Fault-Based Additional Insured Standard*, 18-26 *Mealeys Litig. Rep. Ins.* at 11-12.

I am considerably less impressed with the clarity of the language in the new ISO form. In particular, the forms text stating that there is coverage for the acts or omissions of those acting on behalf of the named policyholder in the course of performing operations for the additional insured can very reasonably be read to mean that if an additional insured

(such as a general contractor) is working on the job site in at least some connection to the work of the named policyholder (such as a subcontractor), that there is coverage for the additional insured regardless of whether the additional insured is sued on a theory of vicarious liability or active negligence. The new language, albeit narrower than the old language, still could be seen by many (or perhaps even most) courts as ambiguous. This is particularly ironic in that ISO had, prior to issuance of the new form, considered using language stating that there was no coverage under the endorsement for claims involving the sole negligence of the additional insured or by those acting on behalf of the additional insured. Now there's language that is unambiguous.

Because ISO was aware of how to write such straight-forward endorsements but declined to put such clear language in the resulting 2004 form, insurers will have some explaining to do in contending that the much more vague 2004 form clearly accomplishes the same result. However, to the extent that courts permit insurers using the 2004 form to introduce extrinsic information such as drafting history, ISOs accompanying materials make it quite clear that under the new form, the intent of the insurance industry is to provide additional insured coverage only when the named policyholders acts or omissions result in suit against the additional insured. In the meantime, insurers appear to continue to use the pre-2004 endorsement language and continue usually to lose when arguing for a restrictive construction of their endorsements in actual use.

Conclusion. For the moment, the key lessons of *Federal Insurance v. American Hardware Mutual* are these: First, insurers who continue to use the traditional pre-2004 arising out of named insured operations language for additional insured endorsements increasingly do so at their peril. Second, insurers who want to expressly write a narrower scope of additional insured coverage into their policies will probably be successful if their drafting is reasonably clear. Third, even where insurers have failed to do this, they may be able to win these coverage disputes in cases where they are able to produce sufficiently probative evidence that narrower scope was intended or that the additional insured had such an understanding or expectation.

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Wiley Rein LLP on the Showdown Looming Over NAIC's Authority

2008 Emerging Issues 330

Wiley Rein LLP on the Showdown Looming Over NAIC's Authority

By Lawrence Mirel

June 23, 2008

SUMMARY: For much of its 137-year history, the National Association of Insurance Commissioners was a forum for state insurance commissioners to meet and share experiences and common problems. That started to change when the NAIC began to serve as a standard-setting and information-sharing public voice for the regulatory community. The Emerging Issues Analysis analyzes the extent of this many-faceted problem from the perspective of the insurance industry.

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ARTICLE: Wiley Rein LLP on the Showdown Looming Over NAIC's Authority

By Lawrence H. Mirel

Since the National Association of Insurance Commissioners was founded in 1871 there have been questions about what, exactly, it is. It is often described as the oldest association of state officials in the United States, a private organization made up of public officials. It is not itself an "official" organization; that is, it has no governmental authority of its own.

Or does it?

For much of its long history the NAIC was a place for state insurance commissioners to meet, discuss common problems, swap stories about the large and diverse industry they collectively regulate, and have a good time. In short, it was much like any other private trade organization, despite the fact that its members were all elected or appointed state officials.

That began to change about 25 years ago, when the NAIC started playing a more central role in the state insurance regulatory system. As the insurance industry grew in both national and international importance the insurance commissioners saw a need for a more robust NAIC, to serve as a standard-setting and information-sharing public voice for the regulatory community. At first the insurance industry, desperate for a measure of uniformity in state regulatory

rules and some protection against redundant and sometimes conflicting examinations, supported this effort. Since the early 1990s, however, when the NAIC began to accredit state insurance departments, the growth of the NAIC has been phenomenal, and it continues to increase dramatically each year. Its size and capability have become a source of concern to the insurance industry, which has started to oppose the NAIC's efforts to function as a kind of national regulatory body.

In the early 1970s the annual budget of the NAIC was less than a million dollars. By 2008 that budget had grown to more than \$68 million, up from \$55 million just five years earlier, dwarfing the funding of all but a handful of the largest state insurance departments. Its paid staff now exceeds 425 persons, and it has an operating *reserve* of more than \$50 million. Its chief executive officer earns \$370,000 a year, many times the annual salaries of the regulators who form the membership of the organization, and other top officials of the organization are likewise well compensated. n1

Prior to 1980 close to two-thirds of the budget of the NAIC came from dues paid by member states. Today only about 3% of the budget comes from dues, and the states get more than that amount back in the form of grants and travel expenses handed out by the NAIC. The rest comes primarily from fees paid by the insurance industry, most of which are mandatory.

It is not hard to figure out what is going on here. Leaving aside the natural tendency of all organizations to grow and to seek power and authority, two main factors are driving this surge in the influence of the NAIC.

First, the very concept of state insurance regulation is under attack. The tradition in the United States of state insurance regulation goes back to an 1869 Supreme Court decision holding that insurance was not interstate commerce. n2 After the Supreme Court reversed itself in 1944 n3 Congress immediately enacted legislation -- the McCarran-Ferguson Act n4 -that ceded federal authority to regulate insurance to the states. The insurance industry supported, and still supports, much of the McCarran-Ferguson law.

But the industry, weary of the cost and difficulty of dealing with more than 50 state regulators (the 50 states plus the District of Columbia, Puerto Rico and the territories), coping with inconsistent rules and regulations, and responding to incessant and overlapping examinations, has been pushing for a single national regulator, at least on an optional basis. An Optional Federal Charter bill is currently pending in both Houses of Congress that would give insurers the same choice that banks have -- to be regulated by the states or to be regulated by the Federal Government. Even though there is no immediate prospect of the Optional Federal Charter bill becoming law, the NAIC feels compelled to fend off the challenge posed by those who seek to weaken or abolish state insurance regulation.

To respond effectively, the NAIC must be able to demonstrate that the state system can achieve a high level of uniformity, can speak with one voice, can maintain a central data bank of information about the industry, and can enforce the rules that it sets. It must, in other words, try to make the prospect of a federal regulator appear unnecessary, thereby enabling it to tap into a deep-seated public aversion to the growth of federal power and bureaucracy.

Second, technological innovation has enabled the NAIC to wield unprecedented power. What was only a few years ago an impossible dream -- to be able to gather vast quantities of data from multiple sources and collate those materials into easily accessible national information -- is now an everyday occurrence. The NAIC has the money, the machinery, and -- most importantly -- the highly trained people who can do far more with insurance industry data than any single state can. Moreover, by collecting such information, aggregating it, and selling it back to the industry that provided it in the first place, the NAIC has found an endless source of revenue. Using its unique position as the central repository of insurance information gathered from the states, the NAIC can maintain a virtual monopoly on highly valuable and much sought after data on the detailed operation of private insurance companies.

The problem with this picture is that the NAIC is not a government agency. It is neither empowered by law to play the role it seeks, nor is it limited by the rules that apply to governmental bodies. It is not subject to any Administrative Procedure Act, for example, which provides fairness and due process to persons who disagree with the activities of a

state or federal agency. No Freedom of Information Act is applicable to the NAIC, neither the provisions requiring public disclosure of information in the hands of the government nor more significantly for the industry-the provisions spelling out what information is private or confidential and therefore exempt from public disclosure. Most states and the federal government have laws protecting "trade secrets" and providing remedies for breaches of those laws, up to and including criminal penalties for officials who disclose such information. The NAIC is subject no such legal limitations.

The NAIC is, as described by its president in 2007, Commissioner Walter Bell of Alabama, "a 501(c)(3) non-profit corporation with voluntary membership and .. not a state government entity. .. When individual insurance commissioners gather as members of the NAIC, they are not considered a governmental entity or public body .. but rather are a private group. As an organization, the NAIC does not have any regulatory authority." n5

How, then, does it get the power to require that insurance companies submit data to it, and to pay fees for doing so? How is it that "[t]he NAIC maintains a vast compendium of financial and subject matter information on all facets of insurance...The NAIC's comprehensive collection of insurance information is the largest in the field. We have also invested heavily in software tools to analyze and enhance the data"? n6

The answer in part lies in statutes that the NAIC has convinced states to enact in recent years specifically mentioning the organization and requiring or, more usually, permitting state insurance regulators to share with it information obtained in the course of examining an insurance company. Typically these statutes provide that:

"All working papers, recorded information, documents, and copies thereof produced by, obtained by, or disclosed to the [regulator] or any other person in the course of any examination must be given confidential treatment, are not subject to subpoena, and may not be made public by the [regulator] or any other persons, except [in certain listed enforcement situations]. Access may also be granted to the National Association of Insurance Commissioners. Those parties must agree in writing before receiving the information to provide to it the same confidential treatment as required by this Section, unless the prior written consent of the company to which it pertains has been obtained."

The language quoted is from an Illinois market conduct examination statute, n7 but 43 states have similar laws. n8 Despite minor variations these statutes are much the same because they are based on model laws developed by the NAIC or by the National Conference of State Insurance Legislators ("NCOIL"). n9

Note that the statutory language says that the NAIC must give the same confidential treatment to the information it receives as is required under the law of the state that shared the information. The NAIC claims that it has signed confidentiality agreements with each of the states that would allow it to receive the information and protect it according to state law. Does that mean that the NAIC provides the same degree of confidentiality as that required under state law? That is not an easy question to answer because state laws vary. If the NAIC gathers information from most or all states, which state laws govern the confidentiality of that information-the most restrictive (i.e., those that provide the greatest confidentiality protection) or the least restrictive (i.e., those that require all information to be public)? n10

Moreover, *can* the NAIC provide the same degree of confidentiality as is required under state law, even if it wanted to? The Illinois statute quoted above provides that the market conduct examination data "are not subject to subpoena." If the information was under the control of the NAIC could the NAIC win a motion to quash a subpoena seeking the information in its possession, citing Illinois law? A state government may attempt to resist a subpoena by asserting sovereign immunity; the NAIC cannot.

More to the point, however, the NAIC shows no genuine interest in or commitment to protecting the confidentiality of company information that is provided to state regulators. To the contrary, the NAIC in recent months has taken several actions which suggest a desire to make all, or most, insurance company data in its possession public, causing shudders of anxiety throughout the industry.

In one of these efforts the Market Conduct and Consumer Affairs (D) Committee of the NAIC has proposed to the NAIC's Executive Committee that all market conduct information on insurance companies currently gathered by the

individual states be submitted to the NAIC yearly as a supplement to the Annual Statement Blank. The Annual Statement Blank, which is used for reporting financial solvency information, is considered a public document. Does that mean that reporting market conduct data on those forms removes them from the protection of state confidentiality laws? The general counsel of the NAIC says yes, that the confidentiality protection afforded market conduct data under state laws applies only to data reported on market conduct forms, not if the same information is reported on the Annual Statement Blank. n11

In another effort the NAIC has recently proposed changing the bylaws of the System for Electronic Rate and Form Filing ("SERFF") to make the board of directors of that joint regulator-industry organization into an advisory committee. SERFF is a cooperative industry-regulator effort that developed a software system allowing insurance companies to file their rates and forms (i.e., their policy language) electronically and uniformly with all states at once -- instead of making separate hard copy submissions to each jurisdiction, on separate, often state-specific, forms. The bylaws of SERFF, which was funded initially by industry and the NAIC, call for a governing board of 13 members, 7 regulators and 6 industry representatives, to make all policy decisions of the organization, subject to approval by the Executive Committee of the NAIC. SERFF was to be self-funded, with all income being used to cover the costs of the system, and for no other purpose. Initially the SERFF concept met with substantial resistance, as states did not want to accept electronic filings and companies were unwilling to file in a format that was not acceptable to the regulators. Over a 15-year period, however, hard effort on the part of the regulators and industry representatives on the SERFF board finally overcame the resistance and in the past year the program has achieved great success. All states now accept SERFF filings for at least some purposes and companies now generally use the system. n12

The industry sees the effort of the NAIC to change authority over the SERFF system by removing the industry representatives as an attempt to hijack a successful system and use it for other purposes, not all of which are acceptable to the industry. The industry worries that the revenues from the system, which are now substantial, will be used for other NAIC purposes not contemplated in the SERFF bylaws, and that the SERFF platform itself will be used to gather and make public individual company data that is now considered confidential. To date the outcome of this effort is not settled. n13

In another recent example, the Interstate Insurance Product Regulation Commission ("IIPRC") has voted to make public product proposals filed by companies that have been withdrawn or have been disapproved by the IIPRC. The IIPRC was formed at the initiative of the NAIC to provide a way for new products to be reviewed once, rather than having to be approved by each state regulator. Created by an interstate compact -- and thereby endowed with actual governmental authority that the NAIC itself lacks -- the IIPRC receives and reviews new product proposals (currently limited to life, annuity and long-term care products) by the use of panels made up of regulators from several jurisdictions. States that have joined the compact (currently 31) agree that they will accept the decision of the IIPRC panel that has reviewed the product and will allow it to be sold in their jurisdictions if the IIPRC has approved it. Submitting new products to the IIPRC is obviously highly advantageous to companies, saving much time and money, but the new proposal of the IIPRC has again raised questions about the operation of a quasi-governmental program.

Once approved, products reviewed by the IIPRC are of course made public. But companies for a variety of reasons do not want to have information about disapproved or withdrawn products publicly available. Moreover, a provision of the compact requires the IIPRC to protect "insurers' trade secrets," and a Drafting Note to that section refers to "product filing information .. as proprietary information of insurers." n14 Despite this clear language, however, the IIPRC, under pressure from the NAIC, is moving to make product filings public from the moment they are received by the IIPRC, regardless of whether they are later approved, disapproved, or withdrawn. n15

What does the industry fear from the new aggressiveness of the NAIC? After all, wouldn't it be better for the industry, as well as for the regulators, if all data was collected centrally so that one filing, and not 50-plus filings, would be possible? If a single federal regulator would make life easier and more efficient for the insurance industry, why not a single state-based regulator, namely the NAIC?

The difference is that a federal regulator would be empowered and limited by law. The NAIC, being a private organization, is not subject to the confidentiality laws that apply to government agencies. Issues of what information should properly be in the public domain and what information should remain confidential, either to protect the privacy of individual insurance company customers or to protect the trade secrets of those companies from competitors, would not be decided by a public regulatory agency, after full debate of the issues, but rather by a trade association with a large staff and a lot of money. Although the members of the NAIC are all state officials, and responsible under the laws of their states for their actions as regulators, they do not have such responsibilities or limitations when they act as members of their trade association. As Commissioner Bell noted, in the letter quoted at the beginning of this article, individual commissioners who participate in the NAIC do so not as government officials but as member of a private group.

Yet what the NAIC seems to be doing, as shown by recent actions described above, is to seek to override specific state confidentiality statutes in order to show that it can become the de facto national regulator of insurance. That is a highly dangerous and unprecedented role for an unaccountable, private trade association to play.

The primary motivation for these actions appears to be to hold off federal insurance regulation. But the effect would be to provide vast amounts of raw data to consumer groups and plaintiffs lawyers about the internal operations of insurance companies, information that the industry is certain will be used against them. Commissioner John Morrison of Montana, himself a plaintiffs' lawyer by profession, heads the D Committee that proposed making market conduct information public. He has claimed several times recently in public that the market conduct information held by the states is already in the public domain, despite the fact that the laws of Montana are clear that market conduct information is confidential in that state. n16 Morrison's view is shared by the representatives of various consumer groups. n17

It can certainly be debated whether and what kinds of insurance company data should be made public, and whether such public disclosure would actually help consumers or would truly harm industry. What should not be on the table, however, are proposals for a private trade association to ignore valid and enforceable state laws in its rush to prove itself capable of becoming a national insurance regulatory agency. We are still a country of laws, and it is through the legislative process that these kinds of issues need to be resolved.

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n1 Reported in BestWire, Jan. 2, 2008.

n2 *Paul v. Virginia*, 75 U.S. 168 (1869).

n3 *United States v. South-Eastern Underwriters Ass'n*, 322 U.S. 533 (1944).

n4 15 U.S.C. §§ 1011-1015.

n5 Letter dated April 9, 2007, from Commissioner Bell to Rhode Island State Representative Brian Kennedy, president of the National Conference of State Insurance Legislators ("NCOIL"), quoted in Mr. Kennedy's testimony before the Subcommittee on Capital Markets, Insurance, and Government Sponsored Enterprises of the U.S. House of Representatives Financial Services Committee, June 10, 2008.

n6 Testimony of Michael T. McRaith, Illinois Director of Insurance, speaking on behalf of the NAIC, before the U.S. House Subcommittee on Capital Markets, Insurance, and Government Sponsored Enterprises, June 10, 2008.

n7 Ill. Ins. Code, 215 ILCS 5/132.5(e).

n8 Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia, Washington, West Virginia, and Wyoming.

n9 NAIC Model Law 693; NCOIL Market Conduct Surveillance Model Law (11/2006).

n10 The Illinois statute, and similar laws in other states, provides for another exception to the confidential protection of the information, namely "the prior written consent of the company to which it pertains." As far as can be determined, the NAIC has never sought and has never obtained written consent from any company to release information in its possession from the confidentiality protection afforded by applicable state laws.

n11 Colloquy between Andrew Beal, Associate Executive Director and Chief Legal Counsel of the NAIC, and lawyers for the American Council of Life Insurers, June 9, 2008.

n12 Although intended to be entirely voluntary on the part of both regulators and insurance companies, in the past year states have begun to require companies to file their rates and forms directly with the NAIC, using the SERFF platform. See, e.g., Alabama (Dept. of Ins. Bulletin April 1, 2007); Colorado (Div. of Ins. Bulletin

B-1.19, effective Sept. 11, 2007); Kansas (Ins. Dept. Bulletin 2007-6 dated July 23, 2007); Massachusetts (Div. of Ins. Bulletin 2008-08 dated May 20, 2008); Minnesota (Dept. of Commerce Bulletin 2007-3, dated July 9, 2007); and Rhode Island (Ins. Bulletin No. 2007-03 dated June 15, 2007). Do such laws transform NAIC from a private organization into a quasi-governmental body?

n13 At a meeting of the SERFF board in San Francisco on May 31, 2008, the chief legal officer of the NAIC argued that the SERFF board was never a properly constituted legal body and that the NAIC had every right to take it over. The following day, however, the Chairman of the SERFF board, Commissioner Roger Sevigny of New Hampshire, said that the NAIC would respect the authority of the SERFF board and would seek changes within the requirements of the SERFF bylaws.

n14 Interstate Ins. Product Regulation Compact, Art. VIII, 1, drafting note (NAIC Model Regulation 692, July 2003).

n15 Although the IIPRC has already voted to make this information public, it has also established a 60-day period for comments from industry and regulators before the new rule goes into effect. That period of review expires in the middle of August. It is conceivable, of course, that based on the comments received, the IIPRC will change its mind.

n16 See Mont. Code Ann. § 33-1-409(6) (stating that "[a]ll working papers, confidential criminal justice information, as defined in 44-5-103, personal information protected by an individual privacy interest, and trade secrets, as defined in 30-14-402, specifically identified and for which there are reasonable grounds of privilege asserted by the party claiming the privilege obtained by or disclosed to the commissioner or any other person in the course of an examination made under this part must be given confidential treatment, are not subject to subpoena, and may not be made public by the commissioner or any other person, except to the extent provided in subsection (5). . . .").

n17 For example, in a letter dated March 28, 2008, addressed to Commissioner Morrison and commending the work of the D Committee, Constance Chamberlin, President and CEO of Housing Opportunities Made Equal in Virginia, Inc, a NAIC Funded Consumer Representative, wrote: "Rather than collecting summaries, as set out in the current proposed data elements, regulators need data on the individual policy level. Data collected should include the race, gender and income of the applicant, credit score if applicable, disposition of application, location of the policy, premium, type of policy, number of claims, etc."

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Richmond on Certificates of Insurance

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Richmond on Certificates of Insurance: Understanding Their Role in Liability Insurance Coverage

By Douglas Richmond

June 19, 2008

SUMMARY: This Emerging Issues Analysis explores court decisions across the nation revealing those dangers and offers practical advice to parties who would issue or rely upon certificates of insurance.

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ARTICLE: Richmond on Certificates of Insurance: Understanding Their Role in Liability Insurance Coverage By Douglas R. Richmond Introduction

When a commercial landowner contracts for construction on its property, it typically requires the general contractor to name it as an additional insured on the contractors commercial general liability (CGL) insurance policy. n1 Similarly, commercial landowners or property managers may require lessees to name them as additional insureds on the lessees CGL policies. Alternatively, a large retailer may require vendors who supply it with potentially hazardous products to name it as an additional insured on the vendors CGL policies. The entity to be named as an additional insured may specify coverages to be procured, or mandate minimum liability limits to be provided. Because the parties in these situations usually have contractual indemnity obligations apart from applicable insurance policies, the party procuring coverage generally may be described as the indemnitor, and the party to be named as an additional insured as the indemnitee. n2

Regardless of the context or specific coverage requirements, a company that is required to procure particular coverage for itself or add another entity or person to its liability policy typically evidences the fulfillment of its obligation by providing the indemnitee with a certificate of insurance. Most certificates of insurance are issued on a standard form prepared by ACORD Corporation for the insurance industry. Much as standardized insurance policies are identified by form number, the current standard certificate of liability insurance is ACORD 25 (2001/08). The forms change slightly over time, although the current form is very similar to its immediate predecessors. A standard certificate identifies the producer (an agent or broker), the insured, and the insurers affording coverage. The certificate also gives basic information about the policies to which it refers, including the names of the insurance companies affording coverage, the type of insurance, the policy numbers, the effective dates and expiration dates of the policies, and the liability limits of the policies. There is space to describe operations, exclusions, etc., added by endorsement to the policies listed, or to identify special policy provisions. The indemnitee is identified on the certificate as the Certificate Holder.

The use of certificates in this context has some advantages. The principal advantage is convenience. Certificates can be prepared and issued expediently, while an insured might not receive its policy for several months after inception. Most certificates are a single page or two, while commercial insurance policies may be lengthy. Certificates are easy to read. Certificates typically are issued by the indemnitors insurance broker, which eliminates the delay expected to accompany the insurers direct involvement in the process.

Additionally, insureds may be reluctant to share all the details of their insurance policies and can avoid doing so by substituting certificates for copies of actual policies. For example, a contract may require the indemnitor to procure a CGL policy with liability limits of \$1 million per occurrence. In fact, the indemnitor has a CGL policy with \$5 million liability limits, but it does not want to reveal its higher limits by furnishing a copy of its policy to the indemnitee because it thinks that information will make it a more appealing target should litigation ever erupt. By requesting that its broker issue a certificate of insurance stating that it has a policy with \$1 million liability limits in place, the indemnitor can satisfy its contractual obligations without revealing what it considers to be sensitive information. n3 Alternatively, the indemnitor may not want its indemnitee or others to know what it pays for coverage. Of course, the declarations page on its policy will reveal the premium amount. By providing a certificate in lieu of its policy, the indemnitor avoids this perceived intrusion into its business affairs as it goes about satisfying its contractual obligations.

While these advantages have made certificates the preferred means of documenting commercial indemnitors maintenance or provision of suitable liability insurance coverage, many business people and lawyers do not understand the limited role of certificates of insurance in liability coverage. They often do not appreciate how little information a certificate conveys about the coverage it identifies, or that as a rule, a certificate does not establish coverage for a loss. It is also unfortunately true that brokers sometimes issue certificates that are incorrect, as where they issue a certificate showing an indemnitee as an additional insured when, in fact, the indemnitee has not been added to the subject policy. n4 In any event, there are ample opportunities for controversy when a claim is made. Certificates of insurance commonly play a role in commercial coverage and indemnification disputes. Basic Principles Regarding Certificates of Insurance

It is perhaps simplest to begin our discussion of basic principles regarding certificates of insurance by identifying what a standard certificate is not, or what it does not do. A standard certificate of insurance does not alter the terms of the parties indemnity agreement or underlying contract. n5 A standard certificate of insurance is not an insurance policy. n6 A certificate does not alone evidence an oral contract of insurance. n7 A certificate is not a binder, i.e., a temporary policy of insurance that is effective until the insurer issues a formal policy. n8 A certificate of insurance alone does not constitute a contract to procure liability insurance with the issuing broker or impose a duty upon the issuer to obtain coverage. n9 For that matter, a standard certificate of insurance is not a contract of any sort. n10 A standard certificate does not even evidence an indemnitors agreement to procure insurance covering an indemnitee as an additional insured. n11

So what is the function of a certificate of insurance in the context of liability coverage? What role does a certificate play in liability insurance? In short, a standard certificate of insurance is solely an informational document. n12 A standard certificate of insurance serves to evidence the existence of the policies to which it generally refers. n13 It is the policies that control coverage, n14 as *Granite Construction Co. v. Bituminous Insurance Cos.* n15 illustrates.

Granite, a general contractor, sought a declaratory judgment that Bituminous, which insured a subcontractor, Brown, had a duty to defend Granite in a personal injury action by a Brown driver. Granite was an additional insured on Browns policy with Bituminous and had received a certificate to that effect. Bituminous denied coverage based on the persons insured provision in its policy. That provision had been amended by endorsement to make Granite an additional insured, but only with respect to liability arising out of operations performed for [Granite] by or on behalf of [Brown]. n16 The sole allegation in the underlying suit was that Granites employee negligently loaded Browns truck, causing it to overturn.

The trial court granted summary judgment for Bituminous, and Granite appealed to the Texas Court of Appeals.

Granite argued that regardless of the persons insured language in the policy, the following provision in the certificate triggered coverage: CERTIFICATE HOLDER IS ADDED AS AN ADDITIONAL NAMED INSURED FOR ALL GRANITE CONSTRUCTION COMPANYS WORK IN THE STATE OF TEXAS. n17 The court rejected this argument, explaining that the certificate itself did not manifest the insurance coverage afforded Granite as an insured. n18 Rather, the certificate merely evidenced Granites status as an insured and, by its very language, specified that any coverage was subject to the specific terms, conditions, and exclusions in the Bituminous policy. n19

Bituminous argued that it had no duty to defend Granite because the persons insured endorsement to its policy restricted coverage to liability for acts performed by Brown, but not for Granites own operations. n20 The court agreed that the underlying claim did not arise out of operations performed for Granite by or on Browns behalf, because it was Granites own employees negligence that gave rise to the suit. n21 Accordingly, the court in *Granite* affirmed the trial court judgment for Bituminous.

The fact that standard certificates of insurance are informational documents only and do not confer coverage should be apparent from their face. Standard certificates bear significant disclaimers. For example, a standard certificate states at the top: THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. The decision in *Handley v. Providence Mutual Fire Insurance Co.* n22 illustrates the importance of this broad cautionary language.

Handley, a home builder and remodeler, required a subcontractor, Miles, to provide him with a certificate of insurance demonstrating that Miles had liability coverage. Miles insurance broker, Olivier, sent Handley a certificate supposedly evidencing Miles coverage through Providence (Olivier was an authorized representative of the company). The certificate did not bear the foregoing disclaimer. n23 In fact, Olivier knew that Miles had no coverage because his premium check bounced. When Handley later sought coverage under Miles policy, Olivier revealed that Miles had no policy with Providence. Handley then sued Providence for negligent misrepresentation. n24 The trial court held that the certificate of insurance issued by Olivier created no contractual relationship or duty on the part of Providence to inform Mr. Handley of any inaccuracies contained in the certificate . . . including whether coverage actually existed. n25 On this basis, the trial court granted Providence summary judgment. Handley appealed.

The Supreme Court of New Hampshire reasoned that the absence of disclaimers on the certificate clearly stating that the document was issued for informational purposes only or that it conferred no rights upon the certificate holder, coupled with false statements in the certificate, made Providences potential liability an issue of fact. n26 The court accordingly reversed the trial court and remanded the case for further proceedings.

Other courts react similarly. Under Illinois law, for example, the lack of such a disclaimer on a certificate may result in the certificate governing the extent and terms of coverage. n27 On the other hand, where the certificate refers to the policy and expressly disclaims any coverage other than that contained in the policy itself, the policy governs the extent and terms of coverage. n28

A standard certificate further provides at the start of the Coverages section: THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

A standard certificate also relieves an insurer of liability for failing to notify the certificate holder that the related policy has been cancelled. This is accomplished by way of the following language: SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING

INSURER WILL ENDEAVOR TO MAIL 30 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED . . . , BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES.

Because a standard certificate of insurance is not an insurance policy and because it bears clear disclaimers, prudent indemnitees obtain copies of the policies to which certificates refer so that they can analyze them. n29 Only then will they know if the policies to which a certificate refers were in fact issued, or truly afford the contemplated coverage. Indeed, an additional insured is arguably obligated to examine the policy to determine applicable coverages. n30 In any event, the mere issuance of a certificate of insurance does not confer additional insured status or impose any duties on an insurer vis--vis the certificate holder. n31 As a rule, a certificate cannot create coverage where none exists under the policy to which the certificate refers. n32

Finally, an insurer generally has no duty to inform an additional insured of inaccuracies in, or subsequent changes to, the information contained in a certificate of insurance. n33 The same is true for a broker who issues a certificate. n34 An insurer generally has no duty to inform the additional insured that the policy to which the certificate refers has been cancelled or was not renewed, as the disclaimer on a standard certificate should make clear. n35 The fact that the policy to which a certificate refers was cancelled or non-renewed before a broker issued the certificate still does not give the indemnitee any rights against the insurer. n36

For all of the foregoing reasons, indemnitees and courts are sometimes skeptical of certificates value. As the New Hampshire Supreme Court once observed, a certificate of insurance bearing the standard disclaimers is a worthless document which does no more than certify that insurance existed on the day the certificate was issued. n37 CASES AND CONTROVERSIES

Certificates may play a role in a variety of controversies. In some states, for example, policy exclusions are invalid unless clearly communicated to the insured in writing. n38 Thus, even where the certificate provides that the policy will control, exclusions that do not appear on the certificate are effective only if the policy itself is provided to the additional insured. n39 If not, the insurance company must provide broader coverage to the additional insured than that afforded the named insured. Similarly, in *Midland Enterprises, Inc. v. St. Paul Fire & Marine Insurance Co.*, n40 an Ohio court concluded that a marine towing company named as an additional insured was entitled to coverage even though the vessel involved in the loss was not scheduled on St. Pauls binder. In determining whether St. Paul had agreed to provide coverage, the court read the binder and a related certificate together. Because the certificate [did] not state that there were any limitations for that coverage, it was proper evidence of the coverage that the towing company thought it had been provided. n41

Midland Enterprises turned on its unusual facts and, accordingly, the case is of limited precedential value. First, the loss occurred before St. Paul issued a policy. Accordingly, the court could never examine the policy to determine coverage. This fact significantly influenced the courts decision. n42 Second, the certificate bore comments specific to coverage for the vessel lost. n43 These comments supported the policyholders claim to coverage. Third, there is nothing in the opinion to indicate that the certificate bore any of the standard disclaimers. Certificates of Insurance and Coverage by Estoppel. Most disputes involving certificates of insurance involve estoppel allegations. In *Marlin v. Wetzel County Board of Education*, n44 for example, the Wetzel County Board of Education contracted with Bill Rich Construction to renovate a school. The contract required Bill Rich to indemnify the Board against claims arising from the companys renovation work; to maintain liability insurance coverage, including contractual liability coverage for its indemnity obligations; and to name the Board as an additional insured on its liability policy. n45 Bill Rich purchased CGL and umbrella coverage from Commercial Union through the B & W Insurance Agency. Bill Rich arranged for B & W to issue a certificate of insurance describing the Board as additionally insured on its Commercial Union policies and identifying the Board as a certificate holder. n46

Workers employed by subcontractors involved in renovating the school alleged that they were exposed to asbestos dust and sued both the Board and Bill Rich. Based on its contract with Bill Rich and the certificate of insurance, the

Board demanded that Commercial Union defend and indemnify it against the workers claims. The insurer refused, asserting that while B & W was its agent for purposes of issuing the certificate, B & W never notified it that the Board was to be afforded additional insured status under Bill Richs policies. n47 Commercial Union never received the certificate or any other document indicating that it needed to amend its policies. Furthermore, Commercial Union argued, the certificate on which the Board relied plainly was issued for informational purposes only and could not alter or amend the related policies. n48

The Board filed a declaratory judgment action against Commercial Union. Both sides moved for summary judgment. The trial court sided with Commercial Union, concluding that the disclaimers on the certificate defeated the Boards expectation of coverage. The court further found that the policies did not cover the Board merely because of the indemnity provisions in the Bill Rich contract. The Board appealed to the Supreme Court of Appeals of West Virginia.

On appeal, the Board argued that because a Commercial Union agent issued a certificate identifying it as an additional insured, it reasonably relied on that representation and to its detriment allowed Bill Rich to perform work for which it was inadequately insured. Thus, the Board claimed, Commercial Union was estopped to deny it coverage as an additional insured. n49 Commercial Union, on the other hand, argued that it never knew of the certificate issued by its agent. It thus did not amend Bill Richs policies to additionally insure the Board. Neither the Board nor Bill Rich paid additional premiums for additional coverage. The disclaimers on the certificate should have signaled the Board that the certificate afforded it no coverage. In sum, because no firm representation of coverage was ever made and the Board could not have reasonably relied on the certificate as evidence of coverage, there could be no estoppel. n50

The Supreme Court of Appeals of West Virginia noted that estoppel may not be used to create coverage where none otherwise exists, or to increase coverage beyond that provided by the policy. n51 This is, of course, the clear majority rule. n52 Yet the court noted that an exception to the general rule may lie where an insurer or its agent makes a misrepresentation at a policys inception that deprives the insured of the opportunity to obtain the coverage it desires. n53 The court thus focused on whether B & Ws issuance of the certificate identifying the Board as an additional insured on Bill Richs policies constituted a misrepresentation entitling the Board to coverage. The court concluded that it did, explaining:

We therefore hold that a certificate of insurance is evidence of insurance coverage, and is not a separate and distinct contract of insurance. However, because a certificate of insurance is an insurance companys written representation that a policyholder has certain insurance coverage in effect at the time the certificate is issued, the insurance company may be estopped from later denying the existence of that coverage when the policyholder or the recipient of a certificate has reasonably relied to their detriment upon a misrepresentation in the certificate.

Examining the record, we believe that the elements of estoppel . . . have been established by the Board. At the inception of coverage for the Board . . . an agent for Commercial Union prepared a certificate of insurance naming the Board as an additional insured. The insurance companys bare, conclusory averment that the certificate naming . . . [the Board] as an additional insured was the result of clerical error was insufficient to overcome the estoppel effect of its misrepresentation, since even an innocent misleading of another party may bar one from claiming the benefits of his deception. n54

The *Marlin* court determined that the trial court erred in ruling for Commercial Union and remanded the case to the trial court for further proceedings. Because the Supreme Court of Appeals had already found that the Boards contract with Bill Rich was an insured contract within the meaning of the contractual liability coverage in the Commercial Union policies, n55 the decision was a clear win for the Board.

Interestingly, the Supreme Court of Appeals of West Virginia never addressed Commercial Unions argument that the disclaimers on the certificate defeated the Boards claim of reasonable reliance, which is an essential element of estoppel. The court seemingly skirted the issue on the basis that denying coverage to the Board in this instance would be unjust, and estoppel is designed to prevent a partys disavowal of previous conduct if such repudiation would not be

responsive to the demands of justice and good conscience. n56 It is difficult, however, to perceive any injustice in these circumstances. The Board presumably was advised by counsel with respect to the Bill Rich contract and it surely had its own liability insurance coverage for the workers claims. Additionally, the disclaimers on the certificate screamed to the Board of the need to verify its coverage as an additional insured. It arguably was unreasonable for the Board to rely on the certificate for coverage given the documents plain disclaimers. n57 The fact that Commercial Union probably suffered no material harm by virtue of its right to indemnity from B & W changes nothing. n58 The *Marlin* court should have addressed the reasonable reliance issue head-on and its failure to do so lessens the opinions persuasive value. n59

Although other courts have also invoked estoppel to find coverage based on certificates of insurance, n60 this approach does not reflect a majority rule. Indeed, there is ample contrary authority.

In *TIG Insurance Co. v. Sedgwick James of Washington*, n61 for example, a company called Via Net was insured under a general liability policy issued by Lumbermens. In March 1996, one of Via Nets customers, Safety Lights, required Via Net to provide a certificate of insurance reflecting Safety Lights status as an additional insured on Via Nets general liability policy. Via Nets insurance broker, Sedgwick, issued a standard certificate bearing all of the customary disclaimers that identified Safety Lights as an additional insured under Via Nets general liability policy with Lumbermens. In 1997, Guy Wright, a deliveryman for Via Net or an affiliated company, was injured making a delivery to Safety Lights. He sued Safety Lights, which notified Sedgwick of the suit and requested a defense and indemnity from Lumbermens by virtue of its additional insured status reflected on the certificate of insurance. Lumbermens declined, asserting that Safety Lights was not an additional insured on the Via Net policy. n62

Safety Lights liability insurer, TIG, defended the Wright lawsuit. After the case settled, TIG and Safety Lights sued Sedgwick and Lumbermens to recover their defense and indemnity costs. Both sides moved for summary judgment, and one of the principal issues was the effect of the certificate that identified Safety Lights as an additional insured on Via Nets general liability policy. The plaintiffs alleged that the certificate created coverage. The district court disagreed, concluding that Safety Lights was not entitled to coverage by virtue of the certificate, and ultimately granted Lumbermens summary judgment on all of the plaintiffs claims. n63

Under Texas law, when a certificate of insurance states that it does not alter, amend or extend the terms of the policy to which it relates, the terms of the certificate are subordinate to the terms of the insurance policy. n64 A certificate will not create coverage where none otherwise exists. n65 In this case, the certificate clearly provided that it did not alter, amend or extend the terms of any policies listed on the document. Lumbermens policy made no provision for additional insured coverage. The certificate was not itself a contract of insurance. n66

Safety Lights contended that it never received a copy of the Lumbermens policy and that it relied on Lumbermens representation of coverage on the certificate. The fact that Safety Lights never received the policy, however, did not change the result. The plaintiffs had no basis to claim that it was reasonable to rely on a certificate of insurance in lieu of actual policy language. Indeed, settled Texas authority supported the practical result that the holder of a certificate of insurance should obtain the insurance policy to ascertain his coverage. n67

TIG and Safety Lights appealed the district courts grant of summary judgment to the Fifth Circuit. They argued on appeal that Lumbermens was bound to provide coverage under the certificate of insurance because, in issuing the certificate, Sedgwick acted as Lumbermens agent. n68 This argument failed, however, because while Sedgwicks agency agreement with Lumbermens authorized Sedgwick to issue certificates on the insurers behalf, it did not authorize Sedgwick to modify policies. n69 The certificate plainly stated that it did not alter or amend the terms of the Lumbermens policy. Sedgwicks issuance of the certificate could not create coverage on either an actual or an apparent authority theory. Sedgwick simply did not have the power to bind Lumbermens contractually. n70

Retreating, TIG and Safety Lights contended that Lumbermens was estopped to deny coverage based on the certificates identification of Safety Lights as an additional insured. This argument was doomed to fail under Texas law,

which holds that (1) estoppel cannot be used to create coverage where none otherwise exists; and (2) when a certificate expressly incorporates the terms of a policy, as did the certificate here, the policy trumps the certificates terms. n71

The plaintiffs made two additional arguments for coverage, both of which the court rejected. The Fifth Circuit therefore affirmed the district court judgment for Lumbermens.

In *Redmond v. State Farm Insurance Co.*, n72 John Redmond purchased an apartment building and sought full coverage on the property from State Farm agent James Reid to satisfy a condition of his mortgage loan. Redmond never received or read the policy he discussed with Reid. The only documents he saw were a certificate of insurance, a price quote, and a brochure on apartment building insurance. Redmond assumed that his new State Farm policy covered everything. n73 The brochure stated that it contained only a general description of coverage and that all coverages were subject to the conditions and exclusions in the policy. n74 The certificate described the policy to which it referred as special form all risk. n75

The State Farm policy contained a lead paint exclusion. When some tenants made lead paint claims, Redmond sued State Farm to determine whether the company was obligated to defend and indemnify him. A jury returned a verdict for State Farm.

Redmond appealed, arguing that State Farm was estopped to deny coverage and that the policy should be reformed to provide coverage. He argued that he had a reasonable expectation of coverage based in part on the certificate of insurance stating that he had all risk coverage. n76 The appellate court disagreed, discussing the certificate of insurance in the process. The court found that the words special form all risk on the certificate did not by themselves manifest an intent to cover lead paint claims. n77 Moreover, the brochure describing the policy expressly stated that all coverages were subject to the conditions and exclusions in the policy. n78 The *Redmond* court thus held that the doctrines of equitable estoppel and reformation did not apply, and affirmed the trial courts determination that there was no contract to provide lead paint coverage as a matter of law. n79

In *Pekin Insurance Co. v. American Country Insurance Co.*, n80 the certificate issued to the additional insured, Ulbrich, bore all the standard disclaimers. A loss involving Ulbrich was excluded by the American Country policy to which the certificate referred. Ulbrich and its liability insurer, Pekin, filed a declaratory judgment action to determine American Countrys duty to defend Ulbrich. They asserted that because the certificate named Ulbrich as an additional insured on a policy which provided commercial general liability insurance . . . but the policy excluded coverage, there is a conflict between the two documents. n81 They reasoned that the language of the certificate should prevail. n82 The *Pekin* court rejected this argument, stating:

[T]here was a clear showing, . . . that the certificate was not part of the policy, and it conveyed no rights to the certificate holder. These statements also informed Ulbrich as a certificate holder that it had to look to the policy to determine the extent of coverage as well as any existing exclusions. n83

The certificate of insurance did nothing more than inform Ulbrich that it had the same coverage afforded the named insured for the project at issue, subject to all of the policys terms and exclusions. There was no conflict between the certificate and the policy. n84

It was Ulbrichs responsibility, not American Countrys, to determine whether the coverage afforded by the American Country policy was adequate for its intended purposes. The *Pekin* court reasoned that to hold otherwise would place an impossible burden on insurers to review all agreements between their named insureds and prospective additional insureds to determine particular insurance needs before issuing certificates. n85 Misrepresentation Cases. In addition to arguing for coverage based on estoppel, indemnitees frustrated by a lack of coverage seemingly provided by a certificate of insurance also assert claims for negligent or fraudulent misrepresentation against indemnitors, insurers and intermediaries. To prevail on a misrepresentation theory, a plaintiff must establish that it reasonably relied on the allegedly false statement. This is a high hurdle where the statement supposedly inducing the plaintiffs reliance appears

in a standard certificate of insurance. The disclaimers on standard certificates tend to make reliance on the document unreasonable. n86 Rather than relying on a certificate of insurance, an indemnitee should obtain a copy of the policy to which the certificate refers and review it to determine the existence or scope of coverage actually afforded. n87 This is, of course, consistent with the general rule that insureds have a duty to read their insurance policies and are charged with knowledge of their provisions. n88

In *Alabama Electric Cooperative, Inc. v. Bailey Construction Co.*, n89 for example, AEC and Bailey entered into a contract in March 2000 for Bailey to remove ash and sludge from one of AECs holding ponds. The contract required Bailey to furnish evidence to AEC that Bailey had procured liability insurance to cover its removal work. Bailey supposedly agreed to have AEC named as an additional insured on its liability insurance policy, although the contract did not include a provision to that effect. Bailey had previously worked for AEC and on those occasions had AEC named as an additional insured on its policies. With respect to those jobs, Bailey had directed its broker, International Assurance, Inc., to issue certificates of insurance to AEC identifying the cooperative as an additional insured on Baileys liability policies.

In October 2000, Willene McLoed, an independent contractor working for Bailey on the holding pond project, was killed on AECs property. The executor of McLoeds estate sued AEC for wrongful death. AEC asked International to furnish it with a certificate of insurance reflecting its status as an additional insured on Baileys liability policy with QBE Insurance Co. It was then determined that AEC was not an additional insured on the QBE policy. Nevertheless, International issued a certificate identifying AEC as an additional insured on the QBE policy without authorization from either Bailey or QBE and sent that certificate to AEC. n90

AEC demanded that Bailey and QBE defend and indemnify it with respect to the McLoed wrongful death action. QBE initially agreed to do so based on the certificate identifying AEC as an additional insured. QBE changed its mind, however, when it discovered that AEC was never actually added to its policy as an additional insured by an endorsement to that effect. n91 AEC and its insurers settled the McLoed action without Baileys or QBEs participation. They then sued Bailey, QBE and International. That case reached the Alabama Supreme Court, where AEC and its insurers contended that Bailey had misrepresented AECs status as an additional insured and that those misrepresentations had induced AEC to enter into the holding pond contract. AEC and its insurers argued that the misrepresentations were contained in the certificates of insurance sent to AEC by International Assurance, [which] indicat[ed] that AEC was an additional insured on Baileys then existing insurance policies. n92 The certificates were issued in connection with projects performed by Bailey before entering into the holding pond contract. n93

Bailey countered that even if it could be held vicariously liable for Internationals alleged misrepresentations in prior certificates of insurance, AEC could not have reasonably relied on those misrepresentations in awarding the holding pond contract. n94 The prior certificates clearly stated that they were issued for informational purposes only and did not alter, amend, extend or modify the coverage provided by the subject policies. n95 Moreover, the reverse side of one of the certificates provided that if the holder was to be an additional insured, the policy itself had to be endorsed to that effect, and that a statement on the certificate did not confer rights to the certificate holder in lieu of such endorsement(s). n96

The Alabama Supreme Court agreed with Bailey, principally relying on the district court decision in *TIG Insurance Co. v. Sedgwick James of Washington*. n97 The *TIG Insurance* court had rejected the plaintiffs misrepresentation claims based on the clear disclaimers on the certificate at issue and the would-be indemnitees failure to read the actual policy to which the certificate referred. n98 AEC and its insurers attempted to distinguish the *TIG Insurance* decision on the basis that the insured there could have reviewed the subject policy had it elected to do so. n99 Here, they contended, AEC was unable to review the policies to which the certificates referred. They based their argument on deposition testimony by an International broker, Andrea Miller, who testified that she would not have given AEC copies of Baileys insurance policies without Baileys permission. n100 In her view, Baileys insurance policies were akin to trade secrets, given that Bailey might not have wanted AEC to know what it was paying for coverage. n101

There were several flaws in the plaintiffs argument. First, there was no evidence that AEC ever attempted to obtain copies of the policies or endorsements that would have existed if it were, in fact, an additional insured. Second, there was no evidence that Baileys insurers would have refused to give AEC copies of their policies or additional insured endorsements had they been asked. Third, there was no evidence that Bailey would have refused to consent to AEC reviewing its insurance policies. Based on these facts, the court held that AEC and its insurers could not establish that AEC reasonably relied on the certificates of insurance in awarding Bailey the holding pond contract. n102 Bailey thus prevailed on the plaintiffs misrepresentation claim.

In *Nazami v. Patrons Mutual Insurance Co.*, n103 a local home improvement contractor, Gifford, was negotiating with Nazami to renovate her home. In June 2001, Giffords insurance broker, Fallon, issued a certificate of insurance identifying Nazami as the holder. The certificate stated that the Patrons policy to which it referred would expire in May 2002. The certificate bore all of the standard disclaimers described above in this commentary. Importantly, it provided that while Patrons would endeavor to mail Nazami written notice should the policy be cancelled before its expiration date, it would bear no liability in the event notice was not mailed. n104

Gifford began work on Nazamis home in November 2001 and, naturally, he blundered enormously. When Nazami made a claim for her damages under Giffords policy with Patrons, she learned that it had been cancelled for non-payment of premiums. She then sued Gifford, Fallon and Patrons. Nazami alleged that she relied on the certificate of insurance in contracting with Gifford and that Fallon knew or should have known that the certificate might lead her to believe that Giffords coverage with Patrons was guaranteed until the policys expiration date. She accordingly asserted claims for common law fraud, negligent misrepresentation, violation of the Connecticut Unfair Insurance Practices Act (CUIPA), and violation of the Connecticut Unfair Trade Practices Act (CUPTA). n105 The trial court granted summary judgment for Fallon and Patrons, and Nazami appealed. The Connecticut Supreme Court accepted transfer from a lower appellate court. n106

The Connecticut Supreme Court rejected Nazamis CUIPA and CUPTA claims on the basis that her misrepresentation allegations were in direct conflict with the language of the certificate. n107 As the court explained:

For example, it is clear that the policy expiration date and the possibility of cancellation are two distinct events contemplated by the language of the certificate. Although the certificate provided that the policy took effect on May 15, 2001, and would expire on May 15, 2002, it also explicitly disclaimed any liability in the event that the policy was cancelled. Indeed, the certificate specifically noted that the stated coverage was subject to all the terms, exclusions and conditions of the policy.

Furthermore, the certificate contemplated cancellation in providing that, [s]hould any of the above described policies be cancelled before the expiration date thereof, the issuing insurer will endeavor to mail [ten] days written notice to the certificate holder. . . . (Emphasis added.) In short, the certificate specifically and repeatedly distinguished between expiration and cancellation of the [Patrons] policy. n108

The certificate simply did not contain any misrepresentations as required to constitute violations of the statutes. n109

The court was equally unimpressed with Nazamis common law fraud and negligent misrepresentation claims. Again, the certificate bore significant disclaimers with respect to cancellation and the restriction of coverage to the terms of the Patrons policy. n110 The certificate did not provide that the Patrons policy was paid in full for its entire term, or that it was in any way guaranteed. n111 After tackling Nazamis other claims, the Connecticut Supreme Court affirmed the trial courts grant of summary judgment for the defendants. PRACTICAL ADVICE

Notwithstanding the scattered cases suggesting that indemnitees may successfully argue for coverage by estoppel based on representations contained in a certificate of insurance, prudent indemnitees should exercise caution when requiring that indemnitors procure liability insurance applicable to their common enterprise. Caution is required

regardless of whether a contractor is only required to procure satisfactory coverage for itself, or whether it is required to name the indemnitee as an additional insured on its policies.

As noted previously, indemnitees are well-advised to obtain copies of the actual policies intended to provide coverage. Only then will they know if the policies to which a certificate of insurance refers were in fact issued, or truly afford the contemplated coverage. In the alternative, an indemnitee might require that the indemnitors insurer, rather than the indemnitors broker, issue a certificate. This approach increases the likelihood that the insurer has, in fact, added the indemnitee as an additional insured to the indemnitors policy where required to do so, but it is not foolproof. Indeed, the indemnitee is still left to speculate about policy terms.

Insofar as additional insureds are concerned, obtaining a copy of the policy to which they have been added is no mere formality. Not all policies are standardized form documents. Surplus lines policies often are manuscript or bear manuscript endorsements. Excess and umbrella policies are commonly manuscript documents. Lloyds of London policies differ from policies issued by most domestic insurers. Even standard liability policies may have unexpected endorsements. There are several standard additional insured endorsements in use, and the selection of the proper endorsement is critical to coverage. n112

Furthermore, it is unfortunately true that insurance brokers sometimes err in procuring additional insured coverage or in issuing certificates of insurance, and that those errors may materially prejudice the indemnitee. An indemnitees ability to detect potential errors is significantly enhanced if it obtains copies of the actual policies under which it desires coverage.

Is this advice impractical? Some construction and insurance industry veterans will argue that it is. Insiders will say that the pace of business demands the convenience that certificates of insurance provide. Reliance on certificates of insurance seldom causes problems and those rare problems can be addressed when (or if) they surface. Furthermore, the use of certificates of insurance is so accepted and widespread that reliance on them is reasonable. These sentiments are understandable. Certainly, the overwhelming majority of transactions in which certificates of insurance are used come off without a hitch. There are deals in which the caution urged here is theoretically unnecessary because the parties have a long business relationship and clearly understand their respective insurance obligations. An indemnitors insurance broker may have intimate knowledge of the indemnitors business and business practices, and provide excellent service with respect to procuring additional insured coverage and issuing certificates. On the other hand, the parties in Alabama Electric enjoyed an established business relationship and had successfully completed projects in which certificates of insurance were used to document key insurance aspects, and their familiarity led to relative disaster.

Looking at matters from the indemnitors perspective, they must clearly understand the insurance obligations they are being asked to undertake. For example, does a contract require only that they procure specified insurance coverage for themselves, or must they also procure coverage for the indemnitee as an additional insured? The failure to procure specified coverage may leave them to satisfy any indemnity obligations out of their own pockets. Additionally, the failure to procure suitable coverage may expose them to liability for breach of contract even where there is other insurance available to the indemnitee.

To the extent indemnitors are presented with repeated demands for additional insured status, they should negotiate blanket additional insured endorsements to their policies. The language of blanket endorsements varies, but such endorsements generally extend coverage to any party that the indemnitor agrees to name as an additional insured to its policy. n113

Intermediaries must appreciate the potential problems posed by their clients use of certificates of insurance. They should not issue certificates of insurance identifying the certificate holder as an additional insured, for example, without knowing whether that can be or has been done. They should be careful to use only standard certificates that bear broad disclaimers. Although agents or brokers have no duty to advise customers on insurance matters, n114 understanding the nature of an insureds business or project needs is an integral part of their own risk management. Intermediaries are

common litigation targets in cases that pivot on allegedly inaccurate or misleading certificates of service.

CONCLUSION

Certificates of insurance are central documents in many coverage disputes involving indemnitors, indemnitees, and multiple insureds. Contracting parties must appreciate that standard certificates of insurance are informational documents only. They are not contracts and they certainly are not insurance policies. Where additional insured status is at issue, both insurers and additional insureds should want the named insured to give the additional insured a copy of the policy at issue, rather than a certificate alone. Only then can the carrier be assured that its policy terms will control and, most particularly, that exclusions in its policy will apply. Conversely, the additional insured needs a copy of the policy so that it can determine whether it has sufficient coverage. This is a question that a certificate of insurance alone cannot answer.

As a general rule, an insurer should not be estopped to assert exclusions or other coverage limitations contained in its policy that are not revealed in a related certificate. Nor should courts generally reform policies to provide coverage because they contain exclusions or other terms that are not revealed in a certificate. The disclaimers prominently displayed on standard certificates of insurance should make clear to indemnitees that they must read the policies to which certificates refer. In most cases, an indemnitee's reliance on a standard certificate of insurance for liability protection is unreasonable.

There are bound to be cases in which an indemnitor does not procure the coverage it promised to provide. That does not mean, however, that the indemnitee should be able to obtain that coverage from the insurer named on a certificate of insurance. Rather, the indemnitee's remedy is to sue the indemnitor for failing to provide the desired coverage. An indemnitee can also hold its indemnitor to any contractual indemnity obligations that exist apart from any agreement to provide insurance. Either way, the insurer's obligations should remain limited to the promises made in the language of its policy.

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n1 For more on additional insureds, see Stacy A. Broman & Jenny L. Sautter, *Additional Insured Endorsements: Recent Efforts to Limit Coverage to the Additional Insured*, 57 Fedn Def. & Corp. Couns. Q. 77 (2006); Douglas R. Richmond, *The Additional Problems of Additional Insureds*, 33 Tort & Ins. L.J. 945 (1998).

n2 A promise to indemnify and a promise to procure insurance are different obligations. *FabArc Steel Supply, Inc. v. Composite Constr. Sys., Inc.*, 914 So. 2d 344, 362 (Ala. 2005) (quoting *Goodyear Tire & Rubber Co. v. J.M. Tull Metals Co.*, 629 So. 2d 633 (Ala. 1993)); *Bramalea Cal., Inc. v. Reliable Interiors, Inc.*, 14 Cal. Rptr. 3d 302, 307 (Cal. Ct. App. 2004); *Estate of Willis v. Kiferbaum Constr. Corp.*, 830 N.E.2d 636, 644 (Ill. App. Ct. 2005). Where there is a promise to obtain insurance, the promisor agrees to procure insurance but does not agree to bear responsibility in the event of injury or loss. . . . A promise to name a third party as an additional insured is not inextricably tied to that party's promise to indemnify the party [with which it contracts]. *Estate of Willis*, 830 N.E.2d at 644. Moreover, an indemnitor's promise to procure insurance is simply that; it is not necessarily an agreement to have its indemnitee named as an additional insured on its policies. *Empire Ins. Co. v. Ins. Corp. of N.Y.*, 40 A.D. 3d 686, 836 N.Y.S.2d 228, 230 (2007) (quoting *Trapani v. 10 Arial Way Assocs.*, 301 A.D.2d 644, 647, 755 N.Y.S.2d 396, 398 (2003)).

n3 There is nothing underhanded about this practice. In this example, the parties contract requires the indemnitor to procure a policy with liability limits of \$1 million per occurrence. The indemnitors policy affords that amount of coverage. The fact that it affords more is irrelevant to the indemnitee at the time of contracting. Of course, the full policy amount probably will be revealed in discovery should there ever be litigation and, for that reason, the indemnitor may opt to reveal it at the outset.

n4 See *Marlin v. Wetzel County Bd. of Educ.*, 569 S.E.2d 462, 470-71 & n.10 (W. Va. 2002) (discussing this problem and collecting related cases in footnote).

n5 *Clarendon Am. Ins. Co. v. Aargus Sec. Sys., Inc.*, 870 N.E.2d 988, 995 (Ill. App. Ct. 2007).

n6 *G.E. Tignall & Co. v. Reliance Natl Ins. Co.*, 102 F. Supp. 2d 300, 304 (D. Md. 2000) (applying Maryland law); *Raintree Trucking Co. v. First Am. Ins. Co.*, 534 S.E.2d 459, 462 (Ga. Ct. App. 2000) (discussing common carriers specialized certificate filed with state agency and different effect of certificate as between insured and injured third parties); *Am. Family Ins. Co. v. Globe Am. Cas. Co.*, 774 N.E.2d 932, 939 (Ind. Ct. App. 2002) (quoting *Postlewait Constr. Co. v. Great Am. Cas. Co.*, 720 P.2d 805, 807 (Wash. Ct. App. 1986)); *Commonwealth v. Gall*, 789 N.E.2d 586, 594-95 (Mass. App. Ct. 2003) (distinguishing role of certificates in group insurance); *Kermanshah Oriental Rugs, Inc. v. Gollender*, 47 A.D.3d 438, 850 N.Y.S.2d 47, 49 (2008) (quoting *Tribeca Broadway Assocs., LLC v. Mt. Vernon Fire Ins. Co.*, 5 A.D.3d 198, 200, 774 N.Y.S.2d 11, 13 (2004)); *Midland Enters., Inc. v. St. Paul Fire & Marine Ins. Co.*, 745 N.E.2d 455, 459 (Ohio Ct. App. 2000); *Gen. Accident Ins. Co. of Am. v. Am. Natl Fireproofing, Inc.*, 716 A.2d 751, 756 (R.I. 1998); *Granite Constr. Co. v. Bituminous Ins. Cos.*, 832 S.W.2d 427, 429-30 (Tex. App. 1992); *Marlin*, 569 S.E.2d at 472.

n7 *Rodless Props., L.P. v. Westchester Fire Ins. Co.*, 40 A.D.3d 253, 835 N.Y.S.2d 154, 155 (2007). But cf. *W. Am. Ins. Co. v. J.R. Constr. Co.*, 777 N.E.2d 610, 615-18 (Ill. App. Ct. 2002) (relying on certificate of insurance in addition to several other critical facts to establish additional insured status).

n8 *Midland Enters.*, 745 N.E.2d at 459.

n9 *Seal v. Hart*, 50 P.3d 522, 529 (Mont. 2002).

n10 *Clarendon Am. Ins. Co.*, 870 N.E.2d at 994-95; see also *Struble v. Am. Family Ins. Co.*, 172 P.3d 950,

956 (*Colo. Ct. App. 2007*) (observing that a certificate of insurance does not create any type of contractual relationship for the holders benefit).

n11 *Clarendon Am. Ins. Co.*, 870 N.E.2d at 994.

n12 The term certificate of insurance also may be used in connection with state financial responsibility laws, as where an insured who has had her driving privileges suspended must submit an SR-22 financial responsibility insurance certificate to obtain a drivers license. This situation differs significantly from the use of certificates as discussed in this article. An insurers issuance of an SR-22 Form may be deemed to be conclusive evidence that an automobile liability insurance policy has been issued that meets the requirements of a state financial responsibility law. *Am. Fam. Ins. Co. v. Globe Am. Cas. Co.*, 774 N.E.2d 932, 939 (*Ind. Ct. App. 2002*).

n13 *Seal*, 50 P.3d at 529; *Blackburn, Nickels & Smith v. Natl Farmers Union Prop. & Cas. Co.*, 482 N.W.2d 600, 603 (N.D. 1992); *Gen. Accident Ins. Co. of Am. v. Am. Natl Fireproofing, Inc.*, 716 A.2d 751, 756 (R.I. 1998); *Via Net v. TIG Ins. Co.*, 211 S.W.3d 310, 314 (Tex. 2006); *Marlin v. Wetzel County Bd. of Educ.*, 569 S.E.2d 462, 470 (W. Va. 2002).

n14 *See, e.g., Ferguson v. Plummers Towing & Recovery, Inc.*, 753 So. 2d 398, 401 (*La. Ct. App. 2000*); *Gen. Accident Ins. Co. of Am.*, 716 A.2d at 756.

n15 832 S.W.2d 427 (Tex. App. 1992).

n16 *Granite Constr. Co.*, 832 S.W.2d at 428.

n17 *Granite Constr. Co.*, 832 S.W.2d at 428 (quoting certificate).

n18 *Granite Constr. Co.*, 832 S.W.2d at 429.

n19 *Granite Constr. Co.*, 832 S.W.2d at 429.

n20 *Granite Constr. Co.*, 832 S.W.2d at 429-30.

n21 *Granite Constr. Co.*, 832 S.W.2d at 430.

n22 898 A.2d 492 (N.H. 2006).

n23 *Handley*, 898 A.2d at 494.

n24 *Handley* also sued Olivier for negligence, but that aspect of the case is not presently relevant. See *Handley*, 898 A.2d at 493.

n25 *Handley*, 898 A.2d at 493.

n26 *Handley*, 898 A.2d at 494-95.

n27 *T.H.E. Ins. Co. v. City of Alton*, 227 F.3d 802, 805 (7th Cir. 2000).

n28 *T.H.E. Ins. Co.*, 227 F.3d at 805.

n29 See *Via Net v. TIG Ins. Co.*, 211 S.W.3d 310, 314 (Tex. 2006) (observing that the failure to do some basic due diligence, i.e., to take . . . certificates at face value, is risky).

n30 See, e.g., *Natl Union Fire Ins. Co. v. Glenview Park Dist.*, 594 N.E.2d 1300, 1304 (Ill. App. Ct. 1992), *affd in part, revd in part on other grounds*, 632 N.E.2d 1039 (Ill. 1994).

n31 *Clarendon Am. Ins. Co. v. Aargus Sec. Sys., Inc.*, 870 N.E.2d 988, 994 (Ill. App. Ct. 2007); *Rodless Props., L.P. v. Westchester Fire Ins. Co.*, 40 A.D.3d 253, 835 N.Y.S.2d 154, 155 (2007).

n32 *Intl Couriers Corp. v. N. River Ins. Co.*, 4 A.D.2d 568, 844 N.Y.S.2d 253, 255 (2007).

n33 *W. Am. Ins. Co. v. Meridian Mut. Ins. Co.*, 583 N.W.2d 548, 551 (Mich. Ct. App. 1998).

n34 See *Broderick Inv. Co. v. Strand Nordstrom Stailey Parker, Inc.*, 794 P.2d 264, 267 (Colo. Ct. App. 1990) (discussing disclaimers on certificate and alleged assumption of duty).

n35 See, e.g., *Nazami v. Patrons Mut. Ins. Co.*, 910 A.2d 209, 212-15 (Conn. 2006) (rejecting plaintiffs statutory and common law theories).

n36 *Prudential Prop. & Cas. Ins. Co. v. Anderson*, 922 A.2d 236, 243 (Conn. App. Ct. 2007).

n37 *Bradley Real Estate Trust v. Plummer & Rowe Ins. Agency, Inc.*, 609 A.2d 1233, 1235 (N.H. 1992).

n38 See, e.g., *Moore v. Energy Mut. Ins. Co.*, 814 P.2d 1141, 1144 (Utah Ct. App. 1991); *Kozlik v. Gulf Ins. Co.*, 673 N.W.2d 343, 348-49 (Wis. Ct. App. 2003).

n39 *Moore*, 814 P.2d at 1144-46.

n40 745 N.E.2d 455 (Ohio Ct. App. 2000).

n41 *Midland Enters.*, 745 N.E.2d at 460.

n42 *Midland Enters.*, 745 N.E.2d at 460.

n43 *See Midland Enters.*, 745 N.E.2d at 458.

n44 569 S.E.2d 462 (W. Va. 2002).

n45 *Marlin*, 569 S.E.2d at 465.

n46 *Marlin*, 569 S.E.2d at 466.

n47 *Marlin*, 569 S.E.2d at 466.

n48 *Marlin*, 569 S.E.2d at 467.

n49 *Marlin*, 569 S.E.2d at 469.

n50 *Marlin*, 569 S.E.2d at 470.

n51 *Marlin*, 569 S.E.2d at 472.

n52 *Wangler v. Lerol*, 670 N.W.2d 830, 833 (N.D. 2003).

n53 *Marlin*, 569 S.E.2d at 472 (quoting *Potesta v. United States Fid. & Guar. Co.*, 504 S.E.2d 135 (W. Va. 1998)).

n54 *Marlin*, 569 S.E.2d at 472-73 (quoting *Bucon, Inc. v. Pa. Mfg. Assn Ins. Co.*, 151 A.D.2d 207, 547 N.Y.S.2d 925, 927 (1989)).

n55 *Marlin*, 569 S.E.2d at 469.

n56 *Marlin*, 569 S.E.2d at 472 (quoting *White v. Austin*, 412 A.2d 829, 830 (N.J. Super. Ct. App. Div. 1980)).

n57 *T.H.E. Ins. Co. v. City of Alton*, 227 F.3d 802, 806 (7th Cir. 2000) (applying Illinois law).

n58 See *Blackburn, Nickels & Smith, Inc. v. Natl Farmers Union Prop. & Cas. Co.*, 482 N.W.2d 600, 604-05 (N.D. 1992) (recognizing insurers right to indemnity where agent improvidently issued certificate of insurance).

n59 See also *Lenox Realty Inc. v. Excelsior Ins. Co.*, 255 A.D.2d 644, 679 N.Y.S.2d 749, 751 (1998) (applying estoppel doctrine to find coverage based on certificate of insurance while brushing aside without explanation contrary argument based on disclaimers on document).

n60 See, e.g., *Criterion Leasing Group v. Gulf Coast Plastering & Drywall*, 582 So. 2d 799, 800-01 (Fla. Dist. Ct. App. 1991); *Blackburn*, 482 N.W.2d at 603-04.

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n82 *Pekin Ins. Co.*, 572 N.E.2d at 1113.

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Opinions expressed here are the authors alone.

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Kraus on Climate Change: Tornadoes Aren't In Kansas Anymore

2008 Emerging Issues 2374

Kraus on Insurance Implications of Climate Change: Tornadoes are not Just in Kansas Anymore--a Discussion on Whether Severe Storms are a Harbinger of Climate Change and How the Insurance Industry can Respond

By Sallie Kraus

June 16, 2008

SUMMARY: Catastrophe models have their weaknesses and are not without controversy. Some argue that carriers are too reliant on models. Others say that carriers are able to critique weaknesses in models and use them with caution. In this article, Sallie Kraus explores some of the alternate financial and insurance products as well as some legislative initiatives that are being considered to address the challenges presented by climate change.

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Photo courtesy of NOAA/NCEP

We may think of tornadoes as a phenomenon limited to the Midwestern Plains as in the Wizard of Oz, but this year they have cut a swath from Texas to Virginia. The spate of severe spring tornadoes in the US, coupled with forecasts of an active hurricane North Atlantic season this year have made weather an even more popular topic of conversation than usual in the U.S. Add to the mix, the escalating climate change debate, Cyclone Nargis in Myanmar and the severe earthquake in China and natural disasters have caused concern among domestic and multinational carriers. This commentary will discuss the most winter storms and spring tornadoes that have occurred throughout the world, project what may lay ahead for the 2008 storm season, review the positions that the scientific community is taking in the ongoing debate over whether global warming is causing more intense weather, and outline the government and insurance industry response to these global occurrences.

Act I: Winter Storms and Spring Tornadoes. Nine catastrophes occurred during the first quarter, the highest number in at least 10 years.

Insurers earnings already hit by \$3.5b weather-related losses in the first quarter may suffer a losing underwriting year in 2008 if forecasts of a severe hurricane season are accurate. ISO defines a catastrophe as an event that causes \$25

million or more in insured property losses. There were nine catastrophes that contributed to the \$3.5b total, but one cat event-- a series of tornadoes and strong storms in February-- caused \$995M of insured losses. A single tornado on March 14 rumbled through downtown Atlanta causing damage first estimated by ISO at \$340M, but the figure could exceed \$1B as claims are settled. n1

Looking on the bright side, the first-quarter losses could provide an impetus to raise commercial property insurance rates that have been falling over the past two years. However, the severe weather has already taken its toll on 2008 earnings for the largest insurance carriers. Allstate, the largest publicly traded homeowners insurer, blamed the unusually high number of tornadoes for \$568 million of catastrophe losses in the first quarter. As a result, the company's first-quarter operating income fell below analyst expectations. Travelers, one of the largest publicly traded commercial carriers, reported \$62 million in catastrophe losses in the first quarter, mostly in commercial lines, more than double the \$29 million total for all of last year. n2

While some insurers may begin increasing their rates following these tornadoes, this action is not likely to be sufficient to make up for the dramatic drop in commercial insurance prices that followed the unusually benign U.S. hurricane seasons in 2006 and 2007

Tornado season usually peaks in the second quarter. While tornadoes tend to be a mile or smaller in diameter and last for only a few minutes their extreme winds can cause extensive damage. These spring tornadoes have brought devastation from Oklahoma to Georgia. Two tornadoes in the US caused at least 22 deaths each on February 5 and May 11.

Neither has bad weather been confined to the US. Windstorm Emma, this winters worst storm, swept through Europe on March 1. It caused up to EUR 1b in damages, gathering strength as it moved east from the UK to Eastern Europe. n3 These storms were not nearly as severe as Kyrill in 2007 or Lothar and Martin, storms in the late 1990s that caused damages of \$7b and \$3b respectively. Note that the top natural catastrophes of calendar year 2007 were all weather-related and were dispersed around the world. n4

Act II: The 2008 Hurricane Season--what lies ahead? While tornadoes have wreaked havoc this year, they may just be the opening act for the hurricane season, which has historically produced the largest insured losses. The largest hurricane loss in history was Hurricane Katrina, a \$41.1 billion in insured event in 2005. It was far bigger and with more widespread impacts than the second largest loss, the World Trade Center attacks of 2001, a \$32.5 billion insurance loss.

The Colorado State University Hurricane Center has predicted that this year's hurricane season that officially begins June 1, will be well above average with a total of 15 storms. Even if the 2008 hurricane season produces only a normal number of average intensity storms, many industry observers think this will be a tough year for many insurers.

Hurricanes have been rising in frequency and intensity in recent years, with seven of the 10 most costly in recorded history occurring since 2004. However, after Katrinas devastation of 2005, no hurricanes hit the U.S. in 2006 and only a few smaller storms came ashore last year.

Just as the local weatherman may be wrong about the forecast for a particular day, seasonal hurricane forecasts are subject to change. Thus, some climatologists find a comparison of seasonal forecasts to actual five year storm data to be more instructive. n5 They explain that the disparity between forecasts and actual hurricane activity may be due to unanticipated levels of dust and dry air that settled across the area of the Atlantic Ocean where tropical systems and hurricanes tend to develop.

Thus, it is somewhat problematic that cat bonds and alternative financing arrangements have ramped up the importance of short term annual weather modeling. To address climate change, cat modelers and insurance

professionals will have to blend traditional and well developed short term weather modeling techniques much less developed long term climate modeling. Models have their weaknesses and are not without controversy. Some experts and regulators take the position that carriers are too reliant on models, especially since Katrina. However, other industry observers say that carriers are able to critique weaknesses in the models and use them with caution. n6

Swiss Re, Berkshire Hathaway and other reinsurers provide conventional coverage for natural catastrophe reinsurance. However, the reinsurers are also expanding insurance-related securities such as cat bonds that have been available since 1997. There are other new vehicles for addressing catastrophes risks, such as the OTC weather risk market. In this way, new capital-based vehicles are available to underwrite climate-related risk. n7

There are many financial developments taking place in the emerging emissions markets that are adjunct to the insurance industry. The Kyoto Protocol's cap and trade system, as implemented by the European Union's emissions trading scheme, is the opening act for the era of global emissions trading. Most countries outside the U.S. have already implemented or are developing regulations that will require private industry to reduce greenhouse gas emissions and comply with the Kyoto Protocol.

Recent U.S. legislative initiatives, including California's Global Warming Solutions Act of 2006 (AB 32), the Northeastern and mid-Atlantic states' Regional Greenhouse Gas Initiative, state Climate Action Registries that facilitate banking of emission credits, the Chicago Climate Exchange are just the first steps in a U.S. market approach to emissions trading.

Further, initiatives from organizations such as the International Trading Association and the International Finance Corporation will have an impact on industries that produce greenhouse gases around the globe. The first insurance product has been offered in the carbon market and of course, emissions and offsets for all six greenhouse gases are traded on the Chicago Climate Exchange. n8

Act III: A Change in the Weather or Climate change? While sophisticated models and financial instruments are being developed as described above, there is still considerable debate in the scientific community as to whether global warming is contributing to an increase in the number and intensity of cyclones. n9 Further, there is not unanimous opinion which factor is most important. Increasing sea surface temperatures is the factor cited most frequently, but there are other scientific reasons as well. n10

Others say recent storms are having a greater impact because of anthropogenic factors that contribute to climate change and patterns of development. In one study, a team of meteorologists, cat modelers and actuaries converted U.S. hurricane damage figures from 1900 to 2005 storms to 2005 values. n11 They estimated the damage that would occur if storms from the past took place under the social, demographic and economic conditions of 2005. In other words, what if hurricanes that battered Florida in the 1930s had taken place in 2005 with all of the expensive homes and increased population already in place? Not surprisingly, the authors found that the amount of damage would have increased exponentially.

Cyclone Nargis killed an estimated 100,000 people in Myanmar on May 2 this month when its 12-foot storm surge reaching 25 miles inland. One meteorologist called it a once-in 500 year event n12 This is because the small but powerful storm that was 90 miles wide, took an unusual track aimed at the lowest point in the country hit at high tide and moved very slowly The delta was made even more vulnerable because 80% of the mangrove forests along the coast had been cut down in the past decade in favor of shrimp farms and rice paddies. n13 Although the trees provide less protection against a slow moving cyclone producing high storm surges, without much natural barrier between the ocean and their flimsy homes, Myanmar's residents were at the mercy of the storms full wrath.

Although there is not enough data to know whether this one event, the 10th worst cyclone on record, was due to climate change, some scientists say that increasing sea temperatures will lead to more severe storms. They theorize that

increasing sea surface temperatures (SSTs) and in turn, that rising SSTs are due to the presence of higher levels of greenhouse gases in the atmosphere. There are additional factors--windshear, stability and humidity--as well as the air circulation changes caused by EL Nino--just to name a few n14 There is an opposing view that global warming should reduce that global frequency of hurricanes, while some may be locally more intense n15

The more intense storms have been hitting less developed countries of late are of particular concern. For example, monsoon season in India has been much more intense in recent years. As the countrys economy and its prosperity has been increasing tremendously, so have property values especially in regions like Mumbai. Recent intense monsoon seasons and the steep increase insured property has driven up insured losses in recent years. Between 1980 and 2004 annual losses averaged no more than \$5M, but by 2006 the annual figure exceeded \$400M. n16

ACT IV: Insurance Carriers and Governments Respond. Changing weather patterns and climate change poses coverage issues and business challenges to the insurance industry. There is already much activity in the insurance industry--on the regulatory, product development and risk management fronts.

So far, there are relatively few cases in which climate change is the alleged culprit. The earliest case did not have much impact on the legal landscape. In *Comer v. Murphy Oil USA Inc.*, S.D. Miss., No. 05-CV-436, 8/30/07) class action plaintiffs alleged that the defendant coal and energy companies emitted significant amounts of greenhouse gases that were linked to more frequent and severe hurricanes like Hurricane Katrina. The plaintiffs were unsuccessful in their efforts to seek damages for personal injuries as well as the loss of properties and businesses from the hurricane. The judge agreed with the defendants that the plaintiffs did not have standing to assert their claims and thus dismissed all the plaintiffs' claims sua sponte and all the other remaining motions as moot.

However, in *Massachusetts, et al. v. Environmental Protection Agency*, 549 U.S. ___, 127 S. Ct. 1438 (2007), the plaintiff was successful in achieving standing to sue and obtaining a ruling that EPA has statutory authority to regulate greenhouse gases. This case has given much hope to the environmental community that more will be done to regulate and reduce greenhouse cases.

It may also be relied upon in coverage cases since the court found that carbon dioxide was a pollutant.

Although there are so few cases, there is already a fairly significant body of literature on which lines of business are likely to be affected by climate change and the types of coverage issues that are likely to be raised. n17 Those theories have been explained in detail in these papers and at various legal seminars. n18 Property is the most obvious and we have already seen much litigation in the flood versus wind suits against carriers that were filed in the wake of Hurricane Katrina. Certainly, suits will be styled to reach the deep pockets of liability carriers. It is also likely that corporations that emit greenhouse will become the target of shareholder suits, which could have an impact on directors and officers coverage.

However, there are impacts that may be more subtle. For example, there could be an impact on life insurers that has not been widely discussed. Obviously, more severe storms increase the possibility that more insured lives will be lost. Just an increase of temperatures on the planet may cause higher mortality rates. The Intergovernmental Panel on Climate Change forecasts that temperatures on the planet will increase between 1.7 and 5 degrees Celsius and there will be more extremely hot days and fewer extremely cold days. Researchers think there could be an impact on the number of weather-related deaths.

Based on these statistical climate changes, a study by researchers from the Harvard School of Public Health concluded that mortality will increase across the U.S. because of climate change, but its impact will be uneven. n19 Cities that commonly have hot summers also usually have more air conditioners. This explains why Houston and Miami would be less affected by a heat wave than Chicago, Detroit and Philadelphia--the cities with the highest increases in mortality during heat waves. These cities also have a large number of poorer residents who are less likely to have air

conditioning. Thus, it is not hard to see that climate change could hit poor people hardest. n20

Clearly, there is both risk and opportunity in addressing climate change. Risk, comes in the form of more losses and erosion of profits. Opportunity, however, comes in a myriad of ways. Carriers are taking advantage of their influence to mitigate risks by encouraging mitigation and better construction. They have also gone green by developing not just new products, but new approaches to doing business. This ranges from encouraging green construction to charging for car insurance according to the number of miles driven. n21

There has also been a great deal of activity at the federal and state level to address the insurance implications of climate change and more severe weather. Much of the activity is in response to the tremendous losses associated with Hurricane Katrina.

For example, the Louisiana state senate voted in late April to allow different, "named storm" deductibles on homeowner policies depending on how far a property is from the hurricane-prone Gulf of Mexico. n22 Louisiana is the only state that currently requires insurers to set a statewide deductible -- so that policies for properties near the Arkansas state line have the same deductible for those along the Gulf, where catastrophic damage from hurricanes is far more likely.

The bill, now pending in the House, would also place a 4 percent cap on named storm deductibles, the states Department of Insurance would be charged with drawing up a map of Louisiana with zones outlining the deductibles for each area of the state. Insurers would then be able to set different deductibles on properties in different zones.

An amendment to the bill was approved that that would force a company that uses that mechanism to then offer those homeowners a lower premium. The amount of the premium reduction would be approved by the insurance department.

There is another proposal in Louisiana to develop all risk policies. Rather than requiring homeowners to purchase separate flood insurance, they could purchase one policy for the typical risks of fire, theft, liability and wind. Under this proposal, the federal government would, in effect, become the reinsurer of the flood line of the policy. n23 These are but two of the legislative responses to the increased risks posed by climate change.

At the federal level, the U.S. Senate just approved a significant overhaul of the federal flood insurance program has been approved. The bill puts the program on better financial footing by paying off the \$17.5b of debt left from Katrina and increasing premiums. It also tightens up coverage, eliminates coverage for some second homes, commercial properties and properties with poor loss experience. It also requires the government to give consumers better information about coverage options and clearly delineates floodplains where flood insurance is required.

Federal climate change legislation is also pending in Congress that address reductions in carbon emissions and the implementation of a cap and trade system. Some commentators have proposed that additional legislation is needed regarding energy efficiency and conservation, forestry and land use practices, transportation and tax incentives. n24

These improvements are so far incremental, but represent a real effort to address the various challenges posed by weather and climate change.

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Zalma on Premium Increases and Climate Change

2008 Emerging Issues 2375

Barry Zalma on Premium Increases and Climate Change

By Barry Zalma

June 12, 2008

SUMMARY: Insurance Coverage lawyer, consultant and expert witness, Barry Zalma, discusses a report suggesting that multiple weather catastrophes that some claim are caused by man-made global warming have increased the cost of insurance. Zalma also explains that insurance premiums are not based on only one set of data--such as weather conditions--and that the prudent insurer does not base its insurance underwriting decisions on global warming alone.

PDF LINK: Click Here for Enhanced PDF of Commentary

ARTICLE: Insurance premiums are based upon a calculation of the amount of risk the insurer is asked to take. It has been reported that premiums are on the rise as a result of multiple weather catastrophes that some claim are caused by man-made global warming. A report from the Environmental Defense Fund at <http://www.edf.org/page.cfm?tagID=14044> found:

Alabama: Premiums 10 times higher

Between 2001 and 2006, some premiums for homes along the east coast of the United States rose more than 10-fold.

Florida: Premiums up 77%

From 2001 to 2006, average homeowner policies increased by 77%, more than in any other state.

Louisiana: Premiums up 65%

Between 2001 and 2006, home insurance premiums rose 65.2%, ranking the state fifth in the nation for rising homeowner costs.

Mississippi: Premiums up 63%

Between 2001 and 2006, average homeowner premiums climbed 63.3%, ranking the state 6th in the nation for increases.

South Carolina: Premiums up 56%

Between 2001 and 2006, homeowner premiums climbed an average of 56.4%.

Virginia: Premiums up 67%

Since 2001, premiums have climbed an average of 67.2%, ranking the state among the top five for biggest premium increases.

Texas: Premiums up 50%

Between 2001 and 2006, average premiums increased more than 50%, from, for example, \$806 to \$1,214.

As serious as the premium increases seem, there is no indication or evidence that global warming is the cause for the increase in premium. Indeed, statements to the contrary suggest a total ignorance of what insurance is and how insurance premiums are calculated.

If there is global warming, its effects--other than making the northern half of North America more temperate and comfortable and relieving the pressures of the Little Ice Age that covered North America during the 18th Century--will be calculated into the premium charged by those insurers who insure against the risk of loss of real property in North America.

Understanding the Nature of Underwriting. In its original usage the operation of the insurance business was known as underwriting. In modern usage underwriting has a more restricted meaning. Underwriting is considered a systematic technique for evaluating risks that are offered to an insurer by prospective insureds. The function of the insurance underwriter involves evaluating, selecting, classifying, and rating each risk. Underwriters establish the amount of protection offered to each risk the underwriter finds acceptable. Underwriters are the risk takers. The underwriter must always be alert for facts that lead him or her to believe that a moral hazard or a physical hazard exists.

Information comes to the underwriter by various means, usually starting with the application for insurance. Information also comes to the insurer from public information sources, newspapers, LexisNexis, Google, Yahoo, or MSN. Insurers also retain the services of professional engineers to inspect the property and provide the underwriter with information that could effect the decision to insure or not insure against the risk of loss of the property. For example, if the building is in a flood or hurricane prone area and built below sea level (like much of the city of New Orleans) that structure would present a different risk of loss than a similar structure built in California where the risk of earthquake damage is greater than in Louisiana. The risk of loss of a condominium structure in over-built Miami, Florida where the value of the property has fallen over the last few years presents a greater risk of a loss than a property in a highly desirable area of Manhattan.

The Underwriter will probably be more interested in the character of the person seeking to be insured. The underwriter will be concerned with the prospective insureds police record, a history of gambling, questionable associates, employment instability, personal habits, frequent changes of residence, poor record of paying bills, claims consciousness (for example, a person who wants to know claims handling procedures, the name of the local claims manager, the names and experience level of the local adjusters, etc.), frequency of claims and claims presented for minor maintenance.

The underwriter will finally look to establish the existence of hazards that increase uncertainty brought about by the indifference of a prospective insured, an increase in uncertainty brought about by the moral character of the prospective insured and an increase in uncertainty brought about by the condition of the property or its location. If the underwriter finds there is an increase in the probability of loss or an increase in the severity of the potential loss the judgment of the underwriter will be effected and he or she may refuse the insurance or will try to control the increased risk by raising the amount of deductible or self-insured-retention, add conditions or limitations to the coverage or exclude certain usually

insured risks of loss.

Insurers have dealt with weather changes over the last three centuries. They have paid millions of claims worth billions of dollars. Over the centuries of paying claims insurers gathered information that allow a statistical study to predict, with some certainty, the number and cost of losses in the future. The people who analyze all of the information available to the insurer and calculate the premium necessary to profitably take certain risks of loss are called actuaries. Actuaries are people versed in the collection and interpretation of numerical data, especially someone who uses statistics to calculate insurance premiums. In the insurance industry an actuary reviews the data of claims filed by policyholders, claims filed with other insurers, data on weather trends, data on earthquake potentiality, data on loss propensities in particular locations, and other data kept secret by the actuaries to determine how risk should be priced. The actuary recommends to the underwriter the amount of premiums that should be charged, the amount of reserves that should be kept, and the amount of dividends paid.

Weather conditions are one of many sets of data considered by underwriters and actuaries. Weather conditions cannot, and could never be, the only reason for an underwriting decision. If an underwriter, working with an actuary, finds that the premiums allowed by the state are inadequate to allow the insurer to deal with the risk and make a profit, the prudent underwriter will not accept the risk. If actuarial studies reflect that there is an increase in hazard as a result of weather then premiums must reflect that risk.

When insurers were faced with the hazards of frozen pipes and the weight of snow and ice in the 18th Century they dealt with the increased hazard caused the Little Ice Age by excluding the risks they were not willing to take or increased premium to cover the risk. Similarly, as weather patterns change in the 20th and 21st Centuries premiums and coverage terms change to meet the increase or decrease in risk that result from the changes.

Because few insurers were willing to take the risk of flood in flood plains, earthquakes in earthquake zones, terrorist acts in high risk areas, brush fires in brush fire areas, and windstorm in hurricane prone areas, government backed insurance became available with the taxpayers funding the losses in excess of the premiums collected. These government backed insurance policies are more a welfare benefit for property owners than insurance because the government, instead of a private business is taking the risk.

Insurance is not so simple a contract that a single event can totally change its availability and affordability. Weather changes are, and have always been, part of the data that an underwriter considers when deciding to accept or reject a risk. Weather changes can be important. Weather changes can be unimportant. But weather changes are only a part of the underwriters decision making process.

Although premiums have increased in certain areas at a precipitous rate that increase cannot when insurance, underwriting and actuarial science are understood be blamed for the increase. It is dangerous in most legal analyses to limit the conclusion to one factual issue. Underwriting insurance requires the analysis of multiple factual issues that can increase or decrease the potential for loss. The underwriter and the actuary want to cover those risks where the insurer can collect sufficient premiums to pay all losses that can be anticipated and to still have enough to make a profit for its stockholders. Insurers cannot allow hysteria over global warming to effect their decisions with regard to a particular risk. They must review all of the potential factors that can effect the risk so that a well run, well built structure on land above sea level in New Orleans would be a risk an insurer is willing to take for a reasonable premium while a home in Beverly Hills, well built home located on stable ground in Beverly Hills owned by a person who has suffered five fire losses in the last ten years and three theft losses in the last five years, would be unacceptable to a prudent underwriter.

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Sonnenschein Nath & Rosenthal, LLP on Bad Faith & Sum. Jdmt. in Iowa

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Sonnenschein Nath & Rosenthal, LLP on Bad Faith & Summary Judgment in Iowa

By William Barker and Robert Johnson

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SUMMARY: Under the bad faith law in most jurisdictions, it is often possible to show that a bad faith claim fails as a matter of law. A recent decision of the Iowa Supreme Court in *Bellville v. Farm Bureau Mutual Insurance Co*, 702 N.W.2d 468 (Iowa 2005), has clarified that subject. This Emerging Issues Analysis argues that Bellville and other Iowa cases support much readier availability of summary judgment than Zimmer recognizes.

PDF LINK: Click here for enhanced PDF of this Emerging Issues Analysis at no additional charge

ARTICLE: Under the bad faith law in most jurisdictions, it is often possible to show that a bad faith claim fails as a matter of law. Even though some facts may be in dispute, the disputed facts are often immaterial to whether the insurer's conduct met the requirements of the law or, if that conduct was arguably deficient in some way, whether the deficiencies had any causal relationship to the harm suffered by the insured. As a result, summary judgment and its procedural cousins (judgment as a matter of law at or after trial and appellate review of evidentiary sufficiency) are important tools in the arsenal of lawyers defending bad faith cases. Moreover, an important factor in evaluating a bad faith case is considering whether there likely will be a good motion for summary judgment. Finally, determining the standards for summary judgment implicates fundamental questions as to the nature of the bad faith tort.

Because of the importance of this subject, one of us has examined it at length in two prior articles. n1 There has been particular dispute as to the availability of summary judgment in Iowa. A recent decision of the Iowa Supreme Court in *Bellville v. Farm Bureau Mutual Insurance Co*. n2 has clarified that subject. But the meaning of *Bellville* is itself contested, as shown by the recent federal decision in *Zimmer v. Travelers Insurance Co*. n3 This commentary will show that *Bellville* and other Iowa cases support much readier availability of summary judgment than *Zimmer* recognizes.

The Logic of Summary Judgment in Bad Faith Cases

The duty of good faith protects the right of an insured to receive the benefits of the insurance contract. An insured can overcome an ill-founded denial by litigating with the insurer. But risks which are insured are normally ones which an insured cannot afford to bear without insurance, so the occurrence of such a loss exerts pressure on an insured to obtain a prompt settlement, even if that may mean foregoing full compensation. n4 If the insured could borrow to finance the loss while suing, the usual right to prejudgment interest should cover the cost of the borrowing. n5 But the

loss itself may render the insured unable to borrow or the insured may have purchased the insurance precisely because the insured lacks that ability, even without a loss.

The pressure created by an unaffordable loss is increased by the fact that any consequential losses that the insured might suffer while payment is delayed are ordinarily not recoverable in an action for breach of contract. n6 Not only does this limitation on recovery leave the insured uncompensated for some harms caused by an erroneous denial, but it also limits the incentive of the insurer to avoid such harms by prompt payment. n7 Moreover, litigation is expensive, although that expense may sometimes be recoverable should the insured prevail in any suit. n8 And, because of the expense and effort required to bring suit, even insureds whose claims are meritorious may not sue. n9

An insured has contracted to be protected against covered losses. Thus, the insurer is required to pay claims where there is no reasonable basis to withhold payment. But an insurer is not liable in tort for mere erroneous denial of a claim. The law of bad faith represents a balance between two competing interests: the right of an insurer to reject an invalid claim and the duty of the carrier to investigate and pay compensable claims. n10 The tort is recognized to protect the insured's right to payment. But the insurer's right to challenge validity limits the circumstances in which liability may be imposed for non-payment, even if the claim ultimately proves meritorious.

There is a powerful reason why insurers cannot properly be held liable for mere erroneous denial of a claim. The *obligation* to pay meritorious claims is accompanied by the *right* to deny those without merit.

This right is more than an ordinary contractual right: it serves an important public interest. Insurance rates are based on insurers' predictions of the claims they will be required to pay. If erroneous denial of a claim can result in expensive tort remedies, insurers may feel compelled to pay questionable claims rather than risk such liability. This is a particular concern with possibly fraudulent claims, where any impropriety of the claim will have been assiduously concealed and may only be detectable by expensive investigation and resort to circumstantial evidence. n11 Such payments, or the expectation of having to make them, would tend to inflate costs for those wishing only coverage for the risks specified in the contract.

In the leading bad faith case of *Anderson v. Continental Insurance Co.*, n12 the court recognized the undesirability of inflating insurance rates by scaring insurers into paying questionable claims because of the threat of a bad faith suit and its excessive damages. n13 The *Anderson* court was confident it had prevented this by adopting a standard that protects any insurer which makes an investigation of the facts and law and concludes on a reasonable basis that the claim is at least debatable. n14 Similarly, in *Travelers Insurance Co. v. Savio*, n15 the court emphasized the need to accord an insurer wide latitude in its ability to investigate claims and to resist false or unfounded efforts to obtain funds not available under the contract of insurance. n16

Accordingly, an insurer is allowed to withhold payment of a claim as long as there is a genuine issue or (to use different words for the same concept) a bona fide dispute as to the insured's entitlement to payment. n17 As the *Anderson* court put the point, when a claim is fairly debatable' the insurer is entitled to debate it, whether the debate concerns a matter of fact or law. n18 As the Texas Supreme Court has put the point, [e]vidence that merely shows a bona fide dispute about the insurer's liability on the contract does not rise to the level of bad faith. n19 This rule recognizes that the parties to an insurance contract will sometimes have a good faith disagreement about coverage. Under such circumstances, the parties may require a court to interpret the policy language for them, or a jury to resolve factual disputes." n20 Stated otherwise, a reasonable basis for denying a claim is one that warrants testing the claim in court. n21

Sometimes this point is expressed by saying that an insurer has a right to be wrong n22 or a right to disagree with the insured. The Indiana Supreme Court has used the latter phrase to summarize the balance of interests limiting the bad faith tort:

It is evident that the exercise of this right [to disagree] may directly result in the intentional infliction of temporal

damage, including the damage of interference with an insured's business (which an insured will undoubtedly consider to be oppressive). The infliction of this damage has generally been regarded as privileged, and not compensable for the simple reason that it is worth more to society than it costs, *i.e.*, the insurer is permitted to dispute its liability in good faith because of the prohibitive social costs of a rule that would make claims nondisputable. Insurance companies burdened with such liability would either close their doors or increase premium rates to the point where only the rich could afford insurance. n23

For summary judgment purposes, the significant point is that an insurer's failure to pay benefits cannot give rise to a bad faith action, under the standards applicable to the first-party bad faith tort, if the insured's right to payment was fairly debatable or subject to a bona fide dispute (two formulations with the same meaning). Existence of grounds for a bona fide dispute is a reasonable basis or a proper cause (two more equivalent formulations) for delay or denial of benefits. So, showing existence of grounds for a bona fide dispute is ordinarily sufficient to preclude bad faith liability. n24

The law of bad faith will charge an insurer with knowledge of all facts favorable to the insured that a reasonable investigation would have revealed, even if the insurer did not actually learn those facts. n25 Nonetheless, if the insurer can show that, at the time benefits were denied, there existed evidence sufficient to create a bona fide dispute as to the insured's entitlement to payment or if it can show existence, at that time, of a fair legal argument challenging the insured's entitlement to payment, then it should be able to defeat bad faith as a matter of law, entitling it to summary judgment or its equivalent at some later stage of the proceedings. Iowa Bad Faith Law Existence of a Reasonable Basis for Denying Benefits Precludes Bad Faith. The *Zimmer* court's summary of the governing standards of Iowa bad faith law is a good starting point to explain why that court failed to understand the proper relationship between those principles and summary judgment. That summary was as follows:

In order to prevail in a claim for bad faith, the insured party must prove by substantial evidence: (1) that the insurer had no reasonable basis for denying benefits under the policy and, (2) the insurer knew, or had reason to know, that its denial was without basis. The first element is objective, and the second element is subjective.

In considering bad faith tort cases against insurers, the Iowa Supreme Court has held that [a] reasonable basis to deny a claim exists when the claim is fairly debatable. Whether a claim is fairly debatable is generally a question of law. The fact that the insurer's position is ultimately found to lack merit is not sufficient by itself to establish the first element of a bad faith claim. The focus is on the existence of a debatable issue, not on which party was correct. n26 A Directed Verdict Rule Is Rejected. In *National Savings Life Insurance Co. v. Dutton*, n27 the Alabama Supreme Court adopted a rule very supportive of summary judgment on bad faith: if the insured is not entitled to a directed verdict on entitlement to benefits, then the insurer is entitled to summary judgment on bad faith. While this rule is now generally recognized as overbroad, it forms part of the background of current Iowa law. So, it is worth brief examination.

Dutton was a medical insurance case turning on whether the insured, Mrs. Dutton, had made material misstatements on her application. In applying for coverage, Mrs. Dutton denied ever having had "high or low blood pressure, pain in chest, varicose veins, disease of heart or circulatory system." Roughly a year later, she visited a physician, complaining of chest pain. The initial history taken by the doctor indicated that she had suffered such pain intermittently for two to three years, but that it recently had become worse. The doctor ordered hospitalization for testing. The hospital record repeated the history of prior chest pain and indicated that Mrs. Dutton took blood pressure medication. The ultimate diagnosis was probable ulcer or gall bladder disease.

The insurer rescinded the policy based on misstatements about chest pains and blood pressure problems, noting that it based its decision on the medical records and inviting corrections. Mrs. Dutton's physician responded with a letter stating that she had no history of hypertension or of medication for that condition. Subsequently, Mrs. Dutton again was hospitalized for chest pain. When her insurer declined to reinstate the policy or pay her claims, she sued for benefits and

bad faith. The trial court granted the insurer summary judgment on the allegation of bad faith, but submitted the misrepresentation claim to the jury. n28

On appeal, the Alabama Supreme Court affirmed the summary judgment on bad faith. The court found that the insurer had a "reasonably legitimate or arguable reason" for seeking rescission, even if it did not ultimately succeed on that point:

Whether an insurance company is justified in denying a claim under a policy must be judged by what was before it at the time the decision is made. Here, the company had before it a hospital record which purported to quote Mrs. Dutton as saying, upon her admission, that she was suffering chest pain and had experienced chest pain for two or three years. This was in direct contrast to the answer which she gave to a direct question on the application. When the company informed her that it was denying the claim and cancelling the policy because her answers to the questions on the application conflicted with the medical records, she did not come forward with any additional information with regard to a history of chest pain. She did not tell the company that the hospital admission record was false; in fact, she did not attempt to refute it in any way except to have her physician write a letter in which he did not dispute the record. He simply said that, insofar as he knew, she had no history of hypertension before he first saw her and hospitalized her. n29

Dutton then formulated its far-reaching summary-judgment rule:

In the normal case in order for plaintiff to make out a prima facie case of bad faith refusal to pay an insurance claim, the proof offered must show that the plaintiff is entitled to a directed verdict on the contract claim and, thus, entitled to recover on the contract claim as a matter of law. Ordinarily, if the evidence produced by either side creates a fact issue with regard to the validity of the claim and, thus, the legitimacy of the denial thereof, the tort claim must fail and should not be submitted to the jury.

The Iowa Supreme Court rejected the *Dutton* rule in *Reuter v. State Farm Mutual Automobile Insurance Co.* n30 Reuter was injured in an accident on September 27, 1984 and received medical and uninsured motorist benefits, including benefits for chiropractic services through December 26, 1985. On May 28, 1986, Reuter began receiving further chiropractic treatments and sought further medical benefits. State Farm's consultant was not able to verify the medical necessity of resuming treatment for the 1984 injury, so State Farm denied benefits for some further treatments, paying \$594 but leaving \$556 unpaid. In response to a request by the chiropractor, a state utilization review committee found the services provided reasonable and necessary, and Reuter sued State Farm for bad faith denial. At trial, Reuter sought a directed verdict on the contract, which was denied. Invoking the *Dutton* rule, State Farm sought directed verdict on bad faith, which was granted. The jury returned a verdict of \$556 on the contract claim and Reuter appealed the directed verdict on bad faith.

While recognizing that where a claim is fairly debatable,' the insurer is entitled to debate it, the Iowa Supreme Court did not agree that the mere denial of a plaintiff's motion for directed verdict establishes that the issue is fairly debatable.' The trial court should carefully review the facts and the particular circumstances in making its determination as to what is the precise issue or issues that are debatable. n31 Nonetheless, on the facts here, the directed verdict was correct, as the consultant's opinion provided a reasonable basis to challenge the claim. n32

In *Bellville*, the Iowa Supreme Court Clarified the Availability of Summary Judgment in Bad Faith Cases. While determining the propriety of summary judgment or directed verdict in various individual bad faith cases, the Iowa Supreme Court said little more on the general standard for some time. But it addressed that subject at length in *Bellville v. Farm Bureau Mutual Insurance Co.* n33 Bellville was injured by an underinsured motorist, with a \$50,000 policy; Farm Bureau's policy provided \$300,000 in underinsured motorist coverage. Bellville demanded (1) consent to accept the tortfeasor's policy limits and (2) payment of \$300,000, later reduced to \$270,000, both of which Farm Bureau denied. Asserting that both denials were in bad faith, Bellville sued Farm Bureau. A jury awarded both compensatory and punitive damages; the Iowa Supreme Court reversed and directed judgment for Farm Bureau.

On the objective element, it reaffirmed the rule that any fairly debatable claim could be denied without incurring bad faith liability:

A reasonable basis exists for denial of policy benefits if the insured's claim is fairly debatable either on a matter of fact or law. A claim is fairly debatable when it is open to dispute on any logical basis. Stated another way, if reasonable minds can differ on the coverage-determining facts or law, then the claim is fairly debatable. n34

For the last point it relied on one of Barker's prior articles. n35

It further recognized that [w]hether a claim is fairly debatable can generally be decided as a matter of law by the court. As one court has explained, [c]ourts and juries do not weigh the conflicting evidence that was before the insurer; they decide whether evidence existed to justify denial of the claim.' n36 It approvingly quoted Steven Ashley's bad faith treatise on the standard:

[A]n insurer is innocent of bad faith as a matter of law if the insurer took a position in regard to the claim that reasonable minds could hold. Unless the trial court is prepared to grant a directed verdict to the insured on his claim under the policy and to hold that reasonable minds could not disagree as to the insured's entitlement to proceeds under the policy, it follows that reasonable minds could disagree about the insured's entitlement to policy proceeds. Therefore, the insurer should be entitled to a directed verdict in its favor on the insured's bad faith claim unless the insured is entitled to a directed verdict in his favor on the policy claim. n37

Looking at Farm Bureau's valuation of the claim, the court noted that the issue was not, as Bellville urged, whether that Farm Bureau's offer was unreasonably low,' [but rather] whether there was no reasonable basis for Farm Bureau's denial of the plaintiff's demand for a \$270,000 payment. n38 As a matter of law, there was such a reasonable basis, because Farm Bureau had valued the claim at \$300,000, attributed 30% of the fault to Bellville, and deducted his \$50,000 recovery from the tortfeasor. n39 It was not enough that Bellville's experts thought Farm Bureau's valuation unreasonable; there must be evidence that the basis for [that] valuation was unreasonable. n40

Here, the investigating officer had found it a contributing circumstance that Bellville had run a traffic light. n41 While this was not admissible evidence at trial, a reasonable person could have relied on it to attribute fault to Bellville. n42 Farm Bureau was not obliged to accept the conflicting views of Bellville's experts. n43 Nor did Bellville prove that he had brought to Farm Bureau's attention any evidence demonstrating that the officer's report was patently wrong. n44 Thus, as a matter of law, Bellville fault was fairly debatable. n45

On Bellville's contract claim against Farm Bureau, the jury had valued his personal injury claim at \$756,714.95 (and found him 5% at fault). n46 But, because Farm Bureau had a reasonable basis to attribute 30% fault to Bellville, its rejection of a \$270,000 demand was not bad faith as long as Farm Bureau had a basis to value the claim at less than \$415,000. n47 An insurer is not obliged to pay based on analysis of jury verdicts in other cases unless their facts are shown to be similar to those in the claim. n48 Nor was it sufficient to offer expert opinions that a reasonable insurer would have paid Bellville's demand, because bad faith is not shown by mere proof of negligence; the plaintiff must negate the existence of a reasonable basis for the insurer's actions. n49 And, in *Bellville*, there were conflicting expert opinions as to the value of the case, which simply demonstrates the obvious: it is difficult, if not impossible to determine with any precision how the jury will value such a claim, particularly its noneconomic components. n50

As a matter of law, it could not be said that Farm Bureau lacked a reasonable basis for rejecting the \$270,000 demand, because that value was subject to debate:

Certainly there may be cases in which the UIM limits are so low or the undisputed damage items so high that there would be no reasonable basis to refuse payment notwithstanding the impossibility of accurately predicting the value of the insured's damages. But this case is not one of those. n51

Turning to Farm Bureau's refusal to consent to settlement with the tortfeasor, the court noted that consent to settle

provisions had previously been upheld, though breach of such a provision would not preclude a claim unless the insurer could show that (absent the settlement) it would have been able to recover from the tortfeasor. The court agreed with *Bellville* that an insurer in Farm Bureau's position should have a good faith duty to consent to settlement if it lacks a reasonable basis to believe that its subrogation claim has value. n52 But the existence of such a duty had been fairly debatable, because the issue had never been decided in Iowa. n53 Moreover, that question was one on which reasonable minds could differ, as illustrated by the fact that the court of appeals had reached a different conclusion. n54

Because each of Farm Bureau's challenged actions had a reasonable basis, Farm Bureau was entitled to judgment as a matter of law. n55

Iowa Has Adopted a Modified Directed Verdict Rule *Bellville* Supports a Modified Directed Verdict Rule. A starting point in this analysis is the Iowa Supreme Court's approving quotation from the Ashley treatise. n56 While that quotation reads like the strict directed verdict rule rejected in *Reuter*, *Bellville* did not overrule *Reuter*, holding only that [w]hether a claim is fairly debatable can *generally* be decided as a matter of law by the court. n57 In fact, both the Ashley treatise and the Barker and Glad article recognized exceptions to any such rule, exceptions that reconcile their rule with *Reuter* and indicate how one can determine when the directed verdict rule will not apply, producing a modified directed verdict rule, which is fully consistent with *Reuter's* rejection of a strict directed-verdict rule.

The Ashley treatise identifies exceptions, such as the insurer's knowing use of false testimony to create a fact issue and reliance on an expert known to be unreliable. n58 The Barker & Glad article similarly identifies exceptions for coverage testimony by lying insurer employees, dishonestly selected experts, and unreasonable insurer-employee experts. n59 As pointed out in *Cabell Electric Co. v. Pacific Insurance Co.*, n60 the justification for an exception to the directed-verdict rule is the bad faith jury's ability to determine, *from additional evidence*, that some of the evidence supposedly creating a factual issue on coverage was known by the insurer to be unworthy of consideration. An insurer cannot, in good faith, rely on evidence it knows or should know to be false or unreliable.

But if there is any evidence that the insurer could, in good faith, rely upon and which would permit a reasonable factfinder to rule against the insured, then the issue is fairly debatable and there can be no bad faith. So, for example, *Bellville* was entitled to rely on the police officer's report in attributing fault to *Bellville*, unless presented with proof that the officer's report was *patently* wrong. n61 As the Iowa Supreme Court succinctly put the point: if reasonable minds can differ on the coverage-determining facts or law, then the claim is fairly debatable. n62

Bellville also approvingly quoted a Texas case saying [c]ourts and juries do not weigh the conflicting evidence that was before the insurer; they decide *whether evidence existed* to justify denial of the claim.' n63 *Bellville* quoted the same case for the proposition that [t]he issue in the bad faith case is not whether the factfinder believes the evidence that [the insurer] believed when it denied the claim; the issue is whether such evidence existed.' n64

All of these statements indicate that juries have an extremely limited role in evaluating the objective element of bad faith: determining whether the evidence creating the fairly debatable coverage issue existed. (As will be discussed, juries may also consider whether the insurer knew (or, perhaps, should have known) that some of the evidence was unworthy of reliance. n65

Gilbert v. USF Holland, Inc. Supports a Modified Directed Verdict Rule. This aspect of the law of bad faith is reinforced by *Gilbert v. USF Holland, Inc.* n66 *Gilbert* reversed an award of workers compensation penalty benefits. The workers compensation statute provides for penalty benefits [i]f a delay in commencement or termination of benefits occurs without reasonable or probable cause or excuse. n67 A reasonable excuse exists if the claim for benefits is fairly debatable. n68 Section 86.13 codifies, in the workers' compensation context, the common law rule that an insurer with a good faith dispute over the legal or factual validity of a claim can challenge the claim, if its basis for doing so presents a fairly debatable issue. n69 Because the substantive standards are identical, denial of penalty benefits precludes any bad faith claim. n70 So, reversal of penalty benefits in *Gilbert* meant there could be no bad faith liability on those facts. In *Gilbert*, as in *Bellville*, the Iowa Supreme Court held that [w]hether the issue was fairly debatable

turns on whether there was a disputed factual issue that, if resolved in favor of the employer, would have supported the employer's denial of compensability. n71

Gilbert was a truck driver for USF Holland. He bent over to pull up a dock plate, a heavy metal ramp balanced in a way that is usually easy to move. This time, it stuck and jerked Gilbert down. He felt some pain but thought nothing of it. A second attempt disengaged the dock plate. He went to a nearby desk and signed a weigh bill. When he straightened up, he felt great pain, which he reported. n72

The next day, Gilbert wrote a report, saying that his neck popped as he was getting up. He had no idea why. He said nothing about the stuck dock plate. Nor did he mention it to his physician, Dr. White. n73

His compensation claim was denied because his injury did not arise out of any peculiar work stress. Gilbert then clarified his report by telling the adjuster about the dock plate. The insurer reaffirmed the denial. n74

About a month later, Gilbert developed severe neck pain and consulted Dr. Carlstrom, whom he told about the entire incident, including the stuck dock plate. Dr. Carlstrom attributed Gilbert's current symptoms to that incident. Eventually, Gilbert returned to work with no restrictions. n75

USF Holland still denied compensability. Gilbert submitted (1) a causation opinion from Dr. Carlstrom, (2) a letter from Dr. Minervi stating that his progress notes never denied work-relatedness, and (3) testimony to the dock plate incident. But compensation was still denied. Gilbert was awarded both benefits and penalty benefits. n76 The award said, 'continued denial of the claim after such matters were addressed by Drs. Carlstrom and Minervi was not fairly debatable and was not reasonable.' n77 But the Iowa Supreme Court struck the penalty benefits.

The compensability issue was whether the injury arose out of Gilbert's employment. Whether the issue was fairly debatable turns on whether there was a disputed factual issue that, if resolved in favor of the employer, would have supported the employer's denial of compensability. n78

Based on Gilbert's initial explanation, USF Holland maintained that the injury had been caused simply by straightening up, not any hazard connected with the employment. n79 The Iowa Supreme Court said the issue remained fairly debatable, even after the doctors supported work-relatedness and the co-worker corroborated Gilbert's account:

Although the physicians concluded that Gilbert's injury was caused by his employment, these opinions were based on Gilbert's revised history of his injury. The employer has never asserted that the act of tugging and lifting on a stuck dock plate could not have caused the injuries suffered by Gilbert. What the employer disputed is whether the employee's revised or amplified version of the events of June 4 -- that he first felt pain when he pulled on a stuck dock plate -- was true. Thus, the industrial commissioner should have focused on whether there was a fair debate over how the injury occurred. We think there indisputably was. n80

If, as Gilbert had first reported, the injury occurred as he straightened up, the occurrence might have been unrelated to his work. The Iowa Supreme Court held that the employer was entitled to rely on Gilbert's original version of his injury even though he subsequently changed his story of how the injury occurred. n81

Gilbert argued that he never changed his story, but simply amplified it when he learned additional facts were relevant. The Iowa Supreme Court held that the difference in accounts created an issue of credibility:

Regardless of how Gilbert's reporting of his injury is characterized, it cannot be disputed that he never mentioned that he first felt pain after pulling up on the dock plate, as opposed to when he straightened up, until *after* his claim had been denied. The employer was certainly entitled to argue that this previously undisclosed fact was a fabrication. Given the fact that not even the eyewitness corroborated this aspect of Gilbert's history, that pulling on the dock plate triggered the onset of pain, resolution of the matter rested on Gilbert's credibility, which the employer was free to challenge. As the deputy noted, there was a credibility issue in this case for the commissioner to resolve. The fact that the

commissioner resolved the credibility issue in favor of the employee did not mean that there was not a reasonable dispute with respect to how the accident occurred. n82

Gilbert also argued that the medical evidence pointed to work causation, and USF Holland never obtained any contrary medical opinions. But the Iowa Supreme Court held that the relevant issue was not medical:

the debatable issue in this case was *factually* how the injury occurred. Medical testimony on causation is simply not relevant to resolution of this contested *factual* issue. In other words, the fact that the physicians relied on the revised history rather than the original history did not resolve the factual dispute as to how the injury occurred. Thus, the commissioner's reliance on the medical testimony as support for her finding that there was not a reasonable basis to contest compensability was erroneous. n83

Finally, Gilbert argued that there had been an inadequate investigation, because the witness to the incident was not interviewed. But, even if that should have been done, there was no evidence that the witness would have added any new information. So, failure to interview the witness did not support the finding that there was no reasonable basis to dispute compensability. n84

Both *Bellville* and *Gilbert* demonstrate that an insurer may view the facts relating to the claim in an adversarial manner, looking solely to whether there is a genuine issue warranting submission of the issue to a trier of fact. Indeed, *Bellville* approvingly cites authorities which make that point. n85 Neither of those cases recognizes any qualification to that rule, except a bar against relying on evidence that the insurer knows is unworthy of reliance.

All Other Iowa Bad Faith Cases Are Consistent with a Modified Directed Verdict Rule. This reading of Iowa law is consistent with other Iowa precedent. Many cases hold bad faith claims precluded because the insured's coverage claim was fairly debatable. n86 One case found the coverage claim not fairly debatable precisely because the insured *had* been entitled to summary judgment on coverage. n87 Another case would fit within an exception just described. n88 In yet another case the injured worker had recovered penalty benefits and, as so far as the opinion indicates, the denial had been based solely on unsupported suspicions. n89 Only two cases suggest that the question of fair debatability may have been for the jury, and in both the insured appears to have been entitled to a directed verdict on coverage.

Nassen v. National States Insurance Co. n90 affirmed judgment on a verdict finding bad faith and fraud. The insurer had claimed application misrepresentations based on supposed hospital diagnoses of pre-existing health conditions, but existence of those conditions was negated by the discharge summary for that hospitalization and other information in the insurer's claim file. n91 Under the circumstances, the question of bad faith was for the jury to decide. n92 In *Nassen's* procedural context, this did not mean that the jury could decide whether the insurance claim was fairly debatable: there clearly was nothing to debate. The subjective element of bad faith might have required jury factfinding. Or the court might have meant only that there was no legal obstacle to the bad faith verdict, perhaps because *Nassen* would have been entitled to summary judgment. Either meaning would support the affirmance.

In *McIlravy v. North River Insurance Co.* n93 the insurer had obtained summary judgment on the issue of bad faith, and the Iowa Supreme Court remanded for trial. It concluded that McIlravy's initial interview provided a reasonable basis for the initial denial, because the injury appeared not to result from any work-related stress. n94 McIlravy's doctor, Dr. Gehrke, said in a letter that the injury was work-related, but provided no factual basis; accordingly, North River had no additional facts or information to reevaluate its earlier response that the injury was not work-related. n95 But North River then deposed Dr. Gehrke, who now explained that McIlravy's job placed him at greater risk of the sort of injury he suffered. n96 Despite this new evidence, North River continued to deny the claim and (so far as the summary judgment record revealed) conducted no further investigation of a claim now *prima facie* established. n97

The Iowa Supreme Court observed that the new information provided in the deposition did not necessarily render

the compensability issue undebatable . n98 In theory, other evidence (not in the summary judgment record) might have kept the issue of compensability in dispute, but that would have at least required North River to have investigated to see whether such evidence could be found.

The court said that Dr. Gehrke's deposition testimony did transform the reasonableness of the continued denial by North River into a jury question. n99 As the court explained:

Bad faith may be inferred from a flawed investigation, and the facts of this case place the adequacy of the investigation conducted by North River after the deposition of Dr. Gehrke into question. We recognize an incomplete investigation will not alone support recovery for bad faith if the insurer nevertheless had a reasonable basis for denial. Yet, the failure of North River to investigate in this case went to the very foundation of the basis for its denial. North River previously denied the claim based on the lack of facts to show the injury was work-related, and the deposition of Dr. Gehrke supplied the missing facts. A reasonable inference to be drawn from North River's failure to investigate further is that it knew it had no reasonable basis for denying McIlravy's claim. n100

McIlravy did not say the dispute requiring jury trial was whether the claim remained fairly debatable. Indeed, unless North River at least sought evidence to dispute work-relatedness, (1) there was no further basis to dispute coverage, and (2) *McIlravy* could have obtained summary judgment in the workers' compensation proceeding. The issue requiring trial apparently was the subjective element of bad faith.

In sum, all Iowa bad faith precedents are consistent with the modified directed-verdict rule that can be extracted from *Bellville* and *Gilbert*.

The *Zimmer* Court Takes a Different View

This issue was recently presented on post-trial motions in *Zimmer v. Travelers Insurance. Co.*, n101 where the federal district court disagreed with the analysis here. Because the case was settled on appeal, that decision will never be reviewed.

Kris Zimmer recovered workers' compensation (WC) benefits for a back injury on June 1, 1999 that aggravated preexisting psychological problems; he then sued for bad faith benefit denial. n102 The jury found bad faith, awarding Zimmer \$10,087,453 in compensatory damages and \$3,000,000 in punitive damages. n103 The district court struck \$571,529 in compensatory damages and \$2,000,000 in punitive damages, for reasons not relevant here. n104 It declined to grant Travelers judgment as a matter of law.

The Zimmer claim was a complicated one, but the argument for judgment as a matter of law focused on a single issue: had it been fairly debatable whether Zimmer had actually suffered the work injury he claimed. The evidence on that point can be summarized as follows.

On June 1, 1999, Zimmer worked at a unit of Wells Fargo. He reported to his superior, Dennis Woolums, that he had suffered a work-related back injury; Woolums sent him home. The next day, Zimmer went to the emergency room (ER) of Des Moines General Hospital, where he was met by Dr. Carol Horner, his regular doctor. Dr. Horner gave him a note: [p]lease excuse Mr. Zimmer from work from 6/1/99 until released due to medical illness. Zimmer has not worked since. n105

Wells Fargo said Zimmer's claim was questionable. The adjuster, Beerbower, interviewed Zimmer:

I called and talked to the IW [injured worker]. He kept telling me that he has had previous back problems and when he bent over to pick up some confidential papers off the ground he felt a rip in his left side of his lower back. He states that he informed Tim Enos [a co-worker] that he had hurt his back when picking up the papers off the ground.

. He kept saying over and over that this was the final straw that broke the camel's back. n106

Pre-June 1 medical records showed that Zimmer had a history of worsening back and emotional problems starting in early 1999. n107 Wells Fargo reported that Zimmer's boss said Zimmer walks like he does every other time he has a bad back. n108 Enos denied having been told of the injury, though saying that Zimmer bent over to pick up the papers. n109

On June 2, Zimmer visited the ER. The hospital records do not mention any June 1 injury. The triage nurse's notes state: Severe back pain. Chronic They describe bruising and discoloration of his fingers. Dr. Abbassi's notes describe Zimmer's [c]hief complaint as [t]ingling sensations on the three fingers of his left hand with discoloration of those fingers. Under review of systems, Dr. Abbassi noted, [t]he patient denied any falls or injury. He does complain of back pain, which is chronic in nature. Dr. Horner ordered tests with a diagnosis of severe back pain, but did not indicate any injury. n110

In the ER, Dr. Horner referred Zimmer to Dr. Rettenmeier. Dr. Rettenmeier wrote a June 3 letter describing the visit, which does not mention any June 1 injury. He said Zimmer presents for evaluation basically of a variety of pain issues, primarily left sided leg greater than arm, as well as some vague discoloration changes in his hands. He dates the onset of his problems to 1988. n111 After discussing the events of 1988 and their consequences, Zimmer said that [a]bout 2 years ago, he started developing other pain issues. He apparently started having some pains that started in the left side of his lower back and chest and moved up into his arm. He talked about pains that radiate up his arm into the left side of his face and neck. Dr. Rettenmeier understood that Zimmer had gained control of that problem. Zimmer then talked about more current problems:

since January of this year, he has had progressive worsening... He talks about low back pain that has been unmanageable. In the past, it has always been manage[able], but has subsequently been unmanageable... Tuesday around 2 p.m., he apparently missed his Xanax, an hour late. He developed the sudden onset of discoloration in his left hand... He also has been having a lot of anxiety issues. This apparently has been a significant problem for several years. About 2 1/2 years ago, he apparently had stress at work and dropped 35 pounds in a quick period of time... He admits to a lot of work stress. He readily admits to anxiety issues... He really does not describe work depressive symptoms... n112

Dr. McGuire had seen Zimmer for his back problems in March 1999; Beerbower had Zimmer see him again, hoping Dr. McGuire could distinguish what was pre-existing from anything caused by the reported June 1 injury. n113 Unfortunately, Dr. McGuire did not address that point. After noting Zimmer's report of the June 1 injury, he said that Zimmer's problems were outside his expertise:

His back is the somatization of all his other problems. There is absolutely nothing for me to do. [] He needs to resolve stress and psychological problems before we can do anything. [] . From my standpoint, as far as his spine is concerned, he can be working full time. As far as his psychological problems and his dealings with superiors and other people, that needs to be resolved and that is in someone else's area of expertise. [] . As far as the back is concerned he could be working. The psychological problems and the job conflict situation would probably prevent him from working. n114

Dr. Horner's records begin on July 8, 1997, discussing back and abdominal pain. They show increasing back problems in early 1999 through late May, including referrals to Dr. Koithan (a psychiatrist), and Drs. Stein, Igram, and McGuire. They include a copy of part of the ER record. They say nothing about what Zimmer said in the ER. Zimmer saw Dr. Horner on June 30, 1999; July 14, 1999; July 23, 1999; July 26, 1999; and July 27, 1999. *The first mention of the reported June 1 injury in Dr. Horner's records was on July 27.*

The July 27 note describes Zimmer's then-current complaints of back, abdominal, and leg pain and his consultation with Dr. Leth. The note then discusses the reported June 1 injury:

The patient's presenting symptoms were reviewed with him at length. The patient reports that he bent over to chase

some papers on June 1, 1999 about 9:10 in the morning on 8th Street outside his home office. He was trying to pick up some of the company's confidential memos. apparently [sic] some QA type forms. . . . The patient was plugging a parking meter with quarters when he looked up and saw the papers flying up the street. Previously, they were in the back seat in a binder. Another employee or co-worker was apparently getting these papers out of the car. Paper hit his leg. The patient picked this up, saw it was confidential, and went in pursuit of the other papers. When bending over to pick these up he noticed the feeling of something ripping or tearing in his left lower back. He had to leave work later that morning, about 10 o'clock, due to the pain in his back. The next day he went to the Des Moines General emergency room where I saw and evaluated him.

The patient reports that he is presently unable to work as he cannot sit for long, cannot bend over or flex, cannot pick things up, cannot walk upstairs. He states that his wife must help him get out of bed or he must use a cane to help him get himself up due to his pain. n115

In July, Zimmer saw Dr. Leth (a pain specialist) and Dr. Koithan (a psychiatrist). He gave both a history that included the June 1 injury. n116 Over the years following, Zimmer saw many other doctors, giving them similar histories. Eventually, Dr. Horner (and Dr. Giordano, who treated Zimmer, starting in 2000) provided an opinion that Zimmer's disability was caused by the June 1 injury. n117

Travelers argued that it was fairly debatable whether Zimmer suffered any work injury on June 1, 1999. The following undisputed evidence existed: (1) Enos's failure to corroborate Zimmer's account; (2) ER records reporting Zimmer's denial of any fall or injury; (3) absence from the ER records and Dr. Rettenmeier's records of any mention of any June 1, 1999 injury; and (4) absence from Dr. Horner's records of any contemporaneous reference to any such injury and, despite two supplements requested by Zimmer, of any indication that Zimmer reported that injury in the ER. This created a factual issue whether the reported work injury had occurred, because an injured worker seeking medical treatment for back problems would be expected to tell doctors about any recent back injury.

These facts closely parallel those in *Gilbert*. Indeed, *Zimmer* is an even clearer case than *Gilbert* for presence of a fairly debatable factual issue. In the emergency room, Zimmer actually denied any fall or injury, something Gilbert never did. Both Zimmer and Gilbert omitted mention of the work injury at crucial points immediately after it allegedly occurred. (To be sure, Zimmer promptly reported the alleged work injury to his supervisor, while Gilbert did not; that makes little difference and is offset by Zimmer's emergency room denial of any recent injury.) In neither case did the witness corroborate the *injury*, though both corroborated the relevant incident. In neither case could the doctors shed any light on the factual question of how the injury occurred, i.e., whether the worker first felt pain at the time claimed. In neither case is there any evidence that further investigation would have produced additional evidence supporting the claim.

The *Zimmer* court offered several distinctions of *Gilbert*, mostly in an unreported memorandum denying a motion to reconsider the motion for judgment as a matter of law. First, *Gilbert* involved review of an administrative decision for substantial evidence, a review that is more searching than review of a jury verdict. n118 But that assumes that there was some relevant fact that the jury could have determined. Bad faith requires that a plaintiff establish two elements, one subjective and one purely objective. Given the close similarity of the facts in *Zimmer* and *Gilbert* and the identity of the legal standards, the standard in *Zimmer* was the same as in *Gilbert*: Whether the issue was fairly debatable turns on whether there was a disputed factual issue that, if resolved in favor of the employer, would have supported the employer's denial of compensability. n119 That depends solely on an objective evaluation of the evidence available to the insurer (about whether the worker felt pain when claimed); the only facts to be found are what that evidence was. Both in *Zimmer* and in *Gilbert*, there was no dispute as to that evidence. The question whether that evidence created a disputed issue was a question of law, not one of fact.

The *Zimmer* court also suggested that the ER notes might be interpreted in a more favorable light to Zimmer, relating the denial of any falls or injury only to the discoloration of his fingers. n120 Moreover, the failure to report the injury to his doctors might be seen as outweighed by his prompt report to his supervisor and to Beerbower, especially as

these reports (unlike Gilbert's) were made before his claim was denied.

The *Zimmer* court held that the existence of competing inferences from the evidence permitted the jury to find that there was no objectively reasonable basis to deny the claim. n121 That misconceives the inquiry. Availability of competing inferences allowed the workers' compensation arbitrator to make *factual findings* favoring Zimmer. But the question on bad faith liability is whether there was an objectively reasonable basis for the insurer to insist upon adjudication of the facts. *Gilbert* held such a basis exists when there is a genuine factual issue, e.g., on when the worker felt pain. n122 *If the available evidence presents a fairly debatable question, then an insurer is entitled to debate that question by denying the claim and requiring that the facts be adjudicated.*

The *Zimmer* court also relied n123 on *Etten v. U.S. Food Service, Inc.* n124 Etten had delayed reporting a slip and fall to his employer because the onset of symptoms had been delayed. n125 Given the delayed onset, the delay in reporting gave no reason to question the injury. Thus, as the *Etten* court said, the questions raised were based purely on speculative inferences from a highly selective reading of [Etten's] medical records.' n126 In contrast, Zimmer reported immediately to his supervisor but, strangely, not to his doctors. Zimmer's failure to tell his doctors, when he would be expected to do so if the injury had occurred, created a question not present in *Etten*. n127 The inference drawn from Zimmer's failure to tell his doctors was not speculative.

The *Zimmer* court pointed to the various medical records, starting with Dr. Horner's July 27 note, that showed Zimmer reporting the injury and even connected it causally with his disability. n128 But there were similar medical records and causation opinions in *Gilbert*, so those cannot be a distinguishing factor. The suspicious fact in *Zimmer* is Zimmer's failure to report his injury to his doctors, *when first seeking treatment*, despite having reported it to his supervisor. Neither later reports nor medical opinions based on those reports can eliminate the resulting question.

Precisely because Dr. Horner's medical records, even as supplemented, say only that Zimmer reported the injury on July 27 -- not June 2 -- the *Zimmer* court erred in thinking it significant that Beerbower denied the claim before getting those records. As *Gilbert* held, inadequate investigation cannot support bad faith unless that investigation would have revealed significant information. On the *factual* issue of whether Zimmer felt acute pain on June 1, Dr. Horner's records contained no significant information. So, while Beerbower's action must be judged *as if* she had waited for those records to arrive, her failure to wait did not make Zimmer's claim undebatable.

Conclusion

If there is any evidence that the insurer could, in good faith, rely upon and which would permit a reasonable factfinder to rule against the insured, then the issue is fairly debatable and there can be no bad faith. As the Iowa Supreme Court succinctly put the point: if reasonable minds can differ on the coverage-determining facts or law, then the claim is fairly debatable. n129

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n1 William T. Barker, *Evidentiary Sufficiency in Insurance Bad Faith Suits*, 6 Conn. Ins. L.J. 82, 99-101 (1999-2000), and William T. Barker & Paul E.B. Glad, *Use of Summary Judgment in Defense of Bad Faith Actions Involving First-Party Insurance*, 30 Tort & Ins. L.J. 49, 52-53 (1994).

n2 *Bellville v. Farm Bureau Mut. Ins. Co.*, 702 N.W.2d 468 (Iowa 2005).

n3 *Zimmer v. Travelers Ins. Co.*, 521 F. Supp. 2d 910 (S.D. Iowa 2007). The authors developed some of the analysis here for use in post-trial motions and appeal in *Zimmer*. The case was settled on appeal, for a confidential amount.

n4 See, e.g., *Fletcher v. Western Nat'l Life Ins. Co.*, 10 Cal. App. 3d 376, 403, 89 Cal. Rptr. 78, 95 (1970) (under disability insurance policy, [t]he very risks insured against presuppose that if and when a claim is made, the insured will be disabled and in strait financial circumstances and, therefore, particularly vulnerable to oppressive tactics on the part of an economically powerful entity).

n5 See, e.g., Tex. Ins. Code Ann. art. 21.55 (allowing a recovery of 18% per annum for wrongful and untimely denials of claims). Even apart from statutes of this sort, state law commonly allows for prejudgment interest on claims for liquidated amounts. See, e.g., *authorities collected in* 47 C.J.S., *Interest & Usury*, § 20, at 55-59 & nn. 90-97 (1982); *id.* at 2 (Supp. 2002).

n6 See *Paulson v. State Farm Mut. Auto. Ins. Co.*, 867 F. Supp. 911, 917-18 (C.D. Cal. 1994) (emotional distress not compensable on contract claim).

n7 See *Arnold v. National County Mut. Fire Ins. Co.*, 725 S.W.2d 165, 167 (Tex. 1987) (in the absence of a tort cause of action, insurers can arbitrarily deny coverage and delay payment of a claim with no more penalty than interest on the amount owed). This is an overstatement, because the insurer must pay the costs of its own defense no matter how the suit turns out, and, depending on state law, may have to pay the insured's attorneys fees and a penalty interest rate if the insured prevails. *But see Union Bankers Ins. Co. v. Shelton*, 889 S.W.2d 278, 286-87 (Tex. 1994) (Cornyn, J., dissenting) (an insurer has more incentive to pay if it will be liable for any consequential damages in addition to interest and attorneys fees).

n8 See Tex. Ins. Code Ann. arts. 21.21, 21.55; Tex. Civ. Prac. & Rem. Code Ann. § 38.006(5). Not all jurisdictions permit recovery of fees as a matter of course on wrongfully denied insurance claims.

n9 Plaintiff-oriented commentators place great emphasis on this point. E.g., Marc S. Mayerson, *First-Party Insurance Bad Faith Claims: Mooring Procedure to Substance*, 38 Tort Trial & Ins. Prac. L.J. 861, 868 (2003) (courts are loath to permit a policy holder's transaction costs in accessing judicial process to create an economic space within which an insurance company can get away with rendering less than what it promised).

n10 *Aranda v. Insurance Co. of N. Am.*, 748 S.W.2d 210, 213 (Tex. 1988).

n11 Detection and prevention of fraud is an interest strongly shared by all honest purchasers of insurance, who would object to paying higher premiums merely to enrich the perpetrators of fraud. *See* Alan O. Sykes, *Bad Faith Breach of Contract by First-Party Insurers*, 25 *J. Legal Stud.* 405, 425-29 (1996). Anything which inhibits insurers from challenging potentially fraudulent claims will not only permit the success of frauds which go undetected as a result, but will also tend to encourage additional fraudulent claims.

n12 *Anderson v. Continental Ins. Co.*, 271 N.W.2d 368 (Wis. 1978), *quoting* John W. Thornton & Milton S. Blacot, *Bad Faith and Insurers: Compensatory and Punitive Damages*, 12 *Forum* 699, 719 (1977).

n13 85 Wis. 2d 693, 271 N.W.2d. at 377. *See also* *Paulson v. State Farm Mut. Auto. Ins. Co.*, 867 F. Supp. 911, 913-14 (C.D. Cal. 1994) (insurance rates are based on estimates of the costs of performance and breach, but tort liabilities are too vague to be accounted for in advance, so scope of tort must be narrowly and precisely defined, lest [t]he ability of an insured to create a tort lawsuit out of a good faith denial of insurance coverage create[] settlement value . . . out of proportion to the merits of the underlying contract dispute[s].) (second alteration in original).

n14 85 Wis. 2d at 693, 271 N.W.2d. at 377.

n15 706 P.2d 1258 (Colo. 1985) (en banc).

n16 *Id.* at 1274. *See also* Robert E. Keeton & Allan I. Widiss, *Insurance Law* § 7.10(a), at 918 (1988) (Policyholders and insureds clearly have an interest . . . in not discouraging insurers from contesting claims when there are reasonable questions about whether the insured's claim is within the scope of the coverage); *Blue Cross & Blue Shield v. Campbell*, 466 So. 2d 833, 841 (Miss. 1984) (court recognizes an obligation to support any insurance company fulfilling its lawful responsibility of investigating any claim which is dubious); *Aranda v. Insurance Co. of N. Am.*, 748 S.W.2d 210, 213 (Tex. 1988) (bad faith law must allow insurers to maintain the right to deny invalid or questionable claims and will not be subject to liability for an erroneous denial of a claim).

n17 *E.g.*, *Transportation Insurance Co. v. Moriel*, 879 S.W.2d 10, 17 (Tex. 1994) (Evidence that merely shows a bona fide dispute about the insurer's liability on the contract does not rise to the level of bad faith.); *Dalrymple v. United States Auto. Ass'n*, 40 Cal. App. 4th 497, 506-07, 46 Cal. Rptr. 2d 845, 849-50 (1995). Authorities are collected in Dennis J. Wall, *Litigation and Prevention of Insurer Bad Faith* §§ 11.04, 11.17 (1985 & Supp. 2003); William T. Barker, *Evidentiary Sufficiency in Insurance Bad Faith Suits*, *supra* note 3, 6 Conn. Ins. L.J. at 99-101; and William T. Barker & Paul E.B. Glad, *supra* note 3, 30 Tort & Ins. L.J. at 52-53.

n18 *Anderson*, 85 Wis. 2d at 691, 271 N.W.2d at 376.

n19 *Moriel*, 879 S.W.2d at 17.

n20 *Id.* at 18 n.8.

n21 *Union Bankers Ins. Co. v. Shelton*, 889 S.W.2d 278, 287 (Tex. 1994) (Cornyn, J., dissenting).

n22 *Hudson Universal Ltd. v. Aetna Ins. Co.*, 987 F. Supp. 337, 341 (D.N.J. 1997).

n23 *Vernon Fire & Cas. Ins. Co. v. Sharp*, 349 N.E.2d 173, 181 (Ind. 1976).

n24 Even if a claim is clearly covered, there may be a bona fide dispute about the amount due; for bad faith purposes, that is considered a coverage question as to the disputed portion of the claim.

n25 *See, e.g.*, *Egan v. Mutual of Omaha Ins. Co.*, 620 P.2d 141 (Cal. 1979) ([A]n insurer cannot reasonably and in good faith deny payments to its insured without thoroughly investigating the foundation for its denial.); *McCormick v. Sentinel Life Ins. Co.*, 200 Cal. Rptr. 732, 737-43 (Cal. Ct. App. 1984) (failure of insurer to seek information missing from statement submitted by doctor precluded it from relying on the omission to deny the claim); *see also* Stephen S. Ashley, *Bad Faith Actions: Liability & Damages* § 5:08 (2d ed. 1997).

n26 *Zimmer v. Travelers Ins. Co.*, 454 F. Supp. 2d 839, 862-63 (S.D. Iowa 2006) (citations omitted).

n27 *National Savings Life Ins. Co. v. Dutton*, 419 So. 2d 1357 (Ala. 1982).

n28 The jury was instructed that only a fraudulent misstatement would support rescission and rendered a verdict for Mrs. Dutton. Because any material misstatement, even if innocent, would support rescission, the instruction was error and required retrial of the coverage issue. *Id.* at 1360-61.

n29 *Id.* at 1362. The court also rejected Mrs. Dutton's claim "that the company had an affirmative duty to investigate further." *Id.* The court noted that the insurer had invited Mrs. Dutton to supply additional information if the information it had was inaccurate, but she did not do so. *Id.*

n30 *Reuter v. State Farm Mut. Auto. Ins. Co.*, 469 N.W.2d 250, 254 (Iowa 1991).

n31 *Id.* at 253-54.

n32 *Id.* at 255.

n33 *Bellville v. Farm Bureau Mut. Ins. Co.*, 702 N.W.2d 468, 473 (Iowa 2005).

n34 *Id.* at 473 (citations omitted).

n35 William T. Barker & Paul E.B. Glad, *supra* note 1.

n36 *Bellville*, 708 N.W.2d at 473-74 (citations omitted), quoting *State Farm Lloyds, Inc. v. Polasek*, 847 S.W.2d 279, 285 (Tex. Ct. App. 1992).

n37 *Bellville*, 708 N.W.2d at 474 (quoting Stephen S. Ashley, *Bad Faith Actions Liability & Damages* § 5:04, at 5-17 to 5-18 (2d ed. 1997) (also discussing exceptions to this rule)).

n38 *Bellville*, 708 N.W.2d at 475.

n39 *Id.*

n40 *Id.*

n41 *Id.* at 477. *Bellville* claimed that, when the light turned yellow, there was not time to stop before entering the intersection.

n42 *Id.* at 477-78.

n43 *Id.* at 478.

n44 *Id.*

n45 *Id.* at 479 (citing *Szumigala v. Nationwide Mut. Ins. Co.*, 853 F.2d 274, 280-81 (5th Cir.1988) (liability for accident fairly debatable because it presented a classic jury question)).

n46 *Id.*

n47 *Id.* at 479-80 & n.3. As the court explained, 30% fault would allow subtraction from a \$415,000 verdict of \$94,500, and the \$50,000 recovery from the tortfeasor would allow subtraction of that amount, leaving a net award of \$270,500. *Id.* n.3.

n48 *Id.* at 480-81.

n49 *Id.* at 481.

n50 *Id.*

n51 *Id.* at 481-82.

n52 *Id.* at 483-84.

n53 *Id.* at 484, *citing, inter alia*, William T. Barker & Paul E.B. Glad, *supra* note 1, 30 Tort & Ins. L.J. at 86 (Many courts have found insurer legal positions reasonable, even in the absence of clear supporting authority, because the issue was an open one or one of first impression in the controlling jurisdiction.).

n54 *Id.* at 484, *citing* William T. Barker & Paul E.B. Glad, *supra* note 1, 30 Tort & Ins. L.J. at 83 (stating the most reliable method of establishing that the insurer's legal position is reasonable is to show that some judge in the relevant jurisdiction has accepted it as correct).

n55 *Id.* at 485.

n56 See text at note 37, *supra*.

n57 *Id.* at 473 (emphasis added).

n58 Stephen S. Ashley, *supra*, § 5:04, at 5-18 to 5-21.

n59 William T. Barker & *Paul E.B. Glad*, *supra* note 1, 30 Tort & Ins. L.J. at 68-74.

n60 *Cabell Elec. Co. v. Pac. Ins. Co.*, 655 F. Supp. 625, 629-30 (S.D. Miss. 1987).

n61 *Bellville*, 708 N.W.2d at 478.

n62 *Id.* at 473.

n63 *Id.* at 474 (quoting *State Farm Lloyds, Inc. v. Polasek*, 847 S.W.2d 279, 285 (Tex. Ct. App. 1992)).

n64 *Id.* at 473 (internal citation omitted).

n65 See discussion at notes 58-61, *supra*.

n66 *Gilbert v. USF Holland, Inc.*, 637 N.W.2d 194 (Iowa 2001).

n67 Iowa Code § 86.13.

n68 *Covia v. Robinson*, 507 N.W.2d 411, 416 (Iowa 1993); *Christensen v. Snap-On Tools Corp.*, 554

N.W.2d 254, 260 (Iowa 1996); *Gibson v. ITT Hartford Ins. Co.*, 621 *N.W.2d* 388, 397 (Iowa 2001).

n69 *Gilbert*, 637 *N.W.2d* at 199.

n70 *Brcka v. St. Paul Travelers Cos.*, 366 *F. Supp. 2d* 850, 857 (S.D. Iowa 2005); *Gilbert v. Constitution State Serv., Co.*, 101 *F. Supp. 2d* 782, 787-88 (S.D. Iowa 2000).

n71 *Gilbert*, 637 *N.W.2d* at 199.

n72 *Id.* at 195.

n73 *Id.* at 195-96.

n74 *Id.* at 196.

n75 *Id.*

n76 *Id.* at 196-97.

n77 *Id.* at 197.

n78 *Id.* at 199.

n79 *Id.*

n80 *Id. at 200.*

n81 *Id.*

n82 *Id.*

n83 *Id.*

n84 *Id. at 201.*

n85 *Bellville*, 708 N.W.2d at 478-79 (because the relationship between an insurer and its insured is arms-length with respect to UIM coverage, Farm Bureau was not required to view the facts of the accident in a light most favorable to Bellville. *Compare N. Iowa State Bank*, 471 N.W.2d at 829 (stating insurer does not occupy a fiduciary relationship to insured when evaluating insured's claim under policy; rather, parties are in an arms-length relationship), with *Long v. McAllister*, 319 N.W.2d 256, 262 (Iowa 1982) (stating in meeting its fiduciary duty to insured, insurer must give as much consideration to its insured's interests as it does to its own); see also *Hutchinson v. Farm Family Cas. Ins. Co.*, 273 Conn. 33, 867 A.2d 1, 10 (2005) (stating relationship between insured and UIM insurer is adversarial, not fiduciary); *Ellwein v. Hartford Accident & Indem. Co.*, 142 Wash. 2d 766, 15 P.3d 640, 647 (2001) (holding relationship between UIM insurer and insured is adversarial, and therefore, insurer does not have to give equal consideration to the insured's interest), *overruled on other grounds by Smith v. Safeco Ins. Co.*, 150 Wash. 2d 478, 78 P.3d 1274, 1278 (2003).).

n86 *Bellville*, 702 N.W.2d at 475-82 (comparative fault of uninsured motorist and amount of insured's damages); *Wilson v. Farm Bureau Mut. Ins. Co.*, 714 N.W.2d 250, 262-63 (Iowa 2006) (insurer's reasonable legal arguments on unresolved coverage issue); *Seastrom v. Farm Bureau Life Ins. Co.*, 601 N.W.2d 339, 347 (Iowa 1999) (conflicting testimony on whether insured given conditional receipt); *Thompson v. U.S. Fid. & Guar. Co.*, 559 N.W.2d 288, 292 (Iowa 1997) (existence of evidence supporting insurer's intoxication defense); *Morgan v. Am. Family Mut. Ins. Co.*, 534 N.W.2d 92, 97 (Iowa 1995) (conflicting evidence on whether injuries caused by accident), *overruled on other grounds by Hamm v. Allied Mut. Ins. Co.*, 612 N.W.2d 775 (Iowa 2000); *Wetherbee v. Economy Fire & Cas. Co.*, 508 N.W.2d 657, 662 (Iowa 1993) (insurer's legal arguments); *Reuter*, 469 N.W.2d at 255 (chiropractic consultant's report challenged bills); *Dirks v. Farm Bureau Mut. Ins. Co.*, 465

N.W.2d 857, 862 (Iowa 1991) (factual dispute as to underinsured motorist's liability); *Kirk v. Farm & City Ins. Co.*, 457 N.W.2d 906, 910-11 (Iowa 1990) (lack of evidence that uninsured motorist was the driver and evidence of possible comparative negligence); *Dolan v. Aid Ins. Co.*, 431 N.W.2d 790, 794-95 (Iowa 1988) (evidence of insured's pre-existing condition); *Hoekstra v. Farm Bureau Mut. Ins. Co.*, 382 N.W.2d 100, 11-12 (Iowa 1986) (evidence of possible arson); *Pirkl v. Nw. Mut. Ins. Ass'n*, 348 N.W.2d 633, 636 (Iowa 1984) (weakness of insured's evidence of theft); *Higgins v. Blue Cross of W. Iowa & S.D.*, 319 N.W.2d 232, 236 (Iowa 1982) (insurer's defense of application misrepresentation provided reasonable basis to deny claim; trial court must have determined that this was so when it denied [the insured's] motion for a directed verdict on that claim.); *M-Z Enters., Inc. v. Hawkeye-Sec. Ins. Co.*, 318 N.W.2d 408, 415 (Iowa 1982) (evidence supporting application of exclusion); *Reid v. Pekin Ins. Co.*, 436 F. Supp. 2d 1002, 1012-13 (N.D. Iowa 2006) (conflicting expert opinions).

n87 *Niver v. Travelers Indem. Co.*, 412 F. Supp. 2d 966, 990-92 (N.D. Iowa 2006).

n88 *Buhmeyer v. Case New Holland, Inc.*, 446 F. Supp. 2d 1035, 1042-44 (S.D. Iowa 2006) (insurer's coverage defense (a) relied on doctor's statement that it knew was based on an erroneous premise and (b) ignored a later report free from that error).

n89 *Etten v. U.S. Food Serv., Inc.*, 446 F. Supp. 2d 968, 976-80 (N.D. Iowa 2006).

n90 *Nassen v. Nat'l States Ins. Co.*, 494 N.W.2d 231 (Iowa 1992).

n91 *Id.* at 236.

n92 *Id.*

n93 *McIlravy v. North River Ins. Co.*, 653 N.W.2d 323 (Iowa 2002).

n94 *Id.* at 331-32.

n95 *Id.* at 332.

n96 *Id.*

n97 *Id.* at 332-33.

n98 *Id.* at 333.

n99 *Id.*

n100 *Id.* (citations omitted).

n101 *Zimmer v. Travelers Ins. Co.*, 521 F. Supp. 2d 910 (S.D. Iowa 2007).

n102 Identity of the defendants is itself a complicated issue. The workers compensation insurer was Continental Casualty Co., erroneously sued as Continental Insurance Co, an error never corrected in light of the affiliation between the two and the indemnification described below. Claims were administered by Constitution State Services, LLC (CSS). Actual claim handling was done on behalf of CSS by employees of St. Paul Travelers Insurance Companies, now Travelers Insurance Companies. The distinctions among the parties make no difference for purposes of this analysis, so all will be described collectively as Travelers.

n103 *Zimmer*, 521 F. Supp. 2d at 915-16.

n104 *Id.* at 961.

n105 *Id.* at 916-17.

n106 *Id. at 918-19.*

n107 *Id. at 916.*

n108 *Id.*

n109 *Id. at 918-19.*

n110 *Id. at 916-17.*

n111 *Id. at 917.*

n112 *Id.*

n113 *Id. at 919.*

n114 *Id. at 919-20.*

n115 This evidence, appearing in the *Zimmer* record, is substantially quoted *id. at 920-21*, where it is mistakenly said to be dated *August 27*.

n116 *Id. at 930.*

n117 Curiously, the *Zimmer* court did not rely on that opinion, and it is not mentioned by the court.

n118 *Zimmer v. Travelers Ins. Co.*, No. 4:04-cv-00542, slip op. at 6 (S.D. Iowa Dec. 20, 2007) (opinion on reconsideration of motion for judgment as a matter of law).

n119 *Gilbert*, 637 N.W.2d at 199.

n120 *Zimmer v. Travelers Ins. Co.*, No. 4:04-cv-00542, slip op. at 7 (S.D. Iowa Dec. 20, 2007) (opinion on reconsideration of motion for judgment as a matter of law).

n121 *Id.* at 8.

n122 *See Bellville*, 702 N.W.2d at 473 (if reasonable minds can differ on the coverage-determining facts or law, then the claim is fairly debatable.).

n123 *Zimmer*, 521 F. Supp. 2d at 930-31; *Zimmer v. Travelers Ins. Co.*, No. 4:04-cv-00542, slip op. at 8 (S.D. Iowa Dec. 20, 2007) (opinion on reconsideration of motion for judgment as a matter of law).

n124 *Etten v. U.S. Food Serv., Inc.*, 446 F. Supp. 2d 968, 976-80 (N.D. Iowa 2006).

n125 *Id.* at 974.

n126 *Id.* at 977.

n127 The District Court also relied on *McIlravy v. North River Insurance Co.*, 653 N.W.2d 323 (Iowa 2002), discussed at notes 93-100, *supra*. *Zimmer v. Travelers Ins. Co.*, No. 4:04-cv-00542, slip op. at 8 (S.D. Iowa Dec. 20, 2007) (opinion on reconsideration of motion for judgment as a matter of law).

n128 *Zimmer v. Travelers Ins. Co.*, No. 4:04-cv-00542, slip op. at 3 (S.D. Iowa Dec. 20, 2007) (opinion on reconsideration of motion for judgment as a matter of law).

n129 *Zimmer*, 521 F. Supp. 2d at 473.

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Robert C. Johnson is a partner in the Chicago office of Sonnenschein Nath & Rosenthal LLP and a past Chair of its national Litigation practice group. Mr. Johnson represents insurers in various complex litigation matters, including bad faith actions and asbestos, environmental, product liability, construction defect, mold and personal injury (including adversting injury) coverage claims. He has handled appeals in the Second, Third, Fourth, Fifth, Seventh, Eighth, Ninth and Eleventh U.S. Circuit Courts of Appeal, and all five districts of the Illinois Appeallate Court. He has been recognized as a leading lawyer in Illinois in insurance coverage litigation by *Chambers USA, Americas Leading Lawyer for Business 2007*.

Sonnenschein Nath & Rosenthal, LLP, regularly handles high-risk and complex matters for financial and insurance industry clients. Staffed with seasoned litigators and former insurance regulators, Sonnenschein lawyers are relentless advocates for its clients interests.

For more than 70 years, Sonnenschein has partnered with insurance companies to understand their business and legal needs. Recent confirmation of Sonnenschein's outstanding insurance industry qualifications came in *Chambers USA: Americas Leading Lawyers for Business*. The 2007 edition identifies Sonnenschein as one of the top firms in the country representing insurers on their most complex matters. The Chambers description speaks for itself:

This powerhouse litigation firm is known for its sophisticated and thorough work in insurance and its ability to pull together a sterling set of resources. The firm fields a wide range of specialists, which it can use to staff complex cases.

Its recent track record ranges from involvement in the WTC litigation to Hurricane Katrina-related issues. Matters are handled by a number of offices at any one time and practitioners are said to work tirelessly and creatively to help manage disputes and create briefings that are strong and impressive. Key areas of interest are bankruptcy and insolvency in insurance companies, class actions and catastrophic loss in both appeals and litigation. The firm also has strength in personal lines insurance and in regulatory proceedings.

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Godes on Sun-Times Media Group, Inc. v. Royal & SunAlliance Insurance Co.

2008 Emerging Issues 2338

Godes on Sun-Times Media Group, Inc. v. Royal & SunAlliance Insurance Co.: Superior Court of Delaware's Decision Requiring the Advancement of Defense Costs Under Directors and Officers Insurance Policies

By Scott N. Godes

June 2, 2008

SUMMARY: In *Sun-Times Media Group, Inc.*, the Delaware Superior Court considered insurers' usual arguments as to why they should be able to refuse to advance defense costs, as they promised to do in their policies. The *Sun-Times* decision considered, and rejected, arguments that the insurers did not have to advance defense costs because of personal conduct exclusions, consent to settle and cooperation clauses, and the priority-of-payments clauses.

PDF LINK: [Click Here for Enhanced PDF of Commentary](#)

ARTICLE: In *Sun-Times Media Group, Inc. v. Royal & SunAlliance Ins. Co. of Canada*, No. 06C-11-108 RRC, 2007 Del. Super. LEXIS 402 (Del. Super. Ct. June 20, 2007) (*Sun-Times*), an insurance coverage dispute, the insurers tried to escape from providing directors and officers insurance coverage for numerous claims, including securities class actions and derivatives actions.

The insurers relied on several arguments in their efforts to refuse to cover. They asserted that they had no obligation to advance defense costs because of (1) personal conduct exclusions [4(a) and 4(c), the fraud and personal profit exclusions]; (2) the consent-to-settle or cooperation clauses; and, (3) the priority-of-payments clause. *2007 Del. Super. LEXIS 402*, at *1-2. Notably, the court rejected the insurers' arguments under general insurance contract principles, because the insurers failed to carry their burden of proof on the appropriate choice of law. *Id.* at *29.

The court decided properly that the fraud and personal profit exclusions did not prevent the advancement of defense costs. The court was correct in refusing to allow the insurers to escape their duty to pay defense costs based on the fraud and personal profit exclusions. The court explained that, notwithstanding the presidents pleading guilty to fraud, other directors of the company could not be precluded from recovering defense costs, as exclusions 4(a) and 4(c) applied only to the organization, not the individual directors. See *id.* at *35. The court also allowed the company to recover defense costs that it paid to defend the directors. The court based its decision, part, on the fact that the policy required the insurers to advance defense costs prior to final disposition of the claim. That is of critical importance, because it required the insurers to advance defense costs contemporaneously, notwithstanding the exclusions. The fraud and personal profit exclusions did not serve to exclude defense costs from innocent directors and officers or from the company, and the insurers could not impute the fraud onto the innocent parties.

The court decided properly that the consent-to-settle or cooperation clauses did not prevent the advancement of defense costs. The insurers also sought to avoid coverage by claiming that the insureds violated the policies consent and cooperation clauses. The insurers argued that they were entitled to rely upon these clauses because they had not denied coverage, but only reserved the rights to do so. The court found that a distinction without a difference, holding:

Because the Defendants reserved their rights with respect to coverage and later denied coverage, they should not have veto power over the settlement process. When the Defendants reserved their rights to accept coverage, Plaintiffs were allowed to take reasonable measures to defend themselves, including settlement.

Id. at *40. In short, the court held that the insurers reservation of rights to deny coverage waived their right to rely on the provisions. *Accord, e.g., Gribaldo, Jacobs, Jones & Assoc. v. Agrippina Versicherungen A.G.*, 3 Cal. 3d 434, 449, 91 Cal. Rptr. 6 (1970) (applying to E&O policy principle that when the insured has requested and been denied a defense, it may ignore the policy provisions forbidding the incurring of defense costs without the insurers prior consent).

Again, the critical point is that the rule that insurers cannot rely on consent provisions after denying coverage applies the same to D&O policies as it does to duty to defend policies (like general liability policies).

The court decided properly that the priority-of-payments clause did not prevent the advancement of defense costs. Finally, the court rejected the insurers efforts to rely on the priority-of-payments clause (also known as the order of payments clause) to deny coverage. The insurers argued that before they paid defense costs to the corporation, there had to be a finding of coverage for the directors and officers and payment to them. The court gave short shrift to that argument, explaining that because it had ruled that the directors and officers were due advancement of defense costs compensation under the policy the priority of payments clause did not preclude coverage. Stated simply, the priority-of-payments clause cannot be used to deny coverage to all parties.

Conclusion. The *Sun-Times* decision correctly rejected the insurers numerous roadblocks to advancing defense costs, as they had promised to do in their policies. Insurers raise the same or similar arguments in directors and officers coverage disputes across the country, and this decision should be considered persuasive authority against the insurers wrongful attempts to deny coverage.

ABOUT THE AUTHOR(S):

Scott N. Godes is an attorney in the Washington, DC office of Dickstein Shapiro LLP. Mr. Godes represents corporate policyholders in insurance coverage disputes. He is an experienced trial lawyer who has litigated complex insurance coverage disputes, including class actions, in state, federal, bankruptcy, and appellate courts, as well as in commercial arbitrations. Mr. Godes has a wide-ranging coverage practice, pursuing insurance in disputes relating to directors and officers claims for alleged securities violations; allegations of damaged computer data, hardware, and software; mass tort liabilities, including asbestos; environmental property damage; flood claims; allegations of improper alcohol advertising; and class actions. Recently, Mr. Godes was lead counsel in *Continental Casualty Co. v. Employers Insurance Co. of Wausau*, a landmark case decided by the New York Supreme Court that ruled there are millions of

dollars of coverage for thousands of asbestos claims, even after the insurers claimed to have paid their full aggregate limits of coverage. Mr. Godes received his B.A., cum laude, from Middlebury College, and his J.D., with honors, from the George Washington University Law School.

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Gerber and Kingsley on Allstate Insurance v. American Home

2008 Emerging Issues 2337

Gerber and Kingsley on Allstate Insurance v. American Home: When and Under What Circumstances can a Reinsurer Decline to Follow the Follow-The-Fortunes Doctrine

By Daniel W. Gerber and Jeffrey L. Kingsley

May 29, 2008

SUMMARY: Typically, a reinsurer in the complex relationship with its reinsured, must adhere to the follow-the-fortunes doctrine. A recent case, *Allstate Insurance v. American Home* appears to have carved out a niche in which a reinsurer does not have to abide by the follow-the-fortunes doctrine if the settlement fails to comply with a courts ruling and is contrary to the reinsureds position during litigation.

PDF LINK: [Click Here for Enhanced PDF of Commentary](#)

ARTICLE: Introduction. Under the follow-the-fortunes doctrine, a reinsurer is typically obliged to indemnify its reinsured for a settlement reached by the reinsured so long as the reinsureds allocation of that settlement is in good faith and within the terms of the reinsurance policy. A recent case in New York, *Allstate Insurance v. American Home*, 43 A.D.3d 113, 837 N.Y.S.2d 138 (1st Dept 2007) however, rejected the premise that a reinsurer cannot inquire into the underlying lawsuit to ensure that the reinsurers position is consistent. With the *Allstate* decision expanding the scope of reinsurers to examine a reinsureds settlement terms, the question then becomes: how far can they go?

Analysis. In *Allstate Insurance v. American Home*, 43 A.D.3d 113, 837 N.Y.S.2d 138 (1st Dept 2007), Allstate Insurance Co., (Allstate) filed a declaratory judgment action to determine its rights and obligations under its reinsurers, American Home Assurance Company (AMA) environmental coverage settlement with its insured.

AMA issued commercial property insurance policies to United Technologies Corporation (UTC) for coverage of loss or damage to the property during the periods of 1975-1978 and 1978-1981. The first policy covering the period of 1975-1978 had a 6 million dollar liability limit for one loss, disaster, or casualty. The second policy covering the 1978-1981 period had a 10 million dollar limit of liability for the same one loss, disaster or casualty. UTC had retained a \$200,000 self-insured deductible for any one occurrence under each policy.

AMA secured reinsurance from Allstate with respect to the UTC policies. The reinsurance policy was structured in three layers. The first layer included a one million dollar reinsurance coverage. The second layer had a five million dollar excess of the one million dollar coverage. The third layer had a four million dollar excess over the first two layers that totaled ten million dollars.

In 1992, UTC commenced a declaration action against AMA in the District Court of Connecticut for indemnification under its policies for physical loss and damage allegedly sustained due to environmental pollution at various sites, including plants in West Palm Beach, Florida, Stratford, Connecticut and Windsor Locks, California.

During that litigation UTC argued to the Court that the losses alleged in the complaint involved multiple occurrences at each of the plants. The main disagreement between UTC and AMA centered on the number of occurrences at each site because determining the number of occurrences would severely impact the \$200,000 per occurrence deductible under the policies. The rationale for UTC was simple -- the fewer deductibles, the more liability AMA had under the UTC policies. Conversely, AMA argued that there were more occurrences in part to increase the number of deductibles.

After a jury trial ruled in favor of UTC in one portion of the trial, both UTC and AMA took the Court regarding the method for determining the number of occurrences per site at the Windsor Locks site. The District Court found that for purposes of calculating deductible amounts seven occurrences took place at the Windsor Locks site. The court then applied, pursuant to the language of the UTC insurance policies, one deductible per occurrence and added an additional deductible for each policy period during which the jury found that UTC suffered a loss.

After that determination, UTC and AMA were scheduled for trial for the remaining portions of the case. A few months prior to the trial, the parties settled the remaining issues for a one time lump sum payment of one hundred and eleven million dollars. During the settlement process, AMA changed its position and applied a one-occurrence-per-site approach, despite the Court's ruling that the Windsor Locks site had seven occurrences. By treating each site as one occurrence, reinsurance was triggered under both policies. As a result, AMA demanded payment from Allstate in the amount of \$2,578,638.21 from the reinsurer under the follow-the-fortunes doctrine.

Allstate moved for partial summary judgment seeking a declaration that it was not obligated to pay AMA under the follow-the-fortunes doctrine on the basis that loss allocation, specifically treating each site as one occurrence, was unreasonable and contrary to the court's ruling. AMA opposed the motion and cross-moved for summary judgment on the same issue arguing that its allocation was reasonable and Allstate was obligated under the follow-the-fortunes doctrine and abide by the settlement terms absent a showing of bad faith or fraud.

The lower court ruled in favor of AMA stating that Allstate's position would force the Court to engage in an intrusive factual inquiry into the reinsured settlement process. Moreover, the lower court found that AMA's one-occurrence-per-site rule, while possibly inconsistent was reasonable because it was applying a bright-line test as opposed to any own subjective belief it had during the lawsuit. Allstate appealed the decision.

In reviewing the issues in this case, the Appellate Division of the First Department in New York outlined the follow-the-fortunes doctrine. According to the court, the follow-the-fortunes doctrines require a reinsurer to indemnify for payments reasonably within the terms of the original policy, even if technically not covered by it. [Citations omitted] Therefore, according to the doctrine, a reinsurer is bound to accept the cedent's good faith decisions on all things concerning the underlying insurance terms and claims against the underlying insured.

The purpose, the court determined, of the follow-the-fortunes doctrine is to promote good faith settlements of the insured's claims. As a result according to the court, the doctrine insulates a reinsured from a reinsurer's challenge unless the settlement was in some way fraudulent, in bad faith, or the payments were beyond the scope of the original policies.

Despite accepting the essential terms of the doctrine, the court stated that the doctrine does not require a reinsurer to blindly accept the reinsured's allocation when the allocation is contrary to the reinsured's prior position in the lawsuit. The court stated that the follow-the-fortunes doctrine applies to allocations as long as the allocation meets the typical follow-the-settlement requirements [that is] good faith, reasonable, and within the applicable policies limits.

As such, the court found that the AMA's allocation position was unreasonable because the one occurrence-per-site allocation of the Windsor Locks site directly contradicts the District Court's ruling as to the number of occurrences at the

site. As such, the court determined that Allstate is not obligated to compensate AMA with respect to the settlement pursuant to reinsurance policies.

Practice Tip. The *Allstate* decision was one of the first decisions that allowed a reinsurer to decline to follow the follow-the-fortunes doctrine when it did not demonstrate bad faith or fraudulent conduct. Rather, the *Allstate* decision provided reinsurers the basis to investigate positions a reinsured makes during the underlying litigation to ensure that its position is consistent.

While *Allstates* impact on the scope of the follow-the-fortunes doctrine is still unknown, the mere fact that the follow-the-fortunes doctrine was not adhered to due to a position the reinsured took during litigation is significant. It is therefore important for attorneys representing reinsurers and reinsured alike to understand that a reinsureds position during the underlying litigation has the possibility of playing a major role in determining whether the reinsured can seek indemnification from its reinsurer.

While the Appellate Division in the *Allstate* decision proclaimed that the factual circumstances in the case were unique, the impact from the decision may be much broader than it even realized. As such, practitioners need to recognize that any position taken by a party during litigation is significant and could have a tremendous impact on reinsurance coverage at a later time.

ABOUT THE AUTHOR(S):

Daniel W. Gerber is a partner of Goldberg Segalla LLP in New York. He maintains an international practice in commercial litigation with a focus on complex insurance coverage disputes and analysis, including reinsurance and excess insurance, as well as mediation and arbitration. He chairs his firms Life, Health, Disability and ERISA practice group and manages its Insurance Coverage practice group. He is an author for the renowned Insurance Treatise, New Appleman's Insurance Law Practice Guide, as well as Mealeys Emerging Insurance Disputes. Mr. Gerber is admitted to the United States Supreme Court, as well as all federal and state courts in New York and Pennsylvania. He argues regularly before the New York Court of Appeals and the U.S. Second Circuit Court of Appeals arguing the seminal case in New York on late notice in insurance law. He has received the Chairperson of the Year Award for his work as Chair of the Insurance Coverage Committee for the New York State Bar Associations Torts, Insurance and Compensation Law Section, and will chair the almost 3,500 member Torts, Insurance and Compensation Law Section in 2008. Mr. Gerber is also an active member of the Association of Life Insurance Counsel, the International Claims Association and the International Association of Defense Counsel, as well as the American Bar Associations Life, Health and Disability Committees. Mr. Gerber possesses an AV rating from Martindale Hubbell, a Super Lawyer designation from Law & Politics Magazine, and has been named consecutively by his peers to Business First's Who's Who in Law.

Jeffrey L. Kingsley is an associate with Goldberg Segalla LLP in New York and he maintains a national practice in the areas of insurance, reinsurance coverage and extra-contractual liability litigation, commercial litigation, and bankruptcy and restructuring. He has presented and authored numerous articles in New York ranging from alternatives to litigation as well as life insurance settlement issues.

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Wiley Rein LLP on Liability Coverage for "Global Warming Claims"

2008 Emerging Issues 297

Wiley Rein LLP on General and Professional Liability Coverage for "Global Warming Claims"

By Theodore Howard, Kenneth Ryan and Justin Heminger

May 27, 2008

SUMMARY: Responding to recent commentaries by policyholder advocates, insurance coverage experts Theodore A. Howard, Esq., Kenneth E. Ryan, Esq. and Justin D. Heminger, Esq. of Wiley Rein LLP consider the extent to which global warming claims against corporate policyholders are likely to impact general and professional liability insurers. The authors briefly explain the scientific principles and public perceptions driving global warming claims and then examine the claims that already have been litigated. After providing this background, the authors analyze the coverage issues that insurers may face as corporate policyholders seek coverage under general and professional liability policies. From this analysis, the authors explain why global warming claims are more likely to be similar to the overhyped Y2K problem than the next asbestos confronting the insurance industry.

PDF LINK: Premium Emerging Issues Commentary (\$)

ARTICLE: Several recent commentaries authored by policyholder advocates suggest that a veritable explosion of insurance coverage litigation arising in connection with liability claims against corporations relating to global warming looms on the horizon, and that general and/or professional liability insurers had best be prepared. n1 In this responsive commentary, following a brief description of the concept of global warming and an overview of how litigation implicating this phenomenon is evolving, we explain why we believe that, from a liability insurers perspective, global warming claims are, ultimately, more likely to resemble the vastly overhyped Y2K problem, in terms of real-world coverage exposure, than the next asbestos confronting the insurance industry.

Global Warming -- What Is It?

Although the underlying scientific principles affecting global warming are numerous and complex, the phenomenon can be described in relatively straightforward terms:

Energy from the sun drives the earth's weather and climate, and heats the earth's surface; in turn, the earth radiates energy back into space. Atmospheric greenhouse gases (water vapor, carbon dioxide and other gases) trap some of the outgoing energy, retaining heat somewhat like the glass panels of a greenhouse. Without this natural greenhouse effect, temperatures would be much lower than they are now, and life as known today would not be possible. Instead, thanks to greenhouse gases, the earth's average temperature is a more hospitable 60F. However, problems may arise when the atmospheric concentration of greenhouse gases increases.

* * *

What has changed in the last few hundred years is the additional release of carbon dioxide by human activities. Fossil fuels burned to run cars and trucks, heat homes and businesses, and power factories are responsible for about 98% of U.S. carbon dioxide emissions, 24% of methane emissions, and 18% of nitrous oxide emissions. Increased agriculture, deforestation, landfills, industrial production, and mining also contribute a significant share of emissions. In 1997, the United States emitted about one-fifth of total global greenhouse gases.

Estimating future emissions is difficult, because it depends on demographic, economic, technological, policy, and institutional developments. Several emissions scenarios have been developed based on differing projections of those underlying factors. For example, by 2100, in the absence of emissions control policies, carbon dioxide concentrations are projected to be 30-150% higher than today's levels. ⁿ²

This aggravation of the so-called greenhouse effect due to the accumulation of excessive concentrations of greenhouse gases in the earth's atmosphere poses potentially stark consequences. Since the industrial revolution, the Earth's average temperatures have increased substantially and rapidly from a historical perspective, and all ten of the hottest years on record have occurred since 1990. 2005 was the hottest year in over a century. ⁿ³ Moreover, scientists expect that the average global surface temperature could rise 1-4.5F (0.6-2.5C) in the next 50 years, and 2.2-10F (1.4-5.8C) within the next century, with significant regional variation. Evaporation will increase as the climate warms, which will increase average global precipitation. Soil moisture is likely to decline in many regions, and intense rainstorms are likely to become more frequent. Sea level is likely to rise two feet along most of the U.S. coast. ⁿ⁴

A watershed development in the protracted scientific debate over whether global warming was actually occurring came in 2001, with the issuance of a report by the Intergovernmental Panel on Climate Change (IPCC), an advisory body to the United Nations Framework Convention on Climate Change. The IPCC concluded that [i]n light of new evidence and taking into account the remaining uncertainties, most of the observed warming over the last 50 years is likely to have been due to the increase in greenhouse gas concentrations, ⁿ⁵ with likely denoting a confidence level by the authors in the range of 66-90 percent. ⁿ⁶

The 2001 IPCC Report catalogued numerous possible weather-related manifestations of the effects of global warming and assessed their probability over the decades of the 21st century. It characterized as very likely to occur -- i.e., at a confidence level of 90-99% ⁿ⁷ -- such problems as more hot days over nearly all land areas, fewer cold days and frost days over nearly all land areas, increases in the heat index, a greater frequency of intense precipitation events, and the like. ⁿ⁸ Predicted as likely (i.e., 66-90% confidence level) were increased summer continental drying and associated risk of drought and increased tropical cyclone wind peak and precipitation intensities. ⁿ⁹ While the need for caution in relying upon such projections has been duly noted within the scientific community, ⁿ¹⁰ at least some of the phenomena the IPCC predicted in 2001 appear to be already occurring, as reflected by media coverage of more recent scientific findings. ⁿ¹¹ Moreover, in a revised analysis more recently released, the IPCC itself has concluded, based on additional data and improved techniques for interpreting prior data, that the confidence levels attending its 2001 predictions as to the anticipated manifestations of climate change have increased. ⁿ¹² In any event, however, perception is reality. From a *perception* standpoint, the causal connection between global warming and a future of climatic problems of increasing variety, frequency and severity appears to be cemented in the minds of the news media and much of the general public.

Insurers share the perception. A 2006 Lloyds of London report, entitled *Climate Change: Adapt or Bust*, surveyed the then-current scientific literature, and summarized the risk implications for international insurers. It anticipated the consequences of global warming in respect to such phenomena as more frequent and more severe hurricanes due to

elevated ocean temperatures, increased sea levels attributable to the melting of glaciers and polar ice caps with attendant inundation of coastal areas (including major metropolitan areas), impacts of increasing land and air temperatures, as manifested by greater drought and wildfire conditions in some areas and more severe precipitation events and resulting flood conditions in others, and the like. n13 More recently, similar reports have been issued by or on behalf of other major insurers, indicating their increasing awareness of global warming and its potential impact on the worldwide insurance industry. n14

Global Warming Claims

Media coverage of the potential impact of global warming on the insurance industry has largely been *forward-looking*. The focus has been: (i) the future exposure implications for insurers due to projected natural catastrophes linked to adverse climate change; and (ii) how insurers have begun, or should begin, to alter their business practices over the long haul -- in respect to underwriting as well as investment philosophy -- in response to risks posed by climate change. n15

Although this emphasis on future first-party exposures and possible avenues of avoidance is certainly appropriate, the insurance industry also should be aware of the prospects for substantial liability coverage claims against corporate policyholders based on these insureds alleged responsibilities for *already-existing manifestations* of global warming. While a critical mass of liability claims against corporations giving rise to such coverage demands has not yet emerged, signs suggest the possibility that it could come soon.

Early Global Warming Litigation. Litigation linking existing and prior corporate business practices to the deleterious present and future impacts of global warming had, until very recently, taken two alternative forms -- neither directly implicating general or professional liability coverage concerns. The first of these two archetypes involves challenges to regulatory inaction -- *i.e.*, cases brought against governmental regulatory authorities, seeking to compel their adoption and imposition of environmental regulations that would require corporate entities to reduce their emissions of greenhouse gases. Highest in profile and most closely-watched within this class of cases was the action resulting in a decision by the Supreme Court of the United States in *Commonwealth of Massachusetts v. U.S. Environmental Protection Agency*. n16

The case began as a notice-and-comment rulemaking proceeding initiated by environmental groups in October 1999, seeking to require the EPA to regulate CO₂ and other greenhouse gas emissions from new automobiles under Section 202(a)(1) of the Clean Air Act. n17 After nearly four years, EPA concluded in August 2003 that it lacked statutory authority to regulate greenhouse gas emissions from motor vehicles and that, even if it had such authority, it would decline to exercise it for a host of policy reasons. n18

Following EPA's denial of the petition, 12 states, three municipalities, two U.S. territories and a host of public interest environmental groups collectively challenged the agency determination in the U.S. Court of Appeals for the D.C. Circuit, n19 contending that the Clean Air Act empowers the EPA to promulgate standards applicable to the emission of any air pollutant from . . . new motor vehicles . . . which . . . cause, or contribute to, air pollution which may reasonably be anticipated to endanger public health or welfare, and that EPA's refusal to regulate greenhouse gas emissions from automobiles under this standard was arbitrary, capricious, and contrary to law. On July 15, 2005, a divided panel of the D.C. Circuit -- assuming, without squarely deciding, that the petitioners had standing to sue -- denied their appeal, concluding that the EPA Administrator acted within the scope of her statutory discretion in refusing to promulgate regulations to limit greenhouse gas emissions from new vehicles. n20

The U.S. Supreme Court granted a petition for *certiorari* in June 2006, to review the D.C. Circuit ruling. Following full briefing, argument and four months deliberations, the Supreme Court rendered its decision on April 2, 2007, reversing the D.C. Circuit's decision by a 5-4 majority. Justice Stevens (joined by Justices Kennedy, Souter, Ginsberg and Breyer), concluding that automobile-emitted greenhouse gases are unquestionably within the broad parameters of the statutory definition of air pollutants as set forth in the Clean Air Act, held that the petitioners had the requisite

constitutional standing to sue and that EPA clearly had statutory authority under the Clean Air Act to regulate such greenhouse gas emissions and could not simply decline to exercise that authority on the basis of broad policy rationales having no foundation in the statutory language. n21 Despite the apparent resolution of this eight-year-old dispute, on April 2, 2008, the one-year anniversary of the Supreme Courts decision, the plaintiffs filed a petition in the D.C. Circuit, requesting that the Court order the EPA Administrator to comply with the Supreme Courts ruling (and the D.C. Circuits subsequent opinion after remand from the Supreme Court) by issuing, within 60 days, its determination that greenhouse gases do endanger public health or welfare, as defined in the Clean Air Act. n22 The D.C. Circuit has yet to rule on the petition.

While much was riding on *Massachusetts v. EPA* from a federal environmental regulatory standpoint, including the critical threshold question as to whether CO₂ and the other greenhouse gases emitted from the exhaust pipes of automobiles constitute air pollutants within the contemplation of Section 202(a)(1) of the Clean Air Act, the case, and others like it, n23 did not directly implicate general or professional liability insurers coverage under current or previously-issued policies. n24 This is because the regulatory actions -- even if successful -- were focused on requiring governmental entities to impose regulations that would mandate prospective behavior modification on the part of corporate policyholders *vis--vis* the emission of greenhouse gases. These lawsuits did not name the corporations as defendants, much less allege any sort of corporate culpability for *previous or existing injury or damage* of the type cognizable under general liability policies or likely to give rise to disgruntled shareholder claims that could implicate professional liability policies.

The second form of global warming litigation previously initiated, as distinct from the regulatory actions just discussed, targeted corporations as defendants. In these lawsuits, various plaintiffs, including environmental groups and state and local governments, sought declaratory and injunctive relief against emitters of greenhouse gases, premising their claims upon common-law public nuisance theories. The most prominent of these cases, *Connecticut v. American Electric Power Co.*, was filed by the States of Connecticut, New York, California, Iowa, New Jersey, Rhode Island, Vermont and Wisconsin, along with the City of New York, against American Electric Power Company, The Southern Company, the Tennessee Valley Authority, XCel Energy, Inc. and Cinergy Corporation in federal district court in New York City in July 2004. n25 As set forth in the plaintiffs initial pleading: Defendants power plants emit large quantities of carbon dioxide and are contributing to an elevated level of carbon dioxide in the atmosphere. . . . This Complaint seeks an order requiring defendants to reduce their emissions of carbon dioxide, thereby abating their contribution to global warming, a public nuisance. n26 In requesting relief under either federal or state common law of public nuisance, plaintiffs sought an order (i) holding each of the defendants jointly and severally liable for contributing to an ongoing public nuisance, global warming, and (ii) enjoining each of the defendants to abate its contribution to the nuisance by capping its emissions of carbon dioxide and then reducing those emissions by a specified percentage each year for at least a decade. n27

The public nuisance-based injunction actions against private corporate defendants have not, thus far, proven viable. n28 Moreover, these cases drew little attention from general and professional liability insurers because, although the cases were premised upon allegations that could, in theory, be read to implicate claims of existing or imminent bodily injury or property damage, the plaintiffs *did not seek monetary relief of any kind, but rather only prospective injunctive relief*, and therefore did not even arguably implicate the as damages inquiry that animated a previous generation of environmental insurance coverage disputes in the general liability context. n29 In many instances, the absence of a demand for monetary relief and the request for solely prospective injunctive relief also would be fatal to an attempt to seek coverage in the professional liability context. n30

Emerging Global Warming Liability Claims. While the global warming-related cases discussed above show that the litigation as a whole targets *prospective* business practices that are perceived to contribute to adverse climate

change, a significant change in this pattern is possible in light of recent developments. Specifically, lawsuits asserting claims against corporate defendants *seeking the recovery of damages for existing injury or damage* allegedly attributable to the effects of global warming caused, at least in part, by these corporations *past conduct*, have commenced. Many more claims realistically can be anticipated. The coverage exposure implications for general and professional liability insurers of targeted companies are apparent, and conceivably serious.

The initial lawsuit presenting tort claims for damages against corporate defendants based upon their alleged responsibility for global warming was a Hurricane Katrina-related class action -- *Comer v. Nationwide Mutual Insurance Co.* -- filed in federal district court in Mississippi in September 2005. The case initially targeted only property insurers, and originally focused solely on the insurers alleged wrongful conduct in limiting or denying coverage for hurricane-related property damage under homeowners policies on the basis of the policies flood exclusions. However, almost immediately, the plaintiffs in *Comer* amended their pleadings in order to add named and John Doe petrochemical companies as additional defendants, against which separate claims for compensatory and punitive damages were asserted. The *Comer* plaintiffs alleged that Hurricane Katrina was the result of environmental conditions caused by global warming and that the Oil Company Defendant Class had ignored warnings about the deleterious effect their actions would have on global warming and continued to engage in oil production and refining . . . activities that have produced the greatest single source of by-products leading to the development and increase of global warming. n31 The plaintiffs fleshed out these allegations by asserting that as a direct and proximate result of the Oil Company Defendant Class activities, global warming had increased until it had produced the conditions whereby a storm of the strength and size of Hurricane Katrina would inevitably form and strike the Mississippi Gulf Coast consequently causing extensive death and destruction. The damages sought by plaintiffs included Loss of Property; Loss of use of their property; Loss of their business and/or income; . . . Loss of loved ones; . . . Mental anguish and emotional distress n32

The court (Senior Judge L.T. Senter, Jr.) quickly recognized that the action framed by the plaintiffs Amended Complaint, which purported to combine -- in one case -- three separate proposed class actions against three disparate sets of defendants, based on three distinct sets of legal theories and claims, was completely unmanageable. The court dismissed the plaintiffs causes of action against non-global warming defendants by order dated February 23, 2006. n33 Shortly thereafter, the plaintiffs filed a third amended pleading, expanding the scope of their global warming allegations and claims to encompass additional defendants including public utilities, power companies and coal mining and chemical manufacturing companies. n34 After protracted motions practice, defendants motions to dismiss were finally granted at a hearing on August 30, 2007, based on the conclusion of District Judge Louis Guirola, Jr. (to whom the case was reassigned) that the plaintiffs lacked standing and that their claims were non-justiciable pursuant to the political question doctrine. n35 An appeal of the dismissal order is pending.

Meanwhile, a second major lawsuit asserting damages claims against private corporate defendants premised expressly upon allegations that they contributed to global warming was commenced in federal district court in San Francisco by the California Attorney General on September 20, 2006. n36 Named as defendants in the action were the Big Six domestic and Japanese automobile manufacturers -- GM, Toyota, Ford, Honda, Chrysler and Nissan -- which, according to the pleading, by their annual emissions in the United States of approximately 289 million metric tons of carbon dioxide and other greenhouse gases, are substantial contributors -- among the worlds largest contributors -- to global warming, and to adverse impacts on California. n37 The Complaint went on to allege generally that global warming had injured Californias environment, economy, and the health and well-being of its citizens, that California had incurred substantial costs in responding to the impacts of global warming, and that, despite the defendants awareness of the ongoing damages caused by global warming, they had chosen to continue producing vehicles that generated carbon dioxide, to the detriment of California. n38

The Complaint emphatically declared, The People seek compensation for the large-scale damage caused by these defendants. n39 Thus, the State sought to hold each defendant jointly and severally liable for contributing to a public nuisance -- global warming and the impacts resulting from global warming in California -- and awarding monetary damages to the State. n40 The State also sought a declaratory judgment that each defendant is jointly and severally liable to pay for such additional damages incurred by California in the future for contributing to the ongoing nuisance of

global warming. Following detailed allegations concerning the science of global warming and its purported impacts on the States property and citizens, the Complaint set forth alternative causes of action, seeking millions (if not billions) of dollars in incurred and prospective money damages under public nuisance theories of recovery pled under federal common law and state law. n41

After extensive briefing and argument of the defendants motions to dismiss, the federal district court ruled in September 2007, holding that the States damages claims implicated non-justiciable political questions which were required to be dismissed, based on reasoning consistent with that articulated by the district court in *Connecticut v. American Electric Power Co.*, *supra*. n42

Notwithstanding the unimpressive results of these early efforts, many commentators believe that *Comer* and *State of California* may represent but the tip of the proverbial (melting) iceberg -- bad pun intended -- in regard to tort actions for damages against corporate defendants, seeking to hold them accountable for their alleged contributions to adverse climate change and its current and future effects. Steven Susman, founding partner of the prominent Houston, Texas trial litigation boutique Susman Godfrey LLP, predicted that a consortium of plaintiffs mass-tort lawyers will devise and pursue a major global warming lawsuit against corporations. n43 Susman compared this predicted collaboration to the so-called *Castano Group* of plaintiffs lawyers that joined forces to craft the theory of tobacco company responsibility for governmental healthcare costs expended to treat citizens tobacco-related illnesses that ultimately resulted in those companies landmark \$206 billion settlement with state attorneys general. n44

The first salvo in this threatened attack by the plaintiffs bar has materialized in a lawsuit that Susman and other lawyers recently filed on behalf of the Native Village of Kivalina and the City of Kivalina against two dozen energy companies. n45 Kivalina, a small Alaskan village of approximately 400 residents situated on a six-mile-long barrier reef in the Chukchi Sea, brought suit on behalf of its citizens in a *parens patriae* capacity alleging that global warming is destroying the village to the point that the entire village must relocate at an estimated cost of between \$95 and \$400 million. The Complaint alleges that defendants are responsible for a substantial portion of the greenhouse gases in the atmosphere that have caused global warming and Kivalinas special injuries and that they knew or should have known of the impacts of their emissions on global warming and on particularly vulnerable communities such as coastal Alaskan villages, yet, [d]espite this knowledge, defendants continued their substantial contributions to global warming. n46 Allegedly as a result of global warming, sea ice that once provided a buffer between the reef on which Kivalina is located and the Chukchi Sea has disappeared, leaving Kivalina exposed to coastal storm waves that are eroding the barrier reef and threatening the communitys property, health and well-being. n47

As with the *State of California* action, the *Kivalina* Complaint includes federal and state public nuisance claims. However, as anticipated by Susman, the Complaint also purports to identify a civil conspiracy among some of the defendants by which they conspired to create a false scientific debate about global warming in order to deceive the public. n48 In support of this assertion, the Complaint recites extensive allegations concerning the defendants financial contributions to and participation in what are dubbed front groups, fake citizens organizations, and bogus scientific bodies, while drawing comparisons to Big Tobaccos disinformation campaign. n49 These allegations culminate in a conspiracy claim based on the defendants purported scheme to mislead the public with respect to the science of global warming and to delay public awareness of the issue so that they could continue contributing to, maintaining and/or creating the nuisance without demands from the public that they change their behavior as a condition of further buying their products. n50

At least some insurers have concluded that the potential implications of global warming litigation for the insurance industry must be taken seriously. Thus, in its *Adapt or Bust* report, n51 Lloyds of London stated:

We foresee an increasing possibility of attributing weather-related losses to man-made climate change factors. This opens the possibility of courts assigning liability and compensation for claims of damage. Legal liability is now being

actively pursued by several groups of lawyers and scientists who wish to use the same lines of argument as used against tobacco companies. If the courts conclude that damage was reasonably foreseeable then liability could follow, as would the search for deep pockets to meet the costs, with insurers a likely port of call. n52

The *Comer* case, brought on behalf of a putative class of private citizens alleging loss of life or property due to Hurricane Katrina, the *State of California* action, brought by the State Attorney General in a *parens patriae* capacity on behalf of the citizens, property and natural resources of the State, and the *Kivalina* suit, brought in a *parens patriae* capacity by a village attempting to relocate its residents, certainly do not define the universe of such actions. It takes no great stretch of imagination to contemplate inter-corporate litigation in this context such as, for example, a timber company owning vast stands of commercial lodgepole pine in British Columbia recently destroyed by the mountain pine beetle, as plaintiff, against corporate defendants it believes contributed to the climate change eliminating beetle-controlling killing frosts that formerly protected the forests, as detailed in one commentary. n53

General Liability Coverage Considerations

Corporate demands for insurance coverage under general liability policies for global warming-related damages cases are likely to bear at least some superficial resemblance to the types of long-tail coverage claims with which general liability insurers have had substantial experience since the 1970s. According to the relevant science, global warming is not an instantaneous phenomenon, but rather has developed gradually over time due, at least in part, to corporations alleged acts or omissions in emitting, or in manufacturing products that emitted, greenhouse gases over many decades. The analogy to delayed manifestation problems such as asbestos-related disease and gradual hazardous waste-caused pollution which have been the principal subjects of long-tail insurance coverage claims and litigation seems apparent. The three actions reviewed above, as illustrative of the types of tort claims for damages based upon global warming that could become commonplace, also reflect the potentially broad temporal scope that is likely to characterize these claims. Insurers thus can reasonably expect to be confronted with a panoply of complex coverage issues analogous to those to which they have become accustomed in the context of long tail claims. Furthermore, in the event that disputes arise between policyholders and general liability insurers over the availability of coverage for global warming claims, the extensive case law developed in resolving other long tail claims provides a sound basis for assessing whether any particular general liability policy is implicated.

Trigger of Coverage. As regards the trigger of coverage -- a critically-important threshold issue in any general liability coverage inquiry -- apparent similarities between putative global warming claims and familiar types of long-tail coverage claims exist, but should not be overstated. For example, while the plaintiffs in *Comer* attempted to establish, by their allegations, a causal chain from: (i) the defendants continuing greenhouse gas emissions; to (ii) the progressive worsening of global warming; to (iii) creation of the climatic conditions allowing a storm such as Hurricane Katrina to develop; to (iv) their injuries and damage resulting from the storm itself, it is far from clear that for purposes of trigger-of-coverage analysis, anything but the injury- or damage-causing storm itself is relevant. Certainly a strong argument could be made, on the facts as alleged, that to the extent coverage were available at all, only policies in effect during the approximately two-week period from Katrinas initial formation as a tropical depression in the Atlantic Ocean through the date of its Gulf Coast landfall as a Category IV hurricane would be triggered. There was simply no contention in *Comer* that global warming *in and of itself* caused the loss of life or other bodily injuries, or the damage to property, for which the plaintiffs sought damages; instead, plaintiffs theory was that global warming at most established *the conditions* under which a storm the size and strength of Katrina could be formed. Thus, triggering any coverage on the basis of the time period in which the defendants alleged acts or omissions merely contributed to global warming would appear to lack factual or legal foundation.

An arguably different analysis, and a potentially different trigger outcome, might apply to the *State of California* and *Kivalina* actions, in which global warming is more directly targeted by allegations as to the specific cause of the harms to the plaintiffs and their property and resources for which damages are sought, and where the alleged harms themselves are of a gradual and progressive, rather than instantaneous, nature. However, the timing and character of each category of alleged injury or damage would require careful examination in this regard.

Other General Liability Coverage Issues. Beyond the complexities presented by the threshold trigger issue, insurers can reasonably expect to be confronted with a panoply of additional complex coverage issues analogous to those they previously have addressed in the context of other long tail claims, such as:

- . Can the policyholder prove the existence and/or terms and conditions of lost policies? Questions over lost policies should be anticipated in light of global warming claims against corporate policyholders that implicate those companies activities dating back as far as the 1950s.

- . What law should apply to a coverage dispute? Complex choice-of-law analyses will almost certainly be required, given the multi-jurisdictional nature of both the insureds alleged acts or omissions and the geographic scope of the resulting global harms.

- . Do the policyholders greenhouse gas-emitting activities, or manufacture of emission-generating products, constitute an occurrence (where the activities and/or the allegedly resulting injury or damage were accidental), or were the injuries or damages expected or intended from the policyholders standpoint and therefore not covered? The plaintiffs pleadings in *Comer* and *State of California* are replete with assertions that the corporate defendants in each case, despite their awareness of warnings concerning the increasingly clear linkage between greenhouse gas emissions and worsening climate change, *knowingly and intentionally* continued to engage in activities that caused such emissions and/or continued to manufacture emissions-generating products. n54 The *Kivalina* complaint goes a step further by alleging that corporate defendants knowingly conspired to cover up the truth about global warming so that their businesses could continue emitting greenhouse gases while avoiding economic pressure to modify their behavior. n55 Allegations of this character will almost certainly provoke the assertion by insurers of expected or intended defenses under the occurrence provisions in their policies or expected/intended exclusions and, depending on the timing of the policies, common-law known loss or loss-in-progress defenses as well.

- . Do the harms upon which the global warming claims for damages against the policyholder are based constitute bodily injury or property damage, as contemplated by the provisions of the policy? While the prospect of actions premised upon actual bodily injury or property damage allegedly attributable to the impacts of global warming is certainly plausible -- the timber company lawsuit for destruction of its lodgepole pine trees hypothesized above is an example -- some lawsuits of this nature may instead be premised upon harm that constitutes pure economic loss for which, under the settled law of most jurisdictions, general liability policies do not provide coverage. n56

- . Alternatively, are the global warming claims for damages against the policyholder for which coverage is sought based upon personal injury, as contemplated by the provisions of the policy? Mirroring insurers past experience in addressing policyholder demands for coverage of environmental contamination claims, some insureds will likely contend that global warming claims for damages asserted against them, particularly those of individual claimants premised upon a private nuisance theory, implicate the enumerated offense of wrongful entry or eviction or other invasion of the right of private occupancy under the Personal Injury provisions of some general liability policies. n57

- . Were there facts and circumstances relating to the alleged causal connection between the policyholders acts or omissions and the emergence and/or exacerbation of global warming brought to the policyholders attention before the time when the third-party claim for damages was asserted, such that the policyholders notice of occurrence obligation under the policy might have accrued long before notice was actually provided to the insurers?

- . Do any policy exclusions preclude a coverage obligation for global warming claims, either in whole or in part? To the extent any exclusion is in play, is its applicability sufficiently clear that coverage can be disclaimed outright, or does uncertainty dictate the insurers assumption of the duty to defend, subject to a reservation of rights? Given that the fundamental premise of damages claims based on global warming is that the corporate defendants have intentionally

engaged in activities causing, directly or indirectly, the emission of greenhouse gases into the atmosphere over extended periods of time, coverage may well be foreclosed by operation of the qualified (*i.e.*, sudden and accidental) pollution exclusions incorporated in general liability policies beginning in 1972 -- especially in those jurisdictions in which the law establishes that sudden has a temporal connotation -- as well as by the absolute (or total) pollution exclusions employed by the insurance industry in policies issued beginning in 1985. The Supreme Courts holding in *Massachusetts v. EPA* that CO₂ and other automobile-emitted greenhouse gases are, as a matter of law, air pollutants under the Clean Air Act would seem to clearly enhance insurers leverage in arguing that their pollution exclusions should categorically bar liability coverage for global warming claims. n58

. Finally, assuming no categorical impediments to coverage, what is its scope -- *i.e.*, is there an applicable aggregate limit of liability and, if not, do the underlying allegations against the policyholder comprising the global warming claim implicate one or multiple per occurrence limits of liability? Moreover, what principles -- if any -- govern the allocation of insurance coverage if policies issued by multiple insurers are triggered?

Professional Liability Coverage Considerations

Although the most likely focus of insurance coverage issues arising out of global warming litigation will be on general liability policies, insurers also may encounter global warming-related claims in the professional liability context. For example, corporate policyholders with significant exposures or litigation costs for global warming liabilities may be faced with securities and derivative suits from shareholders. Directors and officers who allegedly ignored or misstated potential adverse impacts of greenhouse gas emissions or other aspects of their companies operations could face a barrage of lawsuits, and one could anticipate policyholders tendering such claims under Directors and Officers (D&O) and Errors and Omissions (E&O) policies.

In such circumstances, coverage issues likely to arise in addition to some general liability coverage issues addressed above that are equally relevant in the professional liability context may include the following:

. Does the long tail nature of the allegations present an obstacle to coverage? Claims-made policies are intended to afford specified coverage only for claims brought during a specific policy period, allowing insurers to more accurately underwrite exposures and thereby charge lower premiums. The claims-made nature of professional liability policies presents a crucial threshold question when confronting global warming liabilities which, as with other familiar long tail exposures, may be based on decades of corporate acts. Professional liability policies thus often contain exclusions for prior acts -- acts occurring prior to a specified date. Where the prior acts exclusion is worded broadly to disallow coverage for any acts committed in whole or in part prior to the specified date, coverage for global warming claims that include allegations stretching back for years or even decades may be precluded.

. Does the policyholder have a history of global warming-related proceedings that trigger a prior or pending litigation exclusion? As with the prior acts exclusion, claims-made policies often include a provision limiting exposure for claims made during a particular policy period that are related to a claim made during a prior policy period. Thus, to the extent that a global warming claim relates back to a claim made before policy inception, for example an SEC investigation or EPA regulatory action, coverage may be barred.

. Is coverage barred by the pollution exclusion? Although the provision is found in most standard policy forms, its wording can vary greatly. For example, the provision may exclude coverage broadly for any claim arising out of a discharge or release of a defined set of pollutants. In that case, a securities or derivative suit brought against a corporate policyholder and its directors and officers based on a failure to address or disclose global warming liabilities would likely be excluded from coverage. n59 On the other hand, a different provision that only excludes coverage for a claim for the actual discharge or release of pollutants might not bar coverage for a tangentially related securities suit.

. Is coverage barred by the property damage/bodily injury exclusion? As with the pollution exclusion, the precise

wording of the provision can be critical. To the extent that plaintiffs seek to recover amounts for property damage or bodily injury, most professional liability policies would exclude those risks because they are typically addressed by the terms of general liability policies. More often than not, however, the exclusion is worded to bar coverage only for claims for property damage or bodily injury, meaning that it may not necessarily preclude coverage for a securities action alleging that the corporate policyholders directors and officers mismanaged its operations, which contributed greenhouse gases to the environment and led to further liabilities to state or private entities.

. Do the allegations trigger a standard policy exclusion for dishonesty, fraud or willful violation of laws, statutes or regulations? Some policies exclude coverage only as to the specific person(s) who committed the alleged dishonest act, while other policies impute the adverse coverage impact to other insureds.

. Did the policyholder make inaccurate statements in applying for and purchasing a professional liability policy? To the extent that a policyholder or its directors and officers are alleged to have misrepresented their knowledge of global warming risks and/or liabilities in applying for and purchasing the policy, those misrepresentations may form the basis for policy rescission. n60 When plaintiffs allege, as in the *State of California* case, that the corporate defendants knew or should have known . . . that their emissions of carbon dioxide and other greenhouse gases contribute to global warming and to the resulting injuries and threatened injuries, n61 such corporate knowledge, if proven, would likely reside with the directors and officers of the company who originally applied for the policy. Scrutiny of the actions of directors and officers may be even more keen when plaintiffs attempt to prove active misrepresentation and concealment, such as the conspiracy claim alleges in the *Kivalina* suit. n62

What the Future Holds

The range of complex and potentially serious coverage issues that general and professional liability insurers may be required to address, to the extent lawsuits analogous to the *Comer*, *State of California*, and *Kivalina* actions proliferate, does not necessarily suggest that catastrophic indemnity exposure for insurers is looming on the horizon. Based on what is currently known, the opposite inference may well be more likely justified. At present, it appears that plaintiffs in global warming-related actions (existing or putative) against corporations for damages face a truly daunting task in establishing any entitlement to obtain relief. It seems likely that many courts will simply refuse to recognize and wrestle with these claims at all, finding, as did the federal district courts in *State of Connecticut*, *Comer* and *State of California*, that these claims are so inextricably intertwined with matters of domestic and international environmental policy that they present non-justiciable political questions, and thus dismiss the cases accordingly, often at the pleadings stage. n63

Even assuming that the cases survive threshold challenges premised upon lack of standing, non-justiciability and the like, the hurdles posed by the burden of proof upon the plaintiffs with respect to *causation* may well be insurmountable. At a minimum, the claimants inability to establish a proximate cause relationship between a particular corporate policyholders acts or omissions allegedly contributing to global warming and the specific global warming-related injury or damage for which the claimant seeks to be compensated will signal the death knell for many -- if not most or all -- of these cases at the summary judgment stage of the proceedings. In this regard, even though Senior Judge Senter of the Mississippi federal district court permitted the plaintiffs to amend their pleadings for a third time in the *Comer* litigation, prior to the subsequent dismissal of the case, he was constrained to comment on the steeply uphill nature of the plaintiffs ultimate battle:

Without in any way expressing an opinion on the merits of the plaintiffs claims against these defendants, I will observe that there exists a sharp difference of opinion in the scientific community concerning the causes of global warming, and I foresee daunting evidentiary problems for anyone who undertakes to prove, by a preponderance of the evidence, the degree to which global warming is caused by the emission of greenhouse gases; the degree to which the actions of any individual oil company, any individual chemical company, or the collective action of these corporations contribute, through the emission of greenhouse gases, to global warming; and the extent to which the emission of greenhouse gases by these defendants through the phenomenon of global warming, intensified or otherwise affected the weather system that produced Hurricane Katrina. n64

The causation burden for the plaintiff in the *State of California* action may have been even weightier than that confronting the Mississippi homeowner plaintiffs in *Comer*. The State, if the case had been permitted to go forward, would have had to establish that the automaker defendants -- which are not direct emitters of greenhouse gases themselves, but rather are the manufacturers of socially useful but emissions-generating products which are placed into the stream of commerce and purchased by or leased to intervening parties, *i.e.*, *drivers*, who effectively control the nature and extent of the use of the products and thus the volume of their emissions -- were nevertheless not only responsible for causing or exacerbating global warming, but legally responsible for global warming's causation of the injuries and damage to the States people, property and natural resources for which money damages were sought. Even if the causal nexus between automobile emissions and harmful global warming is *presumed* for these purposes, attributing liability to any individual automaker or to the automakers collectively under these circumstances would be no easy task -- indeed, we strongly suspect this objective would prove unattainable under current notions of tort liability. n65

For all of these reasons (and likely a host of others not even touched upon here), it is not the ultimate financial impact of the duty to indemnify under general and professional liability policies that ought to most concern insurers with respect to the specter of global-warming-related coverage claims. That said, a note of caution is in order. There was almost certainly a time, in the nascent stages of the earlier generations of tort litigation premised upon allegations of mass injury or damage caused by substances such as asbestos, hazardous wastes, tobacco, and the like, when prognosticators confidently opined that such claims were contrived, implausible, and doomed to fail in relatively short order. Yet, history has a way of repeating itself, and determined, creative plaintiffs lawyers have time and again demonstrated their capacity to refine and retool their causation theories and liability themes to a point where the claims seem progressively less outlandish and more within the realm of acceptability to a once-skeptical public and judiciary. Corporate defendants and their insurers have been down this road too many times to dismiss global warming-related tort claims as unlikely to ever gain traction in the U.S. courts.

Nevertheless, for the reasons stated, if any immediate problem is presented by global warming claims from the perspective of general and professional liability insurers, it is not the duty to indemnify but *the duty to defend*. Recent history is replete with examples of categories of underlying third-party liability claims that were never any real threat to insurers policy limits of liability from an indemnification standpoint, but which threatened massive defense obligations. That is precisely the concern that may be presented by putative global warming claims which, based on current science, can almost certainly be pled in such a way as to evade characterization as frivolous or dismissal on threshold motions for failure to state a claim. Moreover, these claims can be accompanied by demands for damages of sufficient magnitude that they must be vigorously defended by corporate policyholders and their high-priced defense attorneys, even if the prospect of ultimate liability appears remote.

It is with these concerns in mind that we suggest that general and professional liability insurers watch the emerging trend of claims for damages against corporations for their alleged contributions to the phenomenon of global warming closely, that they begin thinking now about strategies for responding to and/or defending against those corporate policyholders demands for coverage, and that they prepare for the eventuality that substantial defense costs may have to be incurred, even though the potential for substantial indemnification obligations under their respective policies appears unlikely.

Conclusion

While all three principles -- the existence of global warming, the extent to which the phenomenon is a product of human activities, and the extent to which extreme natural catastrophes are attributable to the phenomenon -- may remain subject to serious analysis and debate in some circles, they are no longer open questions insofar as general public perception is concerned. The quest to fix blame and impose liability for the consequences of global warming,

principally upon corporate actors who are perceived, rightly or wrongly, as the main villains in regard to their degree of responsibility for greenhouse gas emissions, has begun and appears likely to intensify in the immediate future. Corporations and their general and professional liability insurers must heed the warning signs and prepare accordingly.

Return to Text

n1 . See, e.g., Clyde M. Hettrick, *The Coming Storm -- Potential Global Warming Liability And the Insurance Assets Available for Companies Defense and Indemnification*, Mealeys Litigation Report -- Insurance, Vol. 22, Issue 23, Apr. 17, 2008, at 17; James M. Davis & Andrea Yassemedis, *Insurance Coverage for Global Warming Litigation*, Emerging Issues Commentary, 2008 LEXIS 273 (May 2008).

n2

[2]. U.S. Environmental Protection Agency, *Global Warming: Climate* at 1-2, available at <http://yosemite.epa.gov/oar/globalwarming.nsf/content/climate.html> (last visited May 14, 2008) (hereinafter *EPA-Global Warming*).

n3

[3]. Allianz Group & World Wildlife Federation, *Climate Change and Insurance: An Agenda for Action in the United States* at 5 (Oct. 10, 2006), available at <http://www.worldwildlife.org/climate/WWFBinaryitem3840.pdf> (citing NASA 2005 Warmest Year In Over A Century (Jan. 24, 2006), available at http://www.nasa.gov/vision/earth/environment/2005_warmest.html).

n4

[4]. *EPA-Global Warming*, *supra*, at 2.

n5

[5]. U.N. Framework Convention on Climate Change, Intergovernmental Panel on Climate Change, Working Group I, *Third Assessment Report -- Climate Change 2001: Summary for Policy Makers, The Scientific Basis*, Jan. 2001, at 10 (hereinafter *2001 IPCC Report*).

n6

[6]. *2001 IPCC Report, supra*, at 2 n.7 (defining probability nomenclature utilized in the Report in accordance with respective confidence levels). The IPCCs assessment was independently corroborated later in 2001 by the National Research Council (NRC) of the National Academy of Sciences. In an NRC study, based on a White House request that the Academy opine on the merits of the IPCCs Report, the NRC definitively stated that [t]he IPCCs conclusion that most of the observed warming of the last 50 years is likely to have been due to the increase in greenhouse gas concentrations accurately reflects the current thinking of the scientific community on this issue. Natl Academy of Sciences, Natl Research Council, *Climate Change Science: An Analysis of Some of the Key Questions* (2001), at 3 (hereinafter *Climate Change Science*).

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[7]. *See supra* n.6.

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[8]. *See* 2001 IPCC Report, *supra*, at 15.

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[9]. *Id*; *see also* U.N. Framework Convention on Climate Change, Intergovernmental Panel on Climate Change, Working Group II, *Third Assessment Report -- Climate Change 2001: Summary for Policymakers: Impacts, Adaptation and Vulnerability*, Feb. 2001, at 7 (elaborating on specific impacts associated with projected increases in the frequency of each of the identified phenomena).

n10

[10]. *See Climate Change Science, supra*, at 22 (noting that the IPCC Working Group I Summary for Policy Makers frequently uses terms (*e.g.*, likely, very likely, unlikely) that convey levels of uncertainty; however, the text less frequently includes either their basis and caveats and cautioning that, without their underlying bases, the IPCC confidence levels could give an impression that the science of global warming is settled, even though many uncertainties still remain.).

n11

[11]. *See, e.g.*, Gautam Naik, *Study Warns of Rapid Rise In Earths Temperature*, Wall Street Journal, Sept. 26, 2006, at A2; Andrew C. Revkin, *NASA Scientists See New Signs of Global Warming*, N.Y. Times, Sept. 14, 2006, at A4; Andrew C. Revkin, *Study Links Tropical Ocean Warming to Greenhouse Gases*, N.Y. Times, Sept. 12, 2006, at A1; Emma Duncan, *Survey-Climate Change: The Heat Is On*, The Economist, Sept. 9, 2006, at 3.

n12

[12]. See generally U.N. Framework Convention on Climate Change, Intergovernmental Panel on Climate Change, Working Group I, *Fourth Assessment Report, Climate Change 2007: The Physical Science Basis, Summary of Policymakers*, Feb. 2, 2007.

n13

[13]. Lloyds of London, *Climate Change: Adapt or Bust* (2006), available at http://www.lloyds.com/News_Centre/360_risk_project/Catastrophe_trends/Climate_change/ (hereinafter *Adapt or Bust*).

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[14]. See, e.g., *Climate Change Futures*, supra, at n.8 (report of The Center for Health and The Global Environment of the Harvard University Medical School, co-sponsored by Swiss Re in conjunction with the United Nations Development Programme); see also Allianz Group & World Wildlife Federation, *Climate Change and Insurance: An Agenda for Action In The United States*, supra, at 30 (listing additional research reports on climate change by European insurers); American International Group, *AIGs Policy and Programs on Environment and Climate Change* (May 2006), available at http://insurance.lbl.gov/documents/aig_climate_change_updated.pdf (last visited May 21, 2008).

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[15]. See, e.g., Matthew Yeomans, *Weather or Not?: Insurance Companies May Have To Save The Climate To Save Their Bottom Line*, Time, Sept. 6, 2006, at A41; see also Ron Scherer, *New Combatant Against Global Warming: Insurance Industry*, The Christian Science Monitor, Oct. 13, 2006, at USA-1; Alison Ryan, *Insurance Industry Sees Real Value In Offering Discounts to Green Building Owners*, St. Louis Daily Rec., Sept. 26, 2006; John Simons, *Risky Business*, CNNMoney.com (Aug. 24, 2006); Marc Gunther, *Insurance Companies Take On Global Warming*, CNNMoney.com (Aug. 23, 2006); Verena Horne, *Feeling The Heat: Growing Insured Losses from Extreme Weather Events Have Thrust Climate Change to The Forefront of Insurers Minds*, Euromoney Institutional Investor, July 1, 2006, at 22; see generally Evan Mills, Ph.D. and Eugene Leconte, *From Risk to Opportunity: How Insurers Can Proactively and Profitably Manage Climate Change* (CERES Aug. 2006).

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[16]. 127 S. Ct. 1438 (2007).

n17 . 42 U.S.C. § 7521

n18 . See generally 68 Fed. Reg. 52922 (Sept. 8, 2003).

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[19]. *Massachusetts v. EPA*, 415 F.3d 50 (D.C. Cir.), reh'g denied, 433 F.3d 66 (D.C. Cir. 2005), cert. granted, 126 S. Ct. 2960 (2006), rev'd, 127 S. Ct. 1438 (2007).

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[20]. See 415 F.3d at 57-59 (Randolph, Cir. J., for the majority); 415 F.3d at 60-61 (Sentelle, Cir. J., concurring in the judgment).

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[21]. Chief Justice Roberts authored the principal dissenting opinion, joined in by Justices Scalia, Thomas and Alito, which focused upon the petitioners purported lack of constitutional standing based upon the Chief Justices view that any injury alleged by the petitioners and purportedly attributable to adverse climate change allegedly caused by automobile emissions of greenhouse gases was completely speculative. 127 S. Ct. at 1463-71 (Roberts, C.J., dissenting, joined by Scalia, Thomas and Alito, JJ.). Justice Scalia issued a separate dissenting opinion, joined by the other three dissenters, attacking the majority decision on the merits. See 127 S. Ct. at 1471-78 (Scalia, J., dissenting, with Roberts, C.J., and Thomas and Alito, JJ., concurring).

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[22]. *Massachusetts v. EPA*, Docket No. 03-1361, Petition for Writ of Mandamus to Compel Compliance with Mandate, 1-2 (D.C. Cir. Apr. 2, 2008).

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[23]. See also *Korsinsky v. U.S. Environmental Protection Agency*, No. 05 Civ. 859 (NRB), 2005 U.S. Dist. LEXIS 21778 (S.D.N.Y. Sept. 28, 2005) (action against EPA and New York State environmental regulatory agencies for contributing to and failing to abate the public nuisance of global warming; case dismissed for lack of Article III standing on the part of the plaintiff), *aff'd*, 192 F. App'x 71 (2d Cir. 2006); *Our Children's Earth Foundation v. U.S. Environmental Protection Agency*, No. CV-03-0770, Complaint (N.D. Cal. Feb. 21, 2003)

(mandamus action seeking to require EPA Administrator to promulgate regulations limiting greenhouse gas emissions from fossil fuel-fired electrical utility plants pursuant to provisions of Clean Air Act; case dismissed by stipulation after issuance by EPA of decision declaring its lack of statutory authority to regulate greenhouse gas emissions in August 2003, as addressed in *Massachusetts v. EPA*, *supra*). A closely-analogous variation on essentially the same theme is presented by *Friends of the Earth, Inc. v. Watson*, No. C 02-4106, 2005 U.S. Dist. LEXIS 42335 (N.D. Cal. Aug. 23, 2005). In that case, environmental groups and several municipalities assert claims against the chief executives of the Overseas Private Investment Corporation (OPIC) and the Export-Import Bank of the United States (Ex-Im Bank), each in their official capacities, alleging that OPIC and Ex-Im Bank have provided funding for fossil fuel-fired power projects in foreign countries which emit greenhouse gases and contribute to global warming, without complying with the National Environmental Policy Act (NEPA) provisions requiring the preparation of environmental impact statements for federally funded projects likely to have an effect on the environment. The district court denied the defendants motion for summary judgment in August 2005, rejecting their arguments that plaintiffs lack Article III standing, that defendants funding decisions did not constitute final agency action subject to judicial review under the Administrative Procedure Act, and that OPIC is not subject to NEPA. 2005 U.S. Dist. LEXIS 42335, at *27-28.

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[24]. For more information on the potential future coverage implications of *Massachusetts v. EPA*, see Robert C. Clifford, *Clifford on Insurance Coverage Issues Raised by Massachusetts v EPA*, Expert Commentary, LexisNexis (Dec. 4, 2007).

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[25]. *State of Connecticut v. Am. Elec. Power Co.*, No. 1:04-CV-05669-LAP, Complaint (S.D.N.Y. filed July 21, 2004).

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[26]. *Id.* 1 at 1.

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[27]. *Id.* 3, 6 at 1-2. A virtually identical lawsuit was filed against the same defendants in the same court on the same day by environmental groups asserting purported rights to protect private lands owned and preserved by them for recreation, conservation, resource and wildlife protection purposes in New York and New Hampshire from the effects of global warming. *Open Space Inst., Inc. v. Am. Elec. Power Co.*, No. 1:04-cv-05670-LAP, Complaint (S.D.N.Y. filed July 21, 2004). The *Open Space Institute* action asserted both public nuisance and private nuisance theories of recovery but, like the *State of Connecticut* action, sought purely declaratory and injunctive forms of relief.

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[28]. See *State of Connecticut v. Am. Elec. Power Co.*, 406 F. Supp. 2d 265, 271-74 (S.D.N.Y. 2005) (dismissing both *State of Connecticut* and *Open Space Institute* actions in consolidated decision on the grounds that complaints in both actions implicated questions of overarching national and international environmental policy constituting non-justiciable political questions beyond the Courts subject-matter jurisdiction).

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[29]. The standard language of the general liability policy, obligating the insurer to indemnify the insured for all sums which the insured shall become legally obligated to pay *as damages* because of bodily injury or property damage to which this insurance applies, caused by an occurrence, and to defend the insured against actions seeking such relief, spawned voluminous litigation regarding whether amounts for which the insured was held liable by a governmental regulatory agency pursuant to an injunctive order requiring the insured to remediate environmental contamination caused by its acts or omissions constituted sums the insured was legally obligated to pay *as damages*. Although the weight of decisional authority ultimately swung in favor of policyholders on this question, a split in the caselaw persists. See and compare *Compass Ins. Co. v. City of Littleton*, 984 P.2d 606, 610, 621-23 (Colo. 1999) (costs to insured of complying with governmental cleanup order constitute damages), with *Patrons Oxford Mut. Ins. Co. v. Marois*, 573 A.2d 16, 18-20 (Me. 1990) (costs to insured of complying with governmental cleanup order are *not* damages). This entire issue is avoided, however, by cases involving claims for purely prospective injunctive relief, without a monetary component, as even courts applying the law of jurisdictions holding that environmental remediation costs are damages have readily recognized. See, e.g., *AIU Ins. Co. v. Superior Court*, 51 Cal. 3d 807, 799 P.2d 1253, 1279 (1990) (distinguishing environmental response costs deemed under California law to constitute damages covered by CGL policies from purely prophylactic costs incurred by the insured to prevent pollution from occurring in the future, for which no coverage exists).

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[30]. Although definitions of Loss vary among professional liability policies, where the term is defined as amounts the insured is legally obligated to pay as damages, the same result reached in the general liability context follows as to the global warming claims which seek purely prospective injunctive relief. See, e.g., 116 *Commonwealth Condominium Trust v. Aetna Cas. & Sur. Co.*, 433 Mass. 373, 742 N.E.2d 76, 78-79 (2001) (surveying cases holding that the term damages does not encompass equitable or injunctive relief and holding that professional liability policy defining Loss as adjudicated damages, settlements and defense expenses was not implicated by underlying action against policyholder that sought only equitable relief and attorneys fees and costs). This same reasoning would apply to prospective injunctive obligations imposed on a policyholder as part of a settlement. Additionally, any potential claim seeking relief in the form of preventing future harm could not, as a matter of logic, be for a Wrongful Act, a fundamental term that defines the scope of coverage afforded by professional liability policies.

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[31]. See *Comer v. Nationwide Mut. Ins. Co.*, No. 1:05-CV-00436-LG-RHW, First Amended Complaint at 11-13 (S.D. Miss. filed Sept. 30, 2005). The plaintiffs Amended Complaint, in an additional Cause of Action, named banks and mortgage-lending companies as yet a third group of defendants, against which claims for declaratory relief were asserted to preclude those defendants from bringing actions against plaintiffs for the value of mortgaged properties, destroyed or damaged by Hurricane Katrina, as to which the defendants failed to independently procure adequate (or any) mortgage insurance. *Id.* 39-44 at 14-16.

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[32]. *Id.* 36 at 13.

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[33]. *Comer v. Nationwide Mut. Ins. Co.*, Order, No. 1:05-CV-436 LTD-RHW, 2006 U.S. Dist. LEXIS 33123 (S.D. Miss. Feb. 23, 2006).

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[34]. *Comer v. Murphy Oil Co.*, *supra*, Third Amended Complaint (S.D. Miss. filed April 19, 2006).

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[35]. *Comer v. Murphy Oil USA, Inc.*, No. 1:05-CV-436-LG-RHW, Order Granting Defendants Motion to Dismiss at 1 (S.D. Miss. Aug. 30, 2007).

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[36]. *People of the State of California ex rel. Lockyer v. General Motors Corp.*, No. 3:06-cv-05755-EMC, Complaint for Damages and Declaratory Judgment (N.D. Cal. Sept. 20, 2006).

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[37]. *Id.* 3 at 2.

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[38]. *Id.* 4-5 at 2-3.

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[39]. *Id.* 5 at 3.

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[40]. *Id.* 6 at 3.

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[41]. *Id.* at 12-14.

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[42]. *See State of California v. General Motors Corp.*, No. 3:06-cv-05755-MJJ, 2007 U.S. Dist. LEXIS 68547 (N.D. Cal. Sept. 17, 2007) ([T]he Court finds that injecting itself into the global warming thicket at this juncture would require an initial policy determination of the type reserved for the political branches of government. A judicial determination of monetary damages for Plaintiffs global warming nuisance tort would improperly place this Court into precisely the geopolitical debate more properly assigned to the coordinate branches[.]); *see also supra* n.28.

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[43]. Juriaan Kamp, *The Courthouse Effect*, Ode, June 2006, at 29 (hereinafter *The Courthouse Effect*).

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[44]. *The Courthouse Effect*, *supra*, at 32-35; *see also* Roberto Cenicerros, *U.N. Climate Report Stirs Liability Fears*, Business Insurance, Feb. 5, 2007, at 1; John Carey & Lorraine Woellert, *Global Warming: Here Come The Lawyers*, BusinessWeek Online (Oct. 30, 2006).

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[45]. *Native Village of Kivalina v. ExxonMobil Corp.*, No. 4:08-cv-01138-SBA (N.D. Cal. Feb. 26, 2008).

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[46]. *Id.* 3, 5 at 1-2.

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[47]. *Id.* 16 at 4-5.

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[48]. *Id.* 5 at 2.

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[49]. *Id.* 190, 223 at 47, 55.

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[50]. *Id.* 269 at 65. The Complaint also includes a claim for Concert of Action under which the defendants allegedly engaged in and/or are engaging in concert with each other over the creation, contribution to and/or maintenance of a public nuisance, global warming. *Id.* 279 at 66.

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[51]. *See supra* n.13.

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[52]. *Adapt or Bust, supra*, at 14.

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[53]. See John Carey, *Business On A Warmer Planet*, BusinessWeek Online (July 17, 2006).

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[54]. See, e.g., *Comer, supra*, Third Amended Complaint, 11 at 10 (Despite warnings from scientists and governmental agencies about the adverse effects of their activities on the environment in general and global warming in particular, the Defendants have knowingly and willfully continued to engage in the activities which cause Global Warming.); *State of California, supra*, Complaint, 58, 61 at 12-13.

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[55]. See *Kivalina*, Complaint, 269 at 65.

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[56]. One commentator theorized a lawsuit brought by the owner of a ski resort against greenhouse gas emitters, asserting that global warming has resulted in a diminution of natural snowfall levels resulting in the resorts loss of business. That type of action would not rest upon allegations of physical injury to the ski resort owners property or loss of use thereof, but rather upon diminished business opportunities and/or profit levels. Insurers would contend that this claim fits squarely within the parameters of the economic loss doctrine, and that general liability coverage would be barred accordingly. See generally 2 Allan D. Windt, *Insurance Claims and Disputes* § 11:1 at 274 & n.9 (4th ed. 2001 & 2006 Supp.) (collecting authorities).

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[57]. Cf. *Titan Holdings Syndicate, Inc. v. City of Keene*, 898 F.2d 265, 272 (1st Cir. 1990); *Martin Marietta Corp. v. Ins. Co. of N. Am.*, 40 Cal. App. 4th 1113, 1131-34, 47 Cal. Rptr. 2d 670, 681-83 (2d Dist. 1995).

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[58]. See *Massachusetts v. EPA*, 127 S. Ct. 1438, 1459-62 (2007).

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[59]. See, e.g., *Natl Union Fire Ins. Co. v. U.S. Liquids, Inc.*, 88 F. App'x 725, 729-31, 2004 U.S. App. LEXIS 2694 at *10-19 (5th Cir. Feb. 17, 2004) (absolute pollution exclusion in D&O policy barred coverage for securities and derivative litigation alleging that the company and its directors and officers concealed information regarding the company's illegal waste disposal activities).

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[60]. See, e.g., *Natl Union Fire Ins. Co. v. Sahlen*, 999 F.2d 1532 (11th Cir. 1993) (inaccurate statements in public filings that are incorporated into a policy application may warrant rescission).

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[61]. *State of California*, *supra*, Complaint, 61 at 13.

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[62]. *Kivalina*, *supra*, Complaint, 269 at 65.

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[63]. Although Davis and Yassemedis have suggested that the *Kivalina* suit is different from the *Comer* and *State of California* suits because of the Big Tobacco-style civil conspiracy and concert of action claims, no analysis is provided as to why this purported difference would likely lead a court to reach a different result. In reality, the *Kivalina* allegations are nothing new. In *Comer*, for example, plaintiffs asserted that [d]efendants actively engaged in Public Relations and Public Policy campaigns to divert the public's attention from the dangers posed by Global Warming, and that the defendants made materially false statements intending to persuade the Federal Government and state governments to refuse to regulate the emission of greenhouse gases, and to seduce the general public into consuming more of Defendants' products. *Comer*, *supra*, Third Amended Complaint, 36, 38 at 18-19. Such allegations were not deemed by the court to constitute any impediment to the dismissal of the case on political question grounds -- a development that Davis and Yassemedis inexplicably fail to even mention.

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[64]. *Comer*, 2006 U.S. Dist. LEXIS 33123, at *12; see Congressional Research Service, *Global Warming: The Litigation Heats Up* at 19 (updated Apr. 3, 2006), available at <http://ncseonline.org/NLE/CRSreports/06Apr/RL32764.pdf> (last visited May 21, 2008) (Causation, of course, is not only a component of the threshold standing test but a component of the plaintiffs' case on the merits. No relief under [Clean Air Act] section 202, the federal common law of nuisance, NEPA, or international law will

be forthcoming unless the science is there to link together the challenged acts of the [greenhouse gas] emitter with the alleged harms to the complainant. . . .[] In either the standing or case-in-chief contexts, the global warming issues before the courts reprise a common problem in environmental law: imposing liability for harms that are remote in time and place from the pollution sought to be abated, particularly where the pollution comes from multiple sources. (Footnotes omitted.)).

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[65]. From the standpoint of the degree of difficulty global warming claims pose to plaintiffs attempting to tie a specific defendant into the causation of an environmental condition to which that defendants entire industry has contributed, the cases might be analogized to the lead paint liability actions in which, due to the generic nature of the injury-causing product itself, the passage of time, and other factors, individual claimants have been unable to offer definitive proof as to which specific paint manufacturer was responsible for the particular paint that injured the claimant and/or his or her child. Although tort doctrines such as market share liability (or enterprise liability) have emerged as an alternative to strict requirements with respect to the establishment of proximate cause in order to respond to such situations -- see generally *Skipworth by Williams v. Lead Indus. Assn, Inc.*, 547 Pa. 224, 690 A.2d 169, 171-72 (1997), citing *Sindell v. Abbott Labs.*, 26 Cal. 3d 588, 607 P.2d 924, cert. denied, 449 U.S. 912 (1980) (describing doctrine) -- courts have been extremely reluctant to broaden the application of these doctrines beyond specific narrow circumstances (see *Skipworth*, 690 A.2d at 172-73), and there is no basis to presume that global warming claims will be held to come within their scope.

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Chandler on Fair Credit Reporting Act (15 USCS § 1681b)

2008 Emerging Issues 2346

Chandler on Fair Credit Reporting Act (15 USCS § 1681b): Congressional Bill Would Outlaw Use of Credit Scores in Personal Lines Insurance

By Seth J. Chandler

May 27, 2008

SUMMARY: Many insurers use credit scores to help underwrite personal lines policies such as automobile and homeowners insurance. Although three states prohibit use of credit scores, most do not. A bill pending in Congress will end the practice, however, if the Federal Trade Commission finds that use of this sort of consumer information is a substitute for race or ethnicity even if the effect is small.

PDF LINK: [Click Here for Enhanced PDF of Commentary](#)

ARTICLE: A bill pending in Congress is likely to effectively bar use of credit scores by personal lines insurers in the United States as a basis for pricing policies or otherwise engaging in underwriting. H.R. 5633, the Nondiscriminatory Use of Consumer Reports and Consumer Information Act of 2008, introduced this March by Representatives Luis Gutierrez (D-IL), Melvin Watt (D-NC), James McDermott (D-WA) and Barney Frank (D-MA), operates by amending section 604 of the Fair Credit Reporting Act (15 USCS § 1681b) to prohibit use of a consumer report or consumer information that the Federal Trade Commission determines would result in racial or ethnic discrimination or that represents a proxy or proxy effect for race or ethnicity.

Although by its terms the bill does not precisely ban use of credit scoring, it is fairly predictable that this will be its effect. The bill proposes to add section 604(h)(4) that defines the prohibited proxy for race or ethnicity as a substitute or stand-in for race or ethnicity, either by design or in effect, without regard to the extent of the effect. One might think that the use of the terms substitute and stand-in mean that the bill requires a high degree of statistical correlation between race/ethnicity and credit score, in which case it might be hard to establish a proxy effect given the existence of numerous variables that affect expected losses on various forms of insurance policies. After all, the bill could have defined proxy to mean simple statistical correlation. The final phrase of the sentence without regard to the extent of the effect will make such a pacifying interpretation of the bill difficult. It appears that the intent of the bill is that, if there is some statistically significant effect that results from the use of credit scores on the prices paid for personal lines insurance by the average member of some racial or ethnic group, the use of this sort of consumer information will be prohibited. Although it is possible that an agency or court unimpressed with the ban would require something more than correlation, there is little in the statutory language that would justify a tougher standard. The difficult case will come if the evidence shows that, yes, credit score and race are correlated but not after income and other correlated variables are taken into account. Will it then be the case that credit score is a substitute or stand-in for race? Statistical concepts are

slippery beasts.

Assuming, however, that mere correlation is required, what is the likelihood that the needed degree of statistical correlation will be found? One might think the proof would be easy to find. It is clearly true that income and wealth are positively correlated with credit score. And it is clearly true that being African American or Hispanic is negatively correlated in the United States with income and wealth. Thus, one might think that it therefore follows, as a matter of transitivity that being African American or Hispanic must be negatively correlated with credit score.

It turns out, however, that statistical correlation is sometimes transitive and sometimes not. Here are two examples of instances where statistical correlation is not transitive. The first comes from baseball. Players base hits and home runs are positively correlated. Players base hits and triples are positively correlated. But players triples and home runs are negatively correlated. The second example comes from the world of law schools LSAT scores and first year grade point average of the students at a school are positively correlated. Undergraduate GPA and first year grade point average of the students at a school are positively correlated. But undergraduate GPA and LSAT scores of the students at a school are negatively correlated. Those wanting to see the gory details may look up the work of Eric Langford, Neil Schwertman and Margaret Owens in the November 2001 issue of the *American Statistician* from which the baseball example is taken.

Still, just because there are exceptions to ones intuition about the transitivity of statistical correlation, does not mean that race and credit score will be one of them. Although the published and peer reviewed evidence on this point is a bit thinner and bit more equivocal than one might believe precisely because of the understandable sensitivity about collection of race-correlated credit scoring data, most of the better work that has been done on this point suggests that use of credit scores will, on balance, hurt African Americans and Hispanics. A study conducted for the Texas Department of Insurance in 2004-05 found African Americans and Hispanics disproportionately represented in groups with the lowest credit scores and underrepresented in groups with the highest credit scores. A 2003 study conducted by the Washington Insurance Commissioner found ethnicity to be correlated with credit score in some cases, though the correlation was not particularly strong after other variables such as age were controlled for. There is, to be sure, a contrary study by the Virginia Department of Insurance on use of credit scores, but the several aspects of the methodology appear flawed, notably the use of zip-code-aggregated data rather than individual data.

H.R. 5633 has several other noteworthy characteristics. For most of American history and certainly since the McCarran Ferguson Act of 1946, insurance regulation has generally been left to the states. This has particularly been the case with automobile insurance and property insurance, less so with health insurance. This bill represents a movement away from the traditions embodied in the McCarran Act. Only three states currently prohibit use of credit scores by automobile insurers (California, Maryland and Massachusetts), though legislative efforts to limit use are well underway in Michigan. The Colorado, Oklahoma, Nebraska and Wyoming legislatures as well as the voters in Oregon have recently rejected credit scoring prohibitions. Evidently, the sponsors of the federal bill believe that the laboratory of state regulation generally permitted by McCarran has run amok on this issue, generally giving too much leeway to insurers.

Second, the methodology by which a determination is to be made as to which types of information represent a proxy effect: for race or ethnicity is unusual. The Commission itself does not have to make a finding that inappropriate discrimination or proxy effects are occurring. No hearings evidently need be held on the subject. Instead, the findings needed to trigger application of the statute can occur simply if they are made in any study for which a report is submitted to Congress. This language, which appears unprecedented in the United States Code, may rest in some tension with the Administrative Procedure Act that generally requires some notice and hearing before findings of this sort are made. The apparent absence of any need for any sort of hearings is particularly problematic given the complexity of statistical analysis in this area.

Third, the limiting principle behind the bill is unclear. If it is thought that use of credit scoring is improper because it correlates with race and does not directly cause accidents, other rating measures may be vulnerable too. Construction

quality, for example, is used in part to set rates for homeowners insurance. Construction quality and race/ethnicity both correlate with the income of a prospective insured. While one can not be sure without further investigation, it would not be surprising if race correlated with construction quality too. It would be a peculiar outcome if the only sort of race-correlated information that could not be used in insurance underwriting was that which happened to emerge from a consumer reporting agency simply because that was the regulatory hook Congress took to address the issue.

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Volpe on Florida Farm Bureau Casualty Insurance Company v. Cox

2008 Emerging Issues 2328

Volpe on Florida Farm Bureau Casualty Insurance Company v. Cox, 2007 Fla. LEXIS 1678: A Total Loss Caused In Part By a Covered Peril and In Part By an Uncovered Peril No Longer Requires Payment of Full Policy Limits By the Insurer

By Timothy Volpe

May 23, 2008

SUMMARY: The Supreme Court of Floridas decision in Cox sets a new precedent. Unlike the previous holding in Mierzwa, which required that full policy limits must be paid to the insured if the structure were deemed a total loss and a covered peril contributed to the loss, regardless if an excluded peril significantly contributed to the loss, the Cox decision lines up with the amendment to the VPL by the Florida Legislature in 2005 (post-Mierzwa).

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ARTICLE: In a stark departure from prior precedent, the Supreme Court of Florida reversed the lower appellate courts decision in this case and answered in the negative the following certified question of great public importance:

Does Section 627.702(1), Florida Statutes (2004), referred to as the valued policy law, require an insurance carrier to pay the face amount of the policy to an owner of a building deemed a total loss when the building is damaged in part by a covered peril but is significantly damaged by an excluded peril?

The unanimous decision provides several important points of guidance for the practitioner.

Prior Case Law. The Cox case, like the earlier *Mierzwa v. Florida Windstorm Underwriting Assn.*, 877 So.2d 774 (Fla. 4th DCA 2004), involved interpretation of homeowners coverages after storm damage in which both covered wind claims and uncovered flood claims were made. n1 In both cases, both perils contributed to the loss; in Cox the wind damage was less than fifty percent of the loss, in *Mierzwa* it was slightly more than fifty percent. n2

In *Mierzwa*, the Fourth District analyzed the prevailing precedent regarding the valued policy law (VPL) to conclude that when a building is covered as to a covered loss and the building is a total loss, the VPL mandates the carrier is liable for the face value of the policy . . . *Mierzwa* at 3. In fact, the *Mierzwa* court concluded the covered peril does not need to be *the* peril causing the total loss, it is sufficient if there is any covered liability which in combination with uncovered perils causes the loss. *Id.* (VPL does not require that a covered peril be *the* covered peril causing the entire loss; it need merely be *a* covered peril.)

Mierzwa paternalistically viewed the VPL as a legislative mandate to expand coverage in cases of total loss. The homeowner got full policy limits if any covered peril was involved in the total loss.

Unhappy with that interpretation, the Florida Legislature promptly responded in 2005 to *Mierzwa* by amending the VPL to limit the insurers liability to the amount of loss caused by the covered peril. *Cox at 3, see also Fla. Stat. § 607.702(1)(b) 2005*. The 2005 amendments to the VPL were expressly not made retroactive. This legislative response prompted the First District Court in *Cox* to conclude that the prior version of the VPL could not be interpreted to reduce an insurers responsibility in a total loss to pay stated policy limits even where covered and uncovered perils combine to produce the loss. *Cox, 2006 Fla. App. LEXIS 17891 at 4*.

The Florida Supreme Court rejected this broad reading of the pre-*Mierzwa* version of the VPL and narrowly construed the statute:

only to set the value of the property insured by the policy in order to conclusively establish the property's value when there is a total loss.

Cox, 2007 Fla. LEXIS 1678 at 3.

The unanimous Court agreed with the dissent filed by Judge Polston of the First District that the *Mierzwa* court erred by reading into the statute a requirement for the insurer to pay for damages caused by both excluded and covered perils. *Id. at 4*. The Supreme Court rejected the notion that the VPL intends that if a covered peril causes part of a total loss, that the insurer is mandated to pay for the total loss. *Id.*

In other words, the VPL does not trump the policy language excluding coverage for certain perils. *Id.* Giving effect to what it described as the plain language of the statute, the *Cox* court disapproved the *Mierzwa* analysis and its holding. *Id. at 5*.

Conclusions for the Practitioner. Given this result, an unwary practitioner might conclude that liability for loss is limited to that portion of the loss caused by covered perils. That is not necessarily so.

The Supreme Court was careful to limit its holding to only those cases in which a covered peril did not cause a total loss or constructive total loss. *Id. at 5 fn. 6*. Plainly, a different result could obtain for cases where a covered peril causes a total loss or constructive total loss.

Counsel should consider that most localities have ordinances providing that where repairs exceed fifty percent (50%) of the value of a structure, current building codes must be met. *See, e.g., Mierzwa, 2004 Fla. App. LEXIS 8804 at 4* (citing Ord. Sec. 104.3(3) of the City of Fort Lauderdale). In many instances this produces a constructive total loss. *Id.* Consequently, in such a case, if a covered peril, wind, produced damage to a structure requiring repairs exceeding 50% of the value of the structure, and additional damage was done by an uncovered peril, flood, then the insurer could be required to pay the full face value of the policy in settlement of the claim³ even though uncovered perils contributed substantially to the loss.

The Supreme Court of Florida's interpretation of the pre-*Mierzwa* VPL brings its approach into conformity with the amended post-*Mierzwa* VPL: if the covered perils alone would have caused the total loss, then the current VPL applies and the full policy face amount must be paid. *See Fla. Stat. § 627.702(1)(b)*.⁴

Conclusion. The Florida Supreme Court in *Cox* reined in arguably overexpansive interpretations of the VPL. This result coupled with the legislative changes in VPL post-*Mierzwa* are happy events for Florida insurers. The practical implications of the *Cox* holding are limited to those circumstances in which a covered peril does not cause a total loss or constructive total loss. Where covered perils alone cause a constructive loss, the VPL still applies to require full policy limits payment.

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n1 . Both policies expressly excluded damages from flood.

n2

[2]. *Mierzwa, 2004 Fla. App. LEXIS 8804 at 4; Cox, 2007 Fla. LEXIS 1678 at 3.*

n3

[3]. In fact, given so-called law or ordinance coverage an additional 25% benefit beyond face may be payable. *See Mierzwa* at 6.

n4

[4]. Given the significant changes to the VPL in 2005 and the express legislative directive to apply such changes prospectively, this is an unusual outcome to say the least.

ABOUT THE AUTHOR(S):

Timothy Volpe of Volpe, Bajalia, Wickes, Rogerson & Wachs focuses on insurance and complex commercial litigation. He received his B. A. degree, with high honors, in 1979, and his M.A. and J. D. from the University of Florida in 1982, with honors. He was the Editor-in-Chief of the University of Florida Law Review. He is a member of The Florida Bar and the Jacksonville Bar Association. He holds the highest rating from Martindale-Hubbell and is admitted to practice in the U. S. District Court, Middle District of Florida, and the U.S. Court of Appeals (Eleventh Circuit). In 2007, Florida Trend magazine named Mr. Volpe as one of Florida's Legal Elite and SuperLawyers magazine placed Mr. Volpe in the top 5% of attorneys in the state.

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Coverage for Global Warming Risks Under D&O Policies

2008 Emerging Issues 284

Hersh on Coverage for Global Warming Risks Under D&O Policies

By Mark Hersh

May 20, 2008

SUMMARY: For many companies, global warming is a new risk management issue. Not only are there financial and other business risks associated with global warming, the risk of legal claims undoubtedly will continue to rise with the earth's temperature. In particular, the actions of directors and officers in managing and disclosing global warming risks likely will face increased scrutiny. What role will D&O insurance play in protecting directors and officers, as well as companies, from global warming claims? D&O insurance practitioner Mark Hersh of Reed Smith LLP examines this issue by considering three questions: (1) whose risks and what kind of risks does D&O insurance typically cover; (2) what sort of claims pertaining to or arising from global warming might potentially fall within the coverage of a D&O policy; and (3) how is a D&O policy likely to respond to such claims, i.e., what coverage issues are likely to be raised. He concludes that D&O policies may provide important protection in the event of global warming claims against officers and directors, and in some cases companies themselves. However, there are potentially serious coverage issues depending on policy language, and companies should try to negotiate for D&O policy language that will maximize the chances of coverage should a global warming claim be made.

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ARTICLE: Coverage for Global Warming Risks Under D&O Policies

By Mark Hersh

Global warming, or climate change, now figures prominently on the national and international agenda. And though skeptics may still exist, there is substantial scientific evidence correlating rising global temperatures and the emission of greenhouse gases from human activity. The United States Supreme Court acknowledged this last year, in holding, *inter alia*, that greenhouse gas emissions fall within the Clean Air Acts definition of pollutant and that the EPA's refusal to regulate greenhouse gases was arbitrary, capricious or otherwise not in accordance with law [see *Massachusetts v. EPA*, 127 S. Ct. 1438, 1460-1463 (2007)].

For many companies, global warming also represents a new risk management issue. Not only are there financial and other business risks associated with global warming, the risk of legal claims undoubtedly will continue to rise with the earth's temperature. When considering insurance coverage for corporate risks associated with global warming, Directors and Officers liability (D&O) insurance may not immediately spring to mind. But with increased attention on

global warming issues, the actions of directors and officers in managing and disclosing global warming risks likely will face increased scrutiny. Even if D&O insurance is less likely to be implicated by global warming claims than other kinds of corporate insurance, there are circumstances where it may come into play.

This commentary examines this issue by considering three questions: (1) whose risks and what kind of risks does D&O insurance typically cover; (2) what sort of claims pertaining to or arising from global warming might potentially fall within the coverage of a D&O policy; and (3) how is a D&O policy likely to respond to such claims, i.e., what coverage issues likely will be raised. As explained below, D&O policies may provide important protection in the event of global warming claims against officers and directors, and in some cases companies themselves. However, there are potentially serious coverage issues depending on policy language, and companies should try to negotiate for D&O policy language that will maximize the chances of coverage should a global warming claim be made.

D&O Coverage Generally

Types of Coverage. Virtually all D&O policies have what is known as Side A and Side B coverage, and many also have Entity coverage. In addition, many companies now purchase supplemental Side A coverage.

Side A coverage. Historically, the purpose of D&O insurance was to protect directors and officers from personal loss resulting from their service to a company. In the vast majority of cases, though, directors and officers are indemnified by their company and never need direct access to D&O insurance proceeds.

Typically, D&O insurance protects directors and officers (and sometimes employees) directly in three situations: (1) if the company is in bankruptcy or otherwise financially unable to meet its indemnification obligations; (2) if the director or officer does not meet the standard of conduct required for indemnification by the company (which is a rare situation); or (3) if a company cannot indemnify directors and officers for derivative judgments and settlements (because such funds simply go right back to the company) [see generally E. Norman Veasey, Jesse A. Finkelstein & C. Stephen Bigler, *Delaware Supports Directors with a Three-Legged Stool of Limited Liability, Indemnification, and Insurance*, 42 *Bus. Law.* 399, 417 (1987)]. D&O coverage provided directly to corporate officers and directors is known as Side A coverage.

Side B coverage. D&O policies also commonly have provided coverage to the company itself for amounts that it indemnifies its directors and officers for claims made against them. This coverage is known as Side B coverage. D&O insurance policies traditionally have provided both Side A and Side B coverage. They typically apply a significant retention deductible to Side B claims, while applying a small or no retention or deductible to Side A claims.

Entity coverage. Over the last 10 to 15 years, it has become increasingly common for D&O policies to include a third kind of coverage, known as entity coverage. This provides coverage for claims made directly against the company. Particularly in the case of public companies, entity coverage usually is limited to Securities Claims against the company, which generally means claims concerning the sale of the company's stock or other securities. One very common example of a Securities Claim is a class action by company shareholders alleging that the stock price of the company was inflated by misrepresentations to the marketplace. Typically, a D&O policy has one set of limits that is shared by the Side A, Side B, and entity coverage.

Supplemental Side A coverage. Some companies also recently have supplemented their D&O insurance policies with stand-alone Side A or last resort policies. A stand-alone Side A D&O policy generally functions in the same way that a Side A section of a traditional D&O policy would respond, i.e. it covers loss where the company cannot (because of insolvency) or is not permitted (under its by-laws or applicable law) to indemnify the directors and officers. However, a supplemental stand-alone Side A policy has its own set of limits, often provides broader coverage terms than the main policy (this is known as difference in conditions, or DIC), and is unlikely to be affected if the company goes into bankruptcy (since it covers only the directors and officers, it likely will not be deemed an asset of the bankrupt estate). A few companies also have purchased stand-alone Side A policies just for their independent directors, who may

be concerned that in the event of a claim, policy limits will be depleted by the corporate insiders, who are more likely to have greater culpability in any wrongdoing.

Scope of Coverage. D&O insurance typically covers Loss arising from Claims made against directors and officers for Wrongful Acts. With respect to insured individuals, a Wrongful Act may include alleged breaches of duty, neglect, errors, misstatements, misleading statements or omissions by the insured in his or her capacity as a director or officer of the company or any matter claimed against a director or officer solely by reason of his or her status as a director or officer. The company itself is insured for the Wrongful Acts of the individual insureds (though usually only with respect to securities claims).

D&O policies are always or virtually always claims made policies, meaning that coverage is triggered when the claim is made, not when the allegedly wrongful conduct took place, as in commercial general liability or occurrencebased policies. Thus, a D&O policy may cover conduct that occurred several years before the policy inception. However, notwithstanding their claims made nature, D&O policies often have provisions excluding coverage for claims based on conduct occurring prior to a specified date. In addition, most D&O policies state that claims that relate to or arise out of the same or essentially the same Wrongful Acts as those alleged in a prior claim will be deemed to have been made at the same time as the prior claim. This related claims language may exclude claims that are based upon or arise out of a claim or Wrongful Acts alleged in a claim made prior to the inception of the policy. On the other hand, it may allow coverage (without application of a new retention or deductible) for claims that may be asserted after a particular policy has expired if those claims are related to a claim that was made during the policy period.

Because the trigger of coverage under a D&O policy generally is when a claim is made, the definition of Claim is important. Virtually all D&O policies now define the term Claim. The definition typically encompasses lawsuits and may include written or verbal demands for monetary or non-monetary relief. Policies vary as to coverage for administrative, arbitration, investigative, or criminal proceedings (though the latter often are covered once there is the return of an indictment or similar charging document). Investigations by regulatory agencies may not be covered if the definition of claim includes only judicial or administrative proceedings. In addition, under some definitions of claim, an informal inquiry may not be covered.

Like all insurance policies, D&O policies have relatively standard exclusions, and may also have exclusions specifically crafted for the particular insured. The exclusions that may be applicable in the context of global warming claims are discussed below. Most D&O policies have policy periods lasting one year, and then may be renewed from year to year. Thus, each year companies with D&O insurance programs are well-advised to evaluate their D&O program to make sure their policies meet or exceed the current market standard. Many of the key terms in D&O policies are negotiable at the time of placement or renewal, and policy language obviously can make all the difference if a claim later is made. As explained below, companies may be able to negotiate some language to maximize their chances of coverage for claims pertaining to global warming.

Global Warming Claims That May Implicate D&O Insurance.

There are three types of claimants that might bring global warming claims against a company or its directors and officers: (1) corporate shareholders; (2) regulators; and (3) third parties who are neither shareholders nor regulators. These are discussed below.

Third-Party Claims. The third category of potential claimants warrants only brief discussion. Because directors and officers primarily owe their duties to the company and its shareholders, claims by third parties directly against directors and officers generally are not viable and therefore are rare. In the context of global warming, there is unlikely to be a viable claim by third parties against officers or directors. However, the costs of defense may be substantial even

for claims without merit, and D&O insurance can pay those costs in such cases (subject to any retention). If a third party were to sue directors or officers in connection with a global warming matter most likely in addition to the company itself it presumably would be a Claim under the D&O policy, subject to the exclusions and other coverage issues discussed below.

Third-party claims against the company itself are much more likely. Just as over the past few decades there have been numerous third-party tort claims against companies relating to environmental issues (e.g. hazardous waste, asbestos, water and air pollution), we may well see many future third-party claims against companies alleging that they have contributed to the problem of global warming. In fact, some lawsuits of this kind already have been filed [see, e.g., Third Amended Class Action Complaint, *Comer v. Murphy Oil, U.S.A.*, No.1:05-cv-00436-LG-RHW (S.D. Miss. Apr. 19, 2006) (post-Katrina class action by Gulf Coast residents against oil and energy companies alleging, *inter alia*, that greenhouse gas emissions contribute to hurricanes); *Connecticut v. American Electric Power Co.*, 406 F. Supp. 2d 265 (S.D.N.Y. 2005) (suits against power companies based on greenhouse gas emissions dismissed as nonjusticiable political question), *appeal docketed*, No. 05-5104-cv (2d Cir. Sept. 22, 2005)].

However, as discussed above, D&O policies for public companies typically limit entity coverage to securities claims, and so environmental tort suits against public companies typically will not fall within even the potential coverage of a D&O policy. For private companies that do have entity coverage for non-securities claims, a global warming claim might fall within the potential coverage of its D&O policy, subject to the coverage issues discussed below (including the pollution exclusion clause, which may preclude any coverage).

Shareholder Claims. A corporate shareholders suit is the sort of legal proceeding that typically does fall within the potential scope of D&O coverage. A shareholder suit involving global warming issues most likely would take one of two forms: securities class actions and derivative suits.

Securities class actions. First, shareholders might bring a securities class action, in which shareholders typically allege that they purchased company stock at artificially inflated prices because the company made misrepresentations to the marketplace, often in its annual or quarterly reports or other SEC filings. These could be affirmative misrepresentations or failures to disclose information where there was a duty to disclose, or both. Typically in securities class actions, the shareholders allege that they lost money when there was some sort of corrective disclosure i.e. the truth came out causing the company's stock price to drop [see *Dura Pharmaceuticals, Inc. v. Broudo*, 125 S. Ct. 1627, 1632-1634 (2005) (shareholder who claims securities fraud must allege and prove that the defendant's conduct caused an actual economic loss); see generally 26A Michael Kaufman, *Securities Litigation Damages* § 20:28 (2006)].

In the global warming context, a securities class action might allege that a public company misrepresented or failed adequately to disclose its policies related to global warming or its global warming risks. Such conduct need only violate broadly worded federal securities laws to be actionable, but class action plaintiffs may strengthen their case by alleging violations of specific disclosure requirements, particularly in cases of non-disclosure. Currently there are no specific disclosure requirements pertaining to global warming under federal law, but some existing general requirements could apply to global warming issues. Two components of SEC Regulation S-K seem particularly applicable. Item 101 requires companies to disclose any material affects of compliance with environmental laws, and Item 303 requires disclosure of information on any known trends, events and uncertainties likely to have a material impact on the company's business [17 C.F.R. §§ 229.10199(c)(xii) & 229.303(a)(3)(ii); see generally Elizabeth E. Hancock, *Red Dawn, Blue Thunder, Purple Rain: Corporate Risk Liability for Global Climate Change and the SEC Disclosure Dilemma*, 17 *Geo. Intl Env'tl. L. Rev.* 233 (Winter 2005)].

Where a company has made misrepresentations to the market regarding global warming issues, the corrective disclosure the event causing the drop in stock price might take a number of forms. These include the announcement of a regulatory action or investigation of the company relating to global warming issues, or the announcement of a significant third-party lawsuit against the company regarding global warming issues. These events, if unexpected, could cause a significant drop in stock price, though how the market will react in such cases involves some guesswork and

likely will depend on the particular circumstances.

If such a class action is filed against a company and it has entity coverage under its D&O policies, it would be a Securities Claim that potentially would fall within the scope of D&O coverage, subject to the exclusions and other coverage issues discussed below. If the lawsuit also named directors or officers, it almost certainly would be a claim against them that potentially could fall within D&O coverage, again subject to coverage issues discussed below.

However, it is uncertain how much exposure directors or officers actually have to securities class actions pertaining to global warming. Under the Private Securities Litigation Reform Act of 1995 (PSLRA), the requirements for pleading securities fraud are high, requiring particularity beyond that of most other types of cases. The PSLRA requires plaintiffs to plead specific facts showing that statements by defendants were false or misleading when made to plead facts giving rise to a strong inference that the defendant acted with the requisite scienter to deceive investors [*15 U.S.C. § 78u-4(b)*]; *see also Tellabs Inc. v. Makor Issues & Rights Ltd.*, 127 S. Ct. 2499, 2504-2505 (2007) (strong inference of scienter means inference that is cogent and at least as compelling as any opposing inference of nonfraudulent intent)].

These requirements apply to each defendant and often are particularly difficult to satisfy with respect to individual defendants, who would have to be shown to be personally responsible for the company's alleged public misrepresentations. Because the assessment of global warming issues and disclosure requirements pertaining to global warming may be something of a grey area, proving or even adequately alleging scienter on the part of individuals could be an especially formidable obstacle to securities class action plaintiffs. Nevertheless, there may be fact patterns such as suspicious insider stock sales that precede a corrective disclosure that could give rise to viable claims against directors or officers.

Derivative suits. The second kind of shareholder suit that might be based on global warming issues is a derivative suit. Though there may be variations depending on the state in which the company is incorporated, a derivative suit is brought by shareholders in the name of the company, so the company itself is not a defendant (though it often is a nominal defendant). Derivative suits essentially allege breaches of fiduciary duties in the management of the company, seeking to hold directors or officers liable for losses incurred by the company [*see generally Tooley v. Donaldson, Lufkin & Jenrette, Inc.*, 845 A.2d 1031 (Del. 2004) (discussing difference between direct and derivative suits)].

Derivative shareholder suits pertaining to global warming are perhaps more likely than securities class actions to be filed against officers and directors. If a company faces or has incurred significant losses because of a global warming issue, a derivative suit could be filed. Such losses could result from regulatory actions, third-party suits or securities class actions (derivative suits often accompany securities class actions), or business losses resulting from allegedly inadequate planning for global warming or other mismanagement.

In derivative suits, decisions by directors (and possibly officers) generally are protected by the business judgment rule, which grants corporate decision-makers considerable latitude to exercise their best judgment and limits the degree to which shareholders or courts may second-guess those decisions [*see In re Walt Disney Co. Derivative Litigation*, 906 A.2d 27, 52-53 (Del. 2006)]. Again, because decisions pertaining to global warming may be relatively uncharted territory, proving a breach of duty by officers or directors may be particularly challenging for derivative action plaintiffs. Nevertheless, future derivative suits stemming from global warming issues seem likely, if not inevitable.

If and when such derivative suits are filed, they are likely to be claims potentially within the coverage of D&O policies. Indeed, Side A coverage under D&O insurance policies is particularly important to derivative action defendants. As stated above, because a derivative suit is on behalf of the company, any recovery by the plaintiffs that is for the benefit of the company generally may not be paid by the company itself. (However, the company may be able to pay the part of any settlement or judgment covering plaintiffs attorneys fees, which may be substantial.) Therefore, either those sums are paid by the individual defendants out of their own assets, or they are paid by the D&O insurer pursuant to Side A coverage.

Regulatory Claims. Both federal and state agencies may regulate companies with respect to environmental issues, though there might be limits on state regulation based on federal preemption or related considerations [see Note, *Foreign Affairs Preemption and State Regulation of Greenhouse Gas Emissions*, 119 *Harv. L. Rev.* 1877, 1878 (2006)]. Thus, global warming claims by federal (and possibly state) environmental regulators may be made in the future. This is particularly true in light of the United States Supreme Courts decision in *Massachusetts v. EPA* [127 S. Ct. 1438, 1458, 1460 (2007)], holding that greenhouse gas emissions fall within the Clean Air Acts definition of pollutant and therefore within the scope of the EPAs regulatory authority, and that the State of Massachusetts had standing to challenge the EPAs refusal to regulate greenhouse gases.

In addition, just as shareholders could bring suits based on alleged corporate misrepresentations concerning global warming issues, federal and/or state corporate or securities regulators could bring regulatory actions for the same alleged misconduct. As discussed above, though at this time public companies have no special disclosure requirements pertaining to global warming issues, the generic requirement that they disclose material information could be grounds for regulatory action.

Moreover, given the heightened awareness of global warming, the regulatory landscape could change. On September 18, 2007, the Washington Post reported that a coalition of state officials, state pension fund managers, and environmental organizations were formally petitioning the SEC to require public companies to assess and disclose their financial risks from climate change and legislation [Steven Mufson, *SEC Pressed to Require Climate-Risk Disclosures*, The Washington Post, Sept. 18, 2007]. The same article reported that four days earlier the N.Y. Attorney General had subpoenaed five energy firms pursuant to an investigation into whether the companies had properly disclosed the financial risks of carbon dioxide emissions from new coal-fired plants. Thus, the disclosure of global warming risks may well be fertile ground for future regulatory and other government action.

When regulatory investigations are opened or enforcement actions are taken against companies or their officers or directors, the threshold coverage question under a D&O policy is whether a claim has been made within the meaning of the policy. D&O policies now almost always define claim, but the definitions vary from policy to policy. In particular, policies vary in their coverage for regulatory or other governmental matters. Frequently, an investigation of a company is not covered, but an investigation of individual directors or officers is covered. However, some investigations are covered only if they are formal, as evidenced by a subpoena, target letter, Wells Notice (essentially an SEC notice that the recipient is a target of an investigation), or similar document. Some policies also provide that an investigation of a company will be covered only if the investigation is also maintained against an individual insured. Companies concerned about this issue should try to negotiate with their D&O insurers for a broad definition of claim that will include investigations.

Once a governmental investigation results in regulatory action, coverage under a D&O policy is more likely. However, absent a formal lawsuit or the filing of a regulatory proceeding, there still is the potential for dispute as to whether a Claim has been made [see, e.g., *Avondale Indus., Inc. v. Travelers Indem. Co.*, 887 F.2d 1200, 1206 (2d Cir. 1989) (where an insured received a demand letter from the Louisiana State Department of Environmental Quality, the demand letter commence[d] a formal proceeding against [the insured] and triggered coverage)]. To minimize ambiguities and thus disputes, the definition of claim now often will include regulatory or administrative proceedings commenced by the filing of a complaint, notice of charges, or similar document. Again, companies should seek the clearest and broadest definition possible to maximize coverage and minimize disputes.

Even if a regulatory action is considered a Claim, there may be coverage issues regarding the relief sought by the governmental agency. D&O policies cover Loss, and always define Loss to include damages. However, fines or penalties are usually, if not always, excluded from the definition of Loss, and thus are not covered. Because governmental regulatory or enforcement actions often do involve fines or penalties, in some cases coverage for such actions may be limited to the costs of defense.

Significant D&O Coverage Issues for Global Warming Claims

Even if a lawsuit or other legal action is a Claim under a D&O policy and thus potentially within the scope of coverage, there are typical exclusions and other policy provisions that may limit or preclude coverage. Some policy exclusions, like the so-called fraud exclusion, might apply in any kind of case depending on the facts, but do not present issues that seem particularly applicable to global warming claims. (A fraud exclusion might apply to a securities fraud case involving global warming, but is virtually always triggered only by a final adjudication or judicial finding of fraud.) A few standard exclusions do present issues that are potentially applicable to global warming claims, however, and they are discussed below. The most significant of these is the pollution exclusion.

In considering the issues discussed below, it bears keeping in mind three widely-accepted principles of insurance policy construction: (1) grants of insurance coverage should be construed broadly; (2) exclusions to coverage should be construed narrowly; and (3) ambiguities in policy language should be construed in favor of the insured [see 2-6 Appleman on Insurance 2d § 6.1].

Pollution Exclusion. One of the standard exclusions in a D&O Policy is known as the pollution exclusion. Though the language of this exclusion will vary from policy to policy, one example of a pollution exclusion clause is as follows:

The insurer shall not be liable to make any payment for Loss in connection with any Claim made against the Directors and Officers or, with respect to insuring Agreement (C), the Company:

(E) for, based upon, arising from, or in any way related to:

(1) the actual, alleged or threatened discharge, dispersal, release or escape of pollutants; or

(2) any direction, request or voluntary decision to test for, abate, monitor, clean up, remove, contain, treat, detoxify or neutralize pollutants, nuclear material or nuclear waste.

Including without limitation any Securities Claim or any other Claim by or on behalf of the Company or its shareholders in their capacity as such.

Pollutants, include, but are not limited to, any solid, liquid, gaseous or thermal irritant or contaminant, including without limitation, smoke, vapor, soot, fumes, acids, alkalies, chemicals, odors, noise, lead, oil or oil products, radiation, asbestos or asbestos-containing products, waste and any electric, magnetic or electromagnetic field of any frequency. Waste includes, but is not limited to, material to be recycled, reconditioned or reclaimed.

Significantly, this particularly provision explicitly excludes even securities and derivative claims the bread and butter of D&O policies that are based on pollution. As discussed further below, pollution exclusion clauses need not be so restrictive in this regard.

The pollution exclusions potential impact on D&O coverage for global warming claims is obvious, at least if greenhouse gases fall within the definition of pollutants. The definition of pollutants above is fairly typical of such insurance policy exclusions in its breadth and might well include greenhouse gas omissions. Certainly insurers would so argue, and would cite to *Massachusetts v. EPA* [127 S. Ct. 1438, 1460 (2007)], in which the Supreme Court held that greenhouse gas emissions fall within the Clean Air Acts definition of pollutant and therefore within the scope of the EPA's regulatory authority. But that case does not dispose of the issue, since the Supreme Court was interpreting a particular statutory provision, not an insurance policy exclusion. Because policy exclusions must be construed narrowly in favor of coverage and any textual ambiguity also must be construed in favor of coverage, policyholders might have some argument that a pollution exclusion clause in their policy does not apply to greenhouse gas emissions, depending on the language of the exclusion.

Assuming that a pollution exclusion clause would apply to greenhouse gases, is this the death knell for any D&O

coverage for global warming claims? Not necessarily. First of all, as discussed above, Securities Claims shareholder class actions and derivative actions are the sort of global warming claims most likely to fall within the potential coverage of a D&O policy. Where a pollution exclusion clause is silent on the question of whether it applies to Securities Claims (unlike the sample clause above), an insured may have some room to argue that it does not. In *Owens Corning v. National Union Fire Insurance Co.* [No. 97-3367, 1998 U.S. App. LEXIS 26233 at *16 (6th Cir. Oct. 13, 1998)], the insured corporation and some of its directors and officers were sued by shareholders based on alleged misrepresentations regarding the company's potential liability for asbestos claims. The Sixth Circuit held that coverage for that Securities Claim was not precluded by an asbestos exclusion in the D&O policy, reasoning that the lawsuit arose out of the alleged misrepresentations rather than the use of asbestos, and that to hold otherwise would render coverage for Securities Claims illusory, since asbestos was at the core of the company's business. A similar argument might be made for a Securities Claims based on global warming, depending on the language of the policy and other circumstances.

However, there is a substantial risk that a court would limit *Owens-Corning* to its particular facts or simply not follow it, and in fact at least one other federal court of appeals has reached a different result based on a similar set of facts. In *Nat'l Union Fire Ins. Co. of Pittsburgh, Pa v. U.S. Liquids, Inc.* [88 Fed. Appx. 725 (5th Cir. 2004)], the insured, a provider of waste management services, was sued in a consolidated securities class action lawsuit and a shareholder derivative suit. The plaintiffs alleged that U.S. Liquids had acquired smaller companies without regard to or disclosure of those companies' improper waste disposal practices, and that it failed to implement regulatory controls in the purchased companies while actively concealing its misdeeds. U.S. Liquids argued that the pollution exclusion clause in its D&O policy did not apply to certain allegations, including the allegations of misrepresentations. The court disagreed, finding that all of the allegations in the case emanated from the alleged pollution and therefore the pollution exclusion clause defeated coverage for the entire lawsuit [see also J. Wylie Donald & Loly Garcia Tor, *Climate Change and the D&O Pollution Exclusion*, 41 Tort Trial & Ins. Practice L. J. 4 (Summer 2006) (extensive discussion of the *Owens Corning* and *U.S. Liquids* decisions)].

Since these decisions were rendered, many D&O pollution exclusion clauses now explicitly address the issue of whether they apply to Securities Claims. In the example above, the clause clearly states that it does apply to Securities Claims. But many D&O insurers now provide language carving out Securities Claims from the pollution exclusion clause. Such language can make the critical difference with respect to coverage for global warming claims under a D&O policy. As discussed above, most companies (at least public ones) have D&O entity coverage only for Securities Claims anyway, and directors and officers are not likely to have global warming claims made against them except by shareholders. By negotiating a pollution exclusion carve-out for Securities Claims in their D&O policies, companies can obtain important protection for their directors and officers as well as for the companies themselves.

Pollution exclusion clauses in D&O policies also may contain a carve-out for non-indemnifiable claims against officers and directors, i.e. Side A claims. This protection is likely to be particularly important for derivative suits, since the company may not indemnify officers or directors for settlement payments or judgments that are for the benefit of the company.

Another way to avoid the effect of the pollution exclusion on D&O coverage for global warming claims is to purchase a policy without a pollution exclusion clause. This probably is not an option for a comprehensive D&O policy with Side A, Side B, and entity coverage, in which pollution exclusions are standard. But D&O insurers commonly do now offer stand-alone Side A difference in conditions policies without a pollution exclusion clause. These will cover officers and directors (but not the company) to the extent that they are not indemnified by the company for claims against them relating to global warming. Accordingly, for companies concerned about protecting their directors and officers from global warming claims, a stand-alone Side A policy may provide an additional layer of protection.

Property Damage and Bodily Injury Exclusion. Another standard exclusion in D&O policies is the exclusion for property damage and bodily injury. Though the language of this exclusion varies by policy, one example is as follows: The insurer shall not be liable to make payment for Loss in connection with any Claim for bodily injury, sickness,

disease, death, or for damage to, destruction of, or loss of use of any tangible property. Depending on the particular facts and the policy language involved, this exclusion could limit coverage for global warming claims under a D&O policy, though this is not likely.

Unlike the pollution exclusion, which usually employs broad language excluding claims based upon, arising from, or in any way related to pollution (as in the example above), the property damage and bodily injury exclusion typically excludes claims for bodily injury or property damage. This limits the scope of the exclusion and likely makes the exclusion inapplicable to shareholder class actions and derivative actions arising from global warming issues. Class action plaintiffs sue for their stock losses, not bodily injury or property damage. Derivative plaintiffs sue on behalf of the company for losses to the company, which is not bodily injury and is unlikely to be property damage. Accordingly, if the narrow for language is not already in the bodily injury and property damage exclusion, companies should negotiate for this language.

Other types of global warming claims conceivably could involve property damage or bodily injury, because plaintiffs could allege the effects of global warming may have implications for both (e.g., flooding, hurricanes, or loss of coastline). However, as discussed above, such tort-based claims by third parties are not likely to be made against the officers and directors of a company under current U.S. law, as they generally do not owe duties to third parties. Regulatory actions against officers and directors for bodily injury or property damage (as opposed to for inadequate disclosures) may be somewhat more likely, though still not probable. Companies concerned about the risk to their officers and directors should explore the purchase of a stand-alone Side A policy that either does not have a property damage and bodily injury exclusion, or has one that carves out global warming claims.

With regard to global warming claims against the company itself, most public companies and many private ones will not be affected by the property damage and bodily injury exclusion, because they will only have entity coverage for Securities Claims. For those companies that have broader entity coverage, a global warming claim alleging property damage or bodily injury possibly could be excluded from coverage, at least in part. In those circumstances, the company should check its policy to see if there is an allocation clause, as it may have an argument for partial coverage if the claim contains allegations that go beyond property damage or bodily injury.

Retroactive Dates, Related Claims and Potential Claims. As discussed above, D&O policies almost always are claims-made policies, so that coverage is triggered when the claim is made, not when the allegedly wrongful conduct took place. However, D&O policies sometimes also have provisions excluding coverage for claims based on conduct occurring prior to a specified date, or for claims related to other claims pending prior to a specified date. Such provisions could potentially preclude coverage for global warming claims.

Typically, where a D&O policy contains an exclusion based on conduct occurring prior to a specified date, the specified date will be at least several years prior to the inception of the policy, often beyond the statute of limitations of most potential claims. Global warming claims conceivably could present special problems in this area, because they may be based on alleged corporate conduct spanning a long period of time going back many years. On the other hand, Securities Claims based on global warming the type of Claim most likely to be covered by a D&O policy in any event are likely to be more temporally limited, for at least two reasons. First, plaintiffs allegations of knowingly or recklessly wrongful conduct will be stronger if based on conduct occurring after the body of scientific evidence related to global warming had been accumulated and the issue was firmly in the public consciousness. Second, shareholder class actions are likely to be more problematic if the alleged class period is too long. Nevertheless, companies should pay close attention to retroactive dates, and the possible effects on global warming claims, when purchasing their policies.

Policies may also contain exclusions for claims related to other claims that were made or pending prior to a specified date. In fact, even without such specific exclusions, policies normally will cover only Claims first made during the Policy Period, and will exclude Claims related to other Claims first made prior to the Policy Period. For example, if a securities class action was filed in 2005 alleging certain misrepresentations, it may be covered by whatever insurance policy was in effect that time. But if another securities class action is filed two years later during a later Policy Period, it

may be excluded from coverage under that later policy if it is deemed to be related to the first claim. (While it could be covered under the previous policy, the previous policy may have depleted limits or less favorable terms.) Depending on the facts, the question of when two claims are related may be difficult to resolve, and it is an issue that has spawned much litigation [*see, e.g., Highwood Props. Inc. v. Executive Risk Indem., Inc.*, 407 F.3d 917, 924 (8th Cir. 2005) (holding that the concept of relatedness is not ambiguous if the facts of the case comfortably fit within the commonly accepted definition of the concept, but is ambiguous if the facts are close to the margins)].

Because there are very few global warming claims at this time, this may not be a significant issue at present. But companies and their directors and officers should keep it in mind for the future. In particular, companies should be alert to regulatory actions that may, several years later, give rise to lawsuits or other Claims. Where possible, companies should negotiate for policy language that will not broadly exclude future claims. And where potential Claims do seem likely to be excluded under a future policy, a company may wish to park a potential Claim in its current policy by providing a notice of circumstances. Most D&O policies allow insureds to report specific circumstances that may give rise to a Claim, and then if a Claim later arises out of those circumstances, it will be considered to have been made at the time of the initial reporting.

Accordingly, if a company is aware of circumstances that may give rise to a global warming claim for example, a regulatory inquiry or a letter threatening litigation there may be tactical advantages to reporting them to its D&O insurance carrier. This is especially true if D&O carriers require more global warming-related disclosures in connection with policy applications and renewals. If a company is required to disclose information pertaining to potential global warming claims in connection with a renewal or the purchase of new insurance, its insurer may attempt to exclude future coverage of such potential claims. In these instances, the company may need to report the potential claim to its current insurer in order to avoid a gap in coverage.

Conclusion

Global warming represents a new risk management issue for companies and their management. The actions of directors and officers in managing and disclosing global warming risks likely will face increased scrutiny in the coming years, resulting in new claims against them. D&O insurance, the main purpose of which is to protect directors and officers from personal loss resulting from their service to a company, may provide important protection for officers and directors (and in some cases companies themselves) in the event of global warming claims against them. In particular, securities class actions and derivative suits are the most likely kinds of global warming claims to be made against officers and directors, and also the most likely to be covered by D&O insurance. However, there are potentially serious coverage issues applicable to global warming claims, in particular a pollution exclusion clause that is common in D&O policies. Many D&O policy terms are negotiable, and companies should try to negotiate for D&O policy language that will maximize the chances of coverage should a global warming claim be made. Carving out securities class actions and derivative claims from the pollution exclusion would be particularly important. Purchasing a stand-alone Side A policy without a pollution exclusion clause would provide an additional layer of protection.

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Manning on NJs Limitation of First Filed Doctrine In Insurance Coverage Cases

2008 Emerging Issues 2313

Slowing The Race To The Courthouse: Diana C. Manning On New Jerseys Recent Limitation of The First Filed Doctrine In Insurance Coverage Cases

By Diana C. Manning

May 15, 2008

SUMMARY: Forum selection is a primary consideration when commencing any civil action. In early 2008, New Jersey courts emphasized the importance of analyzing the special equities when determining the proper forum for a coverage action in two cases. These recent New Jersey Supreme Court decisions serve as a warning that New Jersey courts will not afford deference to first filed actions where strategic tactics dictate choice of forum.

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Forum selection is a primary consideration when commencing any civil action. In the past, coverage counsel could reasonably rely on the presumption that the forum of the first filed action would be favored over that of a later filed action in a different jurisdiction involving substantially similar issues and parties. In early 2008, however, New Jersey courts emphasized the importance of analyzing the special equities when determining the proper forum for a coverage action on two separate occasions. The New Jersey Supreme Court decision in *Sensient Colors, Inc. v. Allstate Ins. Co., et al.*, 193 N.J. 373 (2008) and the Appellate Division decision in *Century Indemnity Co. v. Mine Safety Appliances Co., et al.*, 398 N.J. Super. 422 (App. Div. 2008) serve as a warning that New Jersey courts will not afford deference to first filed actions where transparent strategic tactics dictated the choice of forum, and the second jurisdiction bears a more significant relationship to the issues at hand. Most importantly, such forum jockeying may implicate the insurers duty of good faith.

The First Filed Doctrine. New Jersey recognizes as a general rule that the court which first acquires jurisdiction has precedence in the absence of special equities. *Sensient Colors*, 193 N.J. at 386 (citing *Yancoskie v. Del. River Port Auth.*, 78 N.J. 321 (1978)). [A] New Jersey state court ordinarily will stay or dismiss a civil action in deference to an already pending, substantially similar lawsuit in another state, unless compelling reasons dictate that it retain jurisdiction. *Id.* (citing *OLoughlin v. OLoughlin*, 6 N.J. 321 (1951)). Despite this presumption, both the *Sensient Colors* and *Mine Safety* Courts emphasized the special equities component when rejecting the insurers first-filed choice of forum. Importantly, both Courts frowned on an insurers preemptive strike to gain application of more favorable law.

Sensient Colors, Inc. v. Allstate Ins. Co., et al. *Sensient Colors* involved a dispute over coverage for environmental liabilities stemming from a polluted property located in the city of Camden, New Jersey. After providing a defense under a reservation of rights, Sensients primary insurer without warning filed suit in New York, thereby denying Sensient the opportunity to select its own forum for resolving the coverage dispute. *Sensient Colors*, 193 N.J. at 393. Soon thereafter, the policyholder filed a similarly styled action in the New Jersey Superior Court, Camden County.

The New Jersey trial court dismissed the policyholders second-filed action and the Appellate Division reversed. The New Jersey Supreme Court affirmed the Appellate Division and held that the trial court abused its discretion by failing to properly consider the special equities favoring New Jerseys retention of jurisdiction over the second filed action. The Supreme Court clarified the rule in considering a comity stay or dismissal:

[A] party moving for a comity stay or dismissal must show that there is a first-filed action in another jurisdiction involving substantially the same parties, claims, and legal issues as the action in this state. Once that is established, the party proposing a stay or dismissal must demonstrate the presence of one or more special equities that overcome the presumption favoring the first-filed action.

Id. at 393. Despite this presumption, the special equities favored the second-filed New Jersey action.

Paramount to the Supreme Courts analysis was New Jerseys strong public policy interest in the remediation of environmental contamination within its borders. *Id.* at 394. While recognizing that choice of forum does not dictate the applicable choice of law, the Supreme Court expressed concern regarding the application of New York law to the New Jersey site issues because of the likelihood that New York law would recognize the pollution exclusion contained in many of the policies. New Jersey does not enforce a pollution exclusion applicable to accidental or unintentional pollution. The Supreme Court stated that it was certain that a New Jersey court will apply the laws of this state because New Jerseys laws favor making insurance proceeds available for remediating environmental contamination and compensating the victims of such contamination. *Id.* at 396. Interestingly, the Court seemed to disapprove the insurers jockeying for the more hospitable insurance laws of New York in selecting the forum for its action. *Id.* at 396.

Century Indemnity Co. v. Mine Safety Appliances Co. In *Century Indemnity Co. v. Mine Safety Appliances Co.*, 398 N.J. Super. 422 (App. Div. 2008), the Appellate Division applied the *Sensient Colors* holding in dismissing a first-filed New Jersey action in favor of a later filed Pennsylvania action, both related to the policyholders asbestos related liabilities. Though the Court recognized that the policy interest in remediating contaminated properties was not implicated, and comity was not directly in issue because the Court was considering dismissal of the first-filed action, the Court applied the *Sensient Colors* analysis because it provided a useful framework for analysis of a circumstance in which two competing actions are pending, and a court is called upon to determine which should prevail. *Id.* At 428.

In *Mine Safety*, the forum choice appeared to be driven by the insurers desire to gain application of more favorable law. The insurer sought application of the modified pro rata allocation methodology recognized in *Owens-Illinois, Inc. v. United Ins. Co.*, 138 N.J. 437 (1994), over Pennsylvanias joint and several approach to allocation. *Mine Safety*, 398 N.J. Super. At 428-29. Pennsylvania law also imposed a joinder requirement that would require the insurer to implead the 23,000 underlying asbestos claimants in order to proceed with a declaratory judgment claim. *Id.* At 429. See *Vale Chemical Co. v. Hartford Accid. & Indem. Co.*, 516 A.2d 684 (Pa. 1986). Given these issues, the Court held that a choice of law determination was critical to determining the similarity of the competing actions. If New Jersey allocation law applied, the Pennsylvania action, which under the applicable joinder rules could not proceed as a declaratory judgment action, would not provide the insurer adequate relief. After finding it likely that Pennsylvania law would apply based on a place of contracting analysis because both the insurer and policyholder were incorporated and had their principal place of business in Pennsylvania, the Court held that it [was] reasonable to assume for purposes of determining the adequacy of Pennsylvania as a forum, that no greater relief would be afforded to [the insurer] here than will be afforded in the Pennsylvania action. *Id.* At 437.

Most significant for purposes of forum selection was the Courts disapproval of the insurers preemptive action in the

race to the courthouse. The insurers New Jersey action was filed contemporaneously with a breakdown in cost sharing negotiations, and in response to the policyholders tender of its defense under Pennsylvanias joint and several allocation methodology. Under these circumstances, the Court considered the insurers unseemly haste to establish jurisdiction in a state with which the parties had no relevant contact, but one whose law favors the insurers position. *Id.* At 438-39. The Court emphasized cases in other states dismiss[ing] first-filed preemptory declaratory judgment actions instituted to obtain a forum advantage, so as to permit the natural plaintiffs action to proceed in the plaintiffs chosen court. *Id.* At 438.

Analysis. Both the *Sensient Colors* and *Mine Safety* decisions affirmed the presumption that under principles of comity, the first court to obtain jurisdiction is ordinarily the court to retain jurisdiction. Significant to the insurance coverage practitioner, however, is New Jerseys emphasis on the policyholders choice of forum, and the parties strategic choices in selecting the initial forum.

Indeed, the *Mine Safety* Court expressly referenced decisions permitting the natural plaintiff to proceed in its chosen forum, regardless of whether its action was first filed. *Mine Safety*, 398 N.J. Super. at 438. The *Sensient Colors* Court described the insurers preemptive declaratory judgment action as a strategy designed to deny *Sensient* the opportunity to select its own forum for resolving the coverage dispute. *Sensient Colors*, 193 N.J. at 393. Significantly the preemptive action was mentioned contemporaneously with the Courts citation to the insurers duty to act in good faith with its insured. *Id.* at 393-94 (citing *Pickett v. Lloyds*, 131 N.J. 457 (1993)). While the Court did not engage in any bad faith analysis, its citation to *Pickett* and reference to the duty of good faith highlights yet another important consideration for the practitioner when counseling insurers on the selection of a judicial forum to resolve coverage issues.

Given these recent rulings, the practitioner is cautioned to carefully evaluate a cases connection to the chosen forum. While the first-filed rule remains a rebuttable presumption, both the *Sensient Colors* and *Mine Safety* decisions signal a willingness to find special equities to rebut this presumption where the first-filed action can be characterized as an insurers attempt to avail itself of a more favorable jurisdiction with little connection to the actual controversy at issue. While the costs in battling over the proper forum are certainly significant, the implication of an insurers duty to act in good faith when selecting a judicial forum could raise the stakes even higher. This issue should be of paramount concern to those practitioners representing insurers contemplating the filing of a declaratory judgment action.

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Chandler on Florida Statute § 627.0628: Regulating Insurance for Hurricanes

2008 Emerging Issues 2307

Chandler on Florida Statute § 627.0628: Regulating Insurance for Hurricanes

By Seth J. Chandler

May 15, 2008

SUMMARY: Florida has been understandably on the forefront of the critical issue of how to assess the validity of hurricane modeling. In theory, creation of an approved public model as has occurred under Florida Statute section 627.0628. There is the possibility that the public model, which essentially discounts the effects of global warming, will come to displace rather than supplement or bound private efforts.

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ARTICLE: An issue that will arise with heightened salience if global warming continues to increase the frequency of hurricanes hitting the American coasts is how to assess rates charged by insurers covering windstorm loss. Rates that are too low lead to irresponsible insurers snapping up business but becoming insolvent when the time to pay the bills come dues. The result can be anti-insurance under which people end up transferring their wealth from possible futures in which bad things happen to possible futures in which good things happen. Rates that are too high lead to the amassing of war chests hurt economic development and are particularly burdensome for the poor.

But how is a regulator to tell? Reviewing life insurance rates or auto property claims is not particularly difficult. Regulators and actuaries have access to reams of statistics validated over many years and there is little risk of major change in the relevant risks. Particularly with the uncertainties surrounding global warming, however, modeling of the sort needed to determine a fair premium with any modicum of precision is very much a dark art. It is art, in the sense that no one really knows for sure the future of our terrestrial climate, particularly when one attempts to predict the effects of warming in particular parts of the earth. It is dark in the sense that those who have a clue are understandably reluctant to release the details of their methodologies. Magicians, after all, never tell, not because they are mean but because their tricks are their intellectual property.

Fla. Stat. Part I represents one resolution of this issue, but one likely to cause difficulties for the private insurance market in Florida and, potentially, for Floridas financial solvency. Fla. Stat. § 627.0628 establishes a government body, the Florida Commission on Hurricane Loss Methodology (FCHLM) composed of the state insurance consumer advocate, five government officials and five faculty from Floridas state university system selected by the Chief Financial Officer of the Florida State Board of Administration. The commission has at least two major tasks: reviewing the actuarial methodologies employed by insurance companies setting rates involving windstorm risk and evaluating a public model, which serves as the floor for the rates of Citizens Property Insurance Corporation, the statutory body

created in 2002 under Fla. Stat. § 627.351(6) that has become the largest property insurer in Florida with more than one million policyholders.

The Florida regulatory scheme draws a distinction in the handling of trade secret or proprietary data and algorithms between proceedings before the Commission to determine the reliability of various computer models used in private industry and review of proposed insurance premiums based on those models. Under Fla. Stat. § 627.0628(3)(e), documentary and testimonial submissions to the FCHLM that would disclose trade secrets used in designing and constructing a hurricane loss model are exempt from the various open meeting and sunshine rules that would otherwise apply. But the secrecy lasts only so long. Under the second sentence of Fla. Stat. § 627.0628(3)(c), findings made by FCHLM pursuant to these hearings are admissible and relevant in consideration of a rate filing by the office or in any arbitration or administrative or judicial review only if the office and the consumer advocate appointed pursuant to Fla. Stat. § 627.0613 have access to all of the assumptions and factors that were used in developing the actuarial methods, principles, standards, models, or output ranges, and are not precluded from disclosing such information in a rate proceeding.

The insurance industry protests that this second provision guts both trade secret protection and, derivatively, use of private models. Private modelers, they say, demand genuine trade secret status for the intellectual property in their work that does not disappear the minute there is controversy. Moreover, they say that the statute ends up making it difficult for Florida insurers to reinsure their losses reinsurance that is needed to diversify the risk pool and necessary if smaller insurers with local expertise are to have any chance of doing business in Florida. The reinsurers, many of whom are not directly subject to the jurisdiction of the Florida Office of Insurance Regulation, use these same private models. So, if the reinsurers are pricing policies on the basis of models that can not be revealed and that demand a higher premium than those based on approved models, private insurance basically does not work.

Supporters of the provision say with some justification that review of catastrophe models without access to the devilish details is largely meaningless. Some even question whether the reluctance to provide data is due to their own models lack of support for the rates sought.

The second task of the FHCLM, superintending development of a public model pursuant to is presumably an answer to this dilemma. In 2001, the Florida Office of Insurance Regulation requested development of a public hurricane model to be developed by a team led by Florida International University. Although some submissions to the team would be proprietary, its work and outputs would not be. After several years of work, the team delivered models in 2005 and 2006, but and this appears largely to be a source of some controversy relied on historic data contained in the HURDAT data set from 1900-2003 to determine hurricane landfall frequency and intensity. Thus, although the data set contained some of the high intensity years during the early twentieth century it basically ignored the view of many scientists that global warming had mooted out the relevance of that data. It also apparently disregarded HURDAT data from the 1880s and 1890s, a period of high hurricane intensity in the United States.

FHCLM approved the public model for use in August 2007. Certain aspects of the model such as the damage model were supported by experience with Hurricane Wilma, but the more difficult issue of assessing the validity of frequency and intensity of hurricanes in light of global warming has not been (and realistically can not be) supported by just a few years experience. The problem is not unlike that of predicting performance in sports: is the performance of an athlete to be measured more by recent events or more by a long track record where one has reason to believe but isn't certain, after all that a the athletes performance is declining? Under Fla. Stat. § 627.0628(1)(c), once approved by the FHCLM, insurers in Florida appear to be able to use the public model to justify rate filings.

Florida has been understandably on the forefront of the critical issue of how to assess the validity of hurricane modeling. In theory, creation of a public model as competition for private models is a sensible response to the problems of assessing private models. Whether Floridas choice to disregard global warming and to largely displace private models is a wise one, however, remains to be seen. As all readers of the Harry Potter series know, Defense Against the Dark Arts is a treacherous subject.

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Ossyra on TIG Insurance Co. v. Aon Re, Inc.,

2008 Emerging Issues 2302

Ossyra on TIG Insurance Co. v. Aon Re, Inc., No. 05-11450, 2008 U.S. App. LEXIS 5482 (5th Cir. 2008): Statute of Limitations Issues In Long Developing Reinsurance Disputes

By James D. Ossyra

May 12, 2008

SUMMARY: The statute of limitations is a much litigated issue, particularly where a claim takes a long time to develop, as is often the case in reinsurance related disputes. The law in this area varies in both theory and application from state to state. This case illustrates if an aggrieved party waits for the case to fully develop, the limitations period may pass, and the claim lost, before that party is even aware of the scope of its harm.

PDF LINK: [Click Here for Enhanced PDF of Commentary](#)

ARTICLE: Application of the statute of limitations can be a uniquely local (and difficult) issue, and accordingly, it can be a devastating trap for the unwary practitioner or plaintiff client, or a golden opportunity for the astute defendant. Statutes of limitations are a black and white issue; if a claim is filed after the limitations period has run, it is subject to early and likely complete dismissal. The case of *TIG Insurance Co. v. Aon Re, Inc., No. 05-11450, 2008 U.S. App. LEXIS 5482 (5th Cir. 2008)* provides a perfect example.

The primary issue in application of a statute of limitations is determining the date on which the limitations period begins to run. This issue is often case-dispositive. In some areas of commercial law, such as a reinsurance-related dispute, where a claimed wrong may be a long time developing, a misstep in this analysis can be fatal. In *TIG v. Aon*, it would be fair to say, plaintiff lost its claim before it even knew it had it, because of the application of the unique Texas rule on determining the trigger date for the limitations period.

In *TIG v. Aon, Texas Law on Statute of Limitations Prevented TIG From Pursuing a Seeming Legitimate Claim*. The genesis of *TIG v. Aon* was a prior arbitration between TIG, as an insurer/cedent, and U.S. Life, its reinsurer. U.S. Life sued TIG for rescission of its reinsurance agreement with TIG because Aon, TIGs agent, failed to provide loss information on a substantial book of business before U.S. Life agreed to the reinsurance. U.S. Life won its case and was awarded rescission by the arbitrators. The faulty disclosure took place when the reinsurance agreement was entered into in 1998, the arbitration was filed in late 2002 or early 2003, and it was decided in May 2004. TIG promptly thereafter (in 2004) brought suit against Aon for its breach of duty and negligence in failing to make proper disclosures on TIGs behalf. Aon moved to dismiss that case on the grounds that the applicable two and four year statutes of limitations in Texas (the governing jurisdiction) had run. Although TIG claimed it did not know of Aons malfeasance until U.S. Life brought it up in the arbitration, the District Court granted Aons motion and dismissed TIGs claim. TIG appealed.

The Fifth Circuits decision hinged on the discovery rule. That rule will toll the running of the limitations period until the plaintiff knew or, exercising reasonable diligence, should have known of the facts giving rise to the cause of action. *Id.*, 2008 U. S. App. LEXIS 5482 at *15. Needless to say, whenever the fact pattern extends over a long period of time, as is often the case in reinsurance disputes, this rule presents either a serious problem or opportunity.

In *TIG v. Aon*, the Court applied Texass variation of the rule, relying on *Murphy v. Campbell*, 964 S.W. 2d 265 (Tex. 1997). TIG said the rule applied to toll the statute until the arbitration revealed the problem with Aons disclosures. However, in Texas, the discovery rule is applied objectively and categorically, *i.e.*, the particular knowledge or circumstances of the plaintiff is irrelevant. In Texas, the court must apply a two-pronged analysis of whether the nature of the injury [is] inherently undiscoverable, and whether the injury itself [is] objectively verifiable. *TIG v. Aon*, 2008 U.S. App. LEXIS 5482 at *16. Unless those two questions can be answered in the affirmative, the discovery rule would not apply, and the cause of action accrues and the limitations period begins to run when the alleged wrong has caused a legal injury, however slight. *Id.* at *12. The Court found that Aons failure caused legal injury when the faulty disclosures were made, because that non-disclosure gave U.S. Life a right of rescission at that very moment. Because TIG *could* have reasonably discovered Aons failure to pass on the loss information (*i.e.*, it was not inherently undiscoverable), which failure occurred more than even four years prior to its bringing suit against Aon, TIG could not take advantage of the discovery rule and lost the case.

Other Jurisdictions Handle the Discovery Rule Differently. One particular problem that practitioners and their clients face with the discovery rule is that the formulation, and its application, can vary from state to state. Contrast Texass formulation of the discovery rule with some other important insurance and reinsurance jurisdictions.

Consider the case of *Hermitage Corp. v. Contractors Adjustment Co.*, 166 Ill. 2d 72 (1995), out of the Illinois Supreme Court. That case is very closely analogous to *TIG v. Aon*, but reaches a contrary conclusion. In *Hermitage Corp.*, plaintiff had hired the defendant to prepare and file a mechanics lien (much like TIG hired Aon to submit its loss data). The mechanics lien was faulty, and some years later, after Hermitages lien claims were substantially reduced in litigation over their validity, Hermitage sued defendant Contractors Adjustment for negligence. Contractors Adjustment moved to dismiss on statute of limitations grounds. The circuit court denied the motion but certified the question to the court of appeals. The appellate court reversed, followed the reasoning that was used in *TIG v. Aon*, and dismissed all claims on statute of limitation grounds on the theory that the statute was triggered when the faulty lien was filed. The Illinois Supreme Court however, reversed the appellate court, and found, under its interpretation of the discovery rule, that the limitation period was only triggered when the court had decided that the lien was faulty, some years after it was originally filed. The court applied a generous standard that when a party knows or reasonably should know both that an injury has occurred and that it was wrongfully caused, it must inquire as to its legal remedy, and therefore the statute is triggered at that point. *Id.*, 166 Ill. 2d at 86. The Illinois Supreme Court allowed the claim to proceed (a strong dissent would have followed the theory of cases like *TIG v. Aon*) reasoning that the plaintiff could not have known that its injury was wrongfully caused until the lien was challenged. Accordingly, turning back to *TIG v. Aon*, if TIG had filed its case against Aon in Illinois, it might well have won its limitations argument.

To complicate matters further, some jurisdictions have decided the tolling question legislatively. New York is a case in point. There, the New York legislature has determined that, absent specific situations set out in the statute itself, the limitations period cannot be tolled by date of discovery principles, adopting a strict standard of accrual of a cause of action when all the facts necessary to the cause of action have occurred and an injured party can obtain relief in court. *McCoy v. Feinman*, 99 N.Y. 2d 295, 301 (2002), quoting *Ackerman v. Price Waterhouse*, 84 N.Y. 2d 535, 541 (1994). See N.Y. C.P.L.R. 201. While taking a slightly different approach, New York thus applies a rule like Texas, where accrual time is measured from the day an actionable injury occurs, even if the aggrieved party is then ignorant of the wrong or injury. *McCoy*, 99 N.Y. 2d at 301.

Florida has a similar statutory scheme. Florida has set out the specific situations when tolling might apply, such as evading service of process, adjudicated incapacity of the plaintiff, or partial payment on a written instrument. Fla. Stat. § 95.051. If the situation is not on the list, then the courts are prohibited from extending the period for filing a claim

beyond the limitations period. Fla. Stat. § 95.051(2). Florida courts will, though, analyze when a cause of action accrues initially, and might apply the delayed discovery doctrine to the analysis. See *Hearndon v. Graham*, 767 So. 2d 1179 (Fla. 2000) (holding that the possibility of repressed memory syndrome was such that it could not grant a motion to dismiss a sexual abuse complaint on statute of limitations grounds, and if the syndrome was ultimately proven, then agreeing that the cause of action would not have accrued until the memory was recovered).

In fact, as the Florida case law indicates, a limitations period can be delayed not just by tolling it after an action accrues, but by delaying the accrual altogether. See *Peat, Marwick, Mitchell v. Lane*, 565 So. 2d 1323 (Fla. 1990). In *Peat, Marwick*, the court defined a professional malpractice action to include redressable harm, which in Florida apparently means a defined injury, not just a possible injury based on breach of a duty or contractual right, as in *TIG v. Aon*. *Peat, Marwick*, 565 So. 2d at 1325-27 (action for accountant malpractice accrued when tax court entered judgment against plaintiff, not when the IRS deficiency notice was received).

Evaluation of The Statute of Limitations Must Be Thorough and Come Early In the Process. The long and short of statute of limitations analysis is that it needs to be looked at immediately upon any inkling of a redressable wrong. Further, the lesson of *TIG v. Aon* is that where a wrong has occurred, even if that wrong is nascent, all avenues of recovery must be promptly evaluated with statute of limitations issues firmly in mind. While a cost-conscious approach might lead to putting off an investigation until the real harm is developed, that can be fatal. And, a cursory review to determine the applicable limitation period is clearly not enough; concepts of tolling and accrual can have dramatic impacts on the analysis. *TIG v. Aon* is a clear example. Cases from other jurisdictions illustrate the issue as well. See *Queensway Financial Holdings Ltd., et al. v. Cotton & Allen, P.S.C.*, 237 S.W. 3d 141 (Ky. 2007) (applying an analysis much like *TIG v. Aon*). Some states have rejected a lenient discovery rule outright. See *Antone v. Morriss*, 720 N.W.2d 331 (Minn. 2006). Thus, the jurisdiction in which the dispute is to be decided is also extremely important. A long-tail commercial dispute, like the reinsurance brokers negligence alleged in *TIG v. Aon*, might find a more plaintiff-friendly forum, at least on this particular issue, in jurisdictions like Illinois, instead of Texas.

ABOUT THE AUTHOR(S):

James D. Ossyra is a partner in Foleys General Commercial Litigation and Insurance and Reinsurance Litigation Practices, as well as its Insurance Industry Team. Mr. Ossyra has worked in all areas of complex commercial dispute resolution, primarily in litigation matters in courts throughout the United States. He focuses on reinsurance matters and construction and real estate workouts, and has extensive experience in commercial fraud and other business torts and breach of duty or contract. Mr. Ossyra has experience in all aspects of dispute resolution -- from the initial filing of an action in the courts through the trial and appeal. His experience also includes work on complex negotiated settlements, representation of clients in contested arbitration proceedings, and mediations. Mr. Ossyra has substantial trial experience. Recent cases include a major reinsurance dispute that ultimately resulted in a three-week trial in the federal court in Kansas City, Kansas, and a contentious commercial dispute over a software development contract that resulted in a two-week arbitration in Chicago. A member of the Litigation Section of the American Bar Association and a member of the Chicago Bar Association, Mr. Ossyra is also president and board member of the Evanston Township High School Alumni Association. Mr. Ossyra received his law degree from Boston University (J.D., magna cum laude, 1983) and his undergraduate degree from Harvard University (B.A., cum laude, 1978). He is admitted to practice in Illinois and Colorado and before the U.S. District Court for the Northern District of Illinois, the Court of Appeals for the Fourth and Seventh Circuits, and the U.S. Supreme Court. He is a member of the Trial Bar for the U.S. District Court for the Northern District of Illinois.

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Financial Guaranty Insurance and the Subprime Crisis

2008 Emerging Issues 272

Gkonos and Cawley on Financial Guaranty and the Subprime Crisis

By James Gkonos and Mark Cawley

May 8, 2008

SUMMARY: In their analysis of financial guaranty insurance and the current subprime crisis, authors James S. Gkonos and Mark C. Cawley describe the nature of financial guaranty insurance and trace its history from its roots in suretyship, through the founding of monoline insurance companies dedicated solely to financial guaranty insurance, to the current regulatory regime. The commentary details the state statutes or regulations specifically tailored to the financial guaranty industry and describes basic regulatory principles common to these statutes. The commentary also explores the crisis facing the financial guaranty industry, the roots of that crisis in the subprime mortgage meltdown, and proposals floated by various federal and state officials to adapt the regulatory scheme to the problems highlighted by the subprime crisis and the possibility of additional regulatory restrictions on the activities of financial guaranty companies.

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ARTICLE: Financial Guaranty Insurance and The Subprime Crisis:

The Current State of the Industry and Challenges for the Future

By James S. Gkonos and Mark C. Cawley

INTRODUCTION

Financial guarantees are not new products. Since the inception of suretyship, sureties have been guaranteeing debts. Historically, early sureties were individuals, who guaranteed debts through provision of collateral or directly guaranteeing the underlying debt. Even with the advent of surety companies, various forms of financial guarantees were considered part of the normal lines of business of sureties. Lease bonds, deposit guaranty bonds, appeal bonds, bonds that guaranteed savings from the installation of equipment, commercial bonds that agreed to pay a liquidated amount considered to be the damages resulting from failure to perform, and other bonds referred to as miscellaneous bonds all guaranteed financial obligations.

In the 1970s and 1980s the growth of the financial guaranty business virtually exploded as the capital markets grew dramatically and insurance companies saw significant opportunities to profit from the guarantee of capital markets transactions. Monoline companies (those with only a single line of business) existed, such as Ambac Assurance Corp.

(Ambac) and MBIA Insurance Corporation (MBIA), but their design was a result of their chosen business model rather than any regulatory requirement. Both monoline and multiline companies were, and continue to be, involved in the business of providing financial guarantees. For much of this period, capital markets participants also saw insurers as attractive credit support providers because many had superior credit ratings and premiums were significantly cheaper than letters of credit and other collateral because of the lower capital adequacy requirements imposed by the regulators and rating agencies.

In 1989, New York enacted the first statutory provisions that mandated the separation of financial guarantee insurance from traditional surety products and required that companies licensed in New York issuing such insurance be separately licensed. More importantly, the New York statutory provisions prohibited (with certain exceptions) multiline insurers from issuing financial guarantee insurance and placed significant capital adequacy and risk limitation requirements on the monoline companies. The National Association of Insurance Commissioners (NAIC), the New York legislature and ultimately other states imposed these requirements because they felt that financial guarantees involved low-frequency, high-severity risks in areas that multiline insurance companies lacked experience and training. n1 The NAIC and these legislatures believed that consumers of traditional insurance products, such as auto, property, and casualty, should not be exposed to the effects of the high-severity nature of risks associated with financial guarantees. n2 The legislatures also believed that the high severity nature of these risks required higher capital retentions to avoid the potential that a single loss could affect the solvency of such companies. n3 Further, they recognized, particularly with credit enhanced transactions, because the pricing was linked to the interest savings by the capital markets sellers, that the less experienced insurer was betting against the markets, or was relying on the law of large numbers. n4 As a result, greater regulation of the business was thought to be desirable. Approximately 14 companies have become licensed as monoline companies in New York. Since the enactment in 1989 of the New York laws, several other states have enacted similar laws or regulations.

The recent events regarding subprime mortgages and their effects on the capital markets have vividly demonstrated the propriety of concerns regarding the potential for high severity losses and the need for greater capital adequacy. Unfortunately, the subprime crisis has also exposed an oversight in the legislative structure. The legislative focus on solvency ignored the effect that a mere downgrade of a bonding company's rating would have on the company itself and on important sectors of the capital markets. This commentary will provide some additional perspective on the current state of the regulation of financial guarantee insurance and the monoline companies. It will also address the current regulatory initiatives proposed in the wake of the subprime crisis.

WHAT IS FINANCIAL GUARANTY INSURANCE?

At its most basic level, financial guaranty insurance provides a guarantee, usually unconditional and irrevocable, that protects the holder of a financial obligation against the non-payment of principal and interest. Insurers who issue such coverage are sometimes referred to as monoline carriers because financial guaranty insurance is the only type of insurance they offer. On the other hand, multiline carriers, as discussed above, are generally prohibited from issuing financial guaranty insurance, but offer a variety of other lines such as, property and casualty, errors and omissions, automobile, and the like.

The use of monoline companies to issue financial guaranty insurance is a relatively new concept. The first financial guaranty companies, Ambac and MBIA, were founded in the early 1970s, initially guaranteeing the principal and interest on tax-exempt and taxable bonds issued primarily by states, political subdivisions, and various other public authorities and agencies. Since then, additional monoline carriers have entered the market and, over time, have expanded their business models to provide not only insurance for public debt but also credit support enhancement for other classes of business, such as swaps, hedges, asset-backed securities, and collateralized debt obligations.

Financial guaranty insurance plays a critical role in capital markets transactions. It benefits the debt issuer by increasing the credit worthiness of the debt. For example, if a AAA-rated financial guaranty company insures an A-rated municipality's bonds, the bond issuance acquires the credit-worthiness of the insurer regardless of the

municipalities underlying credit-rating. Such insurance increases the marketability of bonds issued by municipalities with sub-AAA ratings and makes it more likely that investors will invest in such debt, which in turn increases the availability of capital for public finance debt. The municipality obtains an additional benefit in that it can issue bonds at a lower interest rate that reflects the higher credit rating of the insurer and, in the process, save interest costs reflecting the difference in yield on an insured bond from that on the same bond if uninsured. This reduces the debt burden on such municipalities, which presumably is passed on to taxpayers in the form of lower taxes or increased services.

Investors benefit from financial guaranty insurance because it provides a safer investment, reduces price volatility related to changes in the issuers credit quality and increases loss protection in the event of default. Indeed, some investors are prohibited from owning sub-AAA debt (as in the case of some mutual funds) and, without financial guarantee insurance, could not invest in otherwise attractive public debt.

Monolines began expanding their business lines in the late 1990s and through the turn of the millennium by adding new products to their lines of business through the guarantee of credit derivatives and securitization products. Many financial guaranty companies expanded their business models from insuring municipal debt to insuring various credit derivative products--financial instruments whose price and value derives from the creditworthiness of the obligations of a third party. By 2006, the guarantee of credit derivative and asset backed securitization products comprised 40 percent of the revenue of the bond insurers. n5

Credit derivatives are bilateral contracts between a buyer and seller under which the seller sells protection against certain pre-agreed events occurring in relation to a third party, such as bankruptcy or default. Common credit derivatives include hedges and credit default swaps. A credit default swap is a bilateral contract, in which two counterparties agree to isolate and separately trade the credit risk of at least one third-party reference entity. The buyer of a credit swap receives credit protection. The seller guarantees the credit worthiness of the product and the payment of the losses that flow from a default or a drop in credit rating. Losses are often calculated through a marked to market formula that measures the changes in value of the reference entity on a present value basis.

Securitized products are typically debt obligations that are secured by cash flows from underlying collateral, such as mortgages, auto loans or credit card debt. The investor seeks certain minimum returns from its investment, which are to be obtained through the cash flows generated by the underlying collateral. Financial guaranty insurance assures that the cash flows necessary to obtain its required returns will be generated.

Collateralized debt obligations (CDOs) are constructed from a portfolio of fixed-income assets divided into different tranches of debt. The most senior tranches are rated AAA, while the lower tranches contain progressively lower-rated debt. Losses are applied in reverse order of seniority and junior tranches therefore offer higher interest rates to compensate for the added default risk. There are other more complicated products, commonly known as CDO-squareds, which are a type of CDO where the underlying portfolio includes tranches of other CDOs that may not have sold and have higher risks.

THE CURRENT REGULATORY REGIME

In theory, financial guaranty companies are subject to the laws and regulations of each state in which they are licensed or do business. In the majority of states, financial guaranty insurance is not a separate type of insurance. Instead, it is considered part of the surety line of business with no specific provisions relating to financial guarantees. Regulation of financial guaranty insurance is limited to a handful of states, specifically: California, Connecticut, Florida, Maryland, New York, and Wisconsin. Maryland is unique among these states in that it has promulgated regulations--rather than enacting a law--governing financial guaranty insurance. Each states law or regulation generally derives from the NAICs Model Financial Guaranty Insurance Act of 1986 and, for this reason, state regulatory schemes are substantially--but not completely--identical.

Of these states, New Yorks financial guaranty law is arguably the most influential. The simple reason is that the

majority of such insurers are incorporated there and/or are licensed to do business there. Currently, there are eight domestic financial guaranty insurers authorized to do business in New York (Berkshire Hathaway Assurance Co., Capital Markets Assurance Corp., CDC IXIS Financial Services, Inc., Financial Guaranty Insurance Co., Financial Security Assurance Inc., MBIA Insurance Corp., Radian Asset Assurance Co., and XL Capital Ltd.), and six foreign companies licensed to do business there (Assured Guaranty Corp., AMBAC Assurance Corp., Connie Lee Insurance Co., ACA Financial Guaranty Corp., MBIA Insurance Co. of Illinois, and FSA Insurance Co.).

New York's unique extraterritorial application of its insurance laws also guarantees the primacy of its financial guaranty statute. Although the New York Insurance Law does not purport to govern insurance written in another state and that has no connection to New York, section 1106(f) of the Law prohibits a foreign (*i.e.*, non-New York domiciled) insurer licensed in New York from doing outside of New York what it cannot do within New York. Stated differently, a foreign multi-line insurer that is permitted to write financial guaranty insurance in another state may not do so if it wishes to retain its New York license. In its effect, the scope of the New York Insurance Law is therefore quite broad and unabashed in its extraterritorial effect.

Common Regulatory Principles. Financial guaranty statutes share several regulatory principles in common. There are, however, significant differences among them as well. As an initial matter, two states--New York and California--prohibit multi-line insurance companies from writing financial guaranty insurance. ⁿ⁶ Florida-domiciled property and casualty insurers--assuming they meet certain stringent financial requirements--can issue financial guarantees in Florida. ⁿ⁷ A Florida-based property and casualty insurer, however, might place its New York license at risk if it chose to write financial guaranties in Florida.

As noted above, the rationale for these restrictions was in part the public policy concern that property/casualty and other types of insurers would use most of their surplus to write financial guaranty business to the detriment of providing other types of coverage, particularly in personal lines. Also a concern noted above, was the potentially large losses to which an insurer could be exposed in connection with the writing of financial guaranty business and its potential effect on an insurer's surplus and ability to pay claims in more traditional lines of coverage.

The applicable statutes broadly define financial guaranty insurance as any guaranty under which loss is payable, upon proof of occurrence of financial loss, to an insured as a result of any one of the following five events:

(1) a failure of any obligor on or issuer of any debt instrument or other monetary obligation . . . to pay when due to be paid . . . principal, interest, premium, dividend or purchase price of or on, or other amounts due or payable with respect to, such instrument or obligation, when such failure is the result of a financial default or insolvency or, provided that such payment source is investment grade, any other failure to make payment, regardless of whether such obligation is incurred directly or as guarantor by or on behalf of another obligor that has also defaulted;

(2) changes in the level of interest rates, whether short or long term or the differential in interest rates between various markets or products;

(3) changes in currency exchange rates;

(4) changes in asset values; or

(5) other events that the Insurance Commissioner determines to be substantially similar to the foregoing events. ⁿ⁸

Despite this broad definition of financial guaranty insurance, states permit financial guaranty companies to insure only certain types of risk. New York, for example, allows licensed financial guaranty companies to insure the timely payment of U.S. dollar debt instruments or other monetary obligations only in the following categories:

. municipal obligation bonds;

- . special revenue bonds;
- . industrial development bonds;
- . corporate obligations;
- . partnership obligations;
- . certain asset-backed securities, trust certificates and trust obligations;
- . installment purchase agreements executed as a condition of sale;
- . consumer debt obligations;
- . utility first mortgage obligations; and
- . any other debt instrument or financial obligation that the Superintendent determines to be substantially similar to any of the foregoing or shall otherwise be approved by the superintendent. n9

Other states likewise limit the class of insurable risks to a subset of the risks encompassed by the definition of financial guaranty insurance. n10

New York law exempts from the definition of financial guaranty insurance certain other insurance products, including:

- . insurance against default where insurance is payable only upon occurrence of a fortuitous physical event, equipment failure, or inability to recover a natural resource;
- . fidelity and surety insurance;
- . credit insurance;
- . credit unemployment insurance;
- . residual value insurance;
- . mortgage guaranty insurance; and
- . guaranteed investment contracts issued by life insurers. n11

This list varies slightly among state laws governing financial guaranty insurance. For example, California specifically excludes title insurance from the definition of financial guaranty insurance, while Florida excludes, among other things, lease, purchase and sale, or concessionaire surety bonds. n12

Financial guaranty insurance statutes also set forth requirements intended to safeguard the financial solvency of financial guaranty companies. The following financial parameters are common among the states regulating financial guaranty insurance.

Minimum Capital and Surplus. All states impose certain minimum capital and surplus levels. In New York, for example, the minimum initial capital and surplus requirements for a financial guaranty insurer is \$75 million, and at all times the company must maintain a policyholders surplus of at least \$65 million. n13 California is somewhat less stringent in that it requires paid-in capital of at least \$15 million and a surplus of at least \$85 million before it will issue a license to do business. n14

Contingency Reserves. New York and California require financial guaranty insurers to maintain an additional contingency reserve based upon the greater of 50% of premiums written for each category of security guaranteed or a sum arrived at by multiplying specific factors by the principal amount being guaranteed for each class of security. n15 The amounts are based upon both the principal guaranteed and the relative risk of the type of bond, with municipal bonds assigned the lowest factor and non-investment grade securities receiving the highest. Florida requires contingency reserves based on percentages of net principal outstanding on various types of guarantees. n16 Other states, like Connecticut, require contingency reserves calculated according to the accounting requirements of the NAIC Accounting Practices and Procedures Manual. n17

Aggregate Risk Limitations. States also limit the amount and type of securities that a financial guaranty insurer may insure. The limitations are typically expressed in the form of percentages of the insurers surplus and contingency reserves. n18

Single Risk Limits. Additionally, state statutes limit a financial guaranty insurers exposure to any one risk (net of collateral and reinsurance) to a percentage of the aggregate of the insurers surplus to policyholders and contingency reserves. n19 Typically, statutes impose different limitations based on whether the insured obligation is municipal debt, asset-backed securities, or other types of obligations. For example, with respect to municipal debt, the New York financial guaranty law limits exposure to a single municipality's insured annual debt service to no more than 10 percent of the aggregate of the insurers surplus to policyholders and contingency reserves. In addition, the aggregate unpaid principal due by a single municipality at any time may not exceed 75% of the aggregate of the insurers surplus to policyholders and its contingency reserves. The single risk limits for asset backed securities are governed by a more complex formula in which the insured average annual debt service, the insured unpaid principal (as calculated by the prescribed formula), and the single largest asset in any pool supporting the securities cannot exceed 10 percent of the insurers surplus to policyholders and contingency reserves.

A violation of the aggregate or single limit restrictions could result in an order of the insurance department to limit writing to certain lines or to cease writing altogether. In the worst case scenario, the violation could result in the initiation of insolvency proceedings against a monoline. n20 Recently, Financial Guaranty Insurance Corporation (FGIC) announced that it had violated the single limit restriction and had voluntarily ceased writing new business of any kind. n21 As of the date of this commentary in April 2008, the New York Superintendent of Insurance is awaiting a plan from FGIC detailing how it will cure this violation.

Limitation on Non-Investment Grade Securities. States require that the majority of securities insured by financial guaranty companies be investment grade. Typically, states require that at least 95% of such securities be investment grade. n22

Limitation on Investments in Securities Insured. In an effort to avoid an aggregation of risks, California and New York limit a financial guaranty insurers investment in any one entity insured by that insurer to no more than 4% of its assets. n23

Limitations on Reinsurance. Several states also impose limitations on the amount of business that a financial guaranty company can cede under a reinsurance agreement, unless the reinsurer is another licensed financial guaranty insurer. n24 Interestingly, even though New York generally prohibits multi-line insurers from issuing financial guarantees above \$10 million, it permits them to reinsure them in far larger amounts. n25 The ceding monoline, however, can only get a maximum credit for the reinsurance of 50% of the aggregate risk. n26

Rating Company Impact. While the rating companies do not directly regulate the monolines, they have a substantial impact on their ability to do business. Because a transaction will borrow the rating of the insurer or credit support provider, the higher the rating of the insurer the more its services will be in demand. It can also achieve better pricing because of the benefit it provides and the demand for its services. Accordingly, the ratings provided by the rating agencies are crucial to the business success or failure of the monolines.

In addition, in 2000, S&P introduced a new rating product for any insurers providing guarantees or credit support for capital markets transactions: The Financial Enhancement Rating (FER). S&P combined the financial strength rating with an assessment of the ability and willingness of an insurer to pay capital markets immediately and without regard to potential defenses. n27 In published reports regarding the FER, S&P has stated that it believes the failure to honor a claim drawn under an acknowledged policy, regardless of defenses and irrespective of legal or commercial disputes that routinely arise relative to insurance claims, will impair the insurers credibility in the capital markets and, consequently, its market position and financial flexibility. n28 S&P stated that, in the event that a rated insurer failed to pay a claim, particularly on S&P rated transactions, the companys FER rating and its financial strength rating, would likely be reduced. n29 Most of the major monolines have obtained FER ratings from S&P. While not direct regulation, the specter of a ratings downgrade provide ample incentive for monolines to pay promptly.

THE CURRENT BOND INSURER CRISIS

The current crisis for the monoline insurers was brought about by a change in the underwriting philosophy and mix of risks undertaken by the monoline bond insurers. For much of their history, the bond insurers predominant business line was the guarantee of public finance debt. The business was low frequency and low severity risks and was profitable for the bond insurers. However, as these companies sought new ways to grow and earn additional premium, they became more involved in the guarantee of capital markets transactions. This line of business grew to become one of the bond insurers main lines of business. S&P reported in 2006 that guarantees on the public finance business had dropped from 81% of the aggregate business of the bond insurers to 61% in 2004, while asset backed securitizations and structured finance transactions (domestic and international) rose dramatically from 19% to 39%. n30

At least three of the major monoline bond insurers became heavily involved in the guarantee of securitizations of mortgage debt obligations, and more particularly the securitization of subprime mortgage debt obligations. MBIA, Ambac, and FGIC all became heavily involved in the guarantee of swaps, CDOs, and CDO-squareds involving subprime mortgages as the underlying collateral. As the majority of the guaranteed tranches were rated AAA by one or more of the rating agencies, the capital retention requirements were low and the lower premiums charged by the monolines reflected both the lower perceived risk and the lower capital adequacy requirements.

The first major indication of a problem occurred in October, 2007 when Merrill Lynch, one of the major investment bank purveyors of these securitized products, announced that it was taking \$8.4 billion in writedowns on its subprime mortgage securitized business. n31 At that time, analysts became more focused on the potential for losses in the billions.

In December, 2007, Fitch Ratings (Fitch), one of the major ratings agencies, lowered the ratings on over 2000 CDO transactions involving subprime mortgages--dropping the ratings by an average of 9.6 levels. Standard & Poors (S&P), another rating agency, reported during that period that bond insurers faced potential losses of approximately \$19.0 billion. n32 Fitch also required that each of the four major bond insurers raise an additional \$1.0 billion in capital in order to maintain their rating of AAA.

As the bond insurers reported their fourth quarter 2007 financial results, the major bond insurers reported significant losses. For example, MBIA reported a fourth quarter 2007 loss of \$2.33 billion on its guarantees of subprime related business. n33 At least one-third of that loss was reported to be a result of lower ratings of the subprime transactions guaranteed by MBIA, while the other two thirds related to increased defaults on the underlying collateral. n34

In late January and early February of 2008, Fitch downgraded FGIC and placed MBIA on negative watch. Fitch, despite MBIA's request that it withdraw its rating of MBIA, shortly thereafter reduced MBIA's ratings to AA. Moodys reduced FGIC's rating from Aaa to A3. S&P reported that the potential MBIA and Ambac downgrades could also lead to bank credit rating reductions. Moodys also reduced the credit rating of MBIA's major reinsurer, Channel Re, from Aaa to Aa3. In late February, 2008 S&P affirmed the AAA rating with a negative outlook for MBIA and Ambac. Both

MBIA and Ambac, however, reported that that they had not written any significant new business since November, 2007.

As discussed previously, the major benefit to insureds in the public finance business is the reduction in interest rate and the corresponding increase in attractiveness of the investment. The inability of the major bond insurers to write new business dramatically reduced the available capacity of bond insurance for public finance. This lack of capacity meant that some public finance transactions could not go forward, or could only proceed at a substantially increased cost. As a result, badly needed infrastructure or municipal development projects have been delayed or scrapped. Further, the likely result is that projects that have gone forward have done so at higher costs and caused the curtailment of other governmental services or projects.

The substantial losses that the bond insurers have incurred and the less stable nature of their credit ratings also have made them less attractive as credit support for other capital markets transactions. In conjunction with the losses suffered by the commercial banks as a result of the subprime crisis and the tightening of credit as a result, the reduced ability to transfer such debts to the capital markets due to lack of adequate credit support also has contributed to the tightening of credit.

PROPOSED CHANGES TO THE REGULATORY REGIME

The recent credit downgrades of certain major guaranty companies--and the resulting havoc this has wreaked on the municipal debt market--have prompted calls at the federal and state level for changes in the regulation of financial guaranty companies. Representative Paul Kanjorski, who serves as Chairman of the Subcommittee on Capital Markets, Insurance, and Government Sponsored Enterprises, is currently conducting an investigation into the issue. Recently, Treasury Secretary Paulson has added his voice to the calls for federal regulation when he expressed support for an optional federal charter for insurance companies. It is unclear whether the subprime crisis has added the necessary traction for the additional support necessary to overcome the substantial objection of the states to federal regulation.

On April 16, 2008, New York Superintendent Eric Dinallo on behalf of the National Association of Insurance Commissioners testified before Representative Kanjorski's committee and strongly asserted that regulation of insurance should remain with the states. As to state regulation of insurers who interact with the financial sector, Superintendent Dinallo suggested that Congress should go further and make clear that insurance regulators occupy a standing fully equal to that of the SEC, the Federal Reserve, the OCC and other federal regulators [and also to] clarify that state insurance regulators are functionally equivalent to insurance regulators in other nations for the purposes of international negotiations and dialogues. n35

As part of the Subcommittee's investigation, Representative Kanjorski requested the input of various insurance commissioners, including those of New York, Wisconsin and Maryland on the need for reform in the bond insurance market and the monoline insurers. The Commissioners pointed to three main areas of reform: (1) restrictions on lines of business from guaranteeing transactions that are too volatile or too complex to adequately evaluate; (2) decreased reliance on rating agencies and increased reliance on the independent evaluation of risk positions by the domiciliary insurance department; and (3) the potential to change the regulatory standard from a solvency standard to a sustainability of the business model standard.

Restrictions on Writing New Business. Several insurance commissioners have indicated that the new rules of the road going forward might include restrictions on writing new business. Superintendent Dinallo of New York suggested that it may be advisable to restrict [monolines] activities around risks that may be too volatile or lacking in transparency to evaluate accurately. n36 The Wisconsin Insurance Commissioner suggested that the ability of the monoline bond insurers to guarantee exposures other than municipal bond risks may also be limited in this process. n37

Indeed, at the public hearing on February 14, 2008, then-Governor Elliott Spitzer testified that New York was considering the possibility of splitting the public finance business from the capital markets guarantee business a good

business, bad business approach. Since that time several of the major bond insurers, MBIA, Ambac, and FGIC have indicated that they intended to split the public finance business away from other business into a separate company. Although Ambac has since appeared to move away from this structure, MBIA has indicated that it expects to split its business in the next five years. FGIC appears to be considering such a split on a more imminent basis. n38

Since no state except Pennsylvania currently has statutes that permit an insurance company to divide itself, any such split would have to be accomplished through a portfolio transfer and/or some kind of assumption reinsurance vehicle with an affiliated company. n39 While both of those vehicles would leave some potential liability with the ceding company, the reinsurance would provide an adequate credit against the liabilities that might actually be incurred, thus splitting the liabilities and capital requirements between the two companies. It is still too early to tell whether MBIA, FGIC or any other monoline will ultimately carry out such a split, or whether the potential was raised merely as leverage in their respective discussions with banks and potential investors.

Independent Evaluation of Monoline Risks. Superintendent Dinallo also suggested that the New York Insurance Department would no longer rely heavily on rating agencies to evaluate the risks underlying monoline policies, but rather, that the Department would invest in the necessary assets to evaluate risks independently. n40 If the bond insurers are permitted in the future to continue to invest in highly complex transactions like CDOs, then it is unclear how the various Insurance Departments will be any better positioned than the ratings agencies or the companies to assess the risks inherent in such transactions. If, however, the monolines are restricted to writing only public finance transactions and capital markets transactions that are fully transparent, then the need for independent evaluation by the Insurance Departments may not be as necessary. The current pronouncements by the NAIC and the Insurance Departments of New York, Wisconsin, and Maryland give the markets no further guidance as to how the interplay between these two variables will be resolved.

Solvency vs. Business Model Regulation. These new rules of the road may also include a change from reviewing the financials of the bond insurers from a solvency perspective to an evaluation of sustainability of business model. n41 The concept that a regulator will regulate more than solvency is a new and untried concept in insurance regulation.

Traditional notions of insurance regulation have focused on concepts of fair dealing with policyholders, maintaining competition in the marketplace and protecting policyholders when an insurance company became impaired or insolvent. There are no laws in place other than general laws that permit insurance commissioners to take action against insurers when they present a hazard or danger to policyholders. n42 As in the case of New York, those laws only permit the regulator to place the insurer under conservatorship or into liquidation or rehabilitation. Such an action would likely place a monoline in default of its obligations as credit support provider under the standard International Swaps and Derivatives Association (ISDA) documentation for capital markets transactions, which might require the monoline to post significant amounts of collateral, which could jeopardize the monolines financial condition.

Accordingly, it is likely that new statutes and regulations would have to be enacted or promulgated that would permit the insurance commissioners to take action to protect a monoline company in the event of some occurrence that would be considered damaging to its business model. In the case of the monolines, the critical event identified by the regulators is the potential for downgrade by the rating agencies and the effect on the public finance business. How the regulators would be able to regulate the ability of ratings agencies to analyze and rate monolines is at best murky. The regulations could require a specified notice period to the company and the Insurance Department to correct any deficiencies that would cause a ratings downgrade. However, the ratings companies did give the monolines some time to correct their perceived deficiencies, such that MBIA and Ambac were able to preserve their AAA ratings. The mere potential for downgrade created a significant lack of trust in the monolines and brought some of the companies, such as MBIA and Ambac to a near halt.

It is also very unclear how the business model to be sustained would be defined. Would it only apply to AAA companies, whose potential drop (even a small drop) in rating appeared to have the greatest effect on the public finance market, or would it have to be applied to all monolines? How would such regulations avoid being anticompetitive by

protecting existing competitors, whose business might be affected by price competition from new entries in the market. Such potential regulations create a myriad of questions that cannot be answered at this point until the regulators provide more direction as to their thought processes.

It does seem relatively clear that no changes will be forthcoming in the very near future. In his testimony before the House Subcommittee on behalf of the NAIC, Superintendent Dinallo asserted that change in the insurance market should be implemented gradually. Superintendent Dinallo stated:

Any change(s) enacted should provide sufficient time for implementation so that any economic outcomes can be viewed from an approaching distance rather than develop abruptly. Allowing a period of time to assess outcome development will allow the course of regulation to be changed in time to avoid outcomes that later prove to be intolerable or overly onerous. n43

CONCLUSION

The potential for change in the regulation of the monolines does not appear to be imminent. How that change will occur and what effects such changes may have on the monolines business is not yet known with any certainty. It does appear that some further restrictions will be placed on the types of capital markets transactions that monolines may be able to guaranty in the future. It is also likely that further participation in transactions involving CDO-squareds is likely to be banned, and that at least some requirements for minimal levels of transparency in capital markets transactions will be required.

It is unclear whether the bond insurers will split the public finance business from their existing and future capital markets transaction business in the near future. Given the lack of efficient means of achieving a complete cessation of liability for the ceding monoline under existing methods of portfolio transfers and assumption reinsurance, it is more likely that if such a split is contemplated, it will be accomplished over time by the creation of a new company to write new business, with old business runoff from the pre-existing monoline. It is probably also a safe bet that the monolines will continue to endure significant regulatory and market scrutiny. Whether and how such scrutiny will be institutionalized at the regulatory level is yet unclear.

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n1 Report of the National Association of Insurance Commissioners Financial Condition Subcommittee Ex. 4, at 32 (Dec. 7, 1986).

n2 *Id.* at 31.

n3 *Id.*

n4 *Id.* at 30.

n5 *Bond Insurance CEOs Weigh In On Industry Trends and Future*, Standard & Poors Global Bond Insurance Book 2006, at 1-2.

n6 N.Y. Ins. Law § 6902(a); Cal. Ins. Code § 12102(c).

n7 Fla. Stat. Ann. § 627.973(1).

n8 Cal. Ins. Code § 12100(a)(1); Conn. Gen. Stat. Ann. § 38a-92a(1)(A); Fla. Stat. Ann. § 627.971(1)(a); Md. Code Regs. 31.05.10.01.D; N.Y. Ins. Law § 6901(a)(1)(A)-(E).

n9 N.Y. Ins. Law § 6904(b).

n10 *See, e.g.*, Cal. Ins. Code § 12112; Md. Code Regs. 31.05.10.03.A(1).

n11 N.Y. Ins. Law § 6901(2).

n12 Cal. Ins. Code § 12100(a)(2)(B); Fla. Stat. § 627.971(b)(6).

n13 N.Y. Ins. Law § 6902(b).

n14 Cal. Ins. Code § 12107(a).

n15 Cal. Ins. Code § 12108; N.Y. Ins. Law § 6903(a).

n16 Fla. Stat. Ann. § 627.972(3)(a).

n17 Conn. Gen. Stat. Ann. § 38a-92c(a).

n18 See, e.g., Fla. Stat. Ann. §627.973(4); Md. Code Regs. 31.05.10.05.A; N.Y. Ins. Law § 6904(c).

n19 See, e.g., Cal. Ins. Code § 12115; Md. Code Regs. 31.05.10.06; N.Y. Ins. Law § 6904(d).

n20 N.Y. Ins. Law § 6904(e); N.Y. Ins. Law § 7402(c), (f).

n21 N.Y. Times, *Bond Insurer Says Its Risk Exceeded Legal Limits*, March 27, 2008.

n22 See, e.g., Cal. Ins. Code § 12114(a); Conn. Gen. Stat. Ann. § 38a-92i(a); Fla. Stat. Ann. § 627.973(3); Md. Code Regs. 31.05.10.04; N.Y. Ins. Law § 6904(b)(2).

n23 See, e.g., Cal. Ins. Code § 12106(a); N.Y. Ins. Law § 6902(a)(4).

n24 See, e.g., Cal. Ins. Code § 12121; Conn. Gen. Stat. Ann. § 38a-92m(a); Fla. Stat. Ann. § 627.975; N.Y. Ins. Law § 6906.

n25 N.Y. Ins. Law §§ 1113(a)(16)(H), 6906.

n26 *Id.*

n27 *Revised Financial Enhancement Ratings Gauge Insurers Willingness to Provide Timely Payment*, Ratings Standard & Poors RatingsDirect, April 24, 2002.

n28 *Id.* at 4.

n29 *Id.*

n30 *Bond Insurance CEOs Weigh In On Industry Trends and Future*, Standard & Poors Global Bond Insurance Book 2006, at 1-2.

n31 Reuters, *Merrill Lynch Reels from Write-Down*, Oct. 24, 2007.

n32 Bloomberg, *Ambac, MBIA Outlook Lowered by S&P, ACA Cut to CCC*, April 24, 2008

n33 RTTNews, *MBIA Slips to \$2.3 Bln Loss in Q4 On Derivatives Write-downs*, Jan. 31, 2008.

n34 *Id.*

n35 Testimony of the National Association of Insurance Commissioners Before the Subcommittee on Capital Markets, Insurance, and Government Sponsored Enterprises, Committee on Financial Services, United States House of Representatives Regarding Options for Insurance Regulatory Reform, at 6 (Apr. 16, 2008).

n36 Letter of Eric Dinallo, Superintendent of Insurance for the State of New York to Representative Paul E. Kanjorski, at 11 (Feb. 4, 2008) (Dinallo Letter).

n37 Letter of Sean Dilweg, Insurance Commissioner of Wisconsin to Representative Paul E. Kanjorski, at 4 (Feb. 8, 2008).

n38 Wall Street Journal, *FGIC Will Request Break-up*, Feb. 15, 2008.

n39 See 15 Pa. Con. Stat. Ann. § 21205.

n40 Dinallo Letter at 11.

n41 Testimony of the New York State Insurance Department Before the Subcommittee on Capital Markets, Insurance, and Government Sponsored Enterprises, Committee on Financial Services, United States House of Representatives Regarding Bond Insurance, at 4 (Feb. 14, 2008).

n42 See, e.g., N.Y. Ins. Law § 7402(e).

n43 Testimony of the National Association of Insurance Commissioners Before the Subcommittee on Capital Markets, Insurance, and Government Sponsored Enterprises, Committee on Financial Services, United States House of Representatives Regarding Options for Insurance Regulatory Reform, at 7 (Apr. 16, 2008).

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Insurance Coverage for Global Warming Litigation

2008 Emerging Issues 273

Davis and Yassemedis on Insurance Coverage for Global Warming Litigation

By James Davis and Andrea Yassemedis

May 6, 2008

SUMMARY: In its 2007 decision *Massachusetts v. EPA*, the Supreme Court legally recognized global warming as the most pressing environmental challenge of our time and held that certain plaintiffs may have standing to sue for damages due to global warming. As the number of suits alleging damages due to climate change threatens to explode, businesses facing the possibility of massive damage awards and high defense costs will seek coverage under their insurance policies. The purpose of this commentary, written by James M. Davis and Andrea Yassemedis of Reed Smith LLP, is to discuss the key legal issues facing policyholders and their insurers in confronting claims related to global warming under traditional insurance products and to look at ways the insurance industry is developing and innovating in response to a predicted flood of global warming litigation. Overall, the commentary concludes that policyholders should receive coverage for most claims related to global warming, but that the insurance industry must continue to generate new products and programs that help policyholders mitigate their exposure and cover claims that could seriously threaten a company's long-term sustainability.

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ARTICLE: Insurance Coverage for Global Warming Litigation

By James M. Davis and Andrea Yassemedis

INTRODUCTION

In February 2008, Kivalina, a tiny Inuit village on a barrier reef on the Chukchi Sea in Alaska, announced that it had to move to avoid falling into the sea. Rising global temperatures had melted the sea ice, villagers said, and left them unprotected from storms and waves that were rapidly eroding swaths of the coastline. Kivalina's lawyers declared that 20 U.S. oil, coal, and utility companies who emitted large volumes of greenhouse gases should be footing their relocation bill of as much as \$400 million. n1

The startling nature of Kivalina's lawsuit gives a glimpse into the massive potential consequences--both

environmental and economic--of global warming. What makes the Kivalina suit particularly worrisome, to both corporate policyholders and their insurers, is that unlike previous suits this one may not be dismissed on the grounds that global warming is a political question. n2 In addition to state and federal public nuisance claims like those dismissed in other cases as political questions, the Kivalina lawsuit also seeks recovery under theories of civil conspiracy and concert of action. These latter claims are based on allegations of a decades-long and continuing concerted misinformation campaign about the effects of global warming that comes straight from the successful tobacco litigation playbook.

Of course the Kivalina case exists largely due to the 2007 decision in *Massachusetts v. EPA*, wherein the Supreme Court legally recognized the danger of global warming, declaring that

A well-documented rise in global temperatures has coincided with a significant increase in the concentration of carbon dioxide in the atmosphere. Respected scientists believe that the two trends are related. For when carbon dioxide is released into the atmosphere, it acts like the ceiling of a greenhouse, trapping solar energy and retarding the escape of reflected heat. It is therefore a species--the most important species--of greenhouse gas. n3

The Court further held that certain potential plaintiffs had standing to bring lawsuits resulting from damages due to global warming.

Now that the Supreme Court has called global warming the most pressing environmental challenge of our time, n4 the number of suits alleging damages due to climate change is likely to explode. n5 The impact of such suits upon the defendant businesses is clear, but global warming will also have a correspondingly profound effect on the insurance industry that shields people and businesses from risk. Businesses may seek coverage under general or specialized liability policies. If profits fall and disgruntled shareholders seek redress from the corporate officers whom they allege played a role in authorizing the emission of greenhouse gases, those officers may also turn to their insurers. Both businesses and private individuals whose property is destroyed by cataclysmic weather may turn to their casualty insurers. Health insurers may face more and more claims due to heat- and pollution-related injuries. The insurance industry's response to these claims will have an enormous social and financial impact worldwide.

The purpose of this commentary is to discuss the key legal issues facing policyholders and their insurers in confronting claims related to global warming under traditional insurance products and to look at ways the insurance industry is developing and innovating in response to a predicted flood of global warming litigation. Overall, the commentary concludes that policyholders should receive coverage for most claims related to global warming, but that the insurance industry must continue to develop new products that help policyholders mitigate their exposure and cover claims that could seriously threaten a company's long-term sustainability.

GENERAL LIABILITY COVERAGE FOR CLAIMS RELATED TO GLOBAL WARMING

Companies that emit greenhouse gases may face suit from private litigants and state attorneys general who allege damages due to global warming. Private class actions may allege a host of health problems linked to climate change, from heat stress (which caused the death of more than 35,000 upwards of the norm during the European Heat Wave of 2003) n6 to respiratory and coronary disease n7 and childhood asthma. n8 Other private plaintiffs may be homeowners, like the 14 individuals who filed a class action based on global warming against almost 150 oil and coal companies after they were denied coverage for property damage caused by Hurricane Katrina. n9 State attorneys general have already begun to bring suit for damages due to global warming. n10 They could follow the model adopted in the litigation against the tobacco industry in the 1990s n11 and band together to force a settlement from several industries for financial damages they have suffered and will continue to suffer due to global warming. n12 Even if courts dismissed such suits, they would arguably provide a tool by which states could bring public pressure to bear on the federal government to regulate greenhouse gases. n13

Several key issues will determine liability coverage for global warming liabilities. All standard-form general liability policies contain expected or intended and pollution exclusions that must be addressed. Courts interpreting occurrence policies will face a host of other issues, including whether global warming is an occurrence, how many occurrences are at issue in a particular global warming claim, and which of potentially decades of liability policies are triggered. Once the court has made these determinations, it must then decide how to allocate liability for greenhouse gas emissions among triggered policies.

INTERPRETING THE POLLUTION EXCLUSIONS

As one court noted, [r]arely has any issue spawned as many, and as variant in rationales and results, court decisions as has the pollution exclusion clause. n14 The confusing jumble of case law interpreting the pollution exclusion is the results of decades of contention between insurers and their policyholders. n15 Perhaps in part because the law remains unsettled, the pollution exclusion will undoubtedly be a key issue in the coverage battle for global warming claims.

The 1973 Pollution Exclusion. In 1973, the insurance industry responded to the growing number of environmental lawsuits by adopting a pollution exclusion that barred coverage for bodily injury or property damage arising out of the release of irritants, contaminants, or pollutants into the environment, except if the release was sudden and accidental. n16 While insurers represented the exclusion as nothing more than a clarification that intentional pollution was excluded, n17 they soon began denying coverage for most claims related to pollution. Early cases litigating coverage under policies containing the exclusion found many and varied grounds for siding with policyholders. Some courts held that the insurance companies were bound to their earlier representations that the exclusion did nothing more than clarify existing coverage. n18 Other courts found the exclusion ambiguous, and applied the doctrine of *contra preferentem* to interpret the ambiguity against the drafter. n19 Still others looked to the reasonable expectations doctrine, which requires a court to look to the policyholders reasonable expectations when interpreting policy terms--sometimes even when those terms are unambiguous. n20 Some recent decisions have held that the 1973 pollution exclusion unambiguously requires a calamitous one-time release of pollutants, n21 but policyholders have continued to argue successfully that the 1973 pollution exclusion is ambiguous on its face and that the ambiguity must be resolved in their favor to permit coverage for damages resulting from continuing environmental pollution. n22

Applying the 1973 exclusion to global warming will present some new interpretive problems. First of all, it is not certain whether greenhouse gases would be considered irritants, contaminants, or pollutants under the 1973 exclusion. CO₂ is not an irritant or contaminant, and it was not recognized as a pollutant prior to the Supreme Courts decision in *Massachusetts*. n23 Second, the same reasoning that prevented insurers from barring coverage for continuous environmental pollution should apply to global warming claims as well: insurers should be estopped from taking positions contrary to their early representations that the exclusion merely clarified coverage, and the ambiguities in the exclusion should be construed in favor of policyholders based upon the doctrine of *contra preferentem*. Given that companies purchased CGL policies to provide broad protection for their normal business activities, the doctrine of reasonable expectation should apply to cover claims from greenhouse gas emissions that Congress, the executive branch, and administrative agencies have all chosen not to regulate or to characterize as a pollutant. n24

The 1986 Pollution Exclusion. When Congress passed the 1980 Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA) and imposed strict liability for hazardous waste cleanup and response costs, the insurance industry responded by adopting a new, broadened pollution exclusion--the 1986 absolute pollution exclusion--intended to eliminate coverage for liabilities incurred for prolonged release of pollutants. The 1986 exclusion denies coverage for bodily injury or property damage arising out of the actual, alleged or threatened discharge, dispersal, seepage, migration, release, or escape of pollutants. n25 Unsurprisingly, insurers and their policyholders continued to disagree about the coverage provided under the 1986 pollution exclusion. With varying success, insurers argued that the exclusion bars coverage for all toxic torts, and policyholders contended that the exclusion is limited to long-term environmental pollution. n26

The changes incorporated by the 1986 pollution exclusion should not prevent coverage for global warming

liabilities. First of all, liability resulting from emissions that contributed to global warming is vastly different from the CERCLA-type liability discharge the 1986 exclusion was meant to address. Global warming is a worldwide phenomenon, and the steps needed to mitigate and address its effects are completely unlike the local environmental cleanup mandated by CERCLA. n27 Second, the 1986 exclusion is *de facto* ambiguous--dozens of courts have interpreted it in different ways, n28 and documents produced by different insurance companies establish confusion within the industry itself over its meaning and application. n29 Given its ambiguity, the exclusion must be interpreted against the drafter, the insurance company, to provide the insurance coverage reasonably expected by the policyholder.

Applying the Expected or Intended Exclusion. Because insurance companies often deny coverage on the basis that the policyholder expected or intended the accident or occurrence, the interpretation of this exclusion will be a key issue in determining insurance coverage for global warming claims. The first question is whether the exclusion bars coverage only for expected or intended results (the majority rule) or whether it precludes coverage for any damages arising from an intentional act (the minority position). n30 In the context of global warming, a court applying the intended result rule would bar coverage only if it found the company actually intended to raise sea levels, melt snow pack, or cause other severe damage as a result of a worldwide increase in temperatures. A court applying the minority intended act rule, however, would bar coverage based on a company's mere intention to emit greenhouse gases during its regular operations. Because it would punish policyholders for intentions and acts that they, regulators, and insurance companies accepted as innocuous, application of the minority rule to global warming claims would be unreasonably harsh. Courts are far more likely to read the exclusion to apply only where a company expected or intended the damage that resulted from their greenhouse gas emissions.

The second question presented by the expected or intended provision is whether an objective or subjective standard should apply. n31 Under the subjective standard applied by the majority of courts, mere knowledge of pollutant emissions n32 or warnings regarding its dangers n33 does not establish intent to injure--coverage is denied only if the record shows specific evidence of subjective intent. n34 In contrast, the minority of courts that apply the objective standard deny coverage if the damage was reasonably foreseeable or natural and probable, or if injury could be inferred from the policyholders acts. n35 Insurance companies could not convincingly argue that damage due to global warming was reasonably foreseeable prior to its recent recognition by the scientific community and the U.S. legal establishment. n36 No matter which standard the courts apply, the expected and intended provision should not bar coverage for global warming claims.

DEFINING AND COUNTING OCCURRENCES

Courts adjudicating coverage for global warming claims under an occurrence policy n37 must answer several additional questions: whether global warming fits the definition of an occurrence and, if so, how many occurrences there have been.

The meaning of an occurrence is governed by the definition contained in the particular policy at issue. Before 1973, commercial general liability policies with standard-form language defined an occurrence as an accident, including injurious exposure to conditions, which results during the policy period in bodily injury or property damage. n38 The language including exposure to conditions clarifies that the policy covers gradual bodily injury and property damage. n39 Policies with post-1973 standard-form language define occurrence as an accident, including continuous or repeated exposure to conditions, which results in bodily injury neither expected nor intended from the standpoint of the insured. n40 Under either of these definitions, the potential for coverage is clear. Liability for corporate emissions of greenhouse gases would be based upon the continuous or repeated exposure of property or persons resulting from the

release to the atmosphere of greenhouse gases that very few people--and no governmental authority--even recognized as harmful until very recently. n41

Although long-term damage from emission of greenhouse gases plainly fits the policy definition of an occurrence, it is less certain how many occurrences any particular claim would involve. The number of occurrences is often a key issue in insurance litigation because it may determine the amount of coverage available to the insured. Generally, a finding of twice the occurrences means twice the available coverage--but the policyholder will generally pay for that increased coverage with one deductible per occurrence as well. Therefore, where the total losses are greater than a single policy limit, a policyholder cannot receive full indemnification unless the court finds multiple occurrences. On the other hand, where the total losses are less than a single policy limit, a policyholder will recover more if the court finds a single occurrence and thus the policyholder pays only one deductible. n42 Determining the number of occurrences may depend on the particular facts of each claim.

DETERMINING TRIGGER

Determining which policies can be reached to cover a particular claim is a question of trigger. Claims-made policies are simply triggered when a claim is made. Trigger of insurance policies, in contrast, is extraordinarily complicated because the occurrence may involve exposure to conditions over a long period of time or take place years before the injury. Although a continuous trigger is often the appropriate result in long-tail claims, courts have adopted several different trigger theories to address such situations:

- (1) Exposure trigger: Each policy in effect during the claimants course of exposure to the cause of the injury or damage is triggered;
- (2) Manifestation trigger: Each policy in effect when the injury is or should have been discovered is triggered;
- (3) Injury-in-fact trigger: Each policy in effect when there is actual injury or damage is triggered;
- (4) Continuous (or triple) trigger: Each policy in effect at any time from exposure to sickness (or latent damage) through manifestation is triggered. n43

Courts are likely to consider the theory of underlying liability imposed in determining which policies are triggered. If companies are held liable for their entire history of greenhouse gas emissions, courts could apply the exposure theory to trigger each policy in effect during that history. If companies are held liable for emissions only after CO₂ levels reached a level capable of causing significant environmental damage, courts could apply the manifestation theory to trigger policies in effect after measurable damage to the environment due to greenhouse gases was discoverable or a continuous trigger at that point in time. Courts could also apply the injury-in-fact theory and trigger policies in effect at the moment real environmental injury occurs--such as a significant number of hurricanes or rise in sea levels due to melting ice. n44

ALLOCATING LIABILITY

After a court determines which policies must respond to a global warming claim, it must decide how to allocate liability among them. n45 Most CGL policies, whether claims-made or occurrence, promise to pay all sums that the policyholder becomes legally obligated to pay as damages. n46 The majority of courts focus on the all sums language to hold each insurer jointly and severally liable for the policyholders entire loss, up to the limits of that insurers coverage. n47 Thereafter, insurers may seek contribution from each other based upon any other insurance clauses in the policies. n48 A minority of courts allocate liability among triggered insurers on a pro rata basis. Pro rata apportionment

can mean that each insurer pays an equal share of liability, that each insurer pays a share of liability in proportion to its time on the risk, or that each insurer pays a share of liability in proportion to the amount of risk it assumed overall. n49 If the loss is so large that it exceeds a single layer of coverage, courts may require a policyholder to horizontally exhaust by exhausting its insurance at the same level of coverage before seeking indemnity from the next layer of coverage. n50

The long-tail nature of global warming liability will give the courts allocation method profound financial significance for both policyholders and insurance companies. A pro rata approach could place policyholders in financial jeopardy by requiring the policyholder to contribute for years of self-insurance or pay multiple deductibles before reaching coverage. Companies may even be required to litigate with dozens of insurers and successfully recover payment from each before reaching the excess insurance for which they contracted. Pro rata allocation of global warming claims would also result in a windfall for insurance companies who had promised to pay all sums for which their policyholders became liable. The majority all sums approach better assures policyholders of recovering for their losses because each insurer will be jointly and severally liable. This would protect corporate policyholders who might otherwise be bankrupted while still allowing a tapped insurer to distribute the loss by seeking contribution from other triggered insurers. n51

D&O INSURANCE COVERAGE FOR CLAIMS REGARDING GLOBAL WARMING

As corporations come under increasing fire for global warming, they may face shareholder or class action suits alleging that management did not properly disclose potential liability in annual reports, registration statements, or SEC filings. n52 Shareholders are already disgruntled by a perceived lack of action: between 1994 and 2002, 62 shareholder resolutions on global warming issues were filed in the SEC, n53 and in 2005, the Investor Network on Climate Risk convened a summit in New York where leading European and U.S. institutional investors managing over \$3 trillion in assets called on U.S. companies, Wall Street firms, and the SEC to require comprehensive disclosures about the financial risks of climate change. n54

Decisions made by directors and officers--including those regarding greenhouse gas emissions--are protected under the business judgment rule and will not be second-guessed as long as they are made in good faith and do not involve gross negligence or a gross abuse of discretion. n55 Nonetheless, the potential costs of defending these complex suits and paying any settlements or judgments stemming from them are enormous, n56 and corporations will therefore turn to their Directors and Officers (D & O) insurance for coverage. The Coverage A provision of a D & O policy pledges that the insurer will indemnify the directors and officers for all Loss--amounts paid in judgment or settlement and defense costs--that they become legally obligated to pay due to a Wrongful Act committed in their professional capacity. n57 Wrongful Acts generally include negligent acts, errors or omissions, and breach of a director or officers professional duties of care, diligence, and candor. n58 In shareholder suits alleging improper disclosure of potential liability for greenhouse gas emissions, breach of the duty of candor would be the Wrongful Act most at issue.

Like general liability policies, most D & O insurance contains broad exclusions for environmental pollution claims. n59 While the pollution exclusions in D & O policies do not follow a standard form, n60 they typically exclude coverage for claims arising out of actual, alleged or threatened discharge, release, escape, seepage, migration, dispersal or disposal of Pollutants into or on real or personal property, water or the atmosphere. n61 Unlike CGL policies, D & O policies do not contain any sudden and accidental language, and they typically provide shareholder derivative suit carve outs that provide an exception to the broad wording of the pollution exclusion. n62 Cases involving shareholder suits for improper disclosures have therefore focused on the degree of causal connection required by the D & O pollution exclusions arising out of language. The decisions have not been entirely consistent, n63 but some general principles have emerged. It appears that the pollution exclusion may bar coverage for wrongful acts that actively concealed known polluting activity, but that omissions or declines in stock prices that are incidental to environmental issues will be covered. n64 Where a corporate policyholder has failed to disclose potential environmental liability, coverage may depend on how well the policyholder articulates intervening causes between the emissions and the claim. n65

Assuming corporate directors and officers have appropriately accounted for the potential affects of climate change in their deliberations, they should not be liable for business losses resulting from global warming. n66 Insurers, however, are well aware of the enormous risk of large damage awards and high defense costs, and may seek to rescind policies based upon alleged misrepresentations in the application. n67 Policyholders should meet an insurers attempts to rescind a policy by insisting that the insurer meet strict state law requirements, which typically require immediate notice and a material misrepresentation by the policyholder in its completion of a sufficiently clear coverage application. n68 Corporate policyholders should also keep in mind that their D & O policies contain carve-outs that will provide coverage for shareholder derivative suits. There may be ambiguity as to whether greenhouse gases are excluded pollutants under the particular terms of a D & O policy, and directors and officers thus would reasonably have expected coverage for climate change damages. n69

FIRST PARTY INSURANCE CLAIMS REGARDING GLOBAL WARMING

Insurance companies are not just concerned, however, about an impending spike in liability coverage claims. Perhaps even more troublesome is the possibility that global warming could cause an enormous surge in worldwide property damage and business interruption. Thus, global warming could cause a wide swath of insurance policies to be triggered with increasing frequency. Among them: policies covering damage to property, crops, and livestock; business interruption and supply-chain distribution insurance; and a range of health- and life-insurance products. n70 An uptick in claims also means significant collateral costs, including increased litigation expenses. n71

Many industries may suffer firsthand, tangible consequences of global warming. For example, industries that count on natural resources as raw materials--including forestry, fisheries, ranching, and agriculture--undoubtedly will be significantly affected by climate change. n72 So, too, will industries that require certain natural resources as a pre-requisite for their service--including tourism and the ski industry. n73 Commodity and manufacturing industries could experience gaps in their supply chain. n74 In general, almost any kind of business might experience severe business interruption as a result of a catastrophic weather event credited to global warming. n75 A significant percentage of the commercial losses from Hurricane Katrina, for example, were due to business interruptions. n76

LOOKING FORWARD

How Policyholders Should Respond to Global Warming Exposure. Insurance companies often turn to a defense called the known loss doctrine, which applies when a policyholder knows of a threat of economic loss and that loss is certain to occur. n77 The purpose of the known loss doctrine is to preserve the fundamental tenet that only contingent losses may be insured. n78 Some courts apply this defense to bar coverage only if the policyholders liability for damage was already determined when it contracted for the insurance; n79 others permit the defense if the policyholder knew or had reason to know of a substantial probability that it would suffer the loss. n80

The question of when major emitters of greenhouse gases had reason to know of a substantial probability that it would suffer losses due to global warming was made much more difficult by the Supreme Courts ruling in *Massachusetts*. Recent suits filed against oil, coal, and motor vehicle companies arguably put many companies on notice that they too could become targets of global warming litigation. n81 While these arguments are only viable regarding policies issued post-*Massachusetts*, companies that produce large volumes of greenhouse gases should now be taking steps to protect themselves from liability for future emissions, whether through improved efficiency or through carbon-trading programs.

How Insurers Are Responding to Global Warming Exposure. Global warming has the potential to dwarf the risks presented by asbestos and environmental claims. While many casualty insurers have responded by altering their underwriting processes and developing new green products, liability insurers have been slow to respond. A few specialized environmental policies now include exclusions for greenhouse gas emissions, n82 but existing general

liability products neither explicitly provide nor explicitly exclude coverage for losses due to global warming. As of yet, most liability insurers have not altered their underwriting processes to address this increased exposure, n83 and few new liability products have been developed.

Casualty Insurer Response. Some casualty insurers have taken a proactive approach to limiting climate change liability by encouraging engineering improvements in properties they insure. For example, to reduce exposure to hurricanes, MetLife and Allstate provide incentives to customers for wind-proofing their homes, and Allstate and State Farm have pushed for safer building codes in high-risk areas. n84 A number of other property insurers have lobbied the public sector to improve land-use planning and reduce losses. n85 Casualty insurers concerned about global warming exposure have also been introducing new products intended to reduce carbon emissions. As environmentally friendly building practices become increasingly popular, insurers have responded with new products to encourage green and energy-saving building practices. n86 Firemans Funds GreenGuard coverage, for example, is designed to encourage green construction and rebuilding with green technologies after a property is damaged in a covered loss. n87 Some insurers, like Firemans Fund, perceive green building as a way to lower their risk for future losses. n88 AIG, Allianz, Aon, Travelers, and Chubb likewise have formed practice groups specifically dedicated to developing insurance products for green business operations and clean energy. n89

Liability Insurer Response. D & O insurers have been particularly active in considering their potential exposure to global warming liability. For example, Swiss Re began considering climate change risks when evaluating D & O policies as long ago as 2002, and has participated in recent work of the Intergovernmental Panel on Climate Change. n90 Swiss Re also recently began requiring any policy applicant to disclose the companys emissions of greenhouse gases and whether it was responding to any potential threats related to global warming. n91 Although Swiss Re has reportedly discussed climate risk in its underwriting negotiations, n92 it has yet to turn away any applicant or develop any exclusion based on climate risk alone. n93

Another example of insurer concern is Marsh, an insurance broker that collaborated with Yale University and Ceres to launch the Sustainable Governance Forum on Climate Risk in September 2007. n94 In order to inform corporate boards about climate change liability, the Forum raised questions about whether and how a company has allocated responsibility for managing risks related to climate change; whether there is a committee of independent board members addressing climate change issues; whether and how a company quantifies and discloses its emissions profile; and how the company has planned for future regulatory scenarios. n95

Many companies have begun to reduce their greenhouse gas emissions, whether voluntarily or in response to obligations under the European Union Emissions Trading System. n96 Carbon-offset programs, modeled on the Kyoto Protocols Clean Development Mechanism (CDM), allow companies to invest in projects that reduce emissions as an alternative to expensive emissions reductions. As many companies employ carbon-offset projects in order to meet emissions-reduction targets, insurers have stepped in with carbon credit insurance products to aid companies in managing the risks of carbon trading. n97 Swiss Re, Munich Re, and AIG have each developed insurance products for Kyoto Protocol-related risks and carbon credit transactions. n98 In addition to developing these new products, insurance companies have worked with their business policyholders to assess their risks and reduce carbon emissions. n99 For example, Aon worked with the BG group to assess the effect of climate change on their assets and operations and inform them of opportunities presented by carbon trading and alternative fuel use. n100 HSB Solomon, an AIG company, likewise markets a program to identify ways to reduce carbon emissions through carbon trading.

As more and more lawsuits are brought against major emitters of greenhouse gases, the insurance industry will undoubtedly rewrite future policies to include additional broad exclusions explicitly directed to global warming, and it may create specialized liability products that address global warming. n101 What those policies will look like remains to be seen.

CONCLUSION

As the Kivalina villagers lawsuit shows, climate change is an increasingly important insurance issue. After the Supreme Court's ruling in *Massachusetts*--that carbon dioxide was a pollutant, and that potential plaintiffs had standing to raise global warming claims--companies that emit greenhouse gases could face enormous exposure to potential nuisance liability, defense costs, and now claims of conspiracy. Although policyholders are likely to receive coverage for the defense and payment of many claims related to global warming under existing policies, companies with potential liability should carefully examine their insurance strategy in order to reduce their exposure in the future and look to emerging insurance products to mitigate their risk of legal liability for global warming.

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n1 See Felicity Barringer, *Flooded Village Files Suit, Citing Corporate Link to Climate Change*, N.Y. Times, Feb. 28, 2008.

n2 See, e.g., *California v. General Motors Corp.*, No. 3:06CV05755, at * 13 (N.D. Cal. filed Sept. 20, 2006).

n3 127 S. Ct. 1438, 1447 (2007).

n4 *Id.*

n5 See Christina Ross et al, *Limiting Liability in the Greenhouse: Insurance Risk-Management Strategies in the Context of Global Climate Change*, UCLA School of Law Public Law & Legal Theory Research Paper Series 252, 273, 283 (2007).

n6 Rebecca Mowbray, *Business Interruption Insurance Claims Could Account for Half of the Commercial Losses from Katrina, But Many Others Are Still Struggling to Get Payments*, World Interrupted, The Times-Picayune, Sept. 17, 2006.

n7 *Id.*

n8 See Gautam Niak, *Global Warming May Be Spurring Allergy, Asthma*, The N.Y. Times, May 3, 2007.

n9 *Comer v. Nationwide Mut. Ins. Co.*, 2006 U.S. Dist. LEXIS 33123, now *Comer v. Murphy Oil, U.S.A.*, No. 1:05CV436 LTS-RHW (S.D. Miss. Sept. 20, 2005).

n10 *California v. General Motors Corp.*, No. 3:06CV05755, at * 13 (N.D. Cal. filed Sept. 20, 2006)

n11 See J. Kevin Healy & Jeffrey M. Tapick, *Climate Change: Its Not Just a Policy Issue for Corporate Counsel--Its a Legal Problem*, 29 *Colum. J. Envtl. L.* 8, 101 (2004).

n12 *Id.*

n13 John Carey & Lorraine Woellert, *Global Warming: Here Come the Lawyers*, BusinessWeek, Oct. 30, 2006

n14 *Porterfield v. Audubon Indem. Co.*, 856 So. 2d 789, 800 (Ala. 2002).

n15 See Kenneth S. Abraham, *The Rise and Fall of Commercial Liability Insurance*, 87 *Va. L. Rev.* 85, 90-92 (2001).

n16 Richard D. Williams, *Intent of the Drafters: The Pollution Exclusion and the Insurance Commissioner Documents*, 579 *PLI/Comm* 415, 417 (May-June 1991).

n17 *Id.* at 424-25.

n18 *Morton Intl, Inc. v. Gen. Accident Ins. Co. of Am.*, 629 A.2d 831, 855 (N.J. 1993).

n19 See Scott G. Johnson, *Resolving Ambiguities in Insurance Policy Language: The Contra Preferentem Doctrine and Use of Extrinsic Evidence*, 33 A.B.A. The Brief 33 (2004).

n20 Robert E. Keeton, *Insurance Law Rights at Variance with Policy Provisions*, 83 Harv. L. Rev. 961 (1970).

n21 Eugene Anderson et al., *Insurance Litigation Coverage* 15-77 (2d ed. Aspen 2006).

n22 See, e.g., *New Castle County v. Hartford Accident & Indem. Co.*, 933 F.3d 1162, 1198 (3d Cir. 1991); *Broderick Inv. Co. v. Hartford Accident & Indem. Co.*, 954 F.3d 601, 608 (10th Cir. 1991); *Avondale Indust., Inc. v. Travelers Indem. Co.*, 887 F.2d 1200, 1204-06 (2d Cir. 1989).

n23 James M. Davis, *Global Warming Litigation--Implications for Insurance Coverage*, New Appleman on Insurance: Current Critical Issues in Insurance Law 24 (Oct. 2007).

n24 *Id.* at 28.

n25 Jeffrey W. Stempel, *Reason and Pollution: Correctly Construing the Absolute Pollution Exclusion in Context and in Accord with its Purpose and Party Expectations*, 34 Tort & Ins. L. J. 1, 5 (1998).

n26 *Id.* at 5. See also *Richardson v. Natl Mut. Ins. Co.*, 826 A.2d 310, 325 (D.C. 2003); *MacKinnon v. Truck Ins. Exch.*, 73 P.3d 1205, 1210 (Cal. 2003); *Am. States Ins. Co. v. Koloms*, 687 N.E.2d 72, 81 (Ill. 1997); *Assicurazioni Generali, S.p.A. v. Neil*, 160 F.3d 997, 1004-05 (4th Cir. 1998); *Certain Underwriters at Lloyds, London v. C.A. Turner Constr. Co.*, 112 F.3d 184, 188 (5th Cir. 1997); *Auto-Owners Ins. Co. v. Hanson*, 588 N.W.3d 777 (Minn. Ct. App. 1999).

n27 James M. Davis, *Global Warming Litigation--Implications for Insurance Coverage*, New Appleman on Insurance: Current Critical Issues in Insurance Law 24, 27 (Oct. 2007).

n28 See, e.g., *Sullins v. Allstate Ins. Co.*, 667 A.2d 617, 624 (Md. 1995); *Motorists Mut. Ins. Co. v. RSJ, Inc.*, 926 S.W.2d 679, 681 (Ky. Ct. App. 1996).

n29 Eugene Anderson et al., *Insurance Litigation Coverage* 15-106 (2d ed. Aspen 2006).

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n31 *Id.* at 7-8.1.

n32 See, e.g., *Nestle Foods Corp. v. Aetna Cas. & Sur. Co.*, 842 F. Supp. 125, 128-29 (D.N.J. 1993); *Union Pac. Resources Co. v. Aetna Cas. & Sur. Co.*, 894 S.W.3d 401, 404 (Tex. App. 1994)

n33 See, e.g., *City of Johnstown v. Bankers Standard Ins. Co.*, 877 F.2d 1146 (2d Cir. 1989); *New Hampshire Ball Bearings v. Aetna Cas. & Sur. Co.*, 848 F. Supp. 1082 (D.N.H. 1994); *MAPCO Alaska Petroleum, Inc v. Central Natl Ins. Co.*, 784 F. Supp. 1454 (D. Alaska 1991).

n34 Eugene Anderson et al., *Insurance Litigation Coverage* 7-9 (2d ed. Aspen 2006).

n35 *Id.* at 7-8.1-7.9.

n36 See generally Intergovernmental Panel on Climate Change, *Climate Change 2007: The Physical Science Basis, Summary for Policymakers* (2007); *Massachusetts v. E.P.A.*, 127 S. Ct. 1428 (2007).

n37 There are two major types of CGL policies: claims-made and occurrence. The difference lies in what must happen before an insurer faces liability. Under a claims-made policy, the policyholder must give notice or tender a claim during the policy period to receive indemnification. Therefore, policyholders with claims-made liability policies are likely limited to indemnification from a single policy. In contrast, an insurer faces liability under an occurrence policy when an occurrence--which may take place at any time--causes damage during the policy period. Occurrence policies may therefore provide decades of coverage for long-tail liabilities.

n38 Eugene Anderson et al., *Insurance Litigation Coverage* 4-7 (2d ed. Aspen 2006).

n39 *Id.* at 4-20.

n40 *Id.*

n41 James M. Davis, *Global Warming Litigation--Implications for Insurance Coverage*, New Appleman on Insurance: Current Critical Issues in Insurance Law 17 (Oct. 2007).

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n43 Eugene Anderson et al., *Insurance Litigation Coverage* 4-10 (2d ed. Aspen 2006).

n44 James M. Davis, *Global Warming Litigation--Implications for Insurance Coverage*, New Appleman on Insurance: Current Critical Issues in Insurance Law 18 (Oct. 2007).

n45 Some insurance companies argue that a policyholder facing long-tail liability can recover only up to the limits of one policy and cannot stack multiple policies to cover its loss. However, under most CGL policies, one occurrence may be a continuous or repeated exposure that spans decades and triggers multiple policies, and the insurers duty depends only on whether an occurrence causing bodily injury or property damage took place during that policy period. See James M. Davis, *Global Warming Litigation--Implications for Insurance*

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n46 Eugene Anderson et al., *Insurance Litigation Coverage* 4-115 (2d ed. Aspen 2006).

n47 *Id.* at 4-117.

n48 *Id.* at 4-118

n49 *Id.*

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n51 See James M. Davis, *Global Warming Litigation--Implications for Insurance Coverage*, New Appleman on Insurance: Current Critical Issues in Insurance Law 19-20 (Oct. 2007).

n52 See Elizabeth E. Hancock, *Red Dawn, Blue Thunder, Purple Rain: Corporate Risk of Liability for Global Climate Change and the SEC Disclosure Dilemma*, 17 *Geo. Intl Env'tl. L. Rev.* 233, 236 (2005).

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n54 J. Wylie Donald & Loly Garcia Tor, *Climate Change and the D & O Pollution Exclusion*, 41 *Tort & Ins. Practice L.J.* 4, 250 (2006).

n55 William G. Passannante, *Key Issues Affecting D & O Insurance* 23-24 (2007).

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n57 *Id.*

n58 *Id.* at 22.

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n60 Joseph P. Monteleone, *Global Warming--Will There Be Exposure for Directors and Officers and Will It Be Covered?* 5, address at Mealeys Global Warming Insurance Litigation Conference, June 6, 2007.

n61 *Id.*

n62 J. Kevin Healy & Jeffrey M. Tapick, *Climate Change: Its Not Just a Policy Issue for Corporate Counsel--Its a Legal Problem*, 29 *Colum. J. Envtl. L.* 8, 106 (2004).

n63 See, e.g., *Owens Corning v. Natl Union Fire Ins. Co.*, 1998 U.S. App. LEXIS 26233 (6th Cir. 1998) (strong causal connection required by arising out of language in pollution exclusion not shown where stock prices were allegedly inflated due to misrepresentations, not pollution itself); *Natl Union Fire Ins. Co. v. U.S. Liquids, Inc.*, 88 F. App'x 725 (5th Cir. 2004) (per curiam) (causal connection required by arising out of language in pollution exclusion shown where misrepresentations were inextricably intertwined with pollution that caused shareholder losses).

n64 J. Wylie Donald & Loly Garcia Tor, *Climate Change and the D & O Pollution Exclusion*, 41 *Tort & Ins. Practice L.J.* 4 (2006).

n65 *Id.*

n66 See J. Kevin Healy & Jeffrey M. Tapick, *Climate Change: Its Not Just a Policy Issue for Corporate Counsel--Its a Legal Problem*, 29 Colum. J. Envtl. L. 8, 105 (2004).

n67 William G. Passannante, *Key Issues Affecting D & O Insurance* 18 (2007).

n68 *Id.* at 19.

n69 Joseph P. Monteleone, *Global Warming--Will There Be Exposure for Directors and Officers and Will It Be Covered?* 6, address at Mealeys Global Warming Insurance Litigation Conference, June 6, 2007.

n70 See Evan Mills, Ph.D & Eugene Lecomte, *From Risk to Opportunity: How Insurers Can Proactively and Profitably Manage Climate Change*, CERES Report, 7, Aug. 2006.

n71 *Id.*

n72 See Christina Ross et al, *Limiting Liability in the Greenhouse: Insurance Risk-Management Strategies in the Context of Global Climate Change*, UCLA School of Law Public Law & Legal Theory Research Paper Series 252, 276 (2007).

n73 *Id.*

n74 *Id.*

n75 *Id.* at 277.

n76 Rebecca Mowbray, *Business Interruption Insurance Claims Could Account for Half of the Commercial Losses from Katrina, But Many Others Are Still Struggling to Get Payments*, World Interrupted, The Times-Picayune, Sept. 17, 2006.

n77 Eugene Anderson et al., *Insurance Litigation Coverage* 15-137 (2d ed. Aspen 2006).

n78 *Id.* at 15-136.

n79 *Id.* at 15-138.5.

n80 *Id.*; see also *Outboard Marine Corp. v. Liberty Mut. Ins. Co.*, 607 N.E.2d 1204, 1210-22 (Ill. 1992) (policyholders receipt of an EPA administrative order regarding pollution sufficient to preclude coverage under the known loss doctrine).

n81 See, e.g., *Comer v. Nationwide Mut. Ins. Co.*, 2006 U.S. Dist. LEXIS 33123, now *Comer v. Murphy Oil, U.S.A.*, No. 1:05CV436 LTS-RHW (S.D. Miss. Sept. 20, 2005); *California v. General Motors Corp.*, No. 3:06CV05755, at *13 (N.D. Cal. filed Sept. 20, 2006).

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n85 *Id.* at 10.

n86 *Id.* at 16; James M. Davis, *Global Warming Litigation--Implications for Insurance Coverage*, New Appleman on Insurance: Current Critical Issues in Insurance Law 40 (Oct. 2007).

n87 *Id.*; Evan Mills, Ph.D., *From Risk to Opportunity: Insurer Responses to Climate Change*, Ceres Report, 11, 16 (2007).

n88 Evan Mills, Ph.D., *From Risk to Opportunity: Insurer Responses to Climate Change*, Ceres Report, 16 (2007).

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n90 *Id.* at 7.

n91 James M. Davis, *Global Warming Litigation--Implications for Insurance Coverage*, New Appleman on Insurance: Current Critical Issues in Insurance Law 37-38 (Oct. 2007).

n92 *Id.* at 38.

n93 Evan Mills, Ph.D., *From Risk to Opportunity: Insurer Responses to Climate Change*, Ceres Report, 13 (2007).

n94 *Id.* Ceres is the largest coalition of investors, environmentalists and public interest organizations in North America.

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n97 James M. Davis, *Global Warming Litigation--Implications for Insurance Coverage*, New Appleman on Insurance: Current Critical Issues in Insurance Law 40 (Oct. 2007).

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n99 *Id.*

n100 *Id.*

n101 Clyde M. Hettrick, *The Coming Storm: Potential Global Warming Liability and the Insurance Assets Available for Companies Defense and Indemnifications*, 13-6 Mealey's Emerg. Ins. Disps. 16 (March 26, 2008).

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Morrison Mahoney LLP on Hartford Underwriters Ins. v. Foundation Health Services

2008 Emerging Issues 2277

Morrison Mahoney LLP on Hartford Underwriters Ins. Co. v. Foundation Health Services, Inc.: Fifth Circuit Puts a New Wrinkle in Choice of Law Issues Concerning Right to Independent Counsel

By Michael F. Aylward

May 6, 2008

SUMMARY: Few issues have proved as expensive or vexing to insurers over the years as whether and when policyholders may retain their own defense counsel due to claimed conflicts of interest on the part of their insurers. An issue that has received little attention is the extent to which the right to independent counsel may reflect choice of law considerations.

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ARTICLE: Few issues have proved as expensive or vexing to insurers over the years as whether and when policyholders may retain their own defense counsel due to claimed conflicts of interest on the part of their insurers. An issue that has received relatively little attention up to this point, however, is the extent to which the right to independent counsel may reflect choice of law considerations other than those that might ordinarily be assumed to govern the interpretation of the insurance contract itself.

In a recent opinion, the Fifth Circuit has now suggested that the right to independent counsel may arise from the law of the state in which the underlying action that the insurer is defending under a reservation of rights is pending, even if the insurers right to a defense pursuant to the policy is subject to the law of the jurisdiction where the policy was issued or the insured was headquartered.

Hartford Underwriters Ins. Co. v. Found. Health Servs., 2008 U.S. App. LEXIS 7621 (5th Cir. Miss. Apr. 9, 2008) arose out of fourteen different lawsuits that various Mississippi residents brought against Magnolia Health Care, Inc. which operates four nursing homes in Mississippi. Magnolia is a Mississippi corporation but maintains its corporate offices in Louisiana. At the time of the events in question, Magnolia was a subsidiary of Lunch, Inc. (later Foundation Health Services, Inc.), a Louisiana non-profit corporation that through its subsidiaries owns and operates health care facilities and nursing homes throughout the Southeast.

Magnolia tendered the defense of the 14 nursing home suits to Hartford, which had issued liability insurance policies to Lunch in 1997 and 1998. It was undisputed that Lunch, and not Magnolia, had applied for and procured the policies and that the policies were delivered to Lunch in Louisiana, where Lunch paid the policy premiums. Nevertheless, each of the four Magnolia nursing homes in Mississippi was listed on a schedule in the Hartford policies.

Upon receipt of these claims, Hartford issued a reservation of rights but agreed to engage counsel to provide a defense to Magnolia. It is unclear from the factual record recited in the various opinions in this case whether the insured rejected this defense or merely engaged lawyers of its own choosing to serve as shadow counsel. In any event, at the conclusion of the litigation, Magnolia demanded that Hartford reimburse it for fees incurred by independent counsel. After Hartford refused, the parties filed competing actions against each other with Hartford suing in federal court in Louisiana in October 2004 and Magnolia and Foundation bringing suit in state court in Mississippi a week earlier. After Hartford was able to remove its insureds action in Mississippi to federal court, the insured was able to persuade the federal district court in Louisiana to transfer its case to Mississippi so that the cases went forward in the U.S. District Court for the Northern District of Mississippi before Judge W. Allen Pepper.

The crucial question presented by this case was whether the law of Mississippi or Louisiana should control with respect to the question of whether a policyholder is entitled to independent counsel. Mississippi has recognized a right to independent counsel where an insurers reservation of rights creates a conflict of interest. In *Moeller v. American Guarantee & Liability Ins. Co.*,ⁿ¹ a Mississippi Supreme Court had ruled ten years earlier that:

When defending under a reservation of rights . . . a special obligation is placed upon the insurance carrier . . . Not only must the insured be given the opportunity to select his own counsel to defend the claim, the carrier must also pay the legal fees reasonably incurred in the defense.ⁿ²

Whereas Mississippi thus recognizes a policyholders right to independent counsel where its insurer has a conflict of interest, the District Court determined that Louisiana had yet to recognize such a right.ⁿ³ As a result, since a clear conflict existed between the law of Louisiana and Mississippi, the federal district court was forced to choose which law would control as regards the insureds claimed right to be reimbursed for its counsel fees.

Applying Mississippis choice of law rules, which are based upon the *Restatement (Second) of Conflict of Laws*, Judge Pepper concluded that Mississippi had the most significant relationship to the controversy. The District Court emphasized comments in Section 193 of the *Restatement* whereby policies that insure risks located in multiple states may be interpreted with the law of each such state insofar as it is the principal location of the insured risk. In this case, the District Court focused on the fact that Magnolia was an insured under the policies, only operated nursing homes in Mississippi and that Hartford had charged a premium for the risks associated with those Mississippi nursing homes and thus clearly contemplated the possible application of Mississippi law to claims arising out of insured locations in Mississippi. Applying Mississippis center of gravity test, Judge Pepper concluded that Mississippi law would apply. The court observed, moreover, that the present absence of Louisiana law in no way suggested that Louisiana would not ultimately reach the same conclusion as the courts in Mississippi (and many other states) had already reached confirming a policyholders right to independent counsel where a conflict of interest exists between it and its insurer.

Hartford appealed this ruling to the U.S. Court of Appeals for the Fifth Circuit, which affirmed Judge Peppers holding on April 9, 2008. In *Hartford Underwriters Ins. Co. v. Found. Health Servs.*, 2008 U.S. App. LEXIS 7621 (5th Cir. Miss. Apr. 9, 2008), the Court of Appeals affirmed the District Courts adoption of Mississippi law. The Court of Appeals disagreed with Judge Pepper concerning the application of Section 193, however. The Fifth Circuit noted that it had ruled in the past that Section 193 did not require that the law of a separate insured location be applied separately with respect to risks arising out of that location.ⁿ⁴ Unlike the federal district court, the Fifth Circuit found little significance in the fact that the policy in question insured risks in several different states. Accordingly, The location of the insured risk has less significance and Section 193 does not compel us to apply Mississippi law.

Instead, the court focused on the various considerations set forth in Section 188 of the *Restatement* including (a) the place of contracting; (b) the place of negotiation of the contract; (c) the place of performance; (d) the location of the subject matter of the contract; and (d) the domicile, residence, nationality, place of incorporation and place of business of the parties. Furthermore, the court emphasized the fact that these considerations need not be taken into account with

respect to the contract as a whole but could be determined to determine the law applicable to a specific issue, in this case, the right to independent counsel.

Weighing these various Section 188 considerations, the Fifth Circuit pointed out that the policies had been contracted for in Louisiana. However, while recognizing that other courts had declared that the place of contracting and place of negotiation might be paramount in disputes involving contract interpretation, the court observed that this case was different from the typical dispute involving the meaning of an insurance policy as the true issue was not one of contract interpretation wherein the court might have to ascertain the parties intent from the language of the contract and, at times, the circumstances surrounding formation of the contract, but rather involved the nature of the defense that was actually provided in Mississippi. As a result, it found that considerations with respect to the place of performance were of much greater consequence than those concerning the negotiation for and issuance of the actual policy.

As have other courts, n5 the court declared that the place of performance was not where policy premiums were paid or received but rather where the underlying claims triggering coverage were defended by appointed defense counsel. In particular, the court focused on Mississippis interest in ensuring that lawyers trying cases in its courts do not have conflicts of interest. The court declared that:

The duty to provide independent counsel when defending under a reservation of rights in Mississippi state courts is directly related to Mississippis interest in preventing conflicts of interest in litigation. Because this issue is closely connected to Mississippi courts and policy, the fact that the underlying suits were litigated in Mississippi courts is not really fortuitous, it is an important factor in determining which state has the most substantial relationship to the dispute.

The Fifth Circuit declined to find that Mississippis interest with respect to this concern was outweighed by the needs of the inter-state system, the relevant policies of the forum state or the expectations of the parties. As to the latter consideration, the court found that Magnolia would have been justified in expecting that Mississippi law would determine whether it was entitled to independent counsel in suits brought against it in Mississippi state court and that Hartford had no reason to expect otherwise given the fact that it had insured Magnolias nursing homes in Mississippi and might reasonably have anticipated the possibility that it would be obliged to defend Magnolia in Mississippi in tort claims arising out of those operations.

In conclusion, the Fifth Circuit declared that applying Section 188 of the *Restatement*, the most important consideration in this case was Hartfords performance of its obligations under the contract, which had taken place in Mississippi. Because the insureds right to independent counsel pursuant to the Mississippi Supreme Courts holding in *Moeller* that implicated Mississippi policy interests, the Fifth Circuit found that applying Mississippi law to this dispute was consistent with the needs of the inter-state system and in accordance with the reasonable expectations of the parties. The court left open the issue of whether any subsequent contractual disputes concerning the meaning of the policy itself might be subject to the law of Louisiana or some other state.

In the only other case in which such questions have been considered recently, a federal district court reached an opposite conclusion in *PhotoMedex, Inc. v. St. Paul Fire & Marine Ins. Co.*, 2008 U.S. Dist. LEXIS 8526 (E.D. Pa. Feb. 6, 2008), holding instead that the home state of the insured controlled both substantive issues of contract interpretation and issues pertaining to the scope of the insurers duties vis a vis independent counsel.

The issue in *PhotoMedex* was whether the law of Pennsylvania or California should govern concerning a CGL insurers claimed obligation to indemnify a Pennsylvania policyholder for a malicious prosecution award and the extent to which the fees charged by independent counsel should be determined in accordance with California or Pennsylvania law. PhotoMedex was a Delaware corporation with a principal place of business in Pennsylvania that operated throughout the United States. Nevertheless, despite St. Pauls argument that California law should apply in view of the fact that the underlying malicious prosecution claims arose entirely out of business operations conducted by the insured in California, Judge Yohn was persuaded that Pennsylvania law should apply based upon a *Restatement* analysis.

As had the Fifth Circuit in *Hartford Underwriters*, Judge Yohn was not persuaded that Section 193 compelled the application of California law merely because the claims involved a separate location, finding that this was not the principal location of the insured risk. Rather, as had the Fifth Circuit, the Pennsylvania District Court focused on the consideration set forth in Section 188. In *PhotoMedex*, however, Judge Yohn concluded that Pennsylvania had the most substantial contacts with and strongest governmental interest in the policy's coverage of defense and indemnity, focusing on the needs and interests of the home state of the insured being defended in contrast to the Fifth Circuit's focus on the concerns of Mississippi that lawyers litigating in its courts not have conflicts of interest.

These new opinions highlight the complexity and sophistication of choice of law determinations. Although most courts and litigants have presumed over the years that one law should apply with respect to all contract or related issues, courts in the past have sometimes taken into account the law of different states with respect to individual issues. In particular, there is a significant body of case law in which courts have declined to permit coverage for punitive damages focusing on the law of the jurisdiction where the damages are awarded even if the policy as a whole is subject to the law of another state where it was issued or the insured is domiciled. n6

The true mystery presented by *Foundation* is, in some respects, why the case arose at all. Even when an insurer defends under a reservation of rights, its obligation is only to engage one set of lawyers. As courts have recognized, the insurer is under no separate obligation to pay for a second set of lawyers. n7 This is not to say that the insured could not have refused to accept defense counsel appointed by its insurer had a true conflict of interest existed. In such circumstances, however, the insurer's obligation is to pay for one set of lawyers or the other, not both.

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n1 . 707 So.2d 1062 (Miss. 1996)

n2 . *Id.* at 1069.

n3 . The court's declaration in this regard is puzzling as the author's own research has identified several cases in which Louisiana courts have, in fact, apparently recognized a right to independent counsel. See *Dugas Pest Control of Baton Rouge v. Mutual Fire, Marine & Inland Ins. Co.*, 504 So.2d at 1054 (La. App. 1987)(if the insurer chooses to represent the insured but deny coverage, it must employ separate counsel); *T.H.E. Insurance Co. v. Larsen Intermodal Services, Inc.*, 242 F.3d at 675 (5th Cir. 2001) and *Belanger v. Gabriel Chemicals, Inc.*, 787 So.2d at 565 (La. Ct. App. 2001). Although it does not appear that any Louisiana authority was cited in the district court, the Fifth Circuit's opinion took note of the fact that Louisiana has considered this issue in a related context but has taken a somewhat narrower view than Mississippi courts and has only required independent counsel where a concurrent conflict of interest is shown to exist as in cases such as *Belanger* and *National Union Ins. Co. of Pittsburgh v. Circle, Inc.*, 915 F.2d at 991 (5th Cir. 1990)(holding that insured is entitled to use its own lawyers where appointed defense counsel by the insurer is demonstrably inadequate to the task). Nevertheless, it appears that the Fifth Circuit found that these differences were sufficient to warrant a conclusion that a conflict of law existed and required its resolution.

n4 . *Sandefur Oil & Gas, Inc. v. AIG Oil Rig of Texas, Inc.*, 846 F.2d at 324 (5th Cir. 1988)(declaring that Section 193 is inapplicable here because the insured risk was located in various states and thus there was no single principal location of the risks insured).

n5 . A place of performance analysis also led a California Court of Appeal to apply California law to issues involving an insurers claimed duty to defend notwithstanding the fact that the insured was located in Texas and the policy at issue had been issued in Texas. However, the Court of Appeals ruling in *Frontier Oil Corp. v. RLI Ins. Co.*, B189158 (Cal. App. August 6, 2007) did not arise out of the *Restatement* or common law principles governing choice of laws but rather reflected specific language in Californias choice of law statute (Section 1646), which requires that the interpretation of contracts should be governed in accordance with the place of performance. In that case, the Court of Appeal ruled that the place of performance was the location of the lawsuit where the insured was being asked to carry out its contractual obligations by providing a defense and thus applied California law, not that of Texas.

n6 . *See Stonewall Surplus Lines Ins. Co. v. Johnson Controls, Inc.*, 14 Cal. App.4th 637, 17 Cal. Rptr.2d 713 (1993)(availability of coverage for punitive damages depends on the substantive law of the jurisdiction in which the damages are awarded).

n7 . *Herbert A. Sullivan v. Utica Mutual Ins. Co.*, 439 Mass. 837, 788 N.E.2d 522 (2003)(where insured acquiesced in carriers selection of counsel, it may not later demand that the insurer also pay for shadow counsel that it hired to augment the defense being provided by appointed defense counsel). *Accord Driggs Corp. v. Pennsylvania Manufacturers Association Ins. Co.*, 181 F.3d 87 (4th Cir. 1999)(full text available at 1999 U.S. App. LEXIS 9182).

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Michael F. Aylward is a senior partner in the Boston office of Morrison Mahoney LLP where he chairs the firms complex insurance claims resolution group. For nearly 25 years, Mr. Aylward has represented insurers and reinsurers in coverage disputes around the country concerning the application of liability insurance policies to commercial claims involving intellectual property disputes, environmental and mass tort claims and construction defect litigation. He is a frequent lecturer on insurance issues and has authored portions of various insurance treatises and is a frequent contributor to scholarly publications on legal issues. Mr. Aylward has taken a leadership role in legal organizations including the Defense Research Institute (Board of Directors (2000-2003); past Chair, Insurance Law Committee and Law Institute (2004-2006); and the International Association of Defense Counsel (Chair, Reinsurance, Excess and Surplus Lines Committee, Board of Editors, Defense Counsel Journal). He presently serves as the chair of the Reinsurance, Excess and Surplus Lines Committee of the Federation of Defense and Corporate Counsel.

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Morrison Mahoney LLP on CIPS v. Agricultural Ins. Co.

2008 Emerging Issues 2229

Morrison Mahoney LLP on CIPS v. Agricultural Ins. Co: Illinois Court Expands the Obligations of Excess Insurers

By John T. Harding

April 30, 2008

SUMMARY: Although the obligations of a primary insurer to an excess insurer have been the subject of extensive litigation over the past two decades, far less often explored has been the issue of what duties are owed by one excess insurer to another excess insurer in a complex, multi-layered program. In a recent decision the Appellate Court of Illinois arrived at an answer that significantly expands the nature of the excess relationship.

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ARTICLE: It has been widely recognized in jurisdictions throughout the United States that a primary insurer can be liable to an excess insurer for a negligent or bad faith refusal to settle a claim within policy limits, thereby exposing the excess insurer to liability for a judgment that could have been avoided. Courts have found such a cause of action to exist either under the theory of equitable subrogation, in which the excess insurer steps into the shoes of the policyholder to maintain a claim for a breach of the duties owed by the primary insurer to its policyholder or, in a handful of jurisdictions, based upon the theory that the primary insurer owes a direct duty to the excess insurer notwithstanding the absence of a contract between them. *See e.g., Ranger Ins. Co. v. Travelers Indem. Co.*, 389 So.2d 272, 275 (Fla. 1980)(under the doctrine of equitable subrogation, the duty owed an excess insurer is identical to that owed the insured); *First State Ins. Co. v. Utica Mut. Ins. Co.*, 870 F.Supp. 1168, 1175 (D. Mass. 1994)(relationship between primary and excess insurer is one of subrogation where the excess insurer steps into the insured's shoes); *Attorneys Liab. Protection Socy v. Reliance Ins. Co.*, 117 F.Supp.2d 1114, 1124 (D. Kan. 2000)(primary insurer owes a duty of good faith to excess insurer); *General Accident Ins. Co. v. New York Marine and Gen. Ins. Co.*, 727 A.2d 1050, 1054 (N.J. Super. App. Div. 1999)(the duty of good faith running from a primary insurer to an excess insurer exists as a result of the distinctive and unique relationship between the two carriers).

Far less often explored, however, has been the issue of what duties (if any) are owed among the excess insurers in a multi-layered program. For example, at what point does an excess insurer potentially have an obligation to effect the settlement of a claim? Does an excess insurer owe any duties or obligations to insurers that are excess to the layer of coverage it agreed to provide? Can the excess insurer ever be deemed the equivalent of a primary insurer with respect to the duty to settle a claim within the limits of its policy if the coverage beneath it has been exhausted?

In a recent decision that could have significant implications for the relationship between layers of excess insurers with respect to the settlement of claims, the Appellate Court of Illinois (5th District) ruled on January 14, 2008 that a

lower tier insurer owes a duty to insurers in layers above it to engage in meaningful settlement negotiations and that the underlying insurer may still owe that duty even if it could not settle the matter within its available policy limits. *Central Illinois Public Service Co. v. Agricultural Insurance Co., et al.*, 378 Ill.App.3d 728, 880 N.E.2d 1172 (Ill. App. Ct., 5th Dist. 2008)(CIPS). While the ruling did not dispose of the case but instead remanded the matter for trial, the CIPS decision represents a significant expansion of the duties that can be owed by one excess insurer to another in a complex, multi-tiered program.

The CIPS case arose out of an accident at one of the insureds power plants when an elevator dropped 15 floors, injuring 23 boilermakers who were working at the plant. CIPS had several layers of insurance, including primary coverage of \$5 million with Seaboard Surety; a first-layer excess of \$10 million purchased from Steadfast; a second-layer excess insurer (Great American) which provided \$15 million of coverage; and a third layer (American International Specialty Lines AISLIC) which provided the final \$25 million of coverage.

A partial settlement was reached with a group of 10 plaintiffs, which exhausted the coverage available from Seaboard and Steadfast. CIPS then requested that Great American and AISLIC agree to fund a \$29 million settlement with the remaining plaintiffs on the condition that the ultimate responsibility for the settlement would be decided in an allocation trial between CIPS and a co-defendant, Dover Elevator Company (Dover). Both Great American and AISLIC agreed to this procedure while reserving all of their rights. In the allocation trial, a jury found that CIPS was liable for 95% of the settlement. While the trial court reduced this figure slightly on motion, at the end of the day Great American remained responsible for its policy limit of \$15 million, with \$10.325 million being allocated to AISLIC.

CIPS then filed a complaint for a declaratory judgment against the insurers. AISLIC filed a counterclaim against Great American alleging that it had acted negligently and in bad faith, including by ignoring demands by AISLIC to enter into good-faith settlement negotiations with the underlying plaintiffs or to tender its policy limits so that AISLIC could undertake such negotiations. The heart of the claim asserted by AISLIC was that the case could have been settled for far less than the \$49 million that was ultimately paid and/or that a more favorable settlement with Dover could have been reached than the 95%/5% allocation determined by the jury at trial. AISLIC alleged claims against Great American under both theories of direct duty and equitable subrogation. The trial judge dismissed AISLIC's counterclaim, ruling as a matter of law that the assertion that Great American breached a duty to tender its policy limits to AISLIC so that AISLIC could try to settle for less than AISLIC ultimately had to pay after trial is beyond a logical extension of existing law.

On appeal, the Fifth District reversed the dismissal of the counterclaim, however, holding that the claims asserted by AISLIC were legally cognizable and should not have been summarily dismissed at the pleadings stage. The court defined the relevant inquiry as two-fold: *first*, whether an underlying excess insurer can be liable to a higher layer insurer; and *second*, whether the trial court correctly held that any such duty can only arise if there was an opportunity for the lower layer excess insurer to settle the claim within the limits of its own policy, as would typically be the standard applied in a more conventional primary/excess dispute. The court acknowledged that in deciding these issues no Illinois appellate court had directly addressed the question of what duties one excess insurer owes to another excess insurer, although at least one federal case had touched upon the question. *Liberty Mutual Ins. Co. v. American Home Insurance Co.*, 348 F.Supp.2d 940 (N.D. Ill. 2004)(holding that underlying excess insurer could not be liable to higher layer insurer since it lacked substantial control over the litigation).

The Fifth District declined to rule, however, that the decision in *Liberty Mutual* foreclosed the inquiry or controlled the outcome of the case before it. As the court noted:

The difficulty with *Liberty Mutual Insurance Co.* is the assumption that an excess insurer could not have control over litigation to the extent that its actions would not affect another insurer. . . . [and] fails to address the circumstance that complex litigation often progresses through stages in which the involvement, or control, [that] an insurer has in the litigation and settlement changes.

880 N.E.2d at 1179. On the facts before it, the Fifth District concluded that AISLIC had alleged that Great American in fact had the right to control the settlement negotiations, including based upon the provisions of its policies. AISLIC further alleged that once the carriers underlying the Great American policy had actually settled and exhausted their limits, the control of the settlement process passed up to Great American's layer. While Great American denied that it had actual control over the litigation and settlement process, the court noted that the issue of control in this case, however, is a factual question and a dismissal at the early pleading stage of the case was inappropriate. Thus, in the circumstances of this case, the court ruled that AISLIC had a viable claim that Great American was no differently situated than a primary insurer with a duty to defend, notwithstanding its technical status as a second-layer excess insurer. Accordingly, AISLIC could pursue a claim that Great American had negligently or in bad faith failed to negotiate a settlement that would have protected the upper layer insurer, applying the standard of care recognized by the Illinois Supreme Court in *Schal Bovis, Inc. v. Casualty Insurance Co.*, 314 Ill. App. 3d 562, 732 N.E.2d 1082 (1999).

The court went on to hold that the trial court had erred in ruling that Great American only owed a duty to AISLIC if there was proof that Great American could have settled the claim within the limits of its policy. Instead, the court ruled that a multi-factor approach must be employed in determining whether the excess insurer acted in bad faith, including a refusal to negotiate; advice of defense counsel; the prospect of an adverse verdict and the potential for damages in excess of the policy limits. See *O'Neill v. Gallant Ins. Co.*, 329 Ill.App.3d 1166, 769 N.E.2d 100 (2002). The court therefore held that AISLIC was *not* required to prove that the case could have been settled within the limits of the Great American policy for Great American to be potentially liable, noting: Assuming the truth of the allegations of the counterclaim, Great American was not asked to perform an impossible task. The factual question raised by the counterclaim is whether Great American *failed to participate in settlement negotiations in a meaningful way* so that AISLIC was exposed to greater damages. 880 N.E.2d at 1181 (emphasis added). Since this was a quintessential issue of fact, dismissal at the pleadings stage was held to be unwarranted.

The extent to which the *CIPS* decision will have a significant impact on the relationship among excess insurers in a complex program remains to be seen since, at this stage of the case, all that has been established is that AISLIC can pursue its rather novel theory against Great American. However, the decision clearly cautions against an approach to claims handling in which an insurer can feel safe in assuming that because it is relatively high in the food chain it has no obligations to other insurers in a complex program. Insofar as *CIPS* suggests that duties of good faith will be imposed in the factual circumstances of a claim scenario without regard to the technicality of whether an insurer is primary, umbrella, first layer excess or seventh layer excess, it serves as a cautionary note which requires an insurer to give serious consideration to how its decisions regarding settlement may be found in retrospect to have impacted another insurer. Particularly troubling is the courts apparent (and vague) imposition of a standard which requires the excess insurer to engage in meaningful settlement negotiations even when there is no demand within the limits of its layer or face the consequences of paying an excess judgment--a standard that is not routinely imposed on a primary insurer. In this regard, *CIPS* suggests that in certain situations the upper layer excess insurers obligations may be greater than those of the primary insurer who agreed to provide first dollar coverage and a defense.

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John T. Harding is a senior partner in the Boston office of Morrison Mahoney LLP, where he is a member of the firm's complex insurance and reinsurance practice groups. Mr. Harding has twenty years of experience in handling complex insurance, reinsurance and bad faith disputes in trial and appellate courts throughout the United States and in international arbitrations. These cases have involved diverse areas including products liability, pharmaceutical products and other medical devices, asbestos, environmental, employment discrimination and other matters. John has extensive experience serving as trial counsel in these cases, including a recent multi-week trial of an environmental coverage case in the United States District Court for the District of Rhode Island that resulted in a defense verdict. John is the author of numerous articles and a frequent speaker at DRI, Mealeys and other conferences as well as being the Publications Chair for the DRI's Insurance Law Committee. John has been named a Massachusetts Superlawyer in the field of insurance coverage for the past several years. John is a graduate of Duke University and Harvard Law School.

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Cope on Qualcomm, Inc. v. Certain Underwriters at Lloyds London

2008 Emerging Issues 2244

Cope on Qualcomm, Inc. v. Certain Underwriters at Lloyds London: No Drop Down Required, Insureds Expectation of Coverage Defeated by Clear Policy Language to the Contrary

By Carrie Cope

April 30, 2008

SUMMARY: Insurance specialist attorney Carrie E. Cope, a partner in the Chicago office of Tressler, Soderstrom, Maloney & Priess, LLP, discusses *Qualcomm, Inc. v. Certain Underwriters at Lloyds London*, a decision in which the court upheld the language of the excess insurers exhaustion clause as being clear and explicit interpreted in its ordinary and popular sense notwithstanding the insureds asserted expectation of coverage.

PDF LINK: [Click Here for Enhanced PDF of Commentary](#)

ARTICLE: While commercial insurers have been struggling mightily with the effects of a soft insurance market which include coping with reduced premiums and expanded coverage, excess insurers have been winning coverage battles on at least one front. Joining similar decisions in other jurisdictions, a California court has upheld an excess insurers decision not to drop down in the face of a settlement below its policy's limits and assertions that the insureds expectation of coverage should carry the day even notwithstanding the failure to exhaust the underlying limit.

In *Qualcomm, Inc. v. Certain Underwriters at Lloyds London*, 161 Cal. App. 4th 184, 2008 Cal. App. LEXIS 394, Qualcomm employees filed a class action lawsuit related to their alleged right to unvested company stock options. Other Qualcomm employees subsequently sued seeking accelerated vesting of stock options. Qualcomm tendered the claims to its directors and officers liability (D&O) insurers, which included National Union Fire Insurance Company of Pittsburgh, P.A. (National) and Lloyds. National had issued a primary D&O insurance policy to Qualcomm with a \$20 million limit of liability. The Lloyds policy afforded excess D&O coverage. In April 2004, Qualcomm engaged in mediation with both insurers on the issue of coverage for the litigation. Qualcomm ultimately settled with National on terms which released National from all future obligations under its policy in exchange for total payments of \$16 million. Qualcomm subsequently sued Lloyds for more than \$9 million in unreimbursed defenses and settlement expenses it had incurred in the litigation. Lloyds demurred on grounds that Qualcomms complaint failed to state sufficient facts constituting a cause of action and denied coverage on the basis that its policy's coverage had not been triggered since 1) the underlying insurance had not been exhausted by the payment of loss and 2) Qualcomm had violated the policy's maintenance clause. The trial court sustained Lloyds demurrer without leave to amend on grounds that the excess policy had not been triggered and entered judgment in Lloyds favor.

On appeal, Qualcomm challenged Lloyds policy language requiring the underlying policy's exhaustion through

payment of loss. The pivotal language stated: [Lloyds] shall be liable only after the insurers under each of the Underlying Policies [the National policy] have paid or been held liable to pay the full amount of the Underlying Limit of Liability. The policy also contained language stating: This Policy does not provide coverage for any loss not covered by the [National policy] except and to the extent that such loss is not paid under the [National policy] solely by reason of the reduction or exhaustion of the Underlying Limit of Liability through payments of loss thereunder.

Qualcomm disputed the clarity of the relevant excess policy language arguing that it was susceptible to two or more reasonable constructions in view of the Lloyds policy as a whole. Qualcomm also argued that it had a reasonable expectation of coverage in light of other decisions holding that primary insurance had been exhausted even where the primary insurer settled for less than the policy's limit. However, the court strongly rejected Qualcomms arguments, stating: [a]n expectation of coverage cannot *create* an ambiguity; it is merely an interpretive tool used to resolve an ambiguity once it is found to exist. The court also declared: An insured's subjective expectations do not dictate our analysis of the presence of ambiguity in the excess policy language. The court further explained that under the facts of the case, Qualcomms objectively reasonable expectations were that the primary coverage would need to be exhausted before the excess policy could attach.

In addition, the court noted that California case law has consistently protected an excess insurer's position when its obligations are set in clear phases. The court determined that the meaning of the wording of the policy's exhaustion clause, which made Lloyds liable *only after* the underlying insurers *have paid or been held liable to pay the full amount* of the underlying limit of liability, was clear and explicitly interpreted in its ordinary and popular sense. The court also rejected Qualcomms assertion that the purpose of the policy language requiring payment was actually intended to convey the manner of exhaustion rather than exhaustion itself given the plain meaning of the provision. In fact, in making its decision, the court relied on *Comerica Inc. v. Zurich American Ins. Co.*, 498 F. Supp. 2d 1019, 2007 U.S. Dist. LEXIS 54517 (Jul. 27, 2007), a case much analyzed in the D&O industry in recent months due, in part, to the nature of the underlying settlement, in which similar policy language was construed. Quoting *Comerica*, the Qualcomm court noted: Payments by the insured to fill the gap, settlements that extinguish liability up to the primary insurer's limits, and agreements to give the excess insurer credit against a judgment or settlement up to the primary insurer's liability limit are not the same as actual payment.

The court did not review Qualcomms argument that Lloyds had misconstrued the maintenance clause which Qualcomm argued was ambiguous and should be construed in its favor to increase coverage, given that Qualcomm had not complied with it although it was an express condition precedent to coverage. Moreover, the court rejected Qualcomms public policy argument (that promoting settlement and risk-spreading by insurance should compel Lloyds to pay even if the obligation contravenes the policy language), concluding that clear and unambiguous policy language should not be rewritten for any purpose.

Although the decision is a very good one for insurers in more than one respect, as it recognizes the clarity of specific excess wording and confirms the validity of such wording over the sometimes amorphous, often iconic and difficult to rebut concept of public policy, it is worth considering the underlying factual situation that created the coverage gap in the first place. As it is not uncommon for insureds and their insurers to seek a compromise in the midst of a coverage dispute, it is not unusual for such coverage gaps to occur and both parties may be better off addressing this issue on the front end of the insurance transaction in an effort to avoid the need for litigation at a later date.

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Shidlofsky on UPLC v. American Home Assurance

2008 Emerging Issues 2254

Shidlofsky on UPLC v. American Home Assurance: The Use of Staff Counsel by Insurers in Texas

By Lee H. Shidlofsky

April 29, 2008

SUMMARY: An oft-raised question across the country is the legality of an insurers use of salaried staff attorneys to represent its insured when then insurers interests diverge from the clients. The Supreme Court of Texas held that an insurer can employ staff counsel to represent insureds as long as the insureds interest and that of the insurers are aligned in defeating the claim against the insured and no conflict of interest exists between the two.

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Framing the Issue Regarding the Use of Staff Counsel. An oft-raised question across the country is the legality of an insurers use of salaried staff attorneys to represent its insured when then insurers interests diverge from the clients. The Supreme Court of Texas has recently framed the question in *Unauthorized Practice of Law Comm. v. Am. Home Assur. Co.*, 2008 Tex. LEXIS 233 (Tex. 2008).

Liability insurers often obligate themselves to defend their insureds, and give them complete and exclusive control of that defense. In doing so, insurers utilize any one of three types of attorneys: (1) private law firms, whose work is paid for and overseen by the insurer; (2) captive law firms, whose lawyers are not employees of the insurer, but who have no other clients than the insurer; and (3) in-house, salaried corporate staff attorneys. According to the Court, each such attorney has the same obligation: Give the insured the same, unqualified loyalty that it would have if the insured had hired him or her directly and also protect the interests of the insured if the insurers instructions would otherwise compromise those interests. [*Id.* (citing *Employers Cas. Co. v. Tilley*, 496 S.W.2d 552, 558 (Tex. 1973); *State Farm Mut. Auto. Ins. Co. v. Traver*, 980 S.W.2d 625, 627 (Tex. 1998))]. Regarding the use of staff attorneys, a battle exists. Insurers contend that staff attorneys are more efficient, which lowers the insurers costs and--more importantly--the insureds premiums. On the other hand, opponents believe that when an insurer controls its staff attorneys as an employer would control any employee, the attorney-client relationship is at risk from the standpoint of the insured.

Getting to Unauthorized Practice of Law Committee. In 1998, Texas Unauthorized Practice of Law Committee filed a lawsuit against Allstate Insurance Company (Allstate), in which it alleged that Allstates use of salaried, corporate attorneys to defend its insureds in liability claims was conducted in violation of Texas law because it constituted the

unauthorized practice of law. [*Id.* (citing *UPLC v. Collins*, No. 98-8269 (298th Dist. Ct., Dallas County, Tex. 1998)).] Shortly after that suit was filed, Nationwide Mutual Insurance Company filed a declaratory judgment action against the Committee, seeking a declaration that Texas law did not prohibit the use of staff attorneys. In addition, Nationwide claims that, even if it did, such Texas law was in violation of the federal constitution. [*Id.* (citing *Nationwide Mut. Ins. Co. v. UPLC*, 283 F.3d 650, 651 (5th Cir. 2002)).] There, the Fifth Circuit analyzed Texas law and held:

[W]e believe that the law is fairly susceptible to a reading that would permit Nationwide to employ staff counsel on behalf of its insureds. While the Texas courts certainly may decide that Nationwides staff attorneys are engaged in the unauthorized practice of law, we believe that the law is uncertain enough on this issue that we should abstain from ruling on its federal constitutionality.

[*Id.* (quoting *Nationwide*, 283 F.3d at 655).] Thereafter, Nationwide re-filed its action in Texas state court and received a favorable ruling from the trial court, which was affirmed on appeal. The Committee, however, petitioned the Supreme Court of Texas to review the matter while the instant case was pending.

The instant case started as a result of a letter sent by the Committee to Katherine D. Woodruff, a salaried corporate attorney for American Home Assurance Co. (American Home), who was running her practice at Woodruff & Associates. The Committee informed Woodruff that she and her firm were being investigated for the unauthorized practice of law. In response to that letter, American Home, Woodruff & Associates and Travelers Indemnity Co. (Travelers) brought the instant lawsuit in which it sought a declaration that the use of staff attorneys did not constitute the unauthorized practice of law under Texas law. Eventually, after Woodruff and her firm were dismissed from the case, American Home, Travelers and the Committee cross-moved for summary judgment. At the lower court, the insurers' motions were rejected and the Committee's was granted. That court declared that each insurer's use . . . of staff counsel who are employees . . . to defend insureds (third parties) in Texas is the unauthorized practice of law. Judgment, however, was suspended by that court pending appeal. During that time, the parties agreed to the following policy:

If in the course of representing a party insured by [American Home and Travelers] any staff counsel employed in Texas by [such insurer, respectively] seeks advice about a potential conflict of interest between the insured and the insurance company, or any other question of professional ethics, such staff counsel will first consult with the Texas-licensed lawyer who is head of the staff counsel office, and thereafter, if the staff counsel's concerns are not resolved, counsel with an outside Texas firm, designated by [such insurer, respectively], on such question.

[*Id.*] On appeal to the Eleventh District Court of Appeals in Eastland, the lower court was reversed and the Committee's position was rejected in its entirety. [*Id.* (citing *UPLC v. Am. Home Assurance Co.*, 121 S.W.3d 831, 833, 846 (Tex. App.--Eastland 2003, pet. granted)).] In sum, the appellate court held that: (1) staff counsel do not face conflicts any different than counsel from an outside firm; (2) using staff attorneys does not violate any of Texas Disciplinary Rules of Professional Conduct; (3) the Supreme Court of Texas statement that an insurance defense lawyer owes unqualified loyalty to an insured was dicta and thus an insurer can be a client, as long as no conflict exists; (4) the use of staff counsel does not violate the Texas Business Corporation Act or the Texas Government Code, because if that is unauthorized, then so is the use of outside counsel; (5) Section 38.123 of the Texas Penal Code should not be read so as to prohibit the use of staff attorneys anymore than it should be read to prohibit insurance defense in general; and finally (6) only two states--North Carolina and Kentucky--actually prohibit the use of staff attorneys while many more do not. [*Id.* at *3*4 (citing *UPLC v. Am. Home*, 121 S.W.3d at 836*45).]

On appeal to the Court, two issues were presented:

(1) Does an insurer's use of staff attorneys to defend liability claims against its insured as contractually required constitute the unauthorized practice of law?

(2) If not, must the staff attorneys' affiliation with the insurer be fully disclosed to the insured?

Addressing these issues, the Court rejected the request by amicus curiae to determine what the practice of law

should be, and focused instead on what it is under current law. [*Id.*]

Texas High Court Finds that an Insurer Utilizing Staff Counsel is Not Practicing Law without Authorization. The parties in the instant lawsuit agreed that under Texas law a corporation cannot practice law and that the Supreme Court of Texas has inherent power to regulate that practice. In particular, the Court adopts rules governing admission to the practice of law, permitting only individuals meeting particular criteria that opportunity. Entities, including insurance companies, are excluded. [*Id.* at *5.]

Nevertheless, the Committee, argued that a more general provision of the Texas Business Corporation Act applies and it prohibits a corporation from transacting business in the state:

If any one or more of its purposes . . . is to engage in any activity which cannot lawfully be engaged in without first obtaining a license under the authority of the laws of this State . . . and such a license cannot lawfully be granted to a corporation.

[*Id.* (citing Tex. Bus. Corp. Code art. 2.01(B)(2)).] In rejecting that argument, the appellate court found that an insurance company is not organized for the purpose of practicing law. The Supreme Court, though, disagreed with that finding because the provision is not so flexible as it applies whenever any one of a corporations purposes is to engage in a licensed activity. Additionally, the Court rejected the lower courts finding that an insurers defense of its insured is collateral to its purpose of indemnifying its insured. The Court said that one is no less important than another. Regardless, the Court did not believe that it needed to construe that provision of the code because the Courts rules governing admission to practice law are sufficient to exclude insurance companies from engaging in *that* activity. [*Id.* (emphasis in original).]

The Court acknowledged that an insurance company is not engaging in the practice of law when it uses salaried corporate counsel to represent its own interests and such was not disputed by the parties to the case. The Court explained that such practice has long been held acceptable under Texas law because insurers clearly can hire in-house counsel to provide advice regarding the legal affairs of the company, as well as appear in court on the insurers behalf. The Courts view is congruent with that of the State Bar of Texas Committee on Interpretation of the Canons of Ethics, which has never found anything wrong with a corporation using in-house counsel. Quite simply, a corporation does not engage in practicing law by employing an attorney to represent itself, together with the common interests of other employers and affiliates. [*Id.* at *6.]

Moreover, the use of private counsel to defend an insured, does not equate to the practice of law. This is true because the practice of law involves the rendering of legal services *for someone else*. Only when a corporation employs attorneys to represent the unrelated interests of others does it engage in the practice of law. [*Id.* at *7.]

Thus, the more important question was whether an insurer is practicing law when it uses staff counsel to defend its insureds? On that issue, the Court stated that American Homes and Travelers reliance upon its earlier decision in *Utilities Insurance Co. v. Montgomery*, 138 S.W.2d 1062 (Tex. 1940), was clearly misplaced because that case involved the obtaining of non-waiver agreements, which are used to protect the insurers interest and not the insureds. n1 [*Id.* (citing *Montgomery*, 138 S.W.2d at 1064).] In any event, according to the Court, its opinion in *Montgomery* said nothing about the insurers interest in defending its insureds, and, more importantly, the Court never discussed whether the counsel at issue were staff counsel as opposed to private practice attorneys.

Instead, the Court said, its decision four years later in *Hexter Title & Abstract Co. v. Grievance Committee*, 179 S.W.2d 946 (Tex. 1944), was more on point. In that case, the Supreme Court of Texas held that Hexter was engaged in the unauthorized practice of law. The Court said that the corporations purpose was to accept applications for insurance and either insure the title as it was found or refuse to insure it. If defects in title existed, the Court explained, then the applicant had to cure them and the title insurer had no business meddling in the affairs of curing the title. As such, the Court concluded in *Hexter* that the company was engaged in the unauthorized practice of law, but emphasized that

Hexter was permitted to employ salaried attorneys to advise it on the state of title for its own uses; it was prohibited only from providing the same service to customers and prospective customers for their use. [*Id.* at *9.]

The Court gleaned three important factors from that case, which it felt should be considered in determining the issue before it in *UPLC*:

- (1) Is the company's interest being served by the rendition of legal services existing or only prospective?
- (2) Does the company have a direct, substantial financial interest in the matter for which it provides legal services?
- (3) Is the company's interest aligned with that of the person to whom the company is providing legal services?

With regard to the first factor, the Court found that an insurer renders legal services only to fulfill its contractual obligations under its insurance contract and does not use those services as a means of attracting business. Turning to the second factor, the Court acknowledged that the insurer clearly has a direct, substantial financial interest when it uses staff attorneys to defend its insured because if it manages to defeat the claim, then it does not have to pay the claim. Finally, as for the third factor—which the Court said was most important—the Court found that, in the vast majority of cases, the interests of an insurer and its insured are aligned, and such interests differ only when a coverage question exists or the rendering of the legal defense causes consequences that affect them differently. [*Id.*] Applying those factors, the Court said:

[W]e conclude that a liability insurer does not engage in the practice of law by providing staff attorneys to defend claims against insureds, provided that the insurer's interests and the insured's interests in the defense in the particular case at bar are congruent. In such cases, a staff attorney's representation of the insured and insurer is indistinguishable.

[*Id.* at *10.]

The Court then turned its attention to the issues raised by the Committee and several amici briefs regarding the conflicts present between an insured and an insurer, which can be exacerbated because of the employment relationship between the insurer and its staff counsel. More particularly, those parties argued that business pressure and loyalty in the employment relationship can endanger staff counsel's ability to exercise the independent judgment to which the insured is entitled. Further, they argue, the insurer's profit motive . . . is fundamentally inconsistent with the provision of independent legal services through staff attorneys. [*Id.*]

Importantly, the Court took note of the fact that those parties raising the issues did not bring forth any evidence of injury to a private or public interest as a result of staff counsel representing an insured. Considering that staff counsel have been used across the nation for decades, this dearth of evidence was telling. The Court explained that staff counsel resolve conflicts just as other attorneys do, and, if unable to do so, then they can withdraw just as any other attorney can. Importantly, the Court explained that the coverage questions most often raised involve the extent of policy limits and whether the claim at issue falls within the type of coverage provided. Interestingly, the Court said that in cases the insurer can always issue a reservation of rights letter, and, it said, insurers seem to do so now as a prophylactic measure, even though they may have no actual intent to pursue the coverage questions raised therein. On the same note, the Court seemed to give short shrift to reservation of rights letters when it said that [a] reservation-of-rights letter ordinarily does not, by itself, create a conflict between the insured and the insurer because it only recognizes that a conflict might exist later. [*Id.*] Further, the Court would not state that staff attorneys can never represent an insured when a routine reservation of rights letter is issued.

The Court did not dispute that problems can arise when defense counsel obtains information that the insured would expect to be kept confidential and away from the eyes of the insurer. In such situations, however, the Court felt that withdrawal by the attorney may be the best option whether it is a salaried employee of the insurance or works in private practice. [*Id.* at *11.] The Court said that, under Texas law, such knowledge could estop an insurer from using it altogether because it might be imputed to all employees of the insurer whether or not they are attorneys. But, while

these risks are present, they do not necessarily destroy the congruence of the insurers and insureds interest. [*Id.*] Regarding unqualified loyalty, the Court acknowledged that it is possible that counsel may fail to render the loyalty required because of business pressure, but that no evidence exists that a staff attorney is more likely to fail in that regard than counsel from a private firm. Additionally, the Court refused to find that, in comparison to private counsel, a staff attorney is more likely to adhere to its employers litigation guidelines even though doing so might compromise an insureds interests.

The Court, in a brief discussion, also may have answered a long-standing debate in Texas as to whether it is a one-client or two-client state. [*Id.* at *12.] Specifically, the Committee argued that defense counsel can only represent an insured under Texas law and that staff attorneys, by their nature of being employed by the insurer, necessarily violate that rule because they cannot represent the insured as well. In response, the Court said: But we have never held that an insurance defense lawyer *cannot* represent both the insurer and the insured, only that the lawyer *must* represent the insured and protect his interests from compromise by the insurer. *Id.* Accordingly, at least where a congruence of interest exists between the insurer and its insured, the Court suggests that Texas is a two-client state.

In sum, the Court addressed the concerns of the Committee and of amici, but found that they should not be avoided at all cost, as some are satisfactorily resolved. Nevertheless, it admitted that the use of staff counsel comes with risks. *Id.* Accordingly, the Court held:

If an insurer's interest conflicts with an insured's, or the insurer acquires confidential information that it cannot be permitted to use against the insured, or an insurer attempts to compromise a staff attorney's independent, professional judgment, or in some other way the insurer's and insured's interests do not have the congruence they have in the many cases in which they are united in simple opposition to the claim, then the insurer cannot use a staff attorney to defend the claim without engaging in the practice of law. But there are a great many cases that can be defended by staff attorneys without conflict and to the benefit of mutual interests. The use of staff attorneys in those cases does not constitute the unauthorized practice of law.

[*Id.*] In addition, when staff attorneys are representing insureds and congruence of interests exists, those attorneys are obligated to inform the insured of the attorneys relationship with the insurer. [*Id.* at *14.]

Dissenting thoughts . . . Justice Johnson authored a lengthy dissent that was joined by Justice Green. [See *Id.* at *14*22.] There, Justices Johnson and Green agreed that no problem exists when an insurer represents its own interests in a lawsuit if it chooses to do so. Rather, the Justices concern arises because under Texas State Bar Act, an insurer simply cannot represent a client (i.e., its insured). They argued that when a staff attorney acts on behalf of the insured such acts are imputed to the insurer. Thus, when salaried corporate attorneys represent an insured, the *insurer* is representing the insured in violation of the Act, as the insurer is practicing law without a license. Accordingly, Justices Johnson and Green would have reversed the appellate courts decision.

Conclusion. By finding that the use of staff counsel does not constitute the unauthorized practice of law, the Supreme Court of Texas did not diverge from the findings of most states across the nation. In that respect, the Courts opinion is somewhat unremarkable. What raises eyebrows, though, is the Courts seemingly nonchalant opinion of reservation of rights letters. In particular, the Court said that such letters do not necessarily create a conflict of interest between the insurer and the insured and are used more often for prophylactic measures. While it certainly is true that every reservation of rights letter does not create a conflict of interest, the opinion raises an interesting question as to the continued viability of the independent counsel doctrine. In other words, while the Court recognizes the long-standing rule that any type of attorney owes unqualified loyalty to its client (i.e., the insured), it seems to minimize the conflict of interest raised by a reservation of rights. Moreover, the Courts opinion begs the question: When does a sufficient

conflict exist that warrants granting an insured the right to select independent counsel?

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n1 . Notably, while the Court treats reservation of rights letters and non-waiver agreements as the same thing, such is not the case. Reservation of rights letters are unilateral in nature, whereas the non-waiver agreements are bilateral, requiring consent from the insured.

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Vespole on Hager v. Gonsalves

2008 Emerging Issues 2246

Vespole on Hager v. Gonsalves: New Jersey Court Puts New Spin on Cooperation Clause

By Mark R. Vespole

April 29, 2008

SUMMARY: In *Hager v. Gonsalves*, 398 N.J Super. 529 (App. Div. 2008), decided on March 7, 2008, Judge Stephen Skillman, Presiding Judge of the Appellate Division, put a new spin on this old issue, which may give insurers a reason to re-think their coverage strategy when their insureds breach the cooperation clause of the policy.

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ARTICLE: In *Hager v. Gonsalves*, 398 N.J Super. 529 (App. Div. 2008), Rutgers Casualty Insurance Company ("Rutgers") issued an automobile liability insurance policy with a \$50,000 limit to Chilito for his vehicle. The policy included a typical cooperation clause, which required those seeking coverage under the policy to "cooperate in the investigation, settlement or defense of any claim or suit". On October 18, 2002, Gonsalves, who was not a named or listed insured under Chilito's policy, was driving Chilito's insured vehicle while intoxicated and was involved in an accident with Hager, who was injured. According to the police report and two independent eyewitnesses, Gonsalves crossed into Hager's opposing lane of travel while attempting a left-hand turn without yielding, as a result of which the two vehicles collided. Gonsalves was issued multiple summonses for driving under the influence of alcohol, driving with a suspended license, reckless driving, etc. Gonsalves failed to appear in Municipal Court to answer the summonses, and a warrant was issued for her arrest. There was no question that the accident was caused exclusively by Gonsalves negligence, although there also may have been a potential dram shop claim if the intoxicated driver was served alcohol while visibly intoxicated by a tavern or social host. Rutgers first received notice of the accident from Hager's attorney more than five weeks after it had occurred.

Rutgers immediately sent a letter to its insured about the accident and reserved its right to disclaim coverage. Rutgers also made numerous, unsuccessful attempts to contact Chilito and Gonsalves by letter and phone over a period of several months. Having heard nothing from either its insured or the driver of the insured vehicle, on May 1, 2003, Rutgers disclaimed coverage for the October 18, 2002 accident based upon its insured's lack of cooperation with its investigation of the accident.

Subsequently, Hager filed a negligence lawsuit seeking damages for bodily injuries against Chilito and Gonsalves. Rutgers hired an attorney to defend Hager's lawsuit, but also filed a declaratory judgment lawsuit to disclaim coverage based upon breach of the cooperation clause. Finally, based upon Rutgers' disclaimer of coverage, Hager notified his own automobile insurer, High Point Insurance Company ("High Point") of a claim for Uninsured Motorists coverage.

High Point filed a third lawsuit against Chilito, Gonsalves and Rutgers seeking a declaration that Rutgers' policy provided coverage to Chilito and Gonsalves for the accident. The High Point and Hager lawsuit were consolidated.

On cross-motions for summary judgment by Rutgers and High Point, the trial court held that even though Gonsalves and Chilito unquestionably breached the cooperation clause of Rutgers' policy, Rutgers could not establish the likelihood of a successful defense of its insured, even if there had been cooperation. Relying upon established caselaw, the trial judge ruled that since Gonsalves was undeniably responsible for the underlying accident, Rutgers was not prejudiced by the breach of the cooperation clause. Additionally, the trial court rejected as speculative Rutgers' argument that the failure of the insured and the driver of the insured vehicle to cooperate precluded it from determining whether or not Gonsalves was a permissive user of the vehicle.

In reversing the trial court's decision, Judge Skillman held that because the driver of the insured vehicle, Gonsalves, would have been entitled to coverage under Rutgers' policy only if she were a permissive user at the time of the accident, Rutgers "irretrievably lost" the opportunity to determine whether Gonsalves had permission to use the insured vehicle. Judge Skillman found no basis for simply assuming permissive use, especially in light of the New Jersey Supreme Court's opinion in *French v. Hernandez*, 184 N.J. 144, 151 -- 157 (2005) (holding that there was no coverage under an employer's auto liability policy for an employee who did not have implied permission to take a vehicle from the employer's garage on a non-workday while intoxicated). Since Rutgers' lost opportunity was directly attributable to the failure of Gonsalves and Chilito to comply with the cooperation clause of the policy, Rutgers was entitled to disclaim coverage for the Hager accident. Judge Skillman's conclusion that Rutgers was entitled to disclaim coverage was based upon the "total lack of cooperation on the part of Gonsalves and Chilito", as well as the fact that the coverage claim was being pursued by another insurance company, rather than Rutgers' own insured or the injured party.

The Appellate Division did reject Rutgers' alternative argument on appeal that an insurer can disclaim coverage on account of its insured's breach of the cooperation clause of the policy, even if it did not suffer appreciable prejudice. In doing so, the Court relied upon its earlier decision in *Solvents Recovery Service of New England v. Midland Insurance Company*, 218 N. J. Super. 49, 55 (App. Div. 1987). The Court in *Solvents Recovery* applied to the cooperation clause the rationale of the New Jersey Supreme Court's seminal decision in *Cooper v. Government Employee Insurance Company*, 51 N.J. 86 (1968). *Cooper* required an insurer to demonstrate prejudice in order to disclaim coverage based upon an insured's breach of the notice provision of the policy. The Hager court found no reason to change or distinguish the analysis of *Solvents Recovery*.

The primary principle to be gleaned from *Hager* is that in proving "appreciable prejudice, insurers are not limited to "irretrievably lost" rights only impacting its ability to successfully defend its insured for the underlying occurrence. Instead, insurers now need to ascertain whether or not an insured's failure to cooperate has prejudiced their ability to make a coverage determination. An insurer's inability to render a coverage position as a basis for prejudice was not previously raised in any New Jersey cases interpreting either the cooperation or the notice provision of a liability insurance policy. Indeed, even if the underlying claim against the insured is indefensible, irrespective of insured's lack of cooperation, a breach of the cooperation clause could result in a disclaimer of coverage if it prevents the insurer from ascertaining facts necessary to render a coverage determination. Prior to *Hager*, if there was no basis for a meritorious defense of its insured to the underlying claim, insurers typically abandoned any hope of disclaiming coverage, notwithstanding the insured's utter lack of cooperation.

There are several caveats in *Hager*, however, which must be considered. First of all, as noted by Judge Skillman, the coverage claim against Rutgers was asserted by another insurer, the injured plaintiff's Uninsured Motorists insurer, and not the named insured. Of course, if the coverage case in *Hager* had been filed either by the named insured or the driver of the insured vehicle, the coverage issue of permissive use would likely be resolved. More importantly, however, in *Hager*, the coverage claim was not brought by the injured party, who in fact had another available source of recovery through his own Uninsured Motorists coverage.

The curious issue obviously left unresolved by *Hager* is whether or not an insurer will be permitted to establish

appreciable prejudice when an insured's total lack of cooperation prevents it from making a coverage determination, if that would result in the injured plaintiff having no source of recovery for damages. Two factors which may play a role in a Courts decision on this issue are the insurers good faith in attempting to locate and contact its insured and the legitimacy of the coverage issue. The Hager court clearly accepted Rutgers numerous letters and phone calls to the insured and the driver of the insured vehicle as a sufficient effort to obtain cooperation. The Court also found that the coverage issue relating to permissive use was genuine enough to warrant a disclaimer. Whether that will be enough if the injured plaintiff has no other source of recovery remains to be seen. However in anticipating a New Jersey court's response to this issue, insurers should spare no effort in attempting to obtain the cooperation of their insureds, and in articulating a sound basis for its inability to resolve a critical coverage issue.

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Time to Put a Stake Through the Heart of the Tort of Bad Faith

2008 Emerging Issues 268

Zalma on Time to Put a Stake Through the Heart of the Tort of Bad Faith

By Barry Zalma

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SUMMARY: Insurance Coverage lawyer, consultant and expert witness, Barry Zalma, discusses the perceived need to discard the so-called tort of bad faith because it has outlived its usefulness and because it has created a greater abuse than it was designed to cure. Although the tort of bad faith was created with good intentions to cure a perceived wrong it has fallen victim to the law of unintended consequences. The author opines that it is time to put a stake in the heart of the tort of bad faith. He concludes that insureds who are wronged by their insurer should limit their recovery to contract damages.

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ARTICLE: Time to Put a Stake Through the Heart of the Tort of Bad Faith

By Barry Zalma

When US law was first organized based on English Common law, when a contract was breached only contract damages could be recovered. Tort damages were limited to tortious conduct and the two categories of damages were mutually exclusive.

In a typical contract, one party has a duty to perform (construct a building, deliver goods, convey real estate, pay indemnity) and the other party has a duty to pay money. Breach by the performer may take the form of nonperformance, defective performance, or delay in performance. The primary purpose of damages for breach of a contract is to protect the promisee's expectation interest in the promisor's performance. Damages should put the plaintiff in as good a position as if the defendant had fully performed as required by the contract.

Insurance, like all parts of modern society, is subject to the deprivations of the law of unintended consequences. The Law can be defined as the understanding that actions of people -- and especially of government or the courts -- always have effects that are unanticipated or unintended. Insurance is controlled by the courts, through appellate decisions, and by governmental agencies through statute and regulation. Compliance with the appellate decisions,

statutes and regulations different in the various states is exceedingly difficult and expensive.

In the USA alone people pay to insurers more than 700 billion dollars in premiums and insurers pay out in claims as much or more than they take in. Profit margins are small because competition is fierce and a years profits can be lost to a single firestorm, earthquake, hurricane or a flood.

Neither the courts nor the governmental agencies seem to be aware that in a modern, capitalistic society, insurance is a necessity. No person would take the risk of starting a business, buying a home or driving a car without insurance. The risk of losing everything would be too great. By using insurance to spread the risk among all the costs of taking the risk to start a business, buying a home or driving a car becomes possible.

Insurance has existed since a group of Sumerian farmers, more than five thousand years ago, scratched an agreement on a clay tablet that if one of their number lost his crop to storms the others would pay part of their earnings to the one damaged. Over the eons insurance has become more sophisticated but makes essentially the same deal as did the ancient Sumerian farmers.

An insurer, whether an individual or a corporate entity, takes contributions (premiums) from many and holds the money to pay those few who lose their property from some calamity, like fire. The agreement, a written contract to pay indemnity to another in case a certain problem, calamity or damage occurs by accident, is called insurance.

In a modern industrial society almost everyone is involved in or with the business of insurance. Insurers provide protection against

- . the risk of becoming ill
- . losing a car in an accident
- . losing business due to fire
- . becoming disabled
- . losing their life
- . losing a home due to flood or earthquake
- . being sued for accidentally causing injury to another

The persons insured are dependent on their insurer to take the risk the insureds are not willing to take alone.

Insurance contracts can be simple or exceedingly complex, depending upon the risks taken by the insurer. Regardless, insurance is only a contract whose terms are agreed to by the parties to the contract. Over the last few centuries almost every word and phrase used in insurance contracts have been interpreted and applied by one court or another. Ambiguity in contract language became certain. However, the average person saw the insurance contract as incomprehensible and impossible to understand. Ostensibly to protect the public Insurance Regulators decided to require that insurers write their policies in easy to read language. Because they were required to do so by law insurers changed the words in their contracts into language that people with a Fourth Grade education could understand. Precise language interpreted by hundreds of years of court decisions were disposed of and replaced with imprecise, easy to read language.

The law of unintended consequences came into play and instead of protecting the consumer from imprecise language, an attempt to force insurers to deal fairly with the insureds resulted in thousands of lawsuits determined to

impose penalties on insurers for attempting to enforce ambiguous easy to read language. The multiple lawsuits cost insurers and their insureds millions (if not billions) of dollars to get court opinions that interpret the language and reword their easy to read policies to comply with the court decisions. For more than thirty years the unintended consequence of a law designed to avoid litigation has done exactly the opposite.

The attempts by the Regulators and Courts to control insurers and protect consumers were made with the best of intentions. The judges and regulators found it necessary to protect the innocent against what they perceived to be the rich and powerful insurers.

In 1958 the California Supreme Court created a tort new to U.S. jurisprudence when it decided *Comunale v. Traders & General Ins. Co.*, 50 Cal. 2d 654, 658-659, 328 P.2d 198 (1958). A tort is a civil wrong from which one person can receive damages from another for multiple injuries. The tort was called the Tort of Bad Faith and was created because an insurer failed to treat an insured fairly and the court felt that the traditional contract damages were insufficient to properly compensate the insured. The court allowed the insured to receive, in addition to the contract damages that the insured was entitled to receive under the contract had the insurer treated the insured fairly, damages for emotional distress and punitive damages to punish the insurer for its wrongful acts.

Insureds, lawyers for insureds, regulators and courts across the U.S. cheered the action of the California Supreme Court and most of the states adopted the tort created by the California Supreme Court.

After the creation of the tort of bad faith, if an insurer and insured disagreed on the application of the policy to the factual situation, damages were no longer limited to contract damages as in other commercial relationships. If the court found that the insurer was wrong it could be required to pay the contract amount **AND** damages for emotional distress, pain, suffering, punishment damages, attorneys fees and any other damages the insured and the court could conceive. It was hoped that the tort of bad faith would have a salutary effect on the insurance industry and force insurers to treat their insureds fairly. However, claims for \$40.00 wrongfully denied resulted in \$5 million verdicts. Juries, unaware of the reason for and operation of insurance decided that insurers that did not pay claims were evil and that they wrote contracts so they never had to pay. They punished insurers severely even when the insurers conduct was correct and proper under the terms of its contract. The massive judgments were publicized and many insurers decided fighting its insureds in court was too expensive regardless of how correct its position was on the contract.

Most of the massive verdicts were reversed or reduced on appeal. The bad actors raised their premium and lost little business. Other insurers, faced with the massive verdicts allowed fear to control reason, and paid claims that were improper or fraudulent. The extra cost was passed on to all insurance consumers, not to the insurers who acted improperly. They, in fact, profited since they continued their wrongful acts and paid the few insureds that sued while honest insurers paid frauds and claims they did not owe for fear of being painted with the same brush as the bad actor.

The law of unintended consequences struck. The tort of bad faith, designed to help the innocent, resulted in punishing the honest and correct insurers, honoring the insurers who acted in bad faith with profit, allowed many frauds to succeed and caused contract terms and conditions to be ignored.

Basic contract law, including almost all contracts other than insurance contracts, in cases involving a failure to perform, the plaintiff's expectation interest is measured by money damages measured by the difference between the contract price and the cost of completing the contract by another.

In construction contracts, for example, damages for defective or incomplete construction generally are measured by the cost of repair or the cost of completion. In contracts for the sale of goods, on the other hand, damages for nonconformity with the contract generally are measured by the diminution in value of the defective goods. The purpose of both measures is to place the plaintiff in as good a position as if the defendant had performed the contract according to its specifications.

The general rule of damages in tort is that the injured party may recover for all detriment caused whether it could

have been anticipated or not while contract damages are limited to that anticipated by the contract.

In *Comunale* insureds were allowed to recover against insurers in both tort and contract.

In so doing the California Supreme Court changed everything when it held:

Although a wrongful refusal to settle has generally been treated as a tort (see Keeton, Liability Insurance and Responsibility for Settlement, 67 *Harv. L. Rev.* 1136, 1138; Anno., 131 A.L.R. 1499, 1500), it is the rule that where a case sounds both in contract and tort the plaintiff will ordinarily have freedom of election between an action of tort and one of contract. (*Eads v. Marks*, 39 *Cal. 2d* 807, 811 [249 P.2d 257].) An exception to this rule is made in suits for personal injury caused by negligence, where the tort character of the action is considered to prevail (*Huysman v. Kirsch*, 6 *Cal. 2d* 302, 306 [57 P.2d 908]; *Krebenios v. Lindauer*, 175 *Cal. 431* [166 P. 17]), but no such exception is applied in cases, like the present one, which relate to financial damage (cf. *County of Santa Clara v. Hayes Co.*, 43 *Cal. 2d* 615, 619 [275 P.2d 456]; *Jones v. Kelly*, 208 *Cal. 251*, 255 [280 P. 942]).

Comunale was allowed to sue both in contract and tort and obtain contract, and tort damages, for the breach of the contract of insurance and its implied covenant of good faith and fair dealing.

In California the *Comunale* decision established that breach of an implied covenant, that is, breach of contract, as the theoretical basis of the claim allowed the plaintiff to recover contract and tort damages. This was a major change in jurisprudence and because a few people were harmed by bad actors in the insurance industry created an evil system that allows a few to grow rich from insurance claims while those who invest in insurance or who seek only the indemnity promised by the insurance policy, are subject to the law of unintended consequences.

In more than 60 years of application across the U.S. the tort of bad faith has not had a salutary effect on the insurance business. Insurance costs more than is reasonable or necessary so that sufficient funds exist to pay claims and tort damages from those insureds who believed they were done wrong. Suits relating to claims presented for the 1994 Northridge earthquake in California are still pending seeking tort and punitive damages for failure to pay what the insureds believed they were owed. In Louisiana and Mississippi multiple millions were paid to settle claims that flood damage was covered as a result of hurricane Katrina although the policies excluded flood and the plaintiff insureds failed to buy flood insurance. Abuse of insurers is so rampant and so successful that lawyers argue of multimillion dollar fees and have even attempted to (or successfully) bribed judges to increase their recovery.

The tort of bad faith is like the mythical Vampire. It hides in the dark. The truth about the tort of bad faith will die only if it is put into the light of day. It does not solve the problem anticipated. Rather it makes a few lawyers very rich, a few insureds receive indemnity for which they did not bargain and makes the cost of insurance to those who wish only to receive the benefits of the contract prohibitive.

In New York, for example, the courts were unwilling to adopt the widely-accepted tort cause of action for "bad faith" in the context of a first-party claim, because they recognized that to do so would constitute an extreme change in the law of this State. New York accepted the more conservative approach adopted by the minority of jurisdictions that the duties and obligations of the parties [to an insurance policy] are contractual rather than fiduciary [*Beck v Farmers Ins. Exch.*, 701 P2d 795, 798-799 [Utah 1985]].

Therefore, in order to ensure the availability of an appropriate and sufficient remedy, we adopt the reasoning of the Beck court that there is no reason to limit damages recoverable for breach of a duty to investigate, bargain, and settle claims in good faith to the amount specified in the insurance policy. Nothing inherent in the contract law approach mandates this narrow definition of recoverable damages. Although the policy limits define the amount for which the insurer may be held responsible in performing the contract, they do not define the amount for which it may be liable upon a breach. [*Acquista v. New York Life Insurance Company*, No. 2277, 2001 NYSlipOp 06087, (N.Y.App.Div. 07/05/2001)]

New York refused to allow a tort to be created out of a breach of contract. [*Batas v. Prudential Insurance Company Of America*, 281 A.D.2d 260, 724 N.Y.S.2d 3 (N.Y.App.Div. 03/20/2001)]

In California, and most states that allow a breach of an insurance contract to support a tort cause of action only allow it to go in one direction. Insurance litigants are not equal. An insured can obtain tort damages for bad faith breach of the insurance contract but an insurer may not receive tort damages for bad faith breach of an insurance contract.

The inequality of treatment of insurers and insureds resulted in a distinction between tort and contract liabilities that convinced one state supreme court to reject comparative bad faith as a defense in a bad faith action against an insurer because the [insurer's] tort cannot be offset comparatively by the [insureds] contract breach. It characterized the differing legal concepts as apples and oranges. [*Stephens v. Safeco Ins. Co. of America (Mont. 1993)* 852 P.2d 565, 568-569]. In addition a different court rejected a comparative bad faith defense for an insured's misperformance of its contractual duties in a bad faith action against the insurer for refusal to defend. [*First Bank v. Fidelity and Deposit Ins. (Okla. 1996)* 928 P.2d 298, 306-309]

In California, the decision in *Agricultural Ins. Co. v. Superior Court* (1999) 70 Cal.App.4th 385 agreed. *Agricultural* involved a bad faith action arising out of an insurance claim for earthquake damage. After the insurer paid the claim in part controversies arose, ultimately leading to the insureds suit for breach of contract and bad faith. The trial court stayed the action to allow the insurer to complete its investigation. The insurer did, and then cross-complained, contending that the insureds claim was in significant part falsified a ground usually sufficient to allow the insurer to declare the policy void and deny all payments.

The insurer pleaded various contract theories, and also the tort theories of fraud and so-called reverse bad faith, i.e., tortious breach of the covenant of good faith and fair dealing by the insured. The insured demurred to the tort theories, and the trial court sustained the demurrers without leave to amend. The decision made the following amazing conclusion:

Although there is an implied covenant of good faith and fair dealing in every contract, although each party is bound by it, and although this principle applies to insurance contracts (see, e.g., *Liberty Mut. Ins. Co. v. Altfillisch Constr. Co.* (1977) 70 Cal.App.3d 789, 797), the potential liability for breach is different for insurers and insureds. In summary, an insured may be held liable in contract for breaching the covenant, but cannot be held liable in tort. (Emphasis added)

The Fourteenth Amendment to the U.S. Constitution provides, in part:

No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

If the law allows an insured to sue for tort damages as a result of a breach of the covenant of good faith and fair dealing equal protection should allow an insurer to sue the insured for tort damages as a result of the breach of the same covenant. Some litigants cannot, under our system of constitutional law, be more equal than others.

Although the courts may think so, the insured's breach of the covenant of good faith and fair dealing is also separately actionable as a contract claim and that some forms of misconduct by an insured will void coverage under the insurance policy. (*Imperial Cas. & Indem. Co. v. Sogomonian* (1988) 198 Cal.App.3d 169, 182. The court in *Agricultural* believed that contract remedies adequately serve to protect an insurer from the insured's misconduct without creating the logical inconsistencies and troublesome complexities of a defense of comparative bad faith. In so doing it ignores the logical inconsistencies and troublesome complexities of the tort of bad faith. What is good for the insured should be good for the insurer.

In *Kransco v. American Empire Surplus Lines Insurance Company*, 23 Cal.4th 390, 2 P.3d 1, 23 Cal.4th 951, 97 Cal.Rptr.2d 151 (Cal. 06/22/2000) the California Supreme Court agreed with *Agricultural* and held that [A]n insured

does not bear a risk of affirmative tort liability for failing to perform the panoply of indefinite but fiduciary-like obligations contained within the concept of insurance bad faith.

An insurer can commit the tort and is obliged to pay tort and punitive damages. An insured, who is totally evil, whose only interest in the insurance agreement is to defraud the insurer, who refuses to cooperate with the insurers investigation, who does everything possible to harm the insurer, cannot commit the tort. This decision is as logical as stating that only black men can commit a battery while black women, white or Asian men and women cannot commit the tort of battery regardless of how hard the victim is battered. It is a statement that equal protection applies to all citizens of the U.S. except insurers since they can only be the tortfeasor and never the victim. Because of the lack of equal protection, plaintiffs lawyers and their clients take advantage of insurers and use their wits and energies to set up the insurer for bad faith.

In *Wade v. Emcasco Insurance Co.*, 483 F.3d 657 (10th Cir. 04/10/2007) the Tenth Circuit recognized that the undisputed evidence in the record showed that Plaintiff's counsel's sole reason for rejecting the insurers offer of settlement made after the running of an arbitrary deadline was his hope to pursue a bad faith claim against the insurer. As a result it refused to allow the plaintiff to pursue the bad faith case. The Tenth Circuit also noted that although the impetus for insurance bad faith claims derives from the idea that the insured must be treated fairly and his legitimate interests protected. It is designed as a shield for insureds not as a sword for claimants. Courts should not permit bad faith in the insurance milieu to become a game of cat-and-mouse between claimants and insurer, letting claimants induce damages that they then seek to recover, while relegating the insured to the sidelines as if only a mildly curious spectator.

The California Supreme Court recognized, in a footnote to a dissent, in 1985 the problem when Justice Kaus wrote:

It seems to me that attorneys who handle policy claims against insurance companies are no longer interested in collecting on those claims, but spend their wits and energies trying to maneuver the insurers into committing acts which the insureds can later trot out as evidence of bad faith. [*White v. Western Title Insurance Co.*, 40 Cal. 3d 870, 710 P.2d 309, 221 Cal. Rptr. 509 (Cal. 12/31/1985)]

It is time to put a stake in the heart of the tort of bad faith. Insureds who are wronged by their insurer should limit their recovery to contract damages. They should be compelled to waive the tort and sue in assumpsit. If the tort of bad faith must exist it must be applied equally. The abuse of the tort of bad faith has become so extreme that the tort must be eliminated or otherwise made fair.

If there is a tort of bad faith as the courts seem to believe the Fourteenth Amendment to the U.S. Constitution requires equal protection. An insurer who is wronged by its insured should have the same right to tort damages and punitive damages for breach of the covenant as can the insured. Americans do not live on George Orwells Animal Farm. No litigant is more equal than another.

Practice Insights

When faced with a bad faith suit it is essential to plead the violation of equal protection if there are facts to support the allegation.

Insurers who believe they are defrauded should file for both breach of the covenant and for the tort of fraud.

Insurers should seek to have policies declared void if there is a misrepresentation or concealment of a material fact.

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Sonnenschein Nath & Rosenthal LLP on Bad-Faith Claims in New York

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Sonnenschein Nath & Rosenthal LLP on Bad-Faith Claims in New York

By William T. Barker, Justin N. Kattan and Rachel G. Balaban

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SUMMARY: Plaintiffs have long sought to recover in excess of policy limits against insurance carriers who are alleged to have handled or denied claims in bad faith. Until recently, the New York Court of Appeals has squarely rebuffed any such efforts. However, in its decisions in *Bi-Economy Market, Inc. v. Harleysville Insurance Co.*, 2008 N.Y. Lexis 278 (Feb. 19, 2008) and *Panasia Estates, Inc. v. Hudson Insurance Co.*, 2008 N.Y. Lexis 275 (Feb. 19, 2008), the Court of Appeals permitted insureds to seek consequential damages, in excess of policy limits, against an insurer that was alleged to have violated its insurance contract in bad faith. This commentary examines that decision and important questions it left unresolved.

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ARTICLE: Sonnenschein Nath & Rosenthal LLP on Bad-Faith Claims In New York Following *Bi-Economy Market, Inc. v. Harleysville Insurance Co.* and *Panasia Estates, Inc. v. Hudson Insurance Co.*

By William T. Barker, Justin N. Kattan and Rachel G. Balaban

Based on its decisions in *Rocanova v. Equitable Life Assurance Society*,ⁿ¹ and *New York University v. Continental Insurance Co.*,ⁿ² the New York Court of Appeals appeared to have precluded any claim for insurance bad faith in failing to pay first-party benefits. Specifically, the court wrote in *Rocanova* that [a] complaint does not state a claim for compensatory or punitive damages by alleging merely that the insurer engaged in a pattern of bad-faith conduct.ⁿ³ So, an insureds recovery seemed limited to any benefits due plus interest.ⁿ⁴ But, in the recent cases *Bi-Economy Market, Inc. v. Harleysville Insurance Co. of New York*ⁿ⁵ and *Panasia Estates, Inc. v. Hudson Insurance Co.*,ⁿ⁶ the Court of Appeals permitted somewhat broader liability. In each case, the Court of Appeals allowed an insured to seek consequential damages in excess of policy limits against an insurer that was alleged to have violated its insurance contract in bad faith. These decisions raise many significant questions, including: What standard will be applied to determine when an insurer acts in bad faith? What types of damages will be recoverable when bad faith is proven? This commentary explores those issues.

Background: *Rocanova* and NYU

The issue in *Rocanova* was whether the insured had pled actionable claims for punitive damages based on the

carriers rescission of a disability income policy. *Rocanova* alleged breach of the implied covenant of good faith and fair dealing and various common law and statutory tort claims. n7 Equitable moved to dismiss all causes of action, except for the breach of the implied covenant, and to strike the demand for punitive damages. The trial court granted the motion in part, but rejected the motion to strike the demand for punitive damage. Equitable appealed, n8 and the Appellate Division affirmed. The Court of Appeals reversed, finding no basis for punitive damages. It initially defined the requirements for punitive damages as follows:

Punitive damages are not recoverable for an ordinary breach of contract as their purpose is not to remedy private wrongs but to vindicate public rights. However, where the breach of contract also involves a fraud evincing a "high degree of moral turpitude" and demonstrating "such wanton dishonesty as to imply a criminal indifference to civil obligations, punitive damages are recoverable if the conduct was "aimed at the public generally" Punitive damages are available where the conduct constituting, accompanying, or associated with the breach of contract is first actionable as an independent tort for which compensatory damages are ordinarily available, and is sufficiently egregious under the Walker standard to warrant the additional imposition of exemplary damages. Thus, a private party seeking to recover punitive damages must not only demonstrate egregious tortious conduct by which he or she was aggrieved, but also that such conduct was part of a pattern of similar conduct directed at the public generally. Clearly, then, the standard for awarding punitive damages in first-party insurance actions is "a strict one" and this extraordinary remedy will be available only in a limited number of instances. (citations omitted.) n9

All of *Rocanova's* tort claims had been dismissed, unless his bad-faith claim could be classified as a tort claim. The Court of Appeals summarily held that it could not be so classified.

NYU was an action on a commercial crime policy to recover for employee fraud in one of the University's bookstores, causing the University to pay for inventory it never received. n10 The University sued for breach of contract, breach of the duty of good faith, deceptive business practices in violation of a statute, and fraud. n11 The alleged deception and fraud was a false representation that the insurer, Continental, would investigate in good faith and pay covered claims. n12 The Court of Appeals found no sufficient allegation of any common law or statutorily created tort independent of the contract. n13

While the focus of *Rocanova* and *NYU* was punitive damages, they clearly held that bad-faith denial of an insurance claim was not an actionable tort.

A New Day: Bi-Economy Market and Panasia Estates

Notwithstanding the Courts decisions in *Rocanova* and *NYU*, plaintiffs in New York continued to seek ways to recover for what they claimed were bad-faith denials of benefits. The first appellate court to support such a claim was the First Department in *Acquista v. New York Life Insurance Co.* n14 In that case, the trial court dismissed a physicians bad-faith claim against his disability carrier. On appeal, the First Department recognized that to date, this State has maintained the traditional view that an insurer's failure to make payments or provide benefits in accordance with a policy of insurance constitutes merely a breach of contract, which is remedied by contract damages. n15 But the Court also cited to the courts and commentators around the country [who] have increasingly acknowledged that a fundamental injustice may result when benefits are denied in bad faith. n16 The Court further noted that many states have responded by recognizing bad faith as a tort, while others have expanded the scope of contract damages to include various types of foreseeable monetary damages beyond policy limits. Among the latter group, some states excluded compensation for mental and emotional distress, while others allowed for consequential damages for emotional distress. n17

The *Acquista* court declined to recognize a distinct tort cause of action for bad faith. However, it did adopt the reasoning of the Supreme Court of Utah in *Beck v. Farmers Insurance Exchange* that there is no reason to limit damages recoverable for breach of a duty to investigate, bargain, and settle claims in good faith to the amount specified

in the insurance policy. n18 In the First Departments view, [t]he problem of dilatory tactics by insurance companies seeking to delay and avoid payment of proper claims has apparently become widespread enough to prompt most states to respond with some sort of remedy for aggrieved policyholders. n19 Consequently, while plaintiff's cause of action alleging bad-faith conduct on the part of the insurer cannot stand as a distinct tort cause of action, we conclude that its allegations may be employed to interpose a claim for consequential damages beyond the limits of the policy for the claimed breach of contract. n20

While *Acquista* and similar decisions provided support to bad-faith plaintiffs, it remained to be seen whether the New York Court of Appeals would agree with this approach. The issue recently was put before the Court in *Bi-Economy Market, Inc. v. Harleysville Insurance Co. of New York* n21 and *Panasia Estates, Inc. v. Hudson Insurance Co.* n22

The insured in *Bi-Economy Market* asserted that the carriers inadequate and delayed payment of a business interruption claim led to the failure and eventual bankruptcy of its business. In assessing whether the insured could assert a claim for consequential damages, the Court of Appeals first stated the well-settled principal of New York law that contract damages include: . . . damages [which] naturally and directly [flow from the breach], i.e., in the ordinary course of things[and] which should have been foreseen at the time the contract was made. n23 This does not ordinarily allow consequential damages for nonpayment of money, because what the payee plans to do with the money is external to and irrelevant to the contract. n24 However, in reversing summary judgment in favor of the insurer, the Court of Appeals reasoned that the purpose of the agreement what the insured planned to do with the money was at the very core of the contract. n25 Specifically, the very purpose of business interruption coverage would have made [the insurer] aware that if it breached its obligations under the contract to investigate in good faith and pay covered claims, it would have to respond in damages to Bi-Economy for the loss of its business as a result of the breach. n26 The Court further held that the purpose of the insurance agreement at issue was not just to receive money, but to receive it promptly so that in the aftermath of a calamitous event the business could avoid collapse and get back on its feet as soon as possible. n27

The Court therefore concluded that the insurance contract included an additional performance-based component: the insurer agreed to evaluate a claim, and to do so honestly, adequately, and most importantly promptly, and that the insurer was necessarily aware that failure to perform would (a) undercut the very purpose of the agreement and (b) cause additional damages that the policy was purchased to protect against. n28 The Court of Appeals held that for such damages in excess of policy limits, the insurance company should stand liable. n29

Panasia Estates arose out of Hudsons denial of Panasias builders risk claim. The insured sought both contract benefits and consequential damages. n30 Hudson moved for partial summary judgment, including the dismissal of all of Panasias bad faith allegations and all prayers for consequential, extra contractual or incidental damages. The lower court refused to dismiss Panasias claim for consequential damages; the First Department affirmed and granted Hudson leave to appeal to the Court of Appeals. n31 The Court of Appeals affirmed, holding that consequential damages resulting from a breach of the covenant of good faith and fair dealing may be asserted in an insurance contract context, so long as the damages were within the contemplation of the parties as the probable result of a breach at the time of or prior to contracting. n32

Analysis

What Types of Damages Will Be Recoverable? Based on these decisions, it appears that consequential damages will often, perhaps always, be recoverable if they result from failure to evaluate a claim in good faith, i.e. honestly, adequately, and . . . promptly. n33 All insurance is designed to respond to some sort of calamitous event by indemnifying a resulting economic loss, and *Bi-Economy Market* suggests that this is enough to permit recovery of consequential damages for bad-faith denial of benefits.

It is not clear whether this reasoning will be extended to permit recovery of emotional distress damages resulting from bad-faith denial. But *Bi-Economy Market* suggests that it might be so extended. The Court of Appeals, citing the Utah Supreme Courts decision in *Beck* and a host of other state court decisions that contemplate recovery of emotional distress damages, stated that [a]n insured may . . . bargain for the peace of mind, or comfort, of knowing it will be protected in the event of a catastrophe. n34

There is no reason, however, to see *Bi-Economy Market* and *Panasia Estates* as retreating from the high threshold for punitive damages described in *Rocanova*. While the dissents in both decisions characterize the contemplated consequential damages as punitive, n35 the majority explicitly rejected that characterization, insisting that only compensatory damages are at issue. n36

What Does Bad Faith Now Mean? The big unanswered question is what conduct is required of an insurance company evaluating its insureds claim. The dissent in *Bi-Economy Market* fears that the majoritys decision will allow jurors to

decide whether claims should have been paid more promptly, or in larger amounts; whether an insurer who failed to pay a claim did so to put pressure on the insured, or from legitimate motives, or from simple inefficiency; and whether, and to what extent, the insurers slowness and stinginess had consequences harmful to the insured. All these very difficult, often nearly unanswerable, questions will be put to jurors who will usually know little of the realities of either the insureds or the insurers business. The jurors will no doubt do their best, but it is not hard to predict where their sympathies will lie. n37

But the extent to which those issues will be left to juries depends on the legal standard to be applied. Almost all jurisdictions imposing first-party bad-faith liability require, at least, that there be no reasonable basis for denial or delay of payment. n38 Most such jurisdictions add a requirement of subjective culpability, typically that the insurer knows that it lacked a reasonable basis to deny the claim or recklessly disregarded the lack of a reasonable basis. n39 Even under such standards, an insurer should be able to defeat most bad-faith claims on summary judgment, directed verdict, or, if necessary, on appeal. n40

New York will likely impose an even higher threshold than does either of the foregoing standards. *Bi-Economy Market* requires an insurer to evaluate a claim honestly, implying that bad-faith conduct must be dishonest, instead of merely reckless. A requirement of subjective dishonesty would present a substantial barrier to bad-faith claims. At a minimum, one would expect a standard at least as demanding as New York imposes for claims of bad-faith failure to settle third-party claims under a liability insurance policy.

Bad Faith Arising Out of the Failure to Settle. New York has long recognized that an insurers duty of good faith requires it to consider the insureds interest in avoiding exposure to excess judgments. n41 The governing standard for that duty was formulated in *Pavia v. State Farm Mutual Automobile Insurance Co.*, n42 where the Court of Appeals reversed a jurors bad-faith award.

In April, 1985, Pavia was injured in an accident while a passenger in a car driven by Rosato, a State Farm insured. Pavias injuries rendered him a hemiplegic and, by April 1986, State Farm had medical reports attesting to the severity of the injuries, and it had confirmation from its own medical examination by April 1987. Initial investigation indicated that Rosato was 100% liable. n43

Early in June 1987, Rosatos deposition was taken and suggested some possible liability defenses. Although regarding liability as extremely unfavorable, defense counsel recommended further inquiry into these defenses. n44 Late in June, Pavias counsel made a demand for the policys \$100,000 limit, to remain open for only 30 days. The offer expired without a response from State Farm. After the investigation into Rosatos possible defenses proved fruitless, State Farm offered to settle for a policy limit in January, 1988. The settlement offer was rejected. At trial, the jury

returned a verdict in the amount of \$6,322,000, with 85% of the fault attributable to Rosato. n45

Rosato assigned to Pavia his cause of action against State Farm for failure to settle. The jury was charged that State Farm should be found liable if its failure to settle involved a deliberate or reckless decision to disregard the insureds interests. A verdict was returned against State Farm. n46

On appeal, the Court of Appeals found that the jury had been properly instructed:

[T]o establish a prima facie case of bad faith, the plaintiff must establish that the insurers conduct constituted a gross disregard of the insureds interests--that is, a deliberate or reckless failure to place on an equal footing the interests of its insured. In other words, a bad-faith plaintiff must establish that the defendant insurer engaged in a pattern of behavior evincing a conscious or knowing indifference to the probability that an insured would be held personally accountable for a large judgment if a settlement offer within the policy limits were not accepted.

The gross disregard standard, which was utilized by the trial court here, strikes a fair balance between two extremes by requiring more than ordinary negligence and less than a showing of dishonest motives. The former would remove the latitude that insurers must be accorded in investigating and resisting unfounded claims, while the latter would be all but impossible to satisfy and would effectively insulate insurance carriers from conduct that, while not motivated by malice, has the potential to severely prejudice the rights of its insured. The intermediate standard accomplishes the two-fold goal of protecting both the insureds and the insurers financial interests. n47

Turning to the sufficiency of the evidence, the court reasoned that an insurer cannot be compelled to concede liability and settle a questionable claim simply because an opportunity to do so is presented. n48 Rather, it must be shown that an opportunity to settle existed at a time when all serious doubts about the insureds liability were removed. n49 The court rejected the argument

that whenever an injury is severe and the policy limits are significantly lower than a potential recovery the insurer is obliged to accept a settlement offer. The bad faith equation must include consideration of all of the facts and circumstances relating to whether the insurers investigatory efforts prevented it from making an informed evaluation of the risks of refusing settlement. In making this determination, courts must assess the plaintiffs likelihood of success on the liability issue in the underlying action, the potential magnitude of damages and the financial burden each party may be exposed to as a result of a refusal to settle. Additional considerations include the insurers failure to properly investigate the claim and any potential defenses thereto, the information available to the insurer at the time the demand for settlement is made, and any other evidence which tends to establish or negate the insurers bad faith in refusing to settle. The insureds fault in delaying or ceasing settlement negotiations by misrepresenting the facts also factors into the analysis n50

The court was hostile to the very concept that an insurers duties might be shaped by a time limit imposed by an insured:

[D]efendants failure to respond to the letter and overall delay under the circumstances of this case cannot serve as a basis for recovery. Permitting an injured plaintiffs chosen timetable for settlement to govern the bad-faith inquiry would promote the customary manufacturing of bad-faith claims, especially in cases where an insured of meager means is covered by a policy of insurance which could finance only a fraction of the damages in a serious personal injury case. Indeed, insurers would be bombarded with settlement offers imposing arbitrary deadlines and would be encouraged to prematurely settle their insureds claims at the earliest possible opportunity in contravention of their contractual right and obligation of thorough investigation. n51

As the court viewed the facts, Pavias demand came at a relatively early point in the litigation when there remained several significant questions about the insureds liability, which [State Farm] was entitled to investigate and explore. n52 While the investigation could have been completed more expeditiously, one could not convert inattention into a gross disregard for the insureds rights. n53 Moreover,

The facts that State Farms preliminary liability forecasts were unfavorable and that the investigation ultimately proved those forecasts accurate certainly do not establish that the insurer was unjustified in engaging in further investigation and failing to effectuate an early settlement. On the contrary, State Farms failure to conduct the continuing inquiry could have constituted a breach of its obligation to investigate and defend its insured. Moreover, State Farm should not be penalized for the delay in processing the claim and offering the full policy limits in settlement which resulted from its pursuit of an investigation prompted by its insureds representations which ultimately did not materialize.

By any view of the evidence, State Farms failure to promptly respond to the time-restricted demand did not amount to more than ordinary negligence an insufficient predicate for a bad-faith action. n54

Both the requirement of gross disregard for the insureds interests and the ancillary rules announced in *Pavias* sufficiency-of-the-evidence analysis are much more demanding for bad-faith plaintiffs than the rules followed in most other states. Most courts have required insurers to settle within limits, so long as the amount is one which an ordinarily prudent insurer without policy limits would accept. n55 Unless they have inadequate information to evaluate the claim, insurers are required to respect the time limits set by plaintiffs, because they may not get future opportunities to protect their insureds by settling within limits. n56 Nor can they wait until all questions of liability have been resolved, if doing so puts the insured at risk of an excess judgment when a within-limits settlement is a reasonable alternative. n57

Conclusion

The fact that New York law on the duty to settle is so much more demanding for plaintiffs than that elsewhere has two important implications. First, it strongly suggests that New York law on first-party bad faith will be at least as demanding, and probably more demanding than that in other states. More importantly, all or almost all states impose more demanding standards for first-party bad faith than for the duty to settle third-party claims. While the duty to settle is universally recognized, a large minority of states do not recognize any enhanced form of liability for first-party bad faith. n58 In considering settlement, insurers are generally required to compromise even substantial issues of liability or damages. n59 But, on first-party claims, they are entitled, in almost all states recognizing bad faith liability, to deny any claim that is fairly debatable. n60 If New York follows this pattern, it will likely apply the gross disregard standard to first-party claims as well as duty-to-settle claims. If so, there may be very few successful bad-faith claims.

Insurers facing New York bad-faith claims should aggressively argue for the application of a demanding standard to putative bad-faith claims. But carriers should also focus on demonstrating objectively reasonable grounds for delaying or denying payment, a showing that should preclude bad faith even under the least demanding of the standards commonly applied elsewhere. Such a focus may permit them to avoid entanglement in the issues left unresolved by *Bi-Economy Market* and *Panasia Estates*.

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n1 83 N.Y.2d 603, 615 (1994).

n2 87 N.Y.2d 308 (1995).

n3 83 *N.Y.2d* at 615.

n4 *See Acquista v. New York Life Ins. Co.*, 285 A.D.2d 73, 78-79 (1st Dept 2001) (describing traditional approach).

n5 2008 *N.Y. Lexis* 278 (Feb. 19, 2008).

n6 2008 *N.Y. Lexis* 275 (Feb. 19, 2008).

n7 *Rocanova*, 83 *N.Y.2d* at 610-13. A second case, involving plaintiff Marsel Mirror & Glass was consolidated with Rocanovas, but it was disposed of based on a release. *Id.* at 616-17.

n8 New York does not limit appeals to final orders. *See* N.Y. C.P.L.R. §5701 (2008).

n9 *Rocanova*, 83 *N.Y.2d* at 613 (citations omitted).

n10 *NYU*, 87 *N.Y.2d* at 314.

n11 *Id.* at 315.

n12 *Id.* at 318-19.

n13 *Id.* at 317-20.

n14 285 A.D.2d 73 (1st Dept 2001).

n15 *Id.* at 78.

n16 *Id.*

n17 *Id.* at 78-81.

n18 *Id.* at 81, quoting *Beck v. Farmers Ins. Exch.*, 701 P.2d 795, 801 (Utah 1985).

n19 *Id.*

n20 *Id.* at 82.

n21 2008 N.Y. *Lexis* 278 (Feb. 19, 2008).

n22 2008 N.Y. *Lexis* 275 (Feb. 19, 2008).

n23 *Bi-Economy*, 2008 N.Y. *Lexis* 278, at *5-6 (citations omitted).

n24 *Id.* at *7.

n25 *Id.*

n26 *Id.* at *11.

n27 *Id.*

n28 *Id.* at *11-12.

n29 *Id.* at 12.

n30 2008 N.Y. *Lexis* 275, at *1-2.

n31 *Id.* at *2-3.

n32 *Id.* at *3 (quoting *Bi-Economy Market*, 2008 N.Y. *Lexis* 278, at *5).

n33 2008 N.Y. *Lexis* 278, at *11-12.

n34 *Id.* at *8.

n35 *Id.* at *15-16; *Panasia Estates*, 2008 N.Y. *Lexis* 275, at *4-6.

n36 *Bi-Economy Market*, 2008 N.Y. *Lexis* 278, at *7-8.

n37 *Id.* at *19-20.

n38 See Stephen S. Ashley, *Bad Faith Actions: Liability And Damages* § 5:02, at 5-4 to 5-5 & nn.8-10 (2d ed. 1997).

n39 See *id.* at 5-5 to 5-12 & nn.11-15.

n40 See generally, William T. Barker, *Evidentiary Sufficiency in Insurance Bad Faith Suits*, 6 *Conn. Ins. L.J.* 82 (1999-2000); William T. Barker & Paul E.B. Glad, *Use of Summary Judgment in Defense of Bad Faith Actions Involving First-Party Insurance*, 30 *Tort & Ins. L.J.* 49 (1994)

n41 See *Brassil v. Maryland Cas. Co.*, 210 N.Y. 235, 241 (1914).

n42 82 N.Y.2d 445 (N.Y. 1993).

n43 *Id.* at 450.

n44 *Id.*

n45 *Id.* at 451. On further proceedings the verdict was ultimately reduced to \$3,880,000. *Id.*

n46 *Id.*

n47 *Id.* at 453-54.

n48 *Id.* at 454.

n49 *Id.*

n50 *Id.* at 454-55.

n51 *Id.* at 455.

n52 *Id.*

n53 *Id.*

n54 *Id.* at 456 (citations omitted).

n55 See, e.g. *Am. Physicians Ins. Exch. v. Garcia*, 876 S.W.2d 842, 848-49 (1994), relying on Robert E. Keeton, *Liability Insurance and Responsibility for Settlement*, 67 Harv. L. Rev. 1136, 1143-48 (1954); Ashley, *supra* note 38, §§ 2:04-2:06, 3:19.

n56 Ashley, *supra* note 38, § 3:26.

n57 *Id.* §§ 3:14-3:24.

n58 *Id.* § 2:15, at 2-54 to 2-56 & nn. 48-61.

n59 *Id.* §§ 3:14-3:20.

n60 *Id.* §§ 5:02-5:04.

ABOUT THE AUTHOR(S):

William T. Barker is a partner in the Chicago office of Sonnenschein Nath & Rosenthal, L.L.P., with a nationwide practice representing insurers in complex litigation, including matters relating to coverage, claims handling, sales practices, risk classification and selection, agent relationships, and regulatory matters. He is a member of the Editorial Board of *The New Appleman on Insurance Law*, now in preparation, and a Consulting Author of the *New Appleman Insurance Law Practice Guide*. He has published over 100 articles and speaks frequently on insurance and litigation subjects. He was a Contributing Editor and then Editor of *Bad Faith Law Report* until that publication merged with *Insurance Litigation Reporter*, where he is currently Senior Contributing Editor and Editorial Board Director. He has been described as the leading lawyer-commentator on the connections between procedure and insurance. See Charles Silver & Kent Syverud, *The Professional Responsibilities of Insurance Defense Lawyers*, 45 *Duke L.J.* 255, 257 n.4 (1995). Mr. Barker is a member of the American Law Institute.

Justin N. Kattan practices in Sonnenschein's Litigation Practice Group and is

experienced in many areas of litigation, with a particular focus on both property insurance coverage and intellectual property. Most recently, Mr. Kattan represented Royal Indemnity Company in one of the largest property insurance cases in history (involving claims in excess of \$7 billion) -- *SR International v. WTC Properties LLC, et al.* -- in which Royal prevailed against Silverstein Properties with respect to a significant portion of its coverage. For the last two and 1/2 years, he has played a lead role in the court-ordered appraisal to determine the property and rental value losses sustained by the Insureds. Mr. Kattan has also represented prominent artists, songwriters, creative individuals, as well as media, recording and music publishing companies in a variety of intellectual property litigations. Notable cases include:

BMS Entertainment/Heat Music LLC, et al. v. Christopher Bridges, et al., United States District Court for the Southern District of New York, Case No. 04 Civ. 02584 (PKC) -- Obtained federal jury verdict on June 1, 2006 on behalf of recording artists and songwriters Christopher Bridges, p/k/a Ludacris, and Kanye West, and music publisher EMI April Music Inc. in a music copyright infringement case regarding the 2003 hit single *Stand Up*. Previously, briefed a successful discovery sanctions motion to preclude plaintiffs' experts testimony and reports and for fees and costs. *Frost, et al. v. Christopher Bridges, et al.*, United States District Court for the Southern District of New York, Case No. 06 Civ. 0874 (JSR). In September 2006, Mr. Kattan obtained summary judgment against a different set of plaintiffs claiming infringement against Kanye West & Chris Bridges again for the song *Stand Up*. *Scheft-Montilla v. Fernando Botero*, United States District Court for the Southern District of New York, 02 Civ. 7802 (MGC). Mr. Kattan successfully moved to dismiss Plaintiffs claims of defamation of property and unfair competition against renowned artist Fernando Botero. Mr. Kattan also has extensive experience with insurance sales practices claims, ERISA claims, employment and trade secrets litigation, and administrative actions before the Public Service Commission on behalf of large cable television companies.

Rachel G. Balaban is a member of the Litigation Practice Group at Sonnenschein. Her practice consists of commercial litigation and arbitration across a broad range of substantive areas, including business tort and contractual disputes, fraud, insurance, intellectual property and labor and employment-related matters. She also has experience litigating and counseling clients in the areas of constitutional and media law, including First Amendment and libel matters. Ms. Balaban was part of the trial team that successfully defended The Prudential Insurance Company of

America in a two-month jury trial in federal court in Miami, where numerous plaintiffs were seeking extraordinary punitive damages from Prudential for allegedly fraudulent sales practices. The victory was reported as Defense Win of the Month in *The National Law Journal*, March 25, 2002. Ms. Balaban also was part of the trial team that successfully defended Sears, Roebuck and Co. in a patent infringement jury trial in federal court in New Jersey.

About the Law Firm. Sonnenschein Nath & Rosenthal, LLP, regularly handles high-risk and complex matters for financial and insurance industry clients. Staffed with seasoned litigators and former insurance regulators, Sonnenschein lawyers are relentless advocates for its clients interests.

For more than 70 years, Sonnenschein has partnered with insurance companies to understand their business and legal needs. Recent confirmation of Sonnenschein's outstanding insurance industry qualifications came in *Chambers USA: Americas Leading Lawyers for Business*. The 2007 edition identifies Sonnenschein as one of the top firms in the country representing insurers on their most complex matters. The Chambers description speaks for itself:

This powerhouse litigation firm is known for its sophisticated and thorough work in insurance and its ability to pull together a sterling set of resources. The firm fields a wide range of specialists, which it can use to staff complex cases. Its recent track record ranges from involvement in the WTC litigation to Hurricane Katrina-related issues. Matters are handled by a number of offices at any one time and practitioners are said to work tirelessly and creatively to help manage disputes and create briefings that are strong and impressive. Key areas of interest are bankruptcy and insolvency in insurance companies, class actions and catastrophic loss in both appeals and litigation. The firm also has strength in personal lines insurance and in regulatory proceedings.

When products are attacked, when lawsuits go national, when regulators join the fray, when reputations are on the line, leading businesses turn to Sonnenschein.



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Cohen and Frain on 4th Street Investors LLC v. Dowdell

2008 Emerging Issues 2243

Cohen and Frain on 4th Street Investors LLC v. Dowdell : The Application of the Notice-Prejudice Rule in the Context of an Insureds Failure to Provide Any Notice of Claim, When So Required for Coverage Under the Policy

By Richard J. Cohen and Toni L. Frain

April 25, 2008

SUMMARY: In a case of first impression in Pennsylvania, the United States District Court for the Western District of Pennsylvania concluded that the notice-prejudice rule does not apply to claims-made policies in the context of an insureds failure to provide any notice of plaintiffs claim where his claims-made policy explicitly required such notice for coverage.

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ARTICLE: In *4th Street Investors LLC v. Dowdell*, 2008 U.S. Dist. LEXIS 2980 (W.D. Pa. Jan. 15, 2008), Federal Insurance Company (Federal) won summary judgment dismissing garnishment proceedings seeking the proceeds of a Directors and Officers Liability Policy.

In July 1999, James Dowdell founded SafeDrive, a drivers education curriculum which he planned to market to Pittsburgh area high schools. Different from other driving courses, this program focused on interactive computer-based learning and simulated vehicle training. SafeDrives commercial operation began in January 2002, but was not profitable. Accordingly, Dowdell, SafeDrives CEO, explored with Berkowitz Perchalski, Inc. its willingness to recruit investors in SafeDrive, allegedly promising that SafeDrive would show a positive cash flow by the end of the first quarter in 2003 with a million dollar infusion of cash.

BPI agreed and was able to raise over one million dollars from its clients and other individual investors. However, even with this investment, SafeDrive was unable to show a profit. Most of the funds raised were used to amortize debt, leaving too little cash for additional equipment. When SafeDrive filed for bankruptcy protection in September 2003, its stock was virtually worthless.

On November 10, 2003, Federal Insurance Company (Federal), the issuer of a Directors and Officers Liability Policy which covered SafeDrive from 12:01 a.m. on November 11, 2002 to 12:01 a.m. on November 11, 2003 (D & O Policy), received a letter dated November 7, 2003 from BPIs counsel. The letter stated that plaintiff asserts a claim against SafeDrive and Dowdell:

based on certain misrepresentations, acts and omissions made by Mr. Dowdell in his capacity as an officer of the

company. This letter should be considered notice of a claim against the insured under the Directors & Officers Liability Coverage Section of the . . . policy. A copy of our clients Complaint will be sent under separate cover.

On November 11, 2003, Federal received a second letter from plaintiffs counsel, dated November 10, 2003, enclosing a draft complaint that plaintiffs counsel planned to file against Dowdell.

Federal was unable to make immediate contact with Dowdell. When he was finally located, Dowdell did not answer correspondence, or return Federal's phone calls. He did not assert a claim or communicate with Federal regarding coverage under the D & O Policy.

Even after suit was filed against Dowdell, Dowdell did not contact Federal. On May 25, 2005, plaintiffs filed a motion for summary judgment, which Dowdell did not oppose. The uncontested motion was granted and on September 5, 2005, a judgment was entered against Dowdell in excess of \$1 million. Six months later, plaintiffs filed interrogatories to Federal as garnishee, seeking to recover the proceeds of the D & O Policy. Federal filed a counterclaim for a declaratory judgment contesting its liability under the Policy and ultimately filed a motion for summary judgment. As of the time Federal filed its motion, Dowdell had not provided notice of or made a claim of any sort under the policy.

Federal contended that it was entitled to summary judgment because its insured failed to satisfy a condition precedent to coverage by not reporting a claim. An insurer's liability as garnishee is based on the insurer's breach of the insurance contract with the insured. Federal argued that it could not be liable to plaintiffs because its obligation to Dowdell was never triggered. The terms of the Policy specified that written notice of a claim from the insured was an express condition precedent to coverage. Federal argued that the only information it received regarding the policy was not, in fact, a claim, and was not provided by Dowdell.

The Court noted that strict construction of a policy's notice requirements is demanded in some instances, while substantial compliance is sufficient in others. The Court distinguished between occurrence-based policies and claims-made policies on this issue. In an occurrence-based policy, where the peril insured is the occurrence itself, notice provisions are written to aid the insurer in investigating, settling and defending claims. Notice provisions do not define coverage and should be liberally and practically construed. With these kinds of policies, an insurance company cannot invoke late notice to bar coverage unless they are able to demonstrate prejudice.

However, in a claims-made policy, notice clauses serve a different function. In a claims-made policy, where the making of the claim is the peril being insured, regardless of when the occurrence took place, notice clauses provide a certain date after which an insurer knows that it no longer is liable under the policy and allows the insurer to more accurately fix its reserves for future liabilities and compute premiums with greater certainty. A claims-made insurance policy represents a distinct bargained-for exchange between the insurer and insured. An insurer obtains the benefit of a clear and certain cut-off date for coverage. In return, the insured typically pays a lower premium. Allowing reporting to be delayed until after expiration of a claims-made policy would obliterate the distinction between claims-made and occurrence-based policies. It would be tantamount to awarding coverage to the insured gratis, something for which the insurer has not bargained. Thus, the terms of claims-made policies, including notice provisions, are subject to strict interpretation and lack of notice or late notice under a claims-made policy precludes coverage.

Applying these principles to the language of the Policy at issue, the Court found that under the D & O Policy, two things must happen before an insured can be covered. First, a claim must be made during the policy period. Second, the insured must provide Federal with written notice of that claim. If either of these requisites is missing, Federal is entitled to deny coverage. Where a claims-made policy is at issue, as here, an insurer may deny coverage based on lack of notice, without demonstrating prejudice. This benefits the insurer who is able more precisely to calculate risk, and the insured, who pays a significantly lower premium than is available under an occurrence-based policy. Insistence on notice from the insured makes sense for additional reasons. A third-party has no way of knowing whether the insured will invoke coverage for a particular claim. An insured may choose not to report a claim because of concern over

elevated premiums, may also choose to represent himself, or he may have alternate coverage. The Policy was written for his benefit, and it is up to him to decide whether to invoke its coverage.

The Court disregarded the fact that the claimant under the Policy provided the carrier with notice of its claim. The Court looked solely to what was required under the Policy. The Policy required the insured to put the insurer on notice. That the claimant did so did not change the result.

Dowdells complete failure to comply with the reporting provision of his claims-made policy precluded coverage for this claim. Accordingly, summary judgment in favor of Federal was granted.

ABOUT THE AUTHOR(S):

Richard J. Cohen, Esq. is the managing partner of the law firm of Goldberg Segalla L.L.P., which has offices in New York, Philadelphia, Hartford, Princeton, Buffalo, Rochester, Syracuse, Albany, White Plains, and on Long Island, and is the head of its insurance coverage litigation practice group. He graduated from the State University of New York at Buffalo School of Management, with distinction, and its School of Law, cum laude. Mr. Cohen's practice is almost exclusively first- and third-party coverage, bad faith, and reinsurance. He is a member of the New York and Pennsylvania Bars and is a national author and lecturer on coverage and bad faith, having spoken in New York, California, Arizona, Pennsylvania, Illinois, Louisiana, Maryland, Washington, D.C. and elsewhere on a wide variety of topics. Additionally, he is widely published and, among other things, has three times co-authored the annual "Survey of New York Insurance Law," published in the Syracuse Law Review. Mr. Cohen is a former National Co-Chair of the Insurance Company Relations Subcommittee of the Defense Research Institute, and former national membership Chair of DRI's Life, Health and Disability Insurance Section. He currently chairs insurance and construction subcommittees of DRI. He has been a CPCU instructor since 1999.

Toni L. Frain is an associate in the Buffalo office of Goldberg Segalla LLP, practicing in its insurance coverage litigation practice group. Ms. Frain graduated magna cum laude from the University at Buffalo, School of Law. During law school Ms. Frain worked on the Buffalo Environmental Law Journal, serving as Editor-in-Chief from 1998-1999. Prior to entering law school she graduated magna cum laude from the State University of New York, College at Geneseo with a Bachelor of Arts in Philosophy. Ms. Frain is a member of the New York Bar.

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Travel Underwriting: MA statutes that restrict use of travel information

2008 Emerging Issues 2044

Poolman on Travel Underwriting: Mass. statutes that restrict use of travel information

By Jim Poolman

April 23, 2008

SUMMARY: SHORTENED: Former North Dakota Insurance Commissioner Jim Poolman discusses how insurers discriminatory practices in the use of travel information in the issuance, pricing and cancellation of policies first came to light. In addition, Poolman reviews the Massachusetts statutes which restrict insurers use of past or future lawful travel information when underwriting life and disability policies. Poolman also provides an insiders perspective on the industry and regulatory debate leading to the passage of this legislation. EXTENDED: The recent debate about how life insurance companies use applicants past foreign travel experience or potential future foreign travel plans in the underwriting process for their life insurance policies made its way to the Massachusetts legislature in 2006 and resulted in the passage of House Bill 5238 on August 9th of the same year. In this commentary Former North Dakota Insurance Commissioner Jim Poolman discusses how insurers discriminatory practices in the use of travel information in the issuance, pricing, and cancellation of policies first came to light after Congresswoman Debbie Wasserman-Schultz (D-FL) applied for a policy and was denied coverage after her agent asked a series of questions about her past and future travel plans, based on her desire to travel to Israel at some unknown point in the future. Poolman also reviews the Massachusetts statutes which restrict insurers use of past or future lawful travel information when underwriting life insurance and disability policies and some of the problems with the language in those statutes. Poolman writes: Some would argue that the bill is weak and a victory for insurers because of the use of the word solely. Insurance regulators along with policymakers constantly struggle over what the definition of solely really is. Poolman also writes: Some will argue that this use of the term solely provides no teeth in regulating the use of travel information in underwriting of life insurance and disability policies. Companies will have the opportunity to use this information almost completely in their underwriting decisions. There are consumer protection standards written into the law that do require insurers to base their use of travel information upon sound actuarial principles or related to actual or reasonably expected experience. This language could give the Massachusetts regulators an opportunity to investigate companies they believe are using this travel information in an arbitrary fashion. If this is proven the company could be cited for an unfair method of competition or unfair and deceptive act or practice pursuant to chapter 176D. Poolman also provides an insiders perspective on the industry and regulatory debate that lead to the passage of this legislation. Poolman states: There is certainly no consensus by regulators on whether to further regulate the underwriting practices of life insurance carriers. That lack of consensus will also transfer to state houses if they were to consider legislation. The underwriting practices of insurers are considered sacred ground, where regulators should stay out of that business, even though anti-discrimination laws and unfair trade practices statutes certainly apply. Poolman notes: As more Americans across the country travel around the globe, the issue of how companies gauge their risk of loss will become more complicated

and more difficult, and the potential for discrimination or unfair application of their standards could become more frequent. Although the Massachusetts statutes may not go far enough, Poolman concludes that these laws are certainly a start in the right direction.

PDF LINK: [Click Here for Enhanced PDF of Commentary](#)

ARTICLE: Cite as: Poolman, Jim. Travel Underwriting: A Discussion About the Massachusetts Statutes Which Restrict Insurers Use of Past or Future Lawful Travel Information in the Underwriting of Life Insurance and Disability Policies. LexisNexis Expert Commentary, (*Insert date you accessed the document online*).

The recent debate about how life insurance companies use applicants past foreign travel experience or potential future foreign travel plans in the underwriting process for their life insurance policies made its way to the Massachusetts legislature in 2006 and resulted in the passage of House Bill 5238 on August 9th of the same year.

The way life insurers have used travel in determining whether or not to issue a policy, limit coverage, or cancel a policy has come under fire from regulators and legislators around the country. The issue came to light after Congresswoman Debbie Wasserman-Schultz (D-FL) applied for a policy and was denied coverage after her agent asked a series of questions. At first the agent focused these pre-underwriting queries on Rep. Wasserman-Schultz's past foreign travel, but this line of inquiry eventually expanded to include questions about future travel plans that the Congresswoman had. After answering that she had no future foreign travel plans, Wasserman-Schultz was denied a policy based on her desire to travel to Israel at some unknown point in the future.

The Congresswoman took to the halls of Congress to spread her message that life insurance companies were discriminating against Americans who wanted to travel lawfully to foreign countries. The message has resonated with members of the United States House of Representatives as Wasserman-Schultz successfully attached language curtailing the practice to the Terrorism Reinsurance Act. The language was then removed in conference committee and was not included in its final passage. But the simple inclusion in the House of Representatives version shows the issue has struck a chord with other members of Congress, specifically those on the Financial Services Committee.

The use of lawful foreign travel has also resonated with state legislatures. The Massachusetts legislature passed their final version of a bill to address the practice by life insurers in August of 2006. The amendments to Chapter 175 of the General Laws specifically address the issue with both disability insurance and life insurance policies. Section 108J states that disability insurers or producers *shall not make a distinction or otherwise discriminate between persons, reject an applicant, cancel a policy, or demand or require a higher rate of premium for reasons based solely upon an applicants or insureds past lawful travel experiences or future lawful travel plans.* ALM GL ch. 175, § 108J (2008).

The law does not prohibit the use of past or future travel *when that action is based upon sound actuarial principles or is related to actual or reasonably expected experience and is not based solely on the destinations inclusion on the United State Department of State Travel Warning List.* The language is very similar for those insurers issuing life insurance policies. ALM GL ch. 175, § 122A (2008).

Civil Rights groups claimed victory in getting the legislation through the Massachusetts Legislature and signed by then Governor Mitt Romney (R). The Anti-Defamation League testified at a hearing at the National Association of Insurance Commissioners that they would have preferred a stronger bill in Massachusetts, but were happy with the result. The state is the home of a strong life insurance industry.

Some would argue that the bill is weak and a victory for insurers because of the use of the word solely. Insurance regulators along with policymakers constantly struggle over what the definition of solely really is.

In other areas of insurance law dictating what information insurance companies may use in their underwriting practice the word solely has often been used, specifically with property and casualty insurance companies use of credit information. Many states have adopted model legislation stating insurance companies cant base a rate or decline to issue

an insurance policy solely on a consumers credit information. Companies may create underwriting models that use ninety percent of a consumers credit information and ten percent other underwriting factors. Does that mean those companies are not violating the law because they are not basing their underwriting solely based on a consumers credit information?

Some will argue that this use of the term solely provides no teeth in regulating the use of travel information in underwriting of life insurance and disability policies. Companies will have the opportunity to use this information *almost* completely in their underwriting decisions. There are consumer protection standards written into the law that do require insurers to base their use of travel information upon *sound actuarial principles or related to actual or reasonably expected experience*. This language could give the Massachusetts regulators an opportunity to investigate companies they believe are using this travel information in an arbitrary fashion. If this is proven the company could be cited for an *unfair method of competition or unfair and deceptive act or practice pursuant to chapter 176D*.

Even though some will argue that the recent revisions to the Massachusetts law dont go far enough, it certainly is a start in an effort to regulate a practice that some will consider abhorrent. There is certainly no consensus by regulators on whether to further regulate the underwriting practices of life insurance carriers. That lack of consensus will also transfer to state houses if they were to consider legislation. The underwriting practices of insurers are considered sacred ground, where regulators should stay out of that business, even though anti-discrimination laws and unfair trade practices statutes certainly apply.

As more Americans across the country travel around the globe, the issue of how companies gauge their risk of loss will become more complicated and more difficult. The potential for discrimination or unfair application of their standards could become more frequent. Hopefully statutes like the one passed in Massachusetts will become more common.

ABOUT THE AUTHOR(S):

Jim Poolman was elected North Dakota Insurance Commissioner in 2000, and overwhelmingly reelected in 2004. While Insurance Commissioner, he was an outspoken leader at the National Association of Insurance Commissioners, serving as their Vice-President, Chairman of the Midwestern Zone, Chairman of the Life Insurance and Annuities Committee, Executive Committee on Principles Based Reserving, Chairman of the Producer Licensing Working Group; amongst a host of other leadership posts. In North Dakota he was instrumental in preserving a competitive marketplace while passing very important consumer protections ranging in areas from privacy of consumers medical and financial information, suitability in annuity sales, restrictions on the use of claims information, insurance fraud and life settlements, amongst others. Mr. Poolman has been a sought after speaker on numerous insurance topics around the country. In August of 2007, Mr. Poolman resigned his post in North Dakota to start an independent regulatory consulting practice based in Bismarck, North Dakota. Mr. Poolman received his bachelors of Business Administration degree from the University of North Dakota in 1992. Mr. Poolman also served four terms in the North Dakota House of Representatives before being elected Insurance Commissioner.

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Poolman on Travel Underwriting: NAICs attempt to craft new protection standards

2008 Emerging Issues 2047

Poolman on Travel Underwriting: NAICs attempt to craft new protection standards

By Jim Poolman

April 23, 2008

SUMMARY: SHORTENED: Former North Dakota Insurance Commissioner Jim Poolman discusses the NAICs attempt to craft new consumer protection standards for life insurance companies that use information about past and future lawful travel to foreign countries in the underwriting process when issuing new policies or increasing coverage on existing policies. Poolman also reviews statutory and regulatory developments in Florida and the factors impacting whether there will be a consensus regulation on travel underwriting out of the NAIC. EXTENDED: Even though state legislatures in Massachusetts and Florida have passed new consumer protection standards, insurance regulators at the National Association of Insurance Commissioners continue to struggle with the development of a model law or regulation that would provide a uniform template for consideration by state legislatures across the country. In this commentary, former North Dakota Insurance Commissioner Jim Poolman discusses the NAICs attempt to craft new consumer protection standards for life insurance companies that use information about past and future lawful travel to foreign countries in the underwriting process when issuing new policies or increasing coverage on existing policies. Poolman discusses how the issue caught the attention of regulators at the NAIC, specifically Florida Insurance Commissioner Kevin McCarty, when Representative Wasserman-Schultz took to both Congress and the insurance regulatory community to tell the story of how she was denied life insurance based on her desire to travel to Israel at some future undetermined point in time and express her concern about potential discrimination with the use of this information in insurers underwriting practices. Poolman also reviews statutory and regulatory developments in Florida, which have placed a number of new restrictions upon insurers. Poolman also gives an inside perspective on the factors that continue to impact whether there will be a consensus regulation on travel underwriting out of the NAIC, including the ongoing debate between consumer representatives and organizations such as the American Council of Life Insurers and the American Academy of Actuaries that defend the sanctity of underwriting standards used by insurers. Poolman outlines the NAICs dual option approach and clarifies the dilemma that insurers face. Poolman writes: If there is no consensus among regulators on if and how to regulate underwriting as it relates to travel information, then states as the laboratories of innovation will consider their own standards. These standards could very well vary greatly from state to state, thus creating an even larger problem for insurers as they navigate the state based system of regulation. So, the question for insurers is: Do we support a uniform regulation we dont like, but could live with, or have different criteria in different jurisdictions that can create an even larger regulatory bureaucracy? In expressing his belief in the potential of creating a consensus on this issue, Poolman states: The political will of the new top leadership at the NAIC is larger than in the past year, and the lack of action in Congress creates an opportunity for the NAIC to take the lead on this very controversial but important issue. Poolman concludes: The use of travel information in underwriting will not go away

any time soon. If the NAIC does not address the issue in a meaningful way, the risk of Congress stepping in to address the problem will only escalate. Even though Congresswoman Wasserman-Schultz was unsuccessful in keeping language in this TRIREA bill that does not mean she won't be successful in the future. Many regulators are ready and able to tackle the issue responsibly. Keep an eye out for passage of revisions to the NAICs Unfair Trade Practices Model Act in 2008 to address the issue.

PDF LINK: [Click Here for Enhanced PDF of Commentary](#)

ARTICLE: Cite as: Poolman, Jim. Travel Underwriting: A Discussion About the NAICs Attempt to Craft New Consumer Protection Standards for Life Insurance Companies That Use Information About Past and Future Lawful Travel to Foreign Countries in Their Underwriting Process. LexisNexis Expert Commentary, *(Insert date you accessed the document online)*.

Issue: Discrimination or Not. Should lawful travel to foreign countries be used against a consumer who decides to apply for a life insurance policy or increase coverage? Even though state legislatures in Massachusetts and Florida have passed new consumer protection standards, insurance regulators at the National Association of Insurance Commissioners continue to struggle with the development of a model law or regulation that would provide a uniform template for consideration by state legislatures across the country. The NAIC has been discussing the issue for over two years and as of the beginning of 2008, the Life Insurance and Annuities Committee of the NAIC does not yet have a recommended work product.

History: Both State and Federal Issue? The issue arose almost two years ago when Congresswoman Debbie Wasserman-Schultz (D-FL) was denied life insurance because of questions related to past and future travel. She answered negatively when she was asked if she had any future travel plans, but when asked if she were to travel in the future where would she like to travel, she answered that she would love to eventually travel to Israel. She was denied coverage even though she had no future plans to complete any foreign travel. Representative Wasserman-Schultz took to both Congress and the insurance regulatory community to tell the story and express her concern about potential discrimination with the use of this information in insurers underwriting practices.

The issue caught the attention of regulators at the NAIC, specifically Florida Insurance Commissioner Kevin McCarty. McCarty had proposed rules under the Florida Unfair Trade Practices Act that were opposed by life insurers. Eventually the issue was settled by the enactment of amendments to Floridas Unfair Trade Practices Act, which were dubbed the Freedom to Travel Amendments to Section 626.9541 (1) (dd), F.S. This led to further rulemaking by Commissioner McCarty with the adoption of new regulation 69O-125.003, F.A.C. that fully implements the statute changes. The changes have a number of new restrictions on insurers, and a requirement to file the underwriting guidelines with actuarial backup to the Florida department.

A September 2006 hearing at NAIC featured videotaped testimony by Congresswoman Wasserman-Schultz, representatives of the Anti-Defamation League, and Birny Birnbaum from the Center for Economic Justice. The representatives favored restrictive regulation as to how past and future lawful foreign travel should be used. Life insurer representatives, specifically those from the American Council of Life Insurers, testified for no restrictions on the use of the information, or minimal regulation on how the information should be used.

The regulation of specific underwriting standards has long been debated. The theory has always been that if the standards were non-discriminatory, then they were not touched by regulators. The use of travel opened up the debate about whether the standard could be considered discriminatory, and is seen as arbitrary by which country an applicant had traveled to, had plans to travel to, or even considered traveling to in the Congresswomans case. In addition the specific standards with which travel underwriting is employed seem not to exist.

In the hearing, the American Academy of Actuaries defended the sanctity of underwriting standards used by insurers. In writing to the NAIC, the AAA has taken the position that any regulation of travel information should be

limited, which would still allow the travel information to be used if the insurer used sound actuarial principles in its underwriting decisions. Regulators questioned if that shouldnt be the goal of every fair underwriting decision. If so, insurers should be able to show regulators the actuarial basis by which these underwriting decisions are made. This continues to be a source of contention as the regulators continue to consider model regulations.

Will There Be A Consensus Regulation Out of the NAIC? After the September 2006 hearing, the NAIC worked towards creating draft changes to the model Unfair Trade Practices Act through a subcommittee of interested regulators. The NAIC Life Insurance and Annuities Committee failed to adopt the changes on an evenly split vote in March of 2007, in large part due to a requirement that mandated insurers file their guidelines with respective insurance departments so they can verify the use of sound actuarial principles. Insurers forcefully argued that this was unnecessary regulation that would increase bureaucracy and expense with little consumer benefit.

Outspoken leaders at the NAIC like Commissioner McCarty continue to push the formation of uniform regulation to create the standards he believes are necessary to prevent discrimination in underwriting practices as it relates to a consumers past and future travel information. On June 12, 2007 the NAIC took another crack at coming up with a consensus piece that regulators could use across the country when it released a new draft of amendments to the model Unfair Trade Practices Act.

At the fall meeting of the NAIC, the Life Insurance and Annuities Committee decided to take a dual-option approach to addressing the issue. The reason cited at the time was Congresswoman Wasserman-Schultzs successful inclusion of language in the *Terrorism Risk Insurance Revision and Extension Act of 2007 (TRIREA) (H.R. 2761)*. The language was ultimately not included in the final version adopted by Congress and signed by President Bush, so the NAIC is back to square one to consider the June 12 draft.

Insurers are faced with a dilemma. If there is no consensus among regulators on if and how to regulate underwriting as it relates to travel information, then states as the laboratories of innovation will consider their own standards. These standards could very well vary greatly from state to state, thus creating an even larger problem for insurers as they navigate the state based system of regulation. So, the question for insurers is: Do we support a uniform regulation we dont like, but could live with, or have different criteria in different jurisdictions that can create an even larger regulatory bureaucracy?

I believe the potential for creating consensus on this issue is significant. The political will of the new top leadership at the NAIC is larger than in the past year, and the lack of action in Congress creates an opportunity for the NAIC to take the lead on this very controversial but important issue.

Work continues on the revisions. A November 27th conference call of the Life Insurance and Annuities Committee showed progress towards reaching consensus, with affirmative comments coming from the new NAIC President Sandy Praeger (KS), and other key regulators on the Committee.

The use of travel information in underwriting will not go away any time soon. If the NAIC does not address the issue in a meaningful way, the risk of Congress stepping in to address the problem will only escalate. Even though Congresswoman Wasserman-Schultz was unsuccessful in keeping language in this TRIREA bill that does not mean she wont be successful in the future. Many regulators are ready and able to tackle the issue responsibly. Keep an eye out for passage of revisions to the NAICs Unfair Trade Practices Model Act in 2008 to address the issue.

ABOUT THE AUTHOR(S):

Jim Poolman was elected North Dakota Insurance Commissioner in 2000, and overwhelmingly reelected in 2004. While Insurance Commissioner, he was an outspoken leader at the National Association of Insurance Commissioners, serving as their Vice-President, Chairman of the Midwestern Zone, Chairman of the Life Insurance and Annuities Committee, Executive Committee on Principles Based Reserving, Chairman of the Producer Licensing Working Group;

amongst a host of other leadership posts. In North Dakota he was instrumental in preserving a competitive marketplace while passing very important consumer protections ranging in areas from privacy of consumers medical and financial information, suitability in annuity sales, restrictions on the use of claims information, insurance fraud and life settlements, amongst others. Mr. Poolman has been a sought after speaker on numerous insurance topics around the country. In August of 2007, Mr. Poolman resigned his post in North Dakota to start an independent regulatory consulting practice based in Bismarck, North Dakota. Mr. Poolman received his bachelors of Business Administration degree from the University of North Dakota in 1992. Mr. Poolman also served four terms in the North Dakota House of Representatives before being elected Insurance Commissioner.

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Veach on Union Indemnity's Belated Distribution

2008 Emerging Issues 2045

Veach on Union Indemnity's Belated Distribution

By James Veach

April 23, 2008

SUMMARY: James Veach writes about a receiver's efforts to complete the liquidation of Union Indemnity Insurance Company, a New York insurer that failed more than two decades ago. Union Indemnity is a cautionary tale about the unintended consequences of litigation and the effect of legislative changes undertaken during the life of an insurance company receivership.

PDF LINK: [Click Here for Enhanced PDF of Commentary](#)

ARTICLE: Twenty-two years after Union Indemnity Insurance Company (Union) failed, its receiver plans a first (partial) payment to its policyholders. In an Initial Report on the Status of the Liquidation of Union Indemnity Insurance Company of New York" (Report), Deputy Superintendent of Insurance Mark Peters, who heads up the New York Liquidation Bureau (NYLB), addresses the obvious question why did it take so long to make a partial payment?

In his Report, Mr. Peters mentions the indictment of his immediate predecessor, Deputy Superintendent Jodi Hall, but Ms. Halls tenure was relatively brief. Mr. Peters largely blames the delay on years of poor [Bureau] management. *Report*, p. 1. As an example of that poor management, Mr. Peters mentions the failure of the NYLB to have its financial statements properly audited . . . *Id.* (The NYLB recently commissioned an outside auditing firm to review Unions accounts and will, if necessary, adjust Unions balance sheets to establish a distribution percentage.)

Mr. Peters, however, also observes that "extensive litigation regarding . . . the collectibility of (Union's) reinsurance . . . complicated and hampered" his predecessors' efforts to collect reinsurance moneys due Union. *Report*, p. 2. This is a marvelous understatement, but the Report later describes in more detail the litigation fallout that earned the Union estate about \$48 million in damages collected from Union's directors and officers insurers, but cost the Union estate more than \$200 million in reinsurance recoverables.

With apologies to those who lived through it, the saga of the Liquidator's lugubrious litigation merits retelling, even though it can't be done justice in a few paragraphs. Nevertheless, in the spirit of the sub-prime meltdown, the shadow of an optional federal charter, and the wake of talk about "rehabilitating" bond insurers MBIA, Ambac, and FGIC, see, *e.g.*, S. Craig & L. Plevin, *Former Spitzer Aide Drives Bond-Insurer Rescue Talks*, *The Wall St. Journal*, Feb. 6, 2008, p. C1., we take a glance in the rearview mirror.

Rescission and Reinsurers. Broker Frank B. Hall & Company, Inc. (Hall) wholly owned Union, which was domiciled in New York and did business on both an admitted and non-admitted basis in almost every U.S. state, plus the District of Columbia and Puerto Rico. In addition to commercial and personal liability policies, Union also wrote medical malpractice and workers compensation *and* assumed reinsurance. A January 1985 report on examination revealed Unions impairment. In July 1985, when Union and its parent could not restore its surplus to policyholders, the Superintendent, acting pursuant to NYIL § 7405, obtained an order of liquidation.

In the 1980s and early 1990s, Unions Liquidators about seven Superintendents of Insurance (plus or minus acting or interim Superintendents) have filled that role were responsible for waves of litigation that shaped the estate. The Liquidator first hired outside counsel and sued some of Unions reinsurers. These reinsurers moved to compel arbitration. The Liquidator opposed the motion, but Supreme Court Justice Ira Gammerman, then overseeing the liquidation pursuant to NYIL Article 74, ruled for the reinsurers and directed that the parties arbitrate. *Corcoran v. AIG Multi-Line Syndicate, Inc.*, 143 Misc.2d 62 (Sup. Ct., N.Y. Co. 1989) (the AIG action).

The Liquidator appealed Justice Gammerman's judgment and the Appellate Division, First Department, reversed. Relying on case law holding that the liquidation court had exclusive jurisdiction over all claims concerning the Union estate and that arbitrators appointed pursuant to the reinsurance contracts at issue could not invade that exclusive jurisdiction, *Knickerbocker Agency Inc. v. Holz*, 4 N.Y.2d 245 (1958), the First Department sent the parties back to Justice Gammerman. *Corcoran v. AIG Multi-Line Syndicate, Inc.*, 167 A.D.2d 332 (1st Dept 1990). See also, *Corcoran v. Ardra Ins. Co., Ltd.*, 77 N.Y.2d 225 (1990) (decided at about the same time and extending the *Knickerbocker* holding to reinsurance disputes between the liquidator of an insolvent New York insurer and its alien reinsurers).

Meanwhile, the Liquidator had hired another outside law firm to sue Unions and Halls directors, officers, and affiliated companies for fraud and breach of statutory and fiduciary duties. This led to litigation over whether Unions Liquidator had exclusive standing to pursue these claims. Both the trial court and the First Department held that the Liquidator alone could pursue Hall and its D & O insurers on a theory that Hall had used Union as a safe harbor for risks that could not be placed elsewhere. *Corcoran v. Frank B. Hall & Co.*, 149 A.D.2d 165 (1st Dept 1989) (the Hall action).

The beneficiary of a Union surety bond brought a direct action against Union's reinsurers. Unions Liquidator, asserting his standing as the exclusive holder of Unions reinsurance recoverables, intervened, again asserting that he alone had standing to pursue Union's reinsurers. The reinsurers counterclaimed, alleging that their reinsurance contracts were fraudulently procured and that they the reinsurers were the victims of Halls loss-leading fraud. In support of their cross motion, the reinsurers quoted liberally from affidavits submitted during the litigation over who had the right to pursue Hall and its directors and officers for damages inflicted on Union while Hall operated Union.

In deciding the reinsurers' cross motion, Justice Gammerman considered not only the detailed allegations of fraud contained in the Liquidators suit against Hall, its officers, directors, and affiliates, but also the sworn and detailed affidavits submitted to the court describing the fraud. Justice Gammerman concluded that these affidavits and pleadings constituted judicial admissions by the Liquidator.

Relying on these judicial admissions, as well as other evidence of fraud and misrepresentation, the trial court found that Union had misrepresented its financial condition to its reinsurers. The trial court first rescinded the reinsurance contracts, but later on the Liquidators motion to reargue declared that the subject reinsurance contracts were merely unenforceable, thus relieving the reinsurers of their obligation to remit premium. See *In Re Liquidation of Union Indem. Ins. Co. of New York*, 200 A.D.2d 99 (1st Dept 1994), *affd*, 89 N.Y.2d 94 (1996) (the Michigan National action).

The reinsurers in the AIG action, having been forced to litigate rather than arbitrate, moved for summary judgment on the same theory that they too were the victims of Hall's and Union's misrepresentation. The trial court agreed and declared that their reinsurance contracts were unenforceable. The Appellate Division, First Department, affirmed. *Curiale v. AIG Multi-Line Syndicate, Inc.*, 204 A.D.2d 237 (1st Dep't 1994). In a separate decision, however, the First

Department later held that the Liquidator could collect a return of premium after the reinsurers had succeeded in having their reinsurance contracts rescinded. *Curiale v. AIG Multi-Line Syndicate, Inc.*, 225 A.D.2d 409 (1st Dep't 1996). Thus, the *Michigan National* and AIG actions eliminated . . . all of Unions reinsurance recoverables, which were then quantified at approximately \$200,000,000. *Report*, p. 16.

What about the Liquidators suit against: (1) Hall and its affiliates; (2) Halls (and Unions) directors and officers (and their insurers); and (3) Halls auditor, Touche Ross & Co. (and its E & O insurers)? The Liquidator had sued for \$140 million, but in 1997 the Liquidator settled for \$55 million to be paid over time pursuant to a structured settlement. In order to avoid waiting for all the installments, the Liquidator agreed to a \$48 million lump sum payment.

A Change in the Law. When Union failed in 1985, insurers that ceded to an insolvent New York insurer were entitled to share *pro rata* in the distribution of the assuming reinsurer's assets. NYIL § 7434 in McKinney's Consolidated Laws of N.Y., Book 27, p. 209 Legislative History (2000). In 1999, however, the New York legislature enacted a statutory scheme for prioritizing distributions. NYIL § 7434. The 1999 amendment created six classes of creditors. Policyholders were placed in class two; reinsurers were relegated to class six. No distribution could be made to a class six creditor until creditors with allowed claims in classes one through five had been paid in full.

The 1999 amendment effectively eliminated any hope for a reinsurance creditor's recovery in most insolvencies. Nevertheless, the 1999 amendment applied only to an insolvency proceeding commenced *after* June 29, 1999. Thus, the 1999 amendment did not apply to Unions cedants and Union's cedants were still entitled to a *pro rata* distribution.

In 2005, however, the New York Legislature further amended NYIL § 7434 such that the creditor classification scheme adopted in 1999 applied to *distributions* made after the effective date of the 2005 amendment, or May 11, 2005. Unions cedants/creditors are now class six creditors and subordinate to classes one through five.

Hearing on the Report: A Cedant's Objection. In October 2007, the Liquidator provided notice of a hearing to confirm the Report discussed above. In his Report, Mr. Peters provided a balance sheet of the estates assets and liabilities and proposed to use that balance sheet subject to adjustment based on any audit findings to make a first distribution to Union's creditors. The Liquidator asked the Court to set a November 15, 2007 bar date on claims against the estate. This would allow the Liquidator to cut off further submission of new losses covered by timely filed proofs of claim and determine a distribution percentage.

The Report reveals that of the 31,299 claims presented to the estate, 23,545 have been adjudicated. Of these claims, 1,269 were resolved by guaranty funds on the Liquidators behalf, 9,675 claims were allowed by Union's liquidator, and 12,601 claims were either disallowed or recommended for disallowance. 1,722 claims remain open, including 292 open reinsurance claims

At the December 18th hearing, Justice Karla Moskowitz, the Supreme Court Justice now responsible for overseeing the estate, determined that six parties had objected to the Report. The objecting parties consisted of three commercial policyholders, two cedants, and the purchaser of a policyholder claim. By the date of the hearing, however, the three policyholders, dazzled by the prospect of receiving even a partial distribution, had withdrawn their objections.

Of the remaining three objectors, only one appeared an off-shore insurer that had both ceded to and assumed business from Union. In his capacity as a cedant/creditor, the off-shore insurer argued, among other things, that the amendment of NYIL § 7434 discussed above was retrospective and unconstitutional. Justice Moskowitz heard argument on this objection, agreed to accept additional papers from the Liquidator, and took the Liquidators application to approve his Report (and the cedant's objection) under consideration.

* * *

The Union estate has seen many changes. Superintendents have come and gone, as have many administrators at the Liquidation Bureau. New Yorks insurance insolvency laws have been amended significantly. The Liquidation Bureau

itself has survived challenges with respect to how it functions and whether it is a state agency or something other than an agency of the state. See *Dinallo v. DiNapoli*, 9 N.Y.3d 94 (2007); see J. Veach, *Former NY Comptroller's Subpoenas May Affect New York Insurance Superintendent's Plans for Liquidation Bureau*, Mealey's Litigation Report: Insurance Insolvency, Vol. 19, #3, July 2007. And the Union estate sure made a lot of law, some of which is described above, and spent a lot of money doing so. What remains is the distribution of the estates remaining assets.

But the delay in making a first, partial distribution to Union's creditors continues. On January 2, 2008, Governor Eliot Spitzer appointed Justice Moskowitz to serve on the Appellate Division, First Department. J. Stashenko & D. Wise, *Spitzer Fills Two Vacancies on First Department Bench*, N.Y.L.J., Jan. 2, 2008. Another Supreme Court Justice must consider the Report (and the cedant's objection described above), but that assignment has not yet been made. Thus, the delay in making even a partial first distribution continues.

The Report notes that Unions Liquidator has installed new senior management and reorganized the Bureau. *Report*, p. 2. As noted, the Liquidator has hired a firm to conduct a "top-to-bottom audit" of all insolvent insurance estates. The NYLB also recently issued many requests for proposals to bring in other firms or consultants to collect reinsurance recoverables, defend and investigate claims, and provide legal advice and representation. In December, the Liquidator even issued a request for proposals for a "licensed architect" to conduct a "space audit" and provide a design proposal for its offices at 123 William Street in New York City.

Perhaps the Liquidator should also consider hiring an historian. Each failed insurer and reinsurer has its own cautionary tale to tell. Before relegating closed estates to the warehouse, how about a *real* closing report, one that focuses on why the company failed, the role of the regulator in these failures, and the consequences of the ensuing insolvency. A true closing report might help regulators, legislators, insurers, reinsurers, insurance consumers, and liquidators avoid repeating past mistakes.

ABOUT THE AUTHOR(S):

James Veach is a partner in Mound, Cotton, Wollan & Greengrass's New York City office. Mr. Veach has handled insolvency and run-off related matters for many years. His experience embraces New York Insurance Department-approved plans to avoid liquidation pursuant to New York's Regulation 141, as well as arbitration and litigation undertaken on behalf of cedants, reinsurers, general creditors, investors, and Receivers.

Mr. Veach serves on the Publications Committee of the Association of Insurance and Reinsurance Run-off Companies and is a member of the International Association of Insurance Receivers. He is admitted in New York and New Jersey and is also an ARIAS-U.S. certified arbitrator.

Mr. Veach gratefully acknowledges the assistance of Law Clerk Greg Wyles, but takes full responsibility for all errors of omission or commission in this article. Mr. Veach's views, of course, do not necessarily reflect those of MCW&G's clients, his partners, or any other non-attributed person.

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Sonnenschein Nath & Rosenthal, LLP on Winning a Defense Verdict on Damages

2008 Emerging Issues 2046

Sonnenschein Nath & Rosenthal, LLP on Winning a Defense Verdict on Damages

By Alan S. Gilbert

April 23, 2008

SUMMARY: Plaintiffs in breach of contract cases often attempt to sustain their burden of proving proximate causation merely by substantiating but for causation and then forcing Defendants to prove a negative. *Emerald Inv. Limited P'ship v. Allmerica Fin. Life Ins. and Annuity Co.* re-affirmed the often-ignored notion that it is the Plaintiff that bears the burden of proving that the Defendants breach of contract proximately caused the alleged damages.

PDF LINK: [Click Here for Enhanced PDF of Commentary](#)

ARTICLE: *Emerald Investments Limited Partnership v. Allmerica Financial Life Insurance and Annuity Co.*, 2008 U.S. App. LEXIS 3513 (7th Cir. February 20, 2008), exemplifies the importance of the causation requirement in a breach of contract case. In *Emerald*, defendant Allmerica prevailed in a damages-only trial, after a summary judgment that Allmerica breached its contract with Emerald. (Sonnenschein represented Allmerica in the damages phase of the case.) The Seventh Circuit found that Emerald had failed to prove that its purported damages were proximately caused by Allmericas breach. While based on common law principles, the decision reflects the renewed emphasis on causation doctrines developed in the securities area. See *Dura Pharmaceuticals, Inc. v. Broudo*, 544 U.S. 336 (2005).

What Happened?

Background. Emerald purchased two variable annuities from Allmerica. Emerald used the annuities to engage in frequent market-timing trading between mutual fund sub-accounts. Emeralds market-timing trading, known as international time-zone arbitrage, involved buying large quantities of international mutual funds at the 4 pm close of the New York markets to take advantage of stale prices of the underlying international shares within the funds. Due to time zone differences, the international markets where the shares traded closed several hours before 4 pm New York time. The mutual funds were priced at 4 pm New York time based on the underlying shares closing prices in their home markets. Sometimes events during the period between the international markets close and the New York markets close (such as after hours trading, world news or a runup in other markets) indicated that the international shares prices would be higher when their markets opened the next day. At such times, the mutual funds price would not reflect those events. When that occurred, Emerald would take advantage of the funds stale prices by purchasing large quantities of the international mutual funds just before the 4 pm New York market close. After the anticipated international share price

rise was reflected in the mutual fund prices the next day or so, Emerald would sell the international funds and realize a profit.

This market timing essentially usurped profits otherwise available to the mutual funds long term holders and hurt the performance of the mutual funds and the variable annuities that held the funds shares. Facing pressure from the mutual funds to stop such harmful trading, Allmerica restricted Emeralds frequent trading. Emerald sued Allmerica in the federal district court in Chicago, alleging breach of provisions in its annuity contracts that allowed transfer of funds among mutual fund sub-accounts.

The Liability Ruling and Emeralds Damages Case. The district court agreed with Emerald on liability, granting summary judgment that Allmerica had breached the annuity contracts by restricting Emeralds trading. Emeralds damages expert claimed that Emerald would have made over \$150 million in lost profits through market timing trades for the expected duration of the annuities (over 20 years) if it had not been stopped by Allmerica. Emerald argued that but for Allmericas breach it would have continued to reap the huge 35-40% annual returns it had been making through its market timing.

Allmericas Attack On Emeralds Damages. Allmerica defeated Emeralds claims by attacking Emeralds damages theory on several grounds. The key to Allmericas defense was attacking Emeralds proof of causation of its alleged lost profit damages. Allmerica developed and presented evidence that Emerald would not have been able to profit from its market timing strategy even if Allmerica had not restricted its trading.

As a factual matter, Allmerica showed that the Scudder international mutual fund Emerald was trading in would have stopped Emeralds market timing if Allmerica had not. But this evidence was not rock solid; no one could know for sure what would have happened if the restrictions had not been placed on Emeralds trading, because Emerald was not actually able to trade through the Allmerica annuities. A jury facing this circumstantial evidence of what might have happened, along with the Courts clear finding that Allmerica breached its contracts with Emerald, might well have found that Emerald was entitled to all or most of the substantial damages it sought. That was a particular danger because an insurance company is never a jury favorite.

To deal with this, Allmerica turned to a legal strategy of forcing Emerald to bear the burden of proof on this issue. If Emerald bore the burden of proof, it would have to prove that it *would have made* substantial profits if it had not had its trading restricted, rather than Allmerica having to prove a negative that Emerald *would not have made* profits. Allmerica argued that Emerald bore this burden as part of its proof of the causation element of its breach of contract claim, *i.e.*, that Allmericas contract breach caused the damages Emerald claimed. *See e.g., Isaksen v. Vermont Castings, Inc.*, 825 F.2d 1158, 1165 (7th Cir. 1987) (We do not allow plaintiffs to obtain damages awards without proving what compensable damages were actually suffered as a result of the defendants unlawful conduct.) This argument was enhanced by the rule in Illinois, whose law applied, that the lost profits damages Emerald sought must be proved with reasonable certainty. *E.g., Midland Hotel Corp. v. Donnelly Corp.*, 118 Ill.2d 306, 316 (1987).

On the other hand, Emerald argued that Allmerica bore the burden of proving that Scudder would have prevented Emerald from making profits absent the breach since that was an affirmative defense to Emeralds damages claim.

The Burden of Proof Rulings. Both the district court and the Seventh Circuit rejected Emeralds argument. They held that proving that claimed profits would have been made absent a breach is part of the plaintiffs burden of proving damages causation. As Emerald had the burden of proving its damages, Allmerica was not obliged to plead or prove that Scudder would have cut off Allmerica and hence *Emerald*. 2008 U.S. App. LEXIS 3513, at **18. (Practice pointer: Allmerica deliberately did not plead as an affirmative defense that Scudder would have stopped Emeralds trading. If it had been so pleaded, the courts might have been more willing to put the burden of proof on Allmerica to show the cutoff would have occurred.)

The Damages Trial. The burden of proof rulings were critical to the outcome of the case. Since Emerald bore the

burden of proving it would have made profits absent Allmericas breach, Allmerica only had to prevent Emerald from meeting that burden.

Even though Emerald bore the burden of proof on the damages issue, Allmerica bore the burden of coming forward with evidence to rebut plaintiffs case. *See Moore v. Kulicke & Soffa Industries, Inc.*, 318 F.3d 561, 565 (3d Cir. 2003) (defendants must meet burden of producing some evidence to rebut plaintiffs case, but plaintiff retains the ultimate burden of persuasion). Thus, Allmerica developed and presented evidence showing why Emerald would not have made profits in the future. This included (1) documents and testimony from Scudder representatives about their efforts to stop market timing in their funds, (2) internal emails and other documents from Emerald itself about how various other mutual funds (including other Scudder funds) had stopped Emerald from market timing, (3) evidence about how the Securities and Exchange Commission had attempted to stop market timing and (4) Emeralds internal records of its own profit declines before trial due to the multi-pronged efforts to stop market timing.

In addition to showing a lack of damages causation, this evidence moved the focus of the case away from Allmericas judicially determined contract breach and Emeralds profitable history of market timing, bad facts for Allmerica. That evidence placed the focus on Emeralds harmful market-timing trading and Emeralds ever-declining profitability because its trading had been stopped elsewhere, bad facts for Emerald. This undoubtedly helped to lessen the sting before the jury of the courts finding that Allmerica breached its contracts with Emerald.

The Outcome. Having been instructed that Emerald bore the burden of proving that Scudder would not have stopped its trading, *i.e.*, that Emerald would have made the substantial damages it sought if the breach had not occurred, the jury awarded Emerald only a fraction of what it claimed, \$1.1 million.. The court of appeals then reversed even that relatively small award as being speculative, or in other words not proved. (2008 U.S. App. LEXIS 3513, at **11). n2

Analysis: Recent Securities-Law Loss Causation Concepts Are Now Being Applied To Common-Law Claims. In securities cases, courts require more than proof that the damages could not have occurred but for the wrongful act, *i.e.*, transaction causation; there must also be proof that the wrongful act actually caused the purported loss, *i.e.*, loss causation. *See Dura Pharmaceuticals, Inc. v. Broudo*, 544 U.S. 336 (2005). Here, the requirement that Emerald prove that Allmericas breach actually caused Emerald losses was in essence requiring proof of loss causation, even though the Seventh Circuit did not use those terms. Judge Posner, who wrote the *Emerald* decision, has applied this same concept in other non-securities cases. *See Maxwell v. KPMG, LLP*, 2008 U.S. App. LEXIS 5896 (7th Cir. 3/21/08) (relying on securities law loss causation concept, court found that accountant whose allegedly negligent audits led plaintiff to purchase a company, was not liable for loss the acquired company caused plaintiff later when its business dried up due to industry downturn); *Movitz v. First Natl Bank of Chicago*, 148 F.3d 760, 765 (7th Cir. 1998) (relying on securities law loss causation concept, court found in common law tort case that bank not liable for loss in value of office building caused by downturn in real estate market even though plaintiff might not have purchased building at all but for bank errors in evaluating building for investment).

The loss causation concept is itself based on common law notions of proximate causation. *See Dura at 343-44*. Courts have now come full circle and are applying the loss causation doctrine as developed and refined in securities law cases back into common law cases.

Conclusion. The imposition of a loss causation requirement in securities cases has focused courts on the need to prove proximate cause for damages in common law cases. The *Emerald* case demonstrates how strong a causation defense can be, even in a damages-only trial after liability has already been established against the defendant.

[Return to Text](#)

n1 . Mr. Gilbert is a trial and appellate lawyer whose practice focuses on complex financial and commercial cases. He represented Allmerica in the damages phase of the case discussed in this article, both at trial and on appeal.

n2 . The Court of Appeals found damages testimony of Emeralds expert and Emeralds principal unreliable and not supportive of the verdict. In doing so, the Court relied, *inter alia*, on the evidence developed on the causation issue of how Emerald and other market timers generally had not been able to continue profiting from market timing after the date of Allmericas breach.

ABOUT THE AUTHOR(S):

Alan S. Gilbert has extensive experience in litigation and alternative dispute resolution before trial and appellate courts, arbitration tribunals and administrative agencies throughout the United States. He concentrates on complex commercial cases, with a particular emphasis on financial disputes and class actions. Mr. Gilberts litigation experience covers a wide range of areas, including contracts, securities, commodities, class actions, insurance, insolvency, real estate, construction, products liability, constitutional law, trade secrets, banking, lender liability, employee benefits, fiduciary responsibility, corporate control, and partnerships.

Current and recent representations:

Successfully defended variable annuity issuer in damages only case tried to jury after court finding that insurer breached annuity contracts by imposing trading restrictions. Obtained jury verdict of less than 1% of nine-figure damages originally sought and reversal of that verdict on appeal, leaving client with no damages liability

Defending insurer in four week arbitration hearing over \$150 million in residual value insurance coverage for auto leasing company. Case settled before closing arguments on favorable terms

Prosecuting nine-figure actions against accountants, lawyers and bankers of defunct student finance company

Defending company and its cash balance pension plan in putative national class action challenging payments to participants

Serving as national coordinating counsel for various insurers facing class actions in different jurisdictions, including defending Hurricane Katrina class actions in Louisiana and a putative national class action in Arkansas challenging use of claim adjusting software

Before coming to Sonnenschein in 1981, Mr. Gilbert served as law clerk to the Honorable William J. Bauer, formerly the Chief Judge of the United States Court of Appeals for the Seventh Circuit, and spent four years representing the poor in individual and class actions with the Legal Assistance Foundation of Chicago, an affiliate of the federal Legal Services Corporation.

Sonnenschein Nath & Rosenthal, LLP regularly handles high-risk and complex matters for financial and insurance industry clients. Staffed with seasoned litigators and former insurance regulators, Sonnenschein lawyers are relentless advocates for its clients interests.

For more than 70 years, Sonnenschein has partnered with insurance companies to understand their business and legal needs. Recent confirmation of Sonnenschein's outstanding insurance industry qualifications came in Chambers USA: Americas Leading Lawyers for Business. Sonnenschein won the 2008 Chambers Award for Excellence in Insurance. The award recognizes Sonnenschein's work in both the litigation and regulatory areas and further confirms its reputation as a world-class provider of legal services to insurance industry clients. The 2007 edition identifies Sonnenschein as one of the top firms in the country representing insurers on their most complex matters. The Chambers description speaks for itself:

This powerhouse litigation firm is known for its sophisticated and thorough work in insurance and its ability to pull together a sterling set of resources. The firm fields a wide range of specialists, which it can use to staff complex cases. Its recent track record ranges from involvement in the WTC litigation to Hurricane Katrina-related issues. Matters are handled by a number of offices at any one time and practitioners are said to work tirelessly and creatively to help manage disputes and create briefings that are strong and impressive. Key areas of interest are bankruptcy and insolvency in insurance companies, class actions and catastrophic loss in both appeals and litigation. The firm also has strength in personal lines insurance and in regulatory proceedings.

When products are attacked, when lawsuits go national, when regulators join the fray, when reputations are on the line, leading businesses turn to Sonnenschein.

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Stempel on Vigilant Insurance Co. v. The Bear Stearns Co.

2008 Emerging Issues 2144

Stempel on Vigilant Insurance Co. v. The Bear Stearns Cos: Bear Stearns Takes a Hit on Insurance Coverage as Well as Stock Price, Independence

By Jeffrey W. Stempel

April 16, 2008

SUMMARY: The financial world was shocked to discover that investment banking firm Bear Stearns was on its way to being acquired by Morgan Stanley. A unanimous New York Court of Appeals held that Bear Stearns was without insurance coverage for an \$80 million settlement it reached with government regulators in 2002 in the absence of insurer consent. The decision may support stricter enforcement of insurance policy duties of notice and cooperation.

PDF LINK: [Click Here for Enhanced PDF of Commentary](#)

ARTICLE: March 2008 saw another casualty of the subprime mortgage lending crisis. Bear Stearns, a financial services company dating back to the Nineteenth Century, was discovered to be in financial trouble, so much so that there was immediate talk of a bailout or bankruptcy. Within days, investment bank J.P. Morgan rode to the rescue by offering to acquire Bear Stearns at the price of \$2/share, considerably down from the company's relatively recent high of \$80/share. Approximately 30 percent of the company stock is owned by employees or other insiders, many of whom now see their once formidable fortunes crashing down to a comparative pittance. As this is written, there is talk that the J.P. Morgan acquisition price may increase to \$8/share or may be challenged as unfair by disgruntled shareholders, who note that the estimated total acquisition price of \$236 million is less than the estimated value of the Bear Stearns headquarters building in Manhattan (valued at between \$400 and \$500 million).

Whatever the ultimate outcome of the Morgan Stanley-Bear Stearns acquisition and any attendant litigation, one thing is clear: Bear Stearns will not be getting a requested \$50 million of insurance coverage from its insurers in connection with the investment bankers' 2002 settlement of actions brought against it by government regulators. The New York Court of Appeals, in a unanimous March 13, 2008 decision, held that Bear Stearns improperly entered into the settlement without the insurers' consent and that the policyholders' unauthorized action voided coverage. *See Vigilant Ins. Co. v. Bear Stearns Cos.*, 2008 N.Y. LEXIS 542 (Mar. 13, 2008).

The decision, handed down in the midst of the larger bad news for the company, provides a window into the type of problematic, arguably reckless, decisionmaking that critics say was partly responsible for the company's demise. It also provides a roadmap for insurers wishing to protect themselves from voluntary settlements by policyholders and a cautionary tale for policyholders who wish to protect their potential for coverage when sued. In addition, the decision potentially breathes some new life into the sophisticated policyholder defense to coverage and may be part of a modest

trend toward greater judicial enforcement policy provisions designed to protect the insurer from slipshod or unduly self-serving conduct such as nonsettlement, notice, and cooperation clauses.

Insurer Vigilant issued a \$10 million professional liability policy to Bear Stearns that provided liability coverage for wrongful acts of the policyholder. Bear Stearns retained \$10 million of risk, with excess insurers Federal and Gulf providing an additional \$40 million of liability coverage upon exhaustion of the underlying \$20 million of retention and Vigilant coverage. Like most liability policies, the Vigilant policy contained language requiring that the policyholder not enter into settlement without the consent of the insurer if the amount of the settlement exceeded \$5 million. But this consent-to-settle clause was a particularly clear and reasonable one, providing that

The Insured agrees not to settle any Claim, incur any Defense Costs or otherwise assume any contractual obligation or admit any liability with respect to any Claim in excess of a settlement authority threshold of \$5,000,000 without the Insurers consent, which shall not be unreasonably withheld. . . The insurer shall not be liable for any settlement, Defense Costs, assumed obligation or admission to which it has not consented.

*See 2008 N.Y. LEXIS 542 at **8.*

In early 2002, the SEC, the NASD, the NYSE and several state Attorneys General began an investigation into the practices of research analysts working at financial services firms and the potential conflicts that could arise from the relationship between research functions and investment banking objectives with the inquiry focused on allegations that research analysts employed at ten major financial institutions, including Bear Stearns, were improperly influenced by investment banking concerns. *See 2008 N.Y. LEXIS 542 at **2.* This and related investigations taking place in the wake of the Enron and dot.com company collapses of 2001 grew out of concern that financial firms had in essence provided overly rosy analysis of businesses in order to curry favor so that the financial services firms could also score big investment banking fees in connection with public offerings and other capital-raising initiatives for these same businesses. It grabbed headlines at the time and undoubtedly raised significant concerns on Wall Street.

Not surprisingly, the investigation targets began talking about a global settlement with the regulators, undoubtedly as part of an effort to put the story behind it irrespective of the merits of the government claim. More surprisingly, Bear Stearns did not put primary insurer Vigilant or excess insurers Federal and Gulf in the loop, even though all policies restricted coverage if any settlement in excess of \$5 million were made without the insurers consent (the Federal and Gulf excess policies followed form to the Vigilant primary policy). In December 2002, Bear Stearns executed a settlement-in-principle document in which it agreed to consent judgments with the regulators and payment of \$50 million in retrospective relief, plus \$25 million to fund independent research and \$5 million for investor education. *See id.* at **3. The government regulators announced the settlement via press release, noting that it included nine financial firms in addition to Bear Stearns and would yield more than \$1.4 billion in payments. In April 2003, Bear Stearns executed a consent agreement binding it to final judgment in the U.S. District Court for the Southern District of New York. Under the terms of the agreement, the SEC was to present the settlement to the court for final approval. Three days later, Bear Stearns finally wrote to its insurers and requested their consent to the settlement. In October 2003, the federal trial court approved the settlement.

Vigilant, Federal and Gulf all denied coverage and filed the declaratory judgment action that eventually reached New Yorks highest court. In addition to raising the issue of an unauthorized settlement, the insurers also argued that an investment banking exclusion in the policy precluded coverage, that the payments of independent research and investor education did not qualify as losses under the policy, and that \$25 million of funds paid in settlement represented disgorgement of illegal profits and therefore should not be insurable as a matter of public policy. The state trial court and intermediate appellate court reacted differently to these arguments, with the Appellate Division siding with Bear Stearns on the inapplicability of the investment banking exclusion and the no-loss defense and finding triable issues of fact regarding the non-settlement clause and public policy defenses of the insurers.

The Court of Appeals based its ruling solely on the unauthorized settlement defense. In attempting to obtain

coverage even though it clearly had made a settlement deal without its insurers consent, Bear Stearns argued that it was not in breach of the policy because the settlement did not become final through judicial approval until nearly six months after the insurers were notified of the settlement. The Court of Appeals was having none of it, holding that Bear Stearns breached [the settlement] provision when it executed the April 2003 consent agreement before notifying the insurers or obtaining their approval [because] Bear Stearns did everything within its ability to settle the matter and no further action was required on its part. *See id.* at **9. The Court was

unpersuaded by the contention that a triable issue of act exists because the federal court did not approve the settlement until it entered a final judgment in October 2003. Parties are free to enter into a valid settlement agreement that is made subject to court approval. Notably absent from the agreement, however, was any provision similarly subjecting it to the insurers approval. Having signed the consent agreement, Bear Stearns was not free to walk away from it before entry of a final judgment. * * * In executing the April 2003 agreement, Bear Stearns settled a claim within the meaning of the insurance policy provision.

*See 2008 N.Y. LEXIS 542 at **9-**10 (citations omitted).*

The Court of Appeals decision seems unassailable as a matter of policy text, contract law and common sense. The policy states in straightforward language that the policyholder cannot expect coverage (at least for settlements exceeding \$5 million) unless the insurer consents. Because the insurer cannot unreasonably withhold consent, the provision is not unconscionable or otherwise problematic. The which shall not be unreasonably withheld language of the settlement approval provision protects the policyholder from being victimized by insurer intransigence and would put the insurer at risk of bad faith liability it allowed the policyholder to be skewered by a judgment that could have been avoided through a prudent settlement.

Further, unless the insurer is informed about the policyholders settlement activities until after a deal is done, the insurer has no opportunity to participate. Even if the federal court has not formally approved a settlement, the policyholder violates this type of a clause when it makes a deal with a plaintiff without at least notifying the insurer and giving the insurer a meaningful opportunity to participate in the negotiations and evaluate any proposed resolutions. If the insurers had been informed but were holding up a reasonable settlement, Bear Stearns might then have been permitted to properly settle even in the absence of insurer consent and still obtain coverage.

The Court of Appeals was particularly unsympathetic in that it noted that Bear Stearns was a sophisticated business entity that should have appreciated the meaning of the policy provision and the consequence of its acts. *See id.* at **10. Off and on since the 1970s, insurers have on occasion argued that a sophisticated insured approach should prevail to coverage disputes with business policyholders that have experience with particular policies and the assistance of brokers and counsel. In extreme cases, some insurers have argued (with occasional court approval) that contract axioms such as construction of ambiguities against the insurer as policy drafter should not apply. *See Hazel Glenn Beh, Reassessing the Sophisticated Insured Exception, 39 Tort & Ins. L.J. 85 (2003); Jeffrey W. Stempel, Reassessing the Sophisticated Policyholder Defense in Insurance Coverage Litigation, 42 Drake L. Rev. 801 (1994).*

Although this more aggressive version of the sophisticated insured defense to coverage has never taken hold, courts do appear to view sophisticated policyholders as more responsible for the consequences of breach of a policy provision than an unsophisticated policyholder might be. For example, a small business or individual might on occasion be forgiven for failing to apprise the insurer first before seizing on an opportunity for swift settlement or might be forgiven for thinking that the case is not really settled until there is court approval. However, a sophisticated entity such as Bear Stearns is expected to understand the policy provisions, to resist being stampeded into settlement before notifying the insurer, and to understand that a consent agreement effectively resolves the dispute even if formal judicial approval remains to be obtained. At the margin, the *Vigilant v. Bear Stearns* case provides at least a modest shot in the arm for insurers wishing to make renewed use of sophisticated insured arguments.

What explains the Bear Stearns conduct? And what can policyholders and insurers learn from the case?

Although it is possible that Bear Stearns and its counsel simply missed the consent-to-settlement provisions of the policy, this is unlikely in view of the sophistication of company and counsel. More likely is that Bear Stearns, with the advice of counsel, wanted to reach an accord as soon as feasible to put the bad publicity behind it and move the story off the news pages. Getting the insurers into the loop risked scuttling a swift settlement. Before paying \$50 million, the insurers might well want more protracted discovery and negotiation, perhaps even trial all of which conflicted with the policyholders desire to put the case in the rear view mirror as fast as possible. Rather than risk the insurers derailing the express train toward settlement, Bear Stearns perhaps entered the settlement knowing that coverage was at risk but hoping that its argument about formal judicial approval might be accepted by the courts, at least enough for denial of summary judgment and settlement with the insurers for some significant amount of coverage.

In addition to unauthorized settlement provisions, liability policies also contain provisions requiring that the policyholder provide prompt notice to the insurer and cooperate with the insurer in the resolution of a case. The general rule in most states (but not New York) is that late notice vitiates coverage only if the insurer can demonstrate that it was substantially prejudiced by late notice. The same approach is taken by most states regarding failure to cooperate: it defeats coverage only if the insurers ability to defend or settle the claim is substantially prejudiced. *See* Jeffrey W. Stempel, Stempel on Insurance Contracts § 9.01 (3d ed. 2006 & Supp. 2008).

In New York, timely notice is a condition precedent to coverage. Late notice to either a primary or excess insurer precludes coverage. However, a reinsurer can avoid coverage on late notice grounds only if it is prejudiced. Because of the strength of the late notice defense in New York, the Bear Stearns decision to settle without even notifying its primary and excess carriers seems particularly bizarre. Prompt notice to the insurers would not necessarily have scuttled any desire to reach a quick settlement if the settlement is reasonable. Putting an insurer on notice of a claim in New York or elsewhere triggers the insurers duty to settle.

Insurance policy provisions requiring the policyholder to cooperate with the insurer in the defense of a claim are usually subject to a similar analysis. Even a clear failure to cooperate will not result in loss of coverage unless the insurer can demonstrate that it was substantially prejudiced by the failure, which usually means the insurer must show that the policyholders failure to cooperate resulted in a less favorable result for the insurer. Although this places a significant burden on the insurer in failure-to-cooperate cases, it is not insurmountable. *See, e.g., Hager v. Rutgers Casualty Ins. Co., 2008 N.J. Super. LEXIS 52* (N.J. Sup. Ct., App. Div., March 7, 2008) (policyholders failure to cooperate prevented insurer from determining if driver of vehicle at time of accident was a permissive user, effectively precluding insurer from investigating potential coverage defense even if failure to cooperate did not prejudice defense of the underlying auto accident case); *MacLean Townhomes, LLC v. American States Ins. Co., 138 Wn. App. 186, 156 P.3d 278* (Wash. Ct. App. 2007) (policyholders consent to binding arbitration breaches cooperation clause and causes substantial prejudice as a matter of law because it effectively precluded the insurer from raising legal defenses cognizable in litigation but not arbitration).

Like notice and cooperation provisions, policy provisions requiring insurer consent to settlement have sometimes been subjected to a showing of prejudice required approach by the courts but in general have been taken more seriously by courts.

Policyholders would like a world where unauthorized settlements preclude coverage only when the insurer cannot demonstrate that it could have done better in negotiating or defending a case but they by and large have achieved this goal. Unless the insurer has a conflict of interest with the policyholder, defends under a reservation of rights, or fails to defend, the policyholder will generally lose coverage if it settles without the insurers consent. When the policyholder settles without even notifying the insurer or allowing the insurer to participate in settlement or defense activity, the policyholder is highly likely to lose coverage.

To avoid such coverage losses, policyholders should as a general operating principle always give their insurers prompt notice and full opportunity to assume defense and settlement of a case. Where the liability policy is indemnity-only and lacks a duty to defend, the policyholder should still provide prompt notice and keep the insurer

adequately apprised of the posture of the case and settlement activity.

Only where it is impractical or clearly counter-productive or fruitless to involve the insurer should the policyholder engage in an unauthorized settlement. For example, if the insurer breaches the duties of defense or settlement or acts in bad faith, the policyholder will often be freed of any consent-to-settlement requirement in the policy. However, even in such cases, the policyholder should ordinarily keep the insurer informed and give the insurer every chance to resolve a matter or evaluate the case so that it has an opportunity to assess the policyholders proposed settlement of a matter.

Conversely, insurers wishing to avoid being stuck with unauthorized settlements should first give thought to providing clear and fair consent-to-settlement language in their policies. The consent language in the Vigilant policy was both clear and fair, which made it much easier for the New York Court of Appeals to be unforgiving when confronted with the unauthorized settlement actions of Bear Stearns. Thereafter, insurers notified of a past or pending settlement should at least consider attempting to insert themselves into the case in order to oppose judicial approval of an unreasonable settlement or seek to set aside an unreasonable settlement.

Although such efforts are as a practical matter unlikely to be successful, they will make a record in which it is clear that the insurer has done all it could to avoid being prejudiced by the unauthorized settlement just in case the court deciding the coverage dispute is inclined to apply the approach of the late notice and failure-to-cooperate cases that require substantial prejudice to the insurer before a policyholders breach results in loss of coverage.

But what about an unauthorized settlement that is reasonable or likely to be seen as reasonable by the court? In this type of case, the insurer is probably better off following the lead of Vigilant, Federal and Gulf in the Bear Stearns case and simply asserting that insurer consent or at least the opportunity to evaluate and consent is a condition precedent to coverage and that there is no need for an inquiry as to whether the unauthorized settlement resulted in a more adverse financial outcome to the insurer.

The \$80 million Bear Stearns settlement does not seem unduly generous in light of the serious conflict of interest allegations and bad publicity surrounding financial services companies in the post-Enron 2001-2003 time period. Getting several sets of government regulators off the backs of an investment house was probably worth \$80 million to Bear Stearns. But even if the settlement was reasonable, the insurers were deprived of their opportunity to test the government regulators theories and do better in settlement. The actions of the policyholder deprived the insurers of that opportunity. As insurer counsel noted after the decision, the decision provides a place at the settlement table for insurers in cases where the policyholder wants to use insurance money as part of a settlement.

In future cases, even when presented with reasonable settlement opportunities, policyholders, particularly sophisticated ones, should remember the lessons of *Vigilant v. Bear Stearns* and notify and involve their liability insurers as soon as feasible even where this raises some risk that an insurer will delay or perhaps even scuttle an attractive settlement. Although insurer involvement may slow down some momentum toward settlement, the duty to settle and the duty of good faith should ordinarily discourage unreasonable resistance and delay by insurers. In failing to inform its insurers, Bear Stearns took a \$50 million risk that proved to be every bit as misplaced as the big bets the company put on subprime loans.

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Jeffrey W. Stempel is the Doris S. & Theodore B. Lee Professor of Law at the Boyd School of Law-University of Nevada Las Vegas, where he teaches Insurance Law, Professional Responsibility, Contracts, and Civil Procedure. He is also author of the treatise Stempel on Insurance Contracts and co-author of the coursebook Principles of Insurance Law.

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SEIGER AND KINGSLEY ON PANASIA ESTATES AND BI-ECONOMY MARKET

2008 Emerging Issues 2150

SEIGER AND KINGSLEY ON PANASIA ESTATES V. HUDSON INSURANCE COMPANY AND BI-ECONOMY MARKET V. HARLEYSVILLE: NEW YORKS NEW STANDARD WITH RESPECT TO FIRST-PARTY BAD FAITH CLAIMS

By Mark B. Seiger and Jeffrey L. Kingsley

April 16, 2008

SUMMARY: Previously, New Yorks highest Court did not recognize independent tort causes of action for an insurers alleged failure to perform its contractual obligation under an insurance contract. The First Departments decision in *Acquista v. New York Life Insurance Company* was not followed by New York Courts until the Court of Appeals rulings in *Panasia Estates v. Hudson Insurance Company* and *Bi-Economy Market v. Harleysville* on February 19, 2008.

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ARTICLE: The standard for a first-party bad faith claim in New York was perhaps significantly and permanently altered on February 19, 2008 with the Court of Appeals decisions in *Bi-Economy Market, Inc. v. Harleysville Insurance Co. of New York*, __ N.Y.3d __, 2008 N.Y. LEXIS 278 (N.Y., Feb. 19, 2008) and *Panasia Estates, Inc. v. Hudson Ins. Co.*, __ N.Y.3d __, 2008 N.Y. LEXIS 275 (N.Y. Feb. 19, 2008) respectively. Are extra-contractual damages far behind?

Until recently, New Yorks highest court did not recognize an independent tort cause of action for an insurers alleged failure to perform its contractual obligations under an insurance contract. *Rocanova v. Equitable Life Assur. Soc.*, 83 N.Y.2d 603, 634 N.E.2d 940, 612 N.Y.S.2d 339 (1994). The *Rocanova* decision, which was routinely followed throughout the state, stood for the proposition that an insured would typically receive contractual damages for an insurers failure to adhere to the terms and conditions of the insurance policy. Absent a showing of egregious tortious conduct directed at the insured that demonstrates a pattern of similar conduct direct at the public generally, punitive damages and other forms of extra-contractual damages were precluded in an insureds award. *Rocanova, supra*; see also *New York Univ. v. Continental Ins. Co.*, 87 N.Y.2d 308, 662 N.E.2d 763, 639 N.Y.S.2d 283 (1995).

For the past thirteen years since *Rocanova*, the only decision which provided insureds with a pathway towards receiving greater protection in first-party bad faith claims was the Appellate Division, First Departments decision in *Acquista v. New York Life Insurance Company* 285 A.D.2d 73 (2d 2001). In *Acquista*, the First Department noted the potentially adverse consequences to the harsh standard of *Rocanova*. In fact, the First Department noted that New Yorks standard was becoming atypical in the United States:

Yet, for some time, courts and commentators around the country have increasingly acknowledged that a fundamental injustice may result when a traditional contract analysis is applied to circumstances where insurance claims were denied despite the insurers lack of a reasonable basis to deny them

[Under the *Rocanova* standard] an award, at the conclusion of litigation for money damages equal to what the insurer should have paid in the first place, may not have actually achieved the goal of contractual damages, which is to place the plaintiff in the position he would have been in had the contract been performed.

Id.

As such, the *Acquista* court held that an insured may be employed to interpose a claim for consequential damages beyond the limits of the policy for the claimed breach of contract. *Id.* As significant as many practitioners believed *Acquista* to be at the time, it was never followed by any court in a subsequent decision until recently.

In *Panasia Estates v. Hudson*, the Court of Appeals once again revisited the issue of whether an insureds claim for consequential damages is barred by the terms and conditions of the insurance policy. The insured, Panasia Estates, commenced this action against *Hudson*, alleging that it breached the insurance contract by failing to properly investigate the loss and denying the loss as not covered under the policy. Panasia sought both direct and consequential damages that it claimed stemmed from Hudson's breach. Hudson, in turn, citing *Rocanova* moved for summary judgment claiming, among other things, that consequential damages were precluded by the policy's exclusions. The lower court in denying Hudson's motion for summary judgment citing to the reasoning in *Acquista*, namely that an insured may recover foreseeable damages, including consequential damages, beyond the limits of its policy, for breach of a duty to investigate, bargain for and settle claims in good faith.

By applying that logic, the Court held that Contractual exclusion in commercial property insurance policy for consequential loss did not bar Panasia Estate request recovery of consequential damages arising when Hudson's alleged breach arose out of its failure to properly investigate loss occurring when building suffered water damage during renovations.

Likewise, in *Bi-Economy Market v. Harleysville*, Bi-Economy commenced this action against Harleysville, asserting causes of action for bad faith claims handling, tortious interference with business relations and breach of contract, seeking consequential damages for failing to timely pay the full amount of its lost business income claim. Like Hudson, Harleysville, relying heavily upon the New York Standard on bad-faith claims, moved to dismiss the consequential damages portion of the complaint by stating that the terms and conditions of the policy excluded such damages. The lower court and Appellate Division, unlike *Panasia*, granted and affirmed respectively *Harleysville* motion and plaintiff appealed. The Court reversed the Appellate Division and denied Harleysville motion stating that to determine whether consequential damages were reasonably contemplated by the parties, courts must look to the nature, purpose and particular circumstances of the contract known by the parties ... as well as what liability the defendant fairly may be supposed to have assumed consciously, or to have warranted the plaintiff reasonably to suppose that it assumed, when the contract was made *Id.* The Court went on to conclude that the purpose of the contract was not just to receive money, but to receive it promptly so that in the aftermath of a calamitous event, as Bi-Economy experienced here, the business could avoid collapse and get back on its feet as soon as possible. *Id.*

The Courts Of Appeals in the tandem decisions of *Panasia* and *Bi-Economy* appear to breathe life in the *Acquista* position by stating that consequential damages are allowable in a first-party bad faith claim. Both decisions, however, attempt to distinguish between allowing an insured to be eligible for consequential damages while maintaining the position that punitive damages are still prohibited under New York law.

The significant shift in New York's standard was not unanimously adopted, as Judge Robert Smith admonished the majority's rulings in his dissent. Judge Smith claimed that the *Rocanova* standard was abandoned without even a reference to it. Judge Smith explained:

We held that punitive damages are not available for breach of an insurance contract unless the plaintiff shows both egregious conduct directed at the insured claimant and a pattern of similar conduct directed at the public generally. Today, the majority abandons this rule, without discussing it and without acknowledging that it has done so. The majority achieves this simply by changing labels: punitive damages are now called consequential damages, and a bad faith failure to pay a claim is called a breach of a covenant of good faith and fair dealing.

If Judge Smith is correct in his assessment on the significance of the Court of Appeals recent rulings in *Panasia* and *Bi-Economy*, then jurors will now be allowed to weigh in on the sufficiency of an insurers business practices. The end result might be a potential increase in these types of litigations going to trial, and the possibility that jurors might have an opportunity to make punitive-like awards. Practitioners, however, can only wait to see if Judge Smiths bleak view is correct.

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Developments in Bad Faith--Time-Restricted Settlement Offers

2008 Emerging Issues 246

Richmond on Developments in Bad Faith--Time-Restricted Settlement Offers

By Douglas R. Richmond

April 14, 2008

SUMMARY: Allegations of bad faith permeate insurance litigation. In a common bad faith scenario, an insured or its assignee alleges that a liability insurer unreasonably failed to settle a claim against the insured within its policy limits, thus exposing the insured to excess liability. In the vast majority of jurisdictions, an insurer must be presented with a settlement offer or demand within its policy limits to be potentially liable for damages exceeding those limits. When a plaintiff's damages exceed available coverage, the plaintiff is unlikely to be satisfied by a policy-limits settlement offer, and is therefore motivated to attempt the artificial expansion of those limits. A time-restricted settlement offer is the plaintiff's lever for attempting to do so. The plaintiff's lawyer sends the insurer a settlement offer that expires in a relatively short time. The plaintiff's settlement deadline is arbitrary. The plaintiff hopes that the insurer will not accept the offer before it expires, thus supporting a future bad faith claim. In his commentary, Douglas R. Richmond, Senior Vice President in the Professional Services Group of Aon Risk Services, urges the view that time-restricted settlement offers are rarely reasonable, and that most of them are litigation ploys that should not support bad faith allegations.

PDF LINK: Premium Emerging Issues Commentary (\$)

ARTICLE: DEVELOPMENTS IN BAD FAITH--TIME-RESTRICTED SETTLEMENT OFFERS

By

Douglas R. Richmond

Introduction

Allegations of bad faith permeate insurance litigation. In a common bad faith scenario, an insured or its assignee alleges that a liability insurer unreasonably failed to settle a claim against the insured within its policy limits, thus exposing the insured to excess liability. In the vast majority of jurisdictions, an insurer must be presented with a

settlement offer or demand within its policy limits to be potentially liable for damages exceeding those limits if it does not settle and instead takes the case to trial and loses. Most insurers understand their implied duty of good faith and fair dealing and, accordingly, take very seriously any demand or offer within their limits. The problem is that when a plaintiffs damages far exceed available coverage, the plaintiff is unlikely to be satisfied by the insurers policy-limits settlement offer, as where, for example, the plaintiffs injuries are serious and the defendant is insured under a \$25,000 automobile liability policy. In such a case, the plaintiff--and, perhaps more accurately, the plaintiffs lawyer--is motivated to artificially increase the defendants insurance policy limits. A time-restricted settlement offer is the plaintiffs lever for attempting to do so.

In short, the plaintiffs lawyer sends the insurer a settlement offer that by its terms expires in a relatively short time. The plaintiffs deadline is arbitrary. The plaintiff hopes that the insurer will not timely accept the offer. In many cases, the insurer cannot fairly accept the offer in the time allotted. The offer may be sent to an agency instead of a claims office, or to the wrong claims office, whether by accident or design; the insurer may not have sufficient information to responsibly evaluate the claim before the offer expires; or, in cases in which multiple claimants are involved, the insurer may need time to consult with its insured or to evaluate all of the claims. In any event, if the insurer does not accept the offer by the plaintiffs deadline, the plaintiff withdraws it in the hope of obtaining a judgment exceeding the insurers policy limits. If that happens, the plaintiff will argue that the insurers refusal to settle was an act of bad faith, and that the company should be liable for the full amount of any subsequent judgment.

These tactics are often effective. The threat of bad faith liability has caused many insurers to pay more than their policy limits to settle cases in which they did not accept a time-restricted settlement offer before its expiration. In many cases, the insurer was not actually guilty of bad faith, but reluctantly saw settlement as being preferable to expensive, time-consuming, and potentially risky litigation. This is especially true in cases in which the plaintiff and insured entered into a sizable consent judgment following the insurers failure to settle on the plaintiffs terms.

Insurers ensnared in bad faith litigation resulting from their failure to accept time-restricted settlement offers understandably complain that they were set-up. Plaintiffs counsel acknowledge this, but consider their tactics a legitimate strategy to maximize their clients recovery. They reason that their professional duties of competence and diligence compel them to attempt to set-up insurers for bad faith where the policy limits are otherwise inadequate to compensate their clients. Self-interested justifications aside, time-restricted settlement offers are seldom reasonable. Cases in which such an offer is reasonable, perhaps as where a statute of limitations will soon run or pressing procedural deadlines (e.g., expert witness disclosure deadlines, dispositive motion deadlines, etc.) may materially affect the plaintiffs case, are rare. Most time-restricted settlement offers are litigation ploys that should not support bad faith allegations.

Case Law

Grumbling v. Medallion Insurance Co. n1 is among the earliest cases discussing time-restricted settlement offers. The plaintiff there was severely injured, and his wife killed, in an April 1973 automobile collision with Daniels, the defendants insured. Daniels was drunk and driving the wrong way on a four-lane highway. He had no assets other than his Medallion policy, which provided liability limits of \$10,000 per person and \$20,000 per accident.

Medallion immediately investigated the accident and concluded that it was a policy limits case. On June 15, 1973, Medallions adjuster received a letter from the plaintiffs lawyer offering to settle all claims (personal injury and wrongful death) for either Daniels policy limits or \$250,000, whichever was lower. The letter stated that the offer was open for 15 days.

The adjuster promptly called Medallions Portland claims manager, Dennis OLeary, to inform him of the offer, but the adjuster neglected to mention the 15-day time-restriction. The adjuster also forwarded a copy of the letter.

Unfortunately, June 15 was OLeary's last day with the company. He left the company without marking the Daniels file for special attention because (a) the adjuster had not told him of any such need and (b) he had yet to see a copy of the letter. n2 As a result, no one at Medallion with settlement authority reviewed the letter until June 20. An interim claims manager in Portland then forwarded it to the company's home office claims committee in Kansas City. The committee was aware of the plaintiffs deadline and urgently convened a meeting. The committee authorized a policy limits settlement on June 27, but did not timely communicate its decision in writing. No one from Medallion ever called the plaintiffs lawyer to extend the settlement deadline. Medallion did not offer to settle until July 3, one day after the plaintiffs deadline passed. The insurers claims manager received a letter from the plaintiffs lawyer withdrawing the settlement offer that same day. The plaintiff then sued Daniels and proceeded to trial, obtaining judgments against him of just over \$127,000. Daniels assigned his extracontractual claim to the plaintiff.

The *Grumbling* court concluded that Medallion acted in bad faith. The court was troubled by the fact that Medallion never called the plaintiffs lawyer to attempt settlement or to extend the deadline, holding off in favor of written communication to prevent misunderstandings. n3 The court equated the insurers failure to timely call the plaintiffs lawyer because company practice favored correspondence with preferring the insurers interest above those of the insured. n4 Fearing for future plaintiffs attempts to set-up liability insurers for bad faith, however, the court attempted to limit the reach of its holding. Nothing in the decision, the court said, was intended to lay down a rule of law that would mean that a plaintiffs attorney under similar circumstances could set up an insurer for an excess judgment merely by offering to settle within the policy limits and by imposing an unreasonably short time within which the offer would remain open. n5 Rather, the sequence of events, the stage of the proceedings at which the offer is made, and all other circumstances will determine whether duty requires a response to be made within a given time limit. n6

The court in *Grumbling* obviously was upset that Medallions claims staff in Kansas City did not call the plaintiffs lawyer to communicate acceptance of his offer within the time limit. n7 And, indeed, the failure by Medallions senior claims staff to make that call is curious. But all the facts suggest only that the insurer was perhaps negligent in handling the claim. (Even if Medallion was negligent, that negligence harmed no one.) Where was the bad faith? The company offered its full policy limits in settlement almost immediately. It missed the plaintiffs arbitrary deadline by one day. There certainly was no justification for the plaintiffs deadline. Nothing about the sequence of events or the stage of the proceedings--two of the courts principal measures for evaluating the reasonableness of time-restricted settlement offers--mandated swift settlement. Daniels had not even filed suit when his time-restricted offer expired. How was 15 days not an unreasonably short time to accept the offer? Courts typically allow at least 30 days for a defendant to answer a lawsuit even where it has conducted a thorough pre-suit investigation. The court effectively endorsed the bad faith set-up that it seemingly wanted to discourage.

The fact that Medallion apparently could have accepted the plaintiffs offer within the time allotted does not mean that time was reasonable. It remains true that the 15-day limit was tethered to no facts.

Long story short, *Grumbling* is a case about a court that became inflamed and ruled accordingly. The case illustrates the potentially damaging impact that evidence of mindless bureaucratic approaches to straightforward problems may have on juries and courts. The decision should not be read, however, as broadly supporting the use or propriety of time-restricted settlement offers.

Southern General Insurance Co. v. Holt n8 is another case in which a time-restricted settlement offer snagged an insurer. n9 Southern General's insured, Holt, ran a stop sign and struck another car, injuring the second driver, Fortson. Fortson's lawyer initially imposed a 10-day settlement deadline. He later extended the deadline by five days, simultaneously furnishing the company with certified medical records evidencing Fortson's injuries. n10 Southern General did not accept the plaintiffs offer within the time prescribed, nor did it seek additional time to evaluate the offer. Later, the insurer tried twice to settle the case by offering its \$15,000 policy limits. Fortson's lawyer spurned Southern General's overtures, and won an \$82,000 verdict. Holt then assigned to Fortson her claim against Southern General for negligent or bad faith refusal to settle. That in turn led to a \$213,000 verdict against Southern General. The case ultimately reached the Georgia Supreme Court.

The *Holt* court began its analysis by noting that under Georgia law, an insurer may be liable for failing to settle a case within its policy limits when that failure is the product of negligence, fraud or bad faith. n11 In deciding whether to settle, the insurer must give equal consideration to the insureds interests. Whether the insurer did so is a determination that generally rests with the jury, which must decide the issue in view of the existing circumstances. n12 An insurance company does not act in bad faith solely because it fails to accept a settlement offer within the deadline set by the injured persons attorney. n13 In this case, however, there was evidence that Southern General acted unreasonably, including unhelpful admissions by its claims manager and equally bothersome statements by its own expert witness.

According to the court, n14 Southern General argued that an insurance company has no duty to its insured to respond to a deadline to settle a claim within policy limits when [it] has knowledge of clear liability and special damages exceeding the policy limits. n15 The court rejected this argument, stating that the issue is whether all the facts show . . . whether the insurer acted unreasonably in declining to accept a time-limited settlement offer. n16

In *Pavia v. State Farm Mutual Automobile Insurance Co.*, n17 a passenger in the insureds automobile was catastrophically injured in an accident in which the insureds fault seemed clear. In July 1987, the plaintiffs lawyer wrote State Farm and offered to settle for the full amounts of the insureds policy limits, which were \$100,000. That offer was open for 30 days. n18 State Farm never responded, nor did it tell its insureds that there had been a settlement offer within their policy limits. On December 1, 1987, State Farm finally convened a meeting of its claims committee to evaluate the offer. After a short meeting, the committee concluded that the company should offer its policy limits. State Farm finally offered its policy limits on January 7, 1988. The plaintiff rejected State Farms offer, asserting the insurers delay as a principal reason for the rejection. n19

The plaintiff ultimately obtained a judgment of nearly \$4.7 million against State Farm. State Farm argued on appeal that its conduct did not amount to bad faith because its delay in responding to the plaintiffs offer was neither intentional nor deceitful. n20 An intermediate appellate court disagreed, reasoning that while an insurers failure to act before an arbitrary settlement deadline is not dispositive of its bad faith, the record supported the inference that State Farms claims personnel had adopted an attitude of complete indifference to [the plaintiffs] settlement overture. n21 State Farm apparently ignored or overlooked the plaintiffs letter for months without so much as acknowledging its receipt.

The Court of Appeals, New Yorks highest court, reversed the lower appellate court. n22 Applying settled bad faith principles, the Court of Appeals concluded that State Farms failure to meet the plaintiffs settlement deadline did not constitute bad faith. As the *Pavia* court explained:

Permitting an injured plaintiffs chosen timetable for settlement to govern the bad faith inquiry would promote the customary manufacturing of bad faith claims, especially in cases where an insured of meager means is covered by a policy of insurance which could finance only a fraction of the damages in a serious personal injury case. Indeed, insurers would be bombarded with settlement offers imposing arbitrary deadlines and would be encouraged to prematurely settle their insureds claims . . . in contravention of their contractual right and obligation of thorough investigation. n23

While State Farm could have acted more expeditiously, there was no evidence that it failed to investigate the claim, failed to evaluate settlement opportunities, or refused to offer its policy limits before trial once the insureds vulnerability was fully understood. The court thus reasoned that State Farm did not exhibit gross disregard for its insureds interests. State Farms conduct amounted only to mistaken judgment or administrative delay. n24

Wade v. EMCASCO Insurance Co. n25 is the most recent case involving an insurers delayed response to a plaintiffs settlement offer. *Wade* arose out of a serious traffic accident in Wichita, Kansas. EMCASCOs insured, Wade, allegedly ran a red light and struck another vehicle. A passenger in the second vehicle, Nguyen, was rendered quadriplegic as a result. Wades policy with EMCASCO provided a total of \$100,000 coverage for all claimants in an accident. After much pre-suit wrangling over medical records and other investigatory matters, the issue ultimately

became whether EMCASCO acted in bad faith by not settling with the plaintiff until either two or three weeks after the plaintiffs settlement offer expired. One of the plaintiffs lawyers testified that he managed the Nguyen claim, from its inception, with a bad faith claim in mind. n26 The plaintiffs other lawyer admitted that the plaintiffs motive in refusing EMCASCOS settlement offer . . . was to set up a bad faith claim against the insurer. n27

Analyzing Kansas law, the court observed that a plaintiff can recover under a bad faith theory only for excess judgment losses directly and naturally resulting from the insurers breach of duty. If a claimant arbitrarily withdraws an initial settlement offer and later rejects an identical proposal from the insurer, the court noted, then the claimants conduct is the legal cause of the failure to settle. n28 In that case, the insurer should not be required to bear any liability exceeding its policy limits. As the court explained:

The undisputed evidence shows that Mr. Nguyens legal team rejected EMCASCOS . . . settlement offer as part of a strategy to establish a bad faith claim against EMCASCO. . . . Holding an insurance company liable for the excess judgment . . . under these circumstances would be inconsistent with the cause of action for bad-faith or negligent refusal to settle. The cause of action for failure to settle is meant to protect the interests of the insured by requiring the insurer to conduct the litigation, including settlement negotiations, as if the insurance contract had no policy limits. . . . It is not meant to create an artificial incentive for third-party claimants to reject otherwise reasonable settlement offers that are within the policy limits. We would be turning the cause of action on its head by holding an insurance company liable when it eventually offered to settle the claim for the policy limits, but a claimant rejected the offer precisely in order to manufacture a lawsuit against the insurer for bad-faith refusal to settle. n29

The plaintiffs bad faith claim against EMCASCO accordingly failed.

Some Perspective and Practical Advice

Insurers must be wary of time-restricted settlement offers. They must always remember their obligation to give their insureds legitimate interests consideration equal to their own. To the extent possible, they should promptly respond to all time-restricted offers within their policy limits, even if it is only to request additional time to consider the offer. If they need information from a plaintiff to evaluate a claim, they should request it. Concerns about telephone conversations being misconstrued or misinterpreted when time is of the essence are easily avoided by the use of e-mail. Insurers should attempt to investigate claims expediently, so that they are not at an informational disadvantage when a time-restricted offer comes. Insurers should not disregard settlement offers within their policy limits simply because they consider them unreasonable. Serious cases always merit serious attention, especially where a time-restricted settlement offer is involved. If a time-restricted settlement offer is unreasonable, an insurer should consider making a reasonable counter-offer. To the extent possible, insurers should attempt to keep insureds informed of settlement offers and their intentions with respect to them.

Of course, the fact that an insurer does not succeed in accomplishing any of these steps does not necessarily mean that it is guilty of bad faith. The fact that an insurer allegedly errs or fails to meet a plaintiffs expectations does not mean that it has somehow subordinated the insureds financial interests to its own. Despite their best efforts, insurance companies are not always nimble organizations. Claims staff may need to set reserves, obtain settlement authority from superiors, and engage in a variety of legitimate administrative tasks in order to resolve a claim. Key managers may be unavailable at relevant times. The company may need to communicate with its insured before accepting an offer but be unable to do so for reasons beyond its control. The insurer, no matter how diligent, may not have had time to complete its investigation when a settlement offer arrives. Adjusters may fail to complete tasks because of competing critical demands for their time or because of unexpected crises or events. Sometimes adjusters may miss a detail or deadline simply out of normal human error. An adjuster may misunderstand a plaintiffs deadline or wrongly believe a plaintiffs lawyer to be flexible when, in fact, she is not. The list of valid and understandable reasons for not ideally responding to time-restricted settlement offers is lengthy. Again, none of these things are indicia of bad faith. None are necessarily unreasonable. On the other hand, an insurer cannot blindly rely on favored internal operating procedures to excuse a failure to respond to a plaintiffs settlement offer or to otherwise ignore an insureds legitimate interests. n30

If an insurer misses a time-restricted settlement deadline, but considers the plaintiffs offer reasonable, it should attempt to accept the offer after the deadline passes. If the plaintiff refuses to settle on the basis that the deadline has passed, the insurer should still offer to settle with the plaintiff for an identical amount (assuming the plaintiffs offer to have been reasonable, of course). The insurers goal here is to attempt to protect the insureds interests. Insurers must strive to be reasonable even if plaintiffs and their lawyers are not.

Plaintiffs lawyers considering time-restricted offers must give careful thought to them. What legitimate reasons are there for selecting a specific response time? Will your reasons withstand challenge as merely a bad faith set-up? Are the facts such that the insurer should be able to reasonably respond within the time stated? If the offer is within the insurers policy limits but is not for their full amount, what do you do if the insurer misses your settlement deadline? Do you simply withdraw the offer, or do you instead increase it? Under no circumstances should a plaintiffs lawyer behave dishonestly when making a time-restricted offer. For example, a plaintiffs lawyer should not counsel a client to send a time-restricted settlement offer to the incorrect claims office or claims professional in the hope of delaying the insurers response, nor should the lawyer do such things. A plaintiffs lawyer should not knowingly mislead an insurer or unreasonably withhold information in his control. Such tactics likely violate ethics rules that prohibit lawyers from engaging in conduct involving dishonesty, fraud, deceit, or misrepresentation. n31 These tactics may also implicate ethics rules prohibiting conduct prejudicial to the administration of justice. n32 At the very least, such sharp practices have the potential to backfire and impair the plaintiffs case in a variety of ways.

Courts must carefully scrutinize bad faith claims predicated on time-restricted settlement offers. The essential question in any bad faith case is whether the insurer subordinated the insureds legitimate financial interests to its own. The standard here, again, is reasonableness. The fact that an insurer does not accept a time-restricted settlement offer within the prescribed time does not, in and of itself, render the insurers conduct unreasonable. That is especially true where the insurer offers an identical amount in settlement within a reasonable time after a time-restricted offer expires. Courts must always take into account all of the surrounding facts and circumstances. A plaintiffs desire to resolve a claim by a stated date for purely subjective reasons is not a valid basis for imposing bad faith liability.

Courts should treat time-restricted settlement offers that remain open for less than 30 days as presumptively unreasonable. Most jurisdictions allow a defendant at least 30 days to answer a lawsuit, even where the facts on which the suit rests have long been known. Some states permit plaintiffs to recover prejudgment interest if a pre-suit settlement offer is left open for a statutorily prescribed period without being accepted and the plaintiff later recovers a judgment exceeding that offer. n33 In states where the statutory period is, say, 60 or 90 days, that time frame provides a sound basis for measuring the presumptive reasonableness of a time-restricted offer. After all, a legislative body has determined that such a period is required for a defendant to fairly evaluate allegations against it and to decide whether to settle or litigate. Any shorter period is by definition presumptively unreasonable when it comes to evaluating pre-suit settlement offers. On the other hand, there may be cases in which a shorter time restriction is reasonable. A shorter period may be required by the stage of the proceedings or the sequence of events, or because of other facts or circumstances. In such cases, a plaintiff should be able to rebut the presumptions suggested here.

Of course, different states apply different standards when evaluating insurers potential liability for failing to settle within policy limits. The majority rule requires some level of intentional wrongdoing by the insurer to support a bad faith claim. As the Arkansas Supreme Court has observed, [a]n insurance company commits the tort of bad faith when it affirmatively engages in dishonest, malicious or oppressive conduct in order to avoid a just obligation to its insured. n34 Following the majority approach, [m]ere negligence or bad judgment is insufficient so long as the insurer is acting in good faith. n35 Other states allow extracontractual recovery for an insurers mere negligence. Under either standard, however, time-restricted settlement offers should generally be rejected as a basis for extracontractual liability. An insurer will rarely miss a plaintiffs deadline because of dishonesty, malice, or oppression. If negligence is the test, the insurer still should not face extracontractual liability in most cases because the insurers failure to meet a plaintiffs deadline will breach no duty. The duty to settle is not limitless, after all, and an insurer breaches it even in a negligence-based regime only by acting unreasonably. If the insurer misses the plaintiffs arbitrary deadline but makes an identical settlement offer soon thereafter, then the insured or its assignee cannot establish that the insurers alleged

breach of duty caused any harm. n36

Conclusion

In a common bad faith scenario, an insured or its assignee alleges that a liability insurer unreasonably failed to settle a claim against the insured within its policy limits, thus exposing the insured to excess liability. When a plaintiff's damages far exceed available coverage, the plaintiff will often attempt to artificially increase the defendant's insurance policy limits through a time-restricted settlement offer. Though their use is understandable, time-restricted settlement offers are rarely reasonable. For the most part they are litigation ploys. Accordingly, courts should carefully scrutinize them when offered as a basis for a bad faith claim.

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n1 392 F. Supp. 717 (D. Or. 1975), *affd*, 545 F.2d 686 (9th Cir. 1976).

n2

[2] *See Grumbling*, 392 F. Supp. at 719.

n3

[3] *Grumbling*, 392 F. Supp. at 720.

n4

[4] *Grumbling*, 392 F. Supp. at 721.

n5

[5] *Grumbling*, 392 F. Supp. at 721.

n6

[6] *Grumbling*, 392 F. Supp. at 721.

n7

[7] *See Grumbling*, 392 F. Supp. at 721.

n8

[8] 416 S.E.2d 274 (Ga. 1992).

n9

[9] *See also McNally v. Nationwide Ins. Co.*, 815 F.2d 254 (3d Cir. 1987) (holding against insurer).

n10

[10] *Holt*, 416 S.E.2d at 275.

n11

[11] *Holt*, 416 S.E.2d at 276.

n12

[12] *Holt*, 416 S.E.2d at 276.

n13 *Holt*, 416 S.E.2d at 276.

n14

[14] The following argument that the court attributed to Southern General is not apparent in the insurers appellate briefs. Presumably it was made at oral argument.

n15

[15] *Holt*, 416 S.E.2d at 276.

n16

[16] *Holt*, 416 S.E.2d at 276.

n17

[17] 589 N.Y.S.2d 510 (N.Y. App. Div.), *revd*, 626 N.E.2d 24 (N.Y. 1993).

n18

[18] *Pavia*, 589 N.Y.S.2d at 513.

n19

[19] *Pavia*, 589 N.Y.S.2d at 513.

n20

[20] *Pavia*, 589 N.Y.S.2d at 515.

n21

[21] *Pavia*, 589 N.Y.S.2d at 516.

n22

[22] *Pavia v. State Farm Mut. Auto. Ins. Co.*, 626 N.E.2d 24 (N.Y. 1993).

n23

[23] *Pavia*, 626 N.E.2d at 28-29.

n24

[24] *Pavia*, 626 N.E.2d at 29.

n25

[25] 483 F.3d 657 (10th Cir. 2007).

n26

[26] *Wade*, 483 F.3d at 673.

n27

[27] *Wade*, 483 F.3d at 673.

n28

[28] *Wade*, 483 F.3d at 674.

n29

[29] *Wade*, 483 F.3d at 674.

n30 *Hulsey v. Travelers Indem. Co. of Am.*, 460 F. Supp. 2d 1332, 1336 (N.D. Ga. 2006) (quoting *S. Gen. Ins. Co. v. Holt*, 416 S.E.2d 275 (Ga. 1992)).

n31

[31] Model Rules of Prof'l Conduct R. 8.4(c) (2007).

n32

[32] Model Rules of Prof'l Conduct R. 8.4(d).

n33

[33] *See, e.g.*, Mo. Rev. Stat. § 408.040.2 (2007) (requiring that offer be held open for 90 days).

n34

[34] *State Auto Prop. & Cas. Ins. Co. v. Swaim*, 991 S.W.2d 555, 559 (Ark. 1999).

n35

[35] *State Auto*, 991 S.W.2d at 559.

n36

[36] *Wade v. EMCASCO Ins. Co.*, 483 F.3d 657, 674 (10th Cir. 2007) (applying Kansas law).

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Sonnenschein Nath & Rosenthal, LLP on Earthquake Coverage: Then and Now

2008 Emerging Issues 231

Sonnenschein Nath & Rosenthal, LLP on Earthquake Coverage: Then and Now

By Cynthia Mellema, Jeff Butler and Norman Lau

April 2, 2008

SUMMARY: While earthquakes and earthquake insurance are primarily matters of concern in California, there have been earthquakes in 46 states since 1975 and insurers underwrite earthquake policies in all 50 states. The California experience with earthquake insurance is therefore potentially important well beyond the states borders. After the 1994 Northridge Earthquake, earthquake coverage became both expensive and limited. To encourage insurers back into the market, the California Legislature permitted earthquake insurers to reduce the scope of structural coverage, limit coverage for personal property and living expenses, and raise the deductible. Thereafter the California Legislature established the California Earthquake Authority, a privately funded, but publicly managed entity. The CEA now underwrites 70% of earthquake policies in California. The commentary describes how this system, as of yet untested by a major earthquake, is set up to work. This commentary further describes how homeowners, with or without earthquake insurance, should prepare their homes and themselves for the next large earthquake. It discusses the additional measures those with earthquake insurance should take, including dealing with the timing problems caused by the prompt notice provision and contractual limitations period typically found in property insurance policies.

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ARTICLE: Sonnenschein Nath & Rosenthal, LLP on Earthquake Insurance Coverage: Then and Now

By Cynthia Mellema, Jeff Butler and Norman Lau

Introduction

Mention the word earthquake and most people immediately think of California. Earthquakes and earthquake insurance, however, are not just a California problem, but also a national issue. Insurers underwrite earthquake policies in all fifty states. Over 1,000 earthquakes are reported every year in Oregon and Washington. n1 The New Madrid Fault, which runs through Illinois, Kentucky, Missouri, Tennessee, and Arkansas, is another source of seismic activity, as is the Denali Fault in Alaska. Since 1975, the United States Geological Survey reports that there have been earthquakes in 46 out of the 50 states. n2 Nevertheless, population density and earthquake intensity in California have made that state the leader in earthquake law and insurance developments. Indeed, more than half of all earthquake

insurance policies are sold in California.

This is hardly surprising. In a recent article, members of the 1868 Hayward Earthquake Alliance, a diverse group dedicated to preparing the San Francisco Bay Area for the next large earthquake along the Hayward Fault, predicted that such an earthquake could impact five million people and cause more than \$500 billion worth of property damage. ⁿ³ This makes Hayward Americas most dangerous fault. It is difficult to ignore the probability of a catastrophic earthquake in the San Francisco Bay Area in the near future. The last five earthquakes along the Hayward Fault occurred on average 140 years apart and the most recent occurred 140 years ago, in 1868.

If the losses from a large Hayward Fault earthquake are as predicted, they would easily dwarf the losses Hurricane Katrina caused. Yet, where insurance covered somewhere between 30 and 40 percent of Katrinas economic losses, insurance would cover only about 10 percent of losses resulting from an earthquake along the Hayward Fault. ⁿ⁴ As such, it is an understatement to say that, as far as earthquakes go, California homes are pervasively underinsured. In fact, fewer than 12 percent of California homeowners carry earthquake insurance. ⁿ⁵

It is not difficult to fathom why so many Californians gamble by going without earthquake coverage: Following the 1994 Northridge Earthquake, that coverage is both expensive and limited.

Pre-Northridge Earthquake Coverage

In 1986, the California Legislature passed a law requiring residential property insurers to offer earthquake coverage with their homeowner policies. ⁿ⁶ And, before 1995, earthquake coverage offered by most insurers was relatively inexpensive and quite broad. With respect to structural coverage, most policies had a 10 percent deductible, which, while significant, was hardly what it would be today, considering the rise in property values over the last 15 or so years. The structural coverage also extended to appurtenant structures (such as swimming pools), making the deductible easier to reach. The two other major policy coverages personal property and additional living expenses were essentially equivalent to coverage available for other significant perils, such as fire. Moreover, because the insurance industry greatly underestimated the damage and therefore insured losses an earthquake could cause, premiums failed to reflect the risk.

The 1994 Northridge Earthquake a truly revelatory event for the insurance industry changed all that. While the 1989 Loma Prieta Earthquake was a significant seismic event (6.8 on the Richter scale), it resulted in something less than \$2 billion in insurance claims. ⁿ⁷ The Northridge Earthquake, by contrast, registered 6.7 on the Richter scale, but the ground acceleration was the highest ever recorded in an urban area in North America. ⁿ⁸ As such, the insurance industry faced some \$16 billion in Northridge Earthquake claims. ⁿ⁹

Faced with devastating financial losses and an obligation to offer earthquake coverage, and recognizing that losses from a similar (or larger) event in the future could be far higher, virtually all residential property insurers refused, as was their right, to write new homeowners policies in California. ⁿ¹⁰

Earthquake Insurance Coverage Today

To address the resulting earthquake insurance crisis and encourage insurers back into the market, the California Legislature created a no-frills earthquake insurance policy, known as the mini-policy. With the mini-policy, insurers were allowed to reduce the scope of structural coverage, limit coverage for personal property and living expenses, and raise the deductible from 10 to 15 percent. ⁿ¹¹ Naturally, premiums also were set to match the risk.

Then, in 1996, the Legislature established the California Earthquake Authority (CEA), a privately funded, but publicly managed entity. Homeowner insurers were given the option of selling their own earthquake insurance product, or participating in the CEA and offering CEA earthquake insurance policies. Most large insurers opted to discontinue their own earthquake insurance lines and let the CEA underwrite the policies instead. The CEA now underwrites more than 70 percent of earthquake policies in California. ⁿ¹² A combination of special assessments, reinsurance and

existing capital would allow the CEA to pay over \$8 billion in earthquake claims. n13

The standard CEA policy features coverage similar to the mini-policies. Like the mini-policies, a CEA policy is intended to cover damage to the home itself it does not cover damage to detached buildings, fences or retaining walls, swimming pools, irrigation systems and the like. The standard coverage for personal property is limited to \$5,000, though policyholders can pay more for up to \$100,000 in coverage. The standard additional living expense coverage is limited to \$1,500, but policyholders can pay more for coverage up to \$15,000. The standard deductible for CEA policies is 15 percent, although homeowners can pay more to have the deductible lowered to 10 percent. n14 Again, however, considering that a 1,700 square foot ranch house in certain California counties at risk is worth more than \$1 million today, extensive damage will have to occur before triggering even a 10 percent deductible.

While it may not bear on the decision whether to purchase a CEA policy, there may be issues concerning seamless claims handling and payment. As noted above, the CEA issues its policies through individual insurers. Following an earthquake, homeowners will submit claims to their homeowner insurers, not the CEA, and the insurers will adjust those claims. But, the fact that CEA issues the policy may play a significant role in coverage determinations. How this system works in practice has yet to be seen, given there have been no major earthquakes in California since the CEA was created. Inherently, however, this system could well be an administrative nightmare. Further, given the budget deficits in California, an understaffed CEA could end up a bottleneck for insureds obtaining benefits at the time they most need them. Time will tell.

California residents have other, though limited, options for earthquake insurance coverage. For example, some insurers (GeoVera (a St. Paul Travelers subsidiary) and Pacific Select) continue to offer stand-alone earthquake policies. The standard coverage under these stand-alone policies is comparable to CEA, but they offer more options in terms of higher coverage limits. Of course, additional coverage costs more (as it is, standard CEA coverage can cost as much or more than the coverage for all other perils to a home).

Considering the cost and limited coverage, it is not surprising that the percentage of homeowners choosing to purchase earthquake coverage in California has dropped from about 32 percent at the time of the Northridge Earthquake to approximately 12 percent today. n15 With major earthquakes occurring so infrequently, many choose not to think about earthquake insurance. Others assume, with some reason, even if they purchased earthquake coverage, their losses will be below the deductible or simply not covered. Yet others assume the government will provide relief in the event of a large natural disaster, though such governmental funding is often limited. At bottom, whether to purchase earthquake coverage is an intensely personal decision based on a number of factors that vary greatly household by household.

Considerations Before and After an Earthquake: Tips and Traps

With or without earthquake insurance, homeowners should prepare their home and themselves for the next large event. Among things to consider toward that end are bracing the homes water heater to minimize the risk of fire and water damage, installing flexible attachments to gas appliances and a gas shut off valve, fastening cupboard doors with childproof latches to prevent them from opening, fastening bookcases, mirrors, televisions and other tall or heavy objects to wall studs, and moving heavy and breakable objects to lower shelves. All family members should also know how to shut off the gas in case of emergency. Structurally, homeowners should consider bolting the homes wood frame to the foundation, or, for homes on raised foundations, having cripple walls braced. n16

All homeowners should also have an emergency plan in place in case of a large earthquake. The plan would include a designated, easily accessible meeting area for family members. As Californians learned during the past significant earthquake, one should not depend on telephone service or cell networks. Further, everyone should, at a minimum, maintain at home, in the office and each vehicle an emergency kit with food, water, medicine, first aid materials, flashlights, tools and clothing.

Those with earthquake insurance have a few additional considerations following a large earthquake. The first is to

notify their insurance agent and carrier promptly. Insured homeowners should then document the loss by photographing the damage and preparing an inventory of damaged personal property. Second, have a professional inspection of the structure. After both the Loma Prieta and Northridge Earthquakes, homeowners often spent little time visually inspecting the structure. Viewing only small drywall cracks and broken dishes, homeowners did not submit claims, believing their damage fell below the deductible.

The one significant historic trap for homeowners in prior earthquakes was their failure to promptly recognize hidden damage had occurred. Most property policies contain a prompt notice provision and a contractual limitations period. The latter requires insureds to submit a claim within one year of the date damage has occurred and file a lawsuit within one year of the closure of a claim, whether by payment or denial. n17

After serious earthquakes, there are always homeowners who find hidden earthquake damage (such as foundation cracks under carpeting or framing damage in attics) more than a year after the earthquake and submit claims to their insurers. The insurers, in turn, based on the contractual limitations provision deny these claims. In subsequent lawsuits, the courts have upheld these denials. n18 Even where homeowners *did* timely submit claims, the insurers adjusters, working under catastrophe conditions, sometimes missed the hidden damage, leading to the same result. n19

The solution for the potential hidden damage trap is to retain a structural engineer. Most good structural engineers will gather the raw data from the earthquake, determine the impact in each neighborhood, and based on the structures age and characteristics and their inspection, provide the homeowner evidence of earthquake damage or assurances that no hidden damage exists.

And finally, insured homeowners must understand that the burden to prove damage occurred from a covered peril rests with them, not the insurer. Accordingly, retaining consultants such as structural engineers and contractors may mean the difference between a timely submitted covered claim and a claim denied.

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n1 [i] Ruth Ludwin, Earthquake Hazards in Washington and Oregon, The Pacific Northwest Seismic Network, University of Washington,
http://www.ess.washington.edu/SEIS/PNSN/INFO_GENERAL/eqhazards.html.

n2 [ii] United States Geological Survey, Earthquake Facts, available at
<http://earthquake.usgs.gov/learning/facts.php>.

n3 [iii] Thomas Brocher, *et al.*, *The Hayward Fault: Americas Most Dangerous Fault?*, Catastrophe Risk Management Magazine, March 2008.

n4 [iv] *Id.*

n5 [v] California Department of Insurance, Earthquake Premium and Policy Count Data Call, Summary of 2006 Residential Market Totals available at http://www.insurance.ca.gov/0400-news/0200-studies-reports/0300-earthquake-study/upload/EQ2006_SummaryFinal_Mar1108.

n6 [vi] Cal. Ins. Code § 10085.

n7 [vii] Michael Quint, *Insurers Fear \$2.5 Billion in Quake Costs*, New York Times, Feb. 7, 1994, at D-1.

n8 [viii] Southern California Earthquake Data Center, Northridge Earthquake available at http://www.data.scec.org/chrono_index/northreq.html.

n9 [ix] David Morrill, *Homeowners Brave Insurance Quandaries*, Oakland Tribune, Sept. 9, 2005.

n10 [x] California Earthquake Authority, About the CEA: History available at <http://www.earthquakeauthority.com/index.aspx?id=7&pid=1>.

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n14 [xiv] California Earthquake Authority, Insurance Policy information: Coverage available at

<http://www.earthquakeauthority.com/index.aspx?id=58&pid=2>.

n15 [xv] California Department of Insurance, Summary of 1996 Residential Market Totals available at <http://www.insurance.ca.gov/0400-news/0200-studies-reports/0300-earthquake-study/1996-2000/upload/1996-Summary-Data.pdf>

n16 [xvi] For more information see <http://quake.usgs.gov/prepare/prepare.html>.

n17 [xvii] *Marselis v. Allstate*, 121 Cal. App. 4th 122 (2004) (insured could not bring suit more than a year after claim was closed). California Insurance Code section 2051.5 extended the limitations period to two years for claims arising out of a state of emergency.

n18 [xviii] See e.g. *Sullivan v. Allstate Ins. Co.*, 964 F. Supp. 1407 (C.D. Cal. 1997) (summary judgment granted for insurer on statute of limitations for claim brought more than one year after earthquake); *Hill v. Allstate*, 962 F. Supp. 1244 (C.D. Cal. 1997) (same); *Vashistha v. Allstate*, 989 F. Supp. 1029 (C.D. Cal. 1997) (judgment on pleadings granted for insurer for claim brought more than one year after earthquake).

n19 [xix] Since these cases were decided, the California Legislature has enacted consumer friendly provisions to help avoid the one-year limit. For example, California *Code of Civil Procedure* section 340.9 revived Northridge Earthquake claims previously barred by the statute of limitations.

ABOUT THE AUTHOR(S):

Cynthia Mellema, Jeff Butler and **Norman Lau**, are attorneys with Sonnenschein Nath & Rosenthal LLP. Ms. Mellema and Mr. Butler, partners at Sonnenschein, have had extensive experience with earthquake claims, providing advice to insurers and litigating cases arising from the Loma Prieta and Northridge Earthquakes. Both practice in Sonnenscheins San Francisco and Walnut Creek offices. Sonnenscheins Walnut Creek location is dedicated solely to the Firms insurance practice. Norman Lau is an associate attorney in Walnut Creek.

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Wildermuth on Repercussions of the Subprime Mortgage Crisis on E&O Ins.

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Repercussions of the Subprime Mortgage Crisis for the Insurance Industry: Part III of III (E&O Ins.)

By Matthew R. Wildermuth

March 21, 2008

SUMMARY: This commentary explores the nature of the claims against these market participants, the factors that affect potential recovery against them and the extent to which insurance in the form of errors and omissions coverage may currently be available to soften the blow to these entities. In light of the increased scrutiny and proposed additional regulation under consideration in Washington regarding these market participants, this commentary also explores the extent to which these entities are likely to be able to maintain or procure effective insurance coverage for their operations and under what conditions it will be available. More specifically, this commentary addresses:-- Who is suing the loan originators and appraisers and why?;- What obstacles do the originators and appraisers face in having their errors & omissions coverage respond to the claims and suits against them?; and- Will originators and appraisers be able to obtain coverage in the future and, if not, what are the implications for the broader market?

PDF LINK: Enhanced Emerging Issues Commentary (\$)

ARTICLE:

Repercussions of the Subprime Mortgage Crisis for The Insurance Industry: Whos Suing Who and Who Has Coverage for What? Part III of III (Errors & Omissions Liability Policies)

By Matthew R. Wildermuth

Introduction

In a speech to the National Press Club on Thursday, March 13, 2008, Treasury Secretary Henry J. Paulson addressed the most recent statistics measuring the subprime mortgage crisis impact on the U.S. and world economy and described action the federal government was taking and proposed to take to stave off further deterioration in the marketplace. According to Paulson, as leader of the President's Working Group on Financial Markets, "Regulation needs to catch up with innovation and help restore investor confidence but not go so far as to create new problems, make our markets less efficient or cut off credit to those who need it." n1 While this may be a comfort to the broader

market, unless these new regulations will include provisions granting retroactive immunity to the market participants (which is highly unlikely), the marketplace and the courts will have to deal with the rising tide of claims and lawsuits arising out of the collapse of many mortgage-backed investments, including the steady rise in individual home foreclosures.

It is beyond the scope of this commentary to address in any detail the causes, the viability of the proposed remedies or the ultimate fallout of the subprime mortgage crisis. For purposes of this commentary, suffice it to say that the deepening housing slump has adversely affected the value of the collateral securing individual mortgage loans and that this problem has been compounded exponentially by investment vehicles that packaged large pools of mortgages into a single block which was then used as collateral for other debt obligations. These aggregated packages were supposed to be insulated from wild swings in value by the diversity of the properties and rendered more stable by being secured with hard assets (the borrowers homes). Billions of dollars of losses later, it turns out neither proposition was true. n2

Because the losses at issue already exceed tens of billions of dollars, the conduct underlying these losses will be oppressively scrutinized and criticized, with individual homeowners and investors seeking to recoup their losses by targeting not just the deepest pockets but from virtually any pocket capable of reimbursing them for their respective misfortune. This is where the focus can turn to market participants such as the mortgage loan originators and the appraisers who were some of the first parties in the financial food chain to render opinions either on the value of the property securing the loan or the relative ability of the borrowers to repay the loan. Most of these entities will have obtained errors and omissions coverage as a standard business practice to protect themselves against the occasional lawsuit that might arise out of an individual transaction gone bad. It is safe to say that neither the policyholders nor the insurers issuing the policies ever saw the current market conditions coming, and how these issues must be dealt with now that the litigation boom is in full swing has created substantial tension between these interests. This article therefore will explore the extent to which errors and omissions policies issued to these entities may respond to the current and expected claims and how this phenomenon may affect whether such coverage will continue to be available in the future.

Preliminary Considerations

As an initial matter, in exploring the extent to which collateral participants in the subprime mortgage market face liability, there is no getting around the fact that recent legal developments can be expected to have significant influence on who sues whom and the potential outcome of those claims. Although it will take some time before all of its effects are known, the United States Supreme Courts January 15, 2008 decision in *Stoneridge Investment Partners, LLC v. Scientific-Atlanta Inc.*, 128 S. Ct. 761 (2008) will definitely affect pending and future cases brought against institutions selling or trading securities based on an alleged failure to identify or disclose information about the potential risks of such investments, including securities collateralized by mortgage loan portfolios. In *Stoneridge*, investor groups sued cable operator Charter Communications for fraud and also pursued Scientific-Atlanta and Motorola, two companies that sold cable boxes that figured in some of Charter's fraudulent transactions. By a 5-3 vote, the Supreme Court said that because the investors victimized by Charter did not rely on any statements or omissions made by the vendors Scientific-Atlanta and Motorola, the vendors could not be held liable under Section 10(b) of the Securities Exchange Act of 1934. n3

Commentators have described one of the most significant impacts of the Courts ruling to be shielding third-party defendants in securities litigation -- including law firms, accountants and bankers -- from broad "scheme liability" for their tangential role in corporate fraud. n4 Other commentators do not consider the Courts *Stoneridge* opinion, standing alone, to have significant wide-ranging impact. However, when coupled with two other recent Court decisions (*Tellabs Inc. v. Makor Issues & Rights, Ltd.* n5 and *Dura Pharmaceuticals v. Broudo* n6), the Courts decision in *Stoneridge* ultimately makes it substantially more difficult to maintain class action securities claims against securities issuers and virtually impossible to rope in secondary participants such as accountants and lawyers. n7 While it remains to be seen

whether the Court's ruling in *Stonebridge* will have a chilling effect on secondary participant liability in contexts other than securities claims, we can be certain that defendants in suits arising out of the subprime mortgage mess will seek to apply or extend its approach to defeat claims where the claimant either had no contact with or cannot be shown to have relied on any information provided by the individual or entity at issue.

The E&O Policy Provisions Most Likely to Come into Play

In order to address the most prominent insurance coverage issues in this context within the scope of this article, by necessity, the analysis is limited to two specific market participants: loan originators and property appraisers. While other definitions may be more appropriate for purposes of applicable state regulations, for purposes of this discussion, this commentary will use the term loan originator to mean an individual who assists in arranging funding or negotiating contracts for a mortgage client but does not loan the money himself or herself and appraiser means an individual or entity licensed by the state to opine as to the potential value of a specific property, taking into account its location, specifications, features, neighborhood and the comparable value of substantially similar properties in the market at issue.

First, it is important to identify the source of potential exposure to the loan originators and appraisers. Neither participant has any direct role in deciding which individual mortgage loans will be included in any particular aggregation of loans when the securities firms create the collateralized debt obligations (CDOs) and they are not parties to the mortgage itself. Indeed, unless one were to go back to the thick stack of seemingly redundant documents that passed like a blur before the anxious homeowners at the closing, it would be difficult to identify the name of the loan originator or appraiser.ⁿ⁸ As a result, the threat to originators and appraisers arises more from the entities that purchase the loan downstream than from any individual borrower (although that will not prevent them from being named in a suit by the latter). In addition, the FBI has initiated a widespread investigation regarding the collateralization of mortgage loans, including a review of the role originators and appraisers may have played in the marked increase in home value appreciation in many markets that are now a hotbed of foreclosure activity.ⁿ⁹

Perhaps the most significant problem an individual mortgage loan originator faces in connection with the failure of loans included in a portfolio of mortgages sold to another lender is the latter's ability to exercise the repurchase clause of the agreement. Specifically, virtually all such transaction agreements include a warranty from the loan originator regarding the viability of the underlying mortgage loans and provide the purchasing lender an out should it come to light that the originator breached its warranty:

Upon discovery by either Seller or Purchaser of a material and adverse breach of any of the representations and warranties or of a material and adverse defect with respect to a mortgage loan, the party discovering such breach or defect has a duty to give prompt written notice to the other party within thirty (30) days of discovery. Within thirty (30) days of the earlier of its discovery, or Seller's receipt of notice of any breach of a representation or warranty or of such defect, Seller promptly shall cure such breach or defect in all material respects or repurchase the affected loan at a price as specified in Section 6.02.ⁿ¹⁰

The warranties at issue may relate to, among other things, the appraised and actual value of the underlying property, the documentation of the borrowers' income, assets and liabilities, representations regarding whether the property would be occupied by the borrowers and other significant contingencies.ⁿ¹¹ The contracts between the originator and the purchasing lender typically also require the originator to maintain adequate reserves on hand to meet potential repurchase demands from the purchasing lender, which, in practice, happens rarely (if ever).ⁿ¹²

In the typical insuring agreement in an errors & omissions policy issued to a real estate professional such as a loan originator, the insurer promises:

To pay on behalf of the Insured all sums which the Insured shall become legally obligated to pay as Damages resulting from any Claim(s) first made against the Insured and reported to the Insurer during the Policy Period, or

extended reporting period (if applicable), for any Wrongful Act of the Insured or any other person for whose actions the Insured is legally responsible, but only if such Wrongful Act occurs on or after the Retroactive Date and before the end of the Policy Period and occurs solely in the rendering of or failure to render Professional Services, as defined herein.

The policy defines Wrongful Act to mean any actual or alleged breach of duty, neglect, error, misstatement, misleading statement, or omission committed solely in the Insured's Professional Services. In turn, the policy defines Professional Services as the origination, sale, pooling and servicing of mortgage loans secured by real property.

In addition to standard exclusions precluding coverage for situations where the originator engaged in fraud or self-dealing, two exclusions will figure significantly in the coverage disputes between originators and their E&O carriers. The first precludes coverage for damages arising out of the failure of any real or personal property to have at any point in time any projected, estimated, represented, warranted, or guaranteed economic value. The second excuses the insurer from having to pay damages for which the originator is held liable [a]rising out of or in any way involving . . . (3) any loan or loans that have been sold by the Insured which have been repurchased or are required to be repurchased by the Insured; however this provision (3) shall not apply to such Claim(s) made against the Insured resulting solely from the rendering of or failure to render Professional Services.

In light of the depressed property values plaguing the national real estate market, the fight over how these two exclusions will be applied in practice has the potential to spill a lot of blood (or at least red ink). The guidelines governing the loans originators can bundle and sell upstream to other lenders typically contain specific loan to value ratios (LTV), meaning that the amount of the loan is not to fall below a certain value threshold. Lets say the assuming lender agrees to purchase a \$500,000 mortgage secured by the improved property and has an 80% LTV threshold. In order to remain qualified as an acceptable mortgage under the agreement between the assuming lender and the originator, the property must hold value of at least \$400,000 (\$500,000 x 80%). If the assuming lender can establish that the collateralized property's value has dipped below this level, it may be able to require the originator to take back the mortgage (and the risk of the loans default) as in the case described above. The originators failure to do so may result in the assuming lender ceasing to do business with it, a lawsuit compelling the originator to buy the loan back (plus interest, penalties and attorneys fees) or both.

A literal application of the two exclusions quoted above would spell serious trouble for the originator, as it has the potential to lose its entitlement to coverage both coming and going. In the first instance, the assuming lender may demand that the originator deposit funds in escrow with it to make up the difference between the represented property value and the current market value. As this claim arguably stems from the failure of the property to maintain a represented value, it would fall squarely within the exclusion. If the assuming lender did not require the originator to go directly out of pocket but instead opted to exercise the do-over provision requiring the originator to repurchase a substandard loan, the originator would be compelled to refund the amount received from the lender as part of the initial transaction and then have to manage the substandard property to prevent it (if possible) from going into foreclosure. Again, on its face, the second exclusion would bar recovery for any damages to the originator attributable to the lender exercising the repurchase option. Because few originators keep sufficient cash on hand to repurchase more than a few bad loans at any given time, multiple repurchase demands would substantially constrain the originators ability to commit to other loans in the pipeline and could in fact be fatal. If, as appears likely, the originator cannot turn to its E&O policy for relief for its inclusion of a loan that has since soured, the prospects are dim.

Appraisers, in contrast, generally are not required to make any specific and enforceable guarantees that a property will maintain its value for any specific period of time or as compared to other properties against which it was measured. That does not mean, however, that appraisers will be immune from the ravages of the subprime mortgage crisis. Indeed, there has been a significant recent uptick in the number of investigations and suits seeking to hold the appraiser accountable for assessing property values in a manner that was less than candid and objective. In one such case, the homeowners allege that home builder KB Home entered into a joint venture with Countrywide Financial as the mortgage lender and that the venture was using captive appraisers to artificially inflate home prices in California. n13 Specifically, the homeowners contend that the appraisal reports cited pending sales as comparable sales, even when the

sales were no longer pending because the buyers had walked away from the deals, used "dissimilar properties" in other developments as comparable sales and otherwise improperly skewed the results. n14

To the extent claimants such as these establish that the appraiser affirmatively conspired with the builder or lender to inflate prices, coverage under an E&O policy is simply not available. But what about the situations where the appraiser just got it wrong? Before the coverage implications can be assessed, there is a fundamental issue about causation, whether the party crying foul is the homeowner, the lender, or the downstream investor in the CDO. Appropriate questions of the claimant would be precisely how much reliance was placed on the appraisal, the extent to which a different appraisal would have prompted a different course of action and whether in fact an overly optimistic valuation caused the homeowner to no longer be able to afford to make monthly payments? In the authors opinion, the difficulty and associated opportunity costs likely to be incurred attempting to answer these questions with respect to any individual transaction militate against appraisers being targeted in the absence of an ability to tie them into a broader scheme such as that alleged in the KB Home suit. Should a litigant be able to overcome these hurdles, it is substantially likely that the appraisers policy would respond. That said, however, because a standard feature in virtually all E&O policies in place today stipulate that defense costs erode the limits of liability potentially available to respond to a judgment or settlement, a claimant could quickly find that it has cut off its nose to spite its face if the appraiser is not otherwise a deep pocket exclusive of its insurance protection.

Whats Next in the E&O Market for Mortgage Industry Professionals?

The impact of the subprime mortgage meltdown to the liability insurance industry will not be known for years, and part of how the story ends will depend on the extent to which regulatory and market reforms are enacted and enforced. The Bush Administration has promised to establish protocols to provide oversight to virtually every niche in the credit markets from mortgage brokers to the Wall Street firms that package home loans into securities, to the credit-rating firms that assess the risk of those securities, to the regulators who police the system. n15 As Treasury Secretary Hank Paulson explained in his March 13, 2008 speech unveiling the Administrations plans, "We aren't singling out any group of market participants, because ... there were mistakes made by all," including regulators. n16 Though still in the planning stages, regulators are considering a variety of methods to strengthen state and federal oversight of mortgage lenders and brokers, including the potential implementation of "strong nationwide licensing standards" for mortgage brokers. n17 Whether these efforts ultimately will result in real reform is anybodys guess.

Insurance industry analysts are resigned to the fact that insurers will suffer substantial losses related to the subprime mortgage crisis, although they do not expect it to be as dire an event for the industry as some have predicted. n18 Although litigation over a multitude of issues spawned by the subprime mortgage crisis is in its early stages, industry veterans are already projecting that liability insurance losses alone likely will exceed \$1 billion. n19 As much as liability underwriters wish they could steeply raise rates for any person or entity with meaningful exposure to the subprime market collapse, other factors affecting the larger insurance pricing cycle suggest that the market for liability insurance generally remains soft. n20 Underwriters therefore are making up for their inability to substantially raise premiums by establishing more stringent guidelines for undertaking the risk and requiring applicants to make substantially more detailed disclosures about the transactions comprising their loan portfolios. n21

For example, real estate professionals vulnerable to subprime losses and particularly mortgage originators should be prepared to provide at least the following information with their initial application for E&O coverage:

1. Estimated percentage of total loan origination that is Subprime;
2. Total Subprime Loans Originated (including purchased loans) in the past
12 months;
3. Approximate Loan to Value breakdown for Subprime Loans by percentage;

4. Type of Subprime Loans by percentage (Fixed Rate Loans vs. Adjustable Rate Mortgages (ARMS));
5. Percentage of any Subprime ARM Loans with monthly adjustment features;
6. Percentage of Interest Only Loans, New homes loans in a development, Spec Homes, n22 non-owner occupied homes, Refinance Loans, ARM Loans where Applicant only has to qualify at the initial payment level, Second Mortgages, and No Doc n23/Low Doc Loans. n24

In other words, underwriters have developed a high degree of expertise regarding the range of products that fall under the general banner of subprime and have moved aggressively to request information in the application that *should* expose where the real risk lies. However, these improvements in the risk selection process will not insulate insurers from the inevitable costs associated with managing and resolving the waves of claims that will soon be tendered by policyholders seeking a defense and indemnity for losses associated with the subprime phenomenon.

Conclusion

One can argue that the experts in the mortgage lending industry, the securities industry, the financial services industry, the insurance industry and the regulators of all of these entities should have seen this debacle coming. Whether true or not, policyholders and insurers alike currently must face the daunting reality that it will be a very long time before the insurance coverage issues this crisis will spawn will be brought to conclusion. If the industry analysts are correct, the subprime mortgage crisis eventually will be remembered as a mere blip among other, more adverse liability insurance events such as the savings & loan crisis and corporate looting cases such as Enron and WorldCom. Stay tuned.

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n1 [i] Damian Paletta, *U.S. to Revamp Credit Rules, Drawing From Crisis Lessons: Paulson Seeks To Tame Excesses In Mortgage Market*, The Wall Street Journal, March 13, 2008, at A1.

n2 [ii] *Finding Default*, The Economist, Jan. 17, 2008.

n3 [iii] Tony Mauro, *High Court's Stoneridge Ruling a Win for Business Defendants*, Legal Times, Jan. 16, 2008, at 1.

n4 [iv] *Id.*

n5 [v] *Tellabs Inc. v. Makor Issues & Rights, Ltd.*, 127 S. Ct. 2499 (2007).

n6 [vi] *Dura Pharmaceuticals, Inc. v. Broudo*, 544 U.S. 336, 345 (2005).

n7 [vii] Tony Mauro, *High Court's Stoneridge Ruling a Win for Business Defendants*, Legal Times, Jan. 16, 2008, at 1.

n8 [viii] In fact, the serial assignment of mortgage loans among multiple entities has created significant obstacles for many lenders in foreclosure proceedings, where courts increasingly require the foreclosing entity to be able to document its standing as the mortgagee all the way back to the closing. *See, e.g.*, Order dated 11/15/2007, *In Re Foreclosure Cases*, Case No. 3:07-cv-00286-TMR-MRM (S.D. Ohio) [<http://iamfacingforeclosure.com/files/RoseRuling20071115.pdf>].

n9 [ix] Evan Perez & Kara Scannell, *FBI Launches Subprime Probe: 14 Companies Are Investigated for Possible Fraud*, The Wall Street Journal, Jan. 30, 2008, at A3.

n10 [x] *See, e.g.*, *Morgan Stanley Mortgage Capital, Inc. v. Baltimore American Mortgage Corp., Inc.*, Case No. 07 CV 00723 (D. Md. 2008) (Morgan Stanley Memorandum in Support of Motion for Summary Judgment, ECF Doc. No. 20).

n11 [xi] See list of more than 40 criteria in the Morgan Stanley transactional documents at Exhibits A1 and A3 of its Motion for Summary Judgment referenced above).

n12 [xii] Dr. Faten Sabry & Dr. Thomas Schopflocher, *The Subprime Mortgage Meltdown: A Primer*, NERA Economic Consulting, Report, June 21 2007 [http://www.nera.com/publication.asp?p_ID=3209]

n13 [xiii] Michael Corkery, *KB Home, Countrywide Face Suit from Buyers*, The Wall Street Journal, Feb. 8, 2008, at A14.

n14 [xiv] *Id.*

n15 [xv] Damian Paletta, *U.S. to Revamp Credit Rules, Drawing From Crisis Lessons: Paulson Seeks To Tame Excesses In Mortgage Market*, *The Wall Street Journal*, March 13, 2008, at A1.

n16 [xvi] *Id.*

n17 [xvii] *Id.*

n18 [xviii] Gloria Gonzalez, *Impact Of Subprime Crisis Not Expected To Be Severe*, *Business Insurance*, Feb. 18, 2008 (on [businessinsurance.com](http://www.businessinsurance.com)) [http://www.businessinsurance.com/cgi-bin/printStory.pl?article_id=24117].

n19 [xix] *Id.*

n20 [xx] Dave Lenckus, *E&O Rates Soften In Most Of Professional Liability Market*, *Business Insurance*, Jan. 14, 2008.

n21 [xxi] *Id.*

n22 [xxii] A Spec Home is one the builder constructs on speculation that it will sell with the configurations and features included in the plan. This is contrasted with a situation where the homeowner comes to the builder and contracts to have a specific home built pursuant to a specific design or with modifications from the builders basic plan (i.e., customized). The spec home is to the real estate market what the off the rack suit is to the fashion industry.

n23 [xxiii] No Doc loans are those in which the borrower does not have to submit a credit report or document income or employment in order to qualify for the loan. Low Doc is one step above No Doc, in that the borrowers provide some documentation in support of creditworthiness but not to the degree that would be sufficient to qualify for FHA financing or other government-backed programs.

n24 [xxiv] The specific questions used for this illustration were taken from the application form found online at Philadelphia Insurance Co.s website,
http://www.axisins.com/docs/phila_mpl_mortg_brkr_supp_subprime_writable.pdf.

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Matthew R. Wildermuth founded The Law Offices of Matthew R. Wildermuth in 2007 and represents clients in complex insurance coverage disputes and intellectual property litigation. Prior to forming his own firm (www.wildermuthlawoffices.com), Mr. Wildermuth spent 18 years representing domestic and international insurers in high profile coverage litigation nationwide and consistently has been recognized as an Illinois Super Lawyer in Insurance Coverage Litigation and Counseling. He also has been certified as a mediator for the Law and Chancery Divisions of the Circuit Courts of Cook County and DuPage County, Illinois and has been retained privately by parties to mediate insurance coverage disputes (see www.strategicsolutionsadr.com for more information).



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The Erosion of the Duty to Cooperate Under CGL Policies

2008 Emerging Issues 209

Mason on the Duty to Cooperate Under CGL Policies

By Lawrence D. Mason

March 20, 2008

SUMMARY: In his commentary, Lawrence D. Mason examines the increasing problem of commercial general liability (CGL) insurance policyholders converting the claims process into an adversarial relationship with their insurers. The commentary finds that this trend is in direct violation of most CGL policies, specifically the Cooperation Clause in which the policyholder is obligated to cooperate with the insurer. The commentary offers practical guidance to practitioners servicing policyholder and insurer clients on how to proactively solve the problem. The commentary includes a discussion of the purpose of the Cooperation Clause, the duties and responsibilities of a CGL policyholder, and a policyholder's potential motivations for breach. The commentary features an analysis of court decisions of many jurisdictions evaluating the question of whether or not an insurer may successfully rely on its policyholder's failure to cooperate as a valid basis for disclaiming coverage.

PDF LINK: Enhanced Emerging Issues Commentary (\$)

ARTICLE: The Erosion of the Duty to Cooperate Under Commercial General Liability Insurance Policies: An Overview of Cases Across the Nation

By Lawrence D. Mason n1

Introduction

A disturbing trend has emerged in commercial general liability claims. Commercial general liability policyholders are increasingly converting the claims process into an adversarial relationship with their insurers. This "litigation" approach to claims is in direct violation of most commercial general liability ("CGL") policies--specifically, the Cooperation Clause.

Policyholder counsel should consider a more conciliatory approach for their clients. Breach of the CGL Policies duty to cooperate will result in a forfeiture of coverage. Counsel for the insurance industry must prepare their clients for how to address non-cooperative policyholders and provide them with "best practices" in an effort to steer the claims toward a more productive approach. If these efforts are unsuccessful, insurer counsel will need to provide guidance as to

the difficult burden typically placed on an insurer seeking to enforce its Cooperation Clause.

What Is the Purpose of the Cooperation Clause?

The initial purpose for including a "cooperation" clause in CGL policies was to prevent fraud. Insurers were frequently confronted with third-party claims where their policyholders were conspiring with plaintiffs, including making secret arrangements to increase the size of judgments in favor of the policyholders. The insurance industry's desire for protection against unscrupulous policyholders resulted in the drafting of an Insureds "Duties" provision. Most courts evaluating this issue have concluded that the primary objective of the Cooperation Clause is to prevent collusion between the policyholder and the injured, as well as to make possible the insurers investigation. *See, e.g., Martin v. Travelers Indem. Co.*, 450 F.2d 542, 553 (5th Cir. 1971); *M.F.A. Mut. Ins. Co. v. Cheek*, 66 Ill. 2d 492, 496 (1977); *Arton v. Liberty Mut. Ins. Co.*, 163 Conn. 127, 134 (1972); *M.F.A. Mut. Ins. Co. v. Sailors*, 180 Neb. 201, 204 (1966).

Duties and Responsibilities of a Policyholder: What Does the CGL Policy Require?

The standard commercial general liability policy includes conditions setting forth the insured's duties in the event of a claim. For example, a typical CGL policy is likely to contain an "Insureds Duties" provision similar to the following:

CONDITIONS

* * *

Insureds Duties in the Event of Occurrence, Claim or Suit

(a) In the event of an **occurrence**, written notice containing particulars sufficient to identify the **insured** and also reasonably obtainable information with respect to the time, place and circumstances thereof, and the names and addresses of the injured and of available witnesses, shall be given by and for the **insured** to the company or any of its authorized agents as soon as practicable. The **named insured** shall promptly take at his expense all reasonable steps to prevent other **bodily injury** or **property damage** from arising out of the same or similar conditions, but such expense shall not be recoverable under this policy.

(b) If claim is made or suit is brought against the insured, the **insured** shall immediately forward to the company every demand, notice, summons or other process received by him or his representative.

(c) The **insured** shall cooperate with the company and, upon the companys request, assist in making settlement, in the conduct of suits and in enforcing any right of contribution or indemnity against any person or organization who may be liable to the insured because of **bodily injury** or **property damage** with respect to which insurance is afforded under this policy; and the **insured** shall attend hearings and trials and assist in securing and giving evidence and obtaining the attendance of witnesses. The **insured** shall not, except at his own cost, voluntarily make any payment, assume any obligation or incur any expense other than for first aid to others at the time of accident.

* * *

For additional examples of CGL "Insureds Duties" provisions, see *Millers Standard Insurance Policies Annotated*

available on Lexis.com.

While it is clear from the "Insureds Duties" Condition that the policyholder must "cooperate with the company," this requirement is left undefined in the CGL Policy and is merely supplemented with fairly basic requirements related to the defense of the underlying action. Ignoring the true intent of the claims process, some policyholders have curiously argued that the fact that the phrase "cooperate with the company" is broadly worded is a basis for their decision to avoid compliance with contractual responsibilities. However, a closer look at current trends reveals two primary reasons for a policyholder's motivation to breach the Cooperation Clause: to maintain control over the resolution of the claim and to come out ahead financially.

To illustrate: A manufacturer is sued in a products liability action. Fearing that settlement will encourage additional lawsuits from other plaintiffs, the manufacturer withholds important information from its insurer concerning the nature of the claim, including the value of the case (*i.e.*, falsely giving the impression to the insurer that the claim is below the policy's self-insured retention), preventing the insurer's involvement in selection of defense counsel, undermining the insurer's ability to assume control of the defense, and keeping the insurer removed from litigation and settlement strategy.

When Has a Policyholder Breached Its Duty to Cooperate?: What Do the Courts Say?

Many courts have long held that a breach of the duty to cooperate relieves an insurer of responsibility under the CGL Policy and have concluded that any condition in a liability insurance policy requiring cooperation on the part of the policyholder is of great importance. *See, e.g., Waste Mgmt. v. Int'l Surplus Lines Ins. Co.*, 144 Ill. 2d 178 (1991). The duty to cooperate obligates the policyholder to disclose all facts within the policyholder's knowledge that may be significant to the insurer in determining its liability under the policy. *See, e.g., Employers Reinsurance Corp. v. E. Miller Ins. Agency*, 332 Ill. App. 3d 326 (2002). Willfully choosing not to cooperate after being contacted by the insurer constitutes a substantial and material lack of cooperation. *See, e.g., Gallaway v. Schied*, 73 Ill. App. 2d 116 (1966).

In *Employers Reinsurance Corp. v. E. Miller Ins. Agency*, 332 Ill. App. 3d 326 (2002), after receiving notice of a claim, the insurer attempted to investigate the claims in the complaint against the policyholder, but the policyholder failed to answer or supply anything in response to the insurer's request for information. The court stated that the policyholders are controlled by the provisions in the insurance policy with the insurer, which included a duty to cooperate. The court further noted that the cooperation clause imposed a broad duty of cooperation on the policyholder and was without limitation or qualification. Because the policyholder failed to cooperate, the court held that the insurer was excused from its duties to defend and indemnify under the policy. *Id.*, 332 Ill. App. 3d at 340.

In *Waste Mgmt. v. Int'l Surplus Lines Ins. Co.*, 144 Ill. 2d 178 (1991), the policyholder hired its own counsel, defended and settled the underlying action. Subsequently, the policyholder sought indemnification from the insurer for settlement costs and defense costs. The policyholder and the insurer filed declaratory judgment actions seeking a determination of their respective rights under the policy. The policyholder alleged that the settlement and defense costs incurred in the underlying action were reasonable. Moreover, the policyholder alleged that it had provided the insurer with advance notification of the settlement. The insurer denied coverage on the basis that the policyholder breached its duty to cooperate under the policy. During discovery, the policyholder refused to comply with its insurer's requests for information concerning the underlying action. The Illinois Supreme Court held that the policyholder's duty to cooperate required it to produce the requested information to the insurer. *Id.*, 144 Ill. 2d at 191. In reaching its holding, the court emphasized that the terms of the insurance contract control the scope of the policyholder's duties.

In *Waste Management*, the Illinois Supreme Court stated that the principles of law which govern contracts apply with equal force to contracts of insurance. A court must enforce clear and unambiguous provisions of the insurance policy, such as the cooperation clause, according to their plain meaning. *Id.*, 144 Ill. 2d at 191-192. The Illinois

Supreme Court further noted that the cooperation clause imposes a broad duty of cooperation on the policyholder and is without limitation or qualification. The policyholder accepted the contractual obligation of the duty to cooperate when it entered into the contract with the insurer. Moreover, the policyholder's duty to cooperate does not terminate upon the resolution of the underlying action. Under the policy, the policyholder is obliged to cooperate with the insurer for as long as the policyholder seeks to enforce the terms of the insurance agreement. *Id.*, 144 Ill. 2d at 192.

Attorneys researching coverage questions arising out of claims-handling problems may find the California Court of Appeals decision in *Rockwell Intl Corp. v. Aetna Cas. and Sur. Co.*, 26 Cal. App. 4th 1255 (1994) instructive. In *Rockwell*, the policyholder was a defendant in multiple environmental contamination lawsuits that spanned several years and triggered coverage under several CGL policies. Although some of the primary CGL insurers assumed the defense of the policyholder under a reservation of rights, other insurers denied coverage. Rockwell filed a declaratory judgment action seeking resolution of its coverage rights. During the written discovery phase, the insurance carriers demanded complete disclosure of Rockwell's file regarding the underlying lawsuits. Rockwell refused and claimed that some of the information sought was protected by the attorney-client privilege. Relying on the Supreme Court of Illinois' decision in *Waste Management, Inc.*, 144 Ill. 2d 178 (1991), the insurers argued that the attorney-client privilege was inapplicable to the declaratory judgment action because of the cooperation clause found within each insurance policy. Rejecting the theory endorsed by the Illinois Supreme Court in *Waste Management, Inc.*, that the duty to cooperate is without limitation or qualification as "fanciful," the California Court of Appeal noted that compliance under a cooperation clause could be obtained without disgorging every detail to the insurers. *Rockwell*, 26 Cal. App. 4th at 1260. The court concluded that the cooperation clause was drafted to ensure protection against policyholder/injured party collusion and was never intended to "operate as a waiver of the attorney-client privilege." *Id.*, 26 Cal. App. 4th at 1263. The court additionally emphasized that although a policyholder and its insurer can be united in interest, this could not be the case where the insurer has agreed to defend under a reservation of rights. Under those circumstances, the two parties are no longer united in interest, and the policyholder is entitled to select his or her own counsel free from its carrier's influence. *Id.*, 26 Cal. App. 4th at 1263-1264.

Consequently, insurers litigating in jurisdictions likely to follow the *Rockwell* approach will find it extremely difficult to avoid coverage based on a claim that the policyholder violated its duty to cooperate. A successful breach of the duty to cooperate defense is best achieved in those situations where the policyholder has misrepresented a material fact or colluded with the injured party. An insurer may also be successful on a failure to cooperate disclaimer where its policyholder has willfully refused to submit to the insurers reasonable requests. However, an insurer is unlikely to prevail in situations where the policyholder is simply unresponsive.

An Insurer Has a Heavy Burden to Avoid Coverage on the Basis That Its Policyholder Has Breached Its Duty to Cooperate: What Does an Insurer Have to Prove?

An examination of decisions both old and new addressing the issue of when a policyholder has breached its duty to cooperate reveals a fairly consistent trend. While there are some exceptions, most courts hold that an insurer must prove:

- (1) It was substantially prejudiced;
- (2) It exercised reasonable diligence to obtain the insured's cooperation; and
- (3) The policyholder's refusal to cooperate was willful.

See, e.g., *Davila v. Arlasky*, 857 F. Supp. 1258, 1264 (N.D. Ill. 1994); *M.F.A. Ins. Co. v. Cheek*, 66 Ill. 2d 492, 498-99 (1977). See also *Mazzuka v. Eatmon*, 45 Ill. App. 3d 929, 932, 934 (1977).

Clearly, an insurer has a heavy responsibility to actively take all steps possible to obtain its policyholder's cooperation. Given the reluctance of courts to forfeit coverage for an policyholder's failure to cooperate, an insurer must make substantial efforts to procure the policyholders assistance prior to denying a claim. Simply sending

correspondence to the policyholder's address (which goes unanswered) does not satisfy the insurer's burden to diligently seek the policyholders cooperation. Moreover, an insurer attempting to warn its policyholder of the seriousness of the failure to comply with CGL policy conditions, should emphasize that the policyholder's continued failure to cooperate will result in a loss of coverage under the policy. *See, e.g., Bowyer v. Thomas, 188 W. Va. 297 (1992)*. In *Bowyer*, the court held that simply apprising the policyholder of the duty to cooperate without setting forth the penalties was insufficient. *Id.*

As the following cases illustrate, a policyholder's failure to respond to an insurer's requests for information does *not* usually guarantee the insurer a successful denial premised upon the policyholder's non-cooperation.

- *Parr v. Gonzalez, 669 N.W.2d 401 (Minn. Ct. App. 2003)*: The court denied the insurer's lack of cooperation defense in a coverage action where it was found the insurer could have obtained requested information from sources other than the policyholder. The insurer did not establish that it acted diligently in attempting to secure cooperation from its policyholder where it only attempted to contact its policyholder on two occasions, by mail, and never telephoned or attempted to meet with its policyholder.

- *Bowyer v. Thomas, 188 W. Va. 297 (1992)*: Failure to appear at a scheduled deposition, standing alone, does not amount to a breach of the policyholders duty to cooperate. Where the policyholder previously appeared at a meeting with his assigned defense counsel and also contacted the insurer's claims adjuster on numerous occasions throughout the course of the litigation there was no breach of the policy's requirements.

- *Am. Guar. and Liab. Ins. v. Chandler Mfg. Co., 467 N.W.2d 226 (Iowa 1991)*: The policyholder's president failed to respond to multiple letters from assigned defense counsel and also failed to sign and return interrogatories so that they could be served upon defense counsel. The policyholder's president additionally failed to appear at trial despite receiving correspondence requesting his presence. However, the court noted that the insurer-assigned defense counsel could have obtained statements from him, could have obtained his deposition, and could have undertaken greater efforts to ensure that he was present at the trial. Accordingly, it was held that the insurer's attempts to achieve the assistance of the policyholder were not sufficient to support a finding that the policyholder had failed to cooperate.

- *Anderson v. Kemper Ins. Co., 128 Mich. App. 249 (1983)*: The insurer's attempt to extinguish coverage due to its policyholder's failure to cooperate was denied where the insurer was unable to establish it could not have secured the information sought from an additional source. The insurer also failed to establish "good faith" efforts to locate the policyholder.

- *Lappo v. Thompson, 87 Ill. App. 3d 253 (1980)*: Coverage was denied based on the policyholder's failure to appear at trial. Prior to declination, the insurer sent several letters to the policyholder notifying her of the trial. The court held that the insurer had the burden to establish by a preponderance of the evidence that it acted in good faith to secure the attendance of the policyholder at trial and that the policyholder's failure to appear was due to her refusal to cooperate. The court held that the insurer failed to establish the policyholder's refusal to cooperate or that it exercised a reasonable degree of diligence in attempting to secure her cooperation. Important to the court was the fact that the insurer did not attempt to contact the policyholder personally. Additionally, the court found significant that the policyholder misspelled her name when she signed a receipt for a certified letter because it created the possibility that she might have a literacy problem. Since this possibility was never pursued by the insurer, the court ruled that the insurer's burden to diligently seek its policyholder had not been met.

■ *Thrasher v. U.S. Liab. Ins. Co.*, 19 N.Y.2d 159 (1967): There is no doubt the insurer was damaged by its policyholder's failure to appear at trial. However, its attempts to locate its policyholder at the time of trial included calling his place of employment, checking neighborhood bars, and sending a letter to the policyholder the day before the opening of the trial. The court held that this was insufficient to establish that the insurer was diligent in its efforts to locate the policyholder. Moreover, the court also noted that the policyholder could not have willfully violated the duty to cooperate where he was never made aware that the insurer requested his appearance at the trial.

Non-Cooperation Defense Must Be Timely Asserted to Avoid Waiver/Estoppel

An insurer with a valid basis for asserting a failure to cooperate defense must do so promptly or risk waiver and estoppel challenges. The case of *Medical Mut. Liability Ins. Society v. Miller*, 52 Md. App. 602 (Md. Ct. App. 1982), highlights the risks to an insurer that delays in asserting its non-cooperation defense. In *Miller*, the insurer became aware of the policyholders misrepresentations a full year before disclaiming on the grounds that the policyholder failed to cooperate under the terms of his CGL policy. The court held that the insurer's delay was too long and, accordingly, the insurer was estopped from denying coverage.

Is Prejudice Required?

In nearly all jurisdictions, the answer is: **Yes**. For example, in *M.F.A. Mut. Ins. Co. v. Cheek*, 66 Ill. 2d 492 (1977), the Illinois Supreme Court established that in order for an insurer to prove breach of a cooperation clause, the insurer must prove it was substantially prejudiced. Prejudice is never presumed. *Id.*, 66 Ill. 2d at 499. Proof of substantial prejudice requires an insurer to demonstrate that it was actually hampered in its defense of the claim at issue by the violation of the cooperation clause. *Id.*, 66 Ill. 2d at 500. If this burden is not met, breach of the cooperation clause is no defense to coverage.

A minority of states do not require a showing of prejudice. For example, Tennessee applies the standard "no prejudice" rule for lack of cooperation disputes. See *Allstate Indem. Co. v. Fifer*, 47 F. Supp. 2d 913 (W.D. Tenn. 1998), but see *Thaxton v. Allstate Ins. Co.*, 1988 Tenn. App. LEXIS 102 (1988). Similarly, New Jersey and Georgia do not require an insurer to establish prejudice when denying coverage because of a policyholders failure to cooperate. See, e.g., *Griggs v. Bertram*, 88 N.J. 347 (1982); *Wolverine Ins. Co. v. Sorrough*, 122 Ga. App. 556 (1970).

In direct actions commenced against insurers by injured parties, some authority provides that the policyholder's breach of the duty to cooperate is not a valid defense unless there is collusion between the injured party and the policyholder. See *Schaefer v. N. Assurance Co. of Am.*, 513 N.W.2d 615 (Wis. Ct. App. 1994). However, under Wisconsin law, an insurer is no longer required to establish how the breach of the duty to cooperate prejudiced the policyholder. *Id.*

When Has An Insurer Been Prejudiced?

The question of whether or not an insurer has been prejudiced is a fact-specific inquiry. Counsel seeking answers to this issue are likely to find guidance from the following representative cases:

- . Where a policyholder chose to defend the underlying action with counsel of his own choosing without first notifying his insurer and then later sought reimbursement for defense costs at rates well in excess of the insurers standard rates, the court held that the higher defense counsel rates voluntarily incurred by policyholder amounted to a breach of the cooperation clause. See *Kerns v. Interlex Ins. Co.*, 231 S.W.3d 325 (Mo. Ct. App. 2007).

- . Where substantial prejudice has been shown, the policyholder will extinguish the insurer's duty to defend and

indemnify the insured for the underlying action. *See, e.g., Employers Reinsurance Corp. v. E. Miller Ins. Agency*, 332 Ill. App. 3d 326 (2002); *see also Gallaway v. Schied*, 73 Ill. App. 2d 116 (1966).

. Failure to appear and testify at trial, despite repeated requests from the insurer resulted in a finding that the cooperation clause had been violated. The court additionally concluded that the insurer had sustained prejudice due to the policyholder's failure to appear at deposition and at trial, which inhibited the insurer from presenting a defense. *See Allstate Ins. Co. v. State Farm Mut. Auto Ins. Co.*, 363 Md. 106 (2001).

. An insurer that chose not to participate in the litigation and did not criticize the handling of the claim by the policyholder's counsel and did not argue that the settlement amount accepted by the parties in the underlying action was unreasonable could not prove that it had been prejudiced by the policyholder's failure to keep the insurer fully apprised of the underlying action. *See Federal Ins. Co. v. X-Rite, Inc.*, 748 F. Supp. 1223 (W.D. Mich. 1990).

. In *Riffe v. Peeler*, 684 S.W.2d 539 (Mo. Ct. App. 1984), the court found prejudice where the policyholder refused to cooperate with defense counsel in preparing answers to interrogatories. The interrogatory answers were stricken and the court entered an interlocutory judgment on the issue of liability against the policyholder. Thus, the court held that the insurer had been prejudiced by the policyholder's non-cooperation. *Id.*, 684 S.W.2d at 543.

. In *Martin v. The Travelers Indemnity Co.*, 450 F.2d 542 (5th Cir. 1971), the court held that to establish prejudice the insurer must show that the policyholder made false statements or conducted himself in some other fashion materially prejudicing the insurer's ability to defend the action.

. In *Western Farm Bureau Ins. Co. v. Danville Construction Co.*, 463 S.W.2d 125 (Ky. Ct. App. 1971), the court held the non-appearance of the policyholder in the courtroom does not in itself constitute lack of cooperation; the nonappearance of the litigant in the courtroom during the trial will create some degree of detriment, but whether that detriment is material depends on other factors including whether the insured's testimony will be more harmful than beneficial.

. In *Travelers Ins. Co. v. Godsey*, 260 Md. 669 (1971), the court held that there is prejudice when the policyholder collaborates with the claimant to deliberately mislead the insurer and make it appear that the claimant was free from negligence or assumption of risk when in fact he clearly had been negligent or clearly had assumed the risk.

. In *McDonnell v. Hestnes*, 47 Wis. 2d 553 (1970), the court held that the insurer is not prejudiced by its reliance on the policyholder's false statements when these statements are contrary to the known and adjudicated facts.

Thus, it appears that substantial prejudice involves more than a loss of opportunity.

Protecting the Insurer's Rights

When faced with the problem of a non-cooperative policyholder, insurers' counsel should consider the following "best practices" when providing guidance to their clients:

. Be proactive, not reactive: As the case law discussed above illustrates, insurers must be diligent in attempting to secure the cooperation of their policyholders. It is additionally important for insurers to timely assert their non-cooperation coverage defenses.

. Oral and written communications: In this age of far-too frequent impersonal e-mail communications, claims professionals should be encouraged to supplement their written communications with telephone calls to discuss cooperation issues. In-person meetings are an additional tool that should be advocated to promote improved policyholder/insurer relations. It is essential that insurers explain to their policyholders the serious consequences of failure to comply with a commercial general liability policy's Cooperation Clause.

Conclusion

Counsel, whether representing policyholder or insurer interests, are encouraged to remind their clients that the purpose of the claims process is to provide for a non-adversarial exchange of information to assist the insurer in evaluating the claim. This procedure necessarily includes obtaining information relevant to the insurer's coverage determination. Cooperation additionally includes a policyholder's active participation in its own defense to ensure that any policyholder exposure is minimized. Policyholders that adopt a hostile approach and treat their insurers as litigation adversaries thwart these goals. Proactive approaches to non-cooperative policyholder issues are likely to reduce the need for litigation between insurers and their policyholders to resolve Cooperation Clause issues. The time has come for both sides of the insurance industry bar to jointly promote cooperation initiatives to prevent violations of a policyholder's contractual duty to cooperate.

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n2 Practitioners are strongly encouraged to consult Appleman on Insurance 2d and to research other insurance resources on Lexis.com to verify the law as to specific jurisdictions of interest.

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Harbage and Haycock on California Healthcare Reform

2008 Emerging Issues 199

How State Politics and Ideology Derailed California Healthcare Reform

By Peter Harbage and Hilary Haycock

March 14, 2008

SUMMARY: California's year of health reform started with great promise but ended in ideological and political stalemate in the State Senate. Many of the reasons California reform broke-down were due to the state's unique legislative process, which created gridlock on health reform, in particular by isolating and alienating various members of the legislature. This extensive commentary by Peter Harbage and Hilary Haycock of Harbage Consulting explains the concepts and history of the health reform proposal in California. (Mr. Harbage has served as the senior health policy advisor to presidential candidate and former Senator John Edwards, as well as advised Governor Arnold Schwarzeneggers health reform team. During his career, he also served as the Assistant Secretary for Health at the California Health and Human Services Agency and as Special Assistant to the Administrator of the federal Health Care Financing Administration.) The commentary further analyzes each section of the comprehensive proposed legislation. To varying degrees, the legislation may be used as a template for future attempts at providing universal healthcare. The health reform effort in California offers important lessons for the national debate: it is possible to build broad coalitions of support for comprehensive reform if policymakers can make the tough compromises and tradeoffs necessary. But, ultimately, the commentary concludes that health reform will only be successful if leaders can overcome the power of ideologues on the Right and Left to block compromise reform in their effort to pursue their own perceived "perfect" solution.

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ARTICLE: How State Politics and Ideology Derailed California Health Care Reform

By Peter Harbage and **Hilary Haycock**

INTRODUCTION

In January 2007, California Governor Arnold Schwarzenegger announced the most aggressive health reform plan since President Clintons effort in the early 1990s. Twelve months after he launched his campaign, and a month after receiving the blessing of the California State Assembly, the Senate Health Committee voted down the health reform plan compromise. The reasons for the failure are difficult to discern, as a disappointed Governor Schwarzenegger stated the day after the Senate Health Committee vote, We have to find out what is the reason and why it did not pass, adding, Not what has been given to the public, but what is the real reason . In acting, we call it the sub-layers, the different

colors underneath [Anthony York, *Postmortem analysis of health care bill*, Capitol Weekly, Jan. 31, 2008.]

This commentary discusses the reasons why a health reform effort with so much promise abruptly ended, in a majority-Democrat health committee no less. Simply put, Californias internal politics played a greater role than anything having to do with the policy debate, and so the story of Californias setback is primarily one about California. At the same time, California does hold important lessons for the national debate. The first lesson is to find the policy compromises that are necessary to achieve the second lesson, which is to build broad coalitions of support. The third lesson from California is the tragic power of extreme ideologues on the Right and Left to block compromise reform in their effort to pursue their own perceived perfect solution.

BACKGROUND

Encouraged by Massachusetts successful adoption of comprehensive health reform in 2006, Governor Schwarzeneggers 2007 State of the State address launched the year of health reform in California [Gov. Arnold Schwarzenegger, State of the State Address, Jan. 9, 2007, <http://gov.ca.gov/index.php?/press-release/5089/>]. California, however, faced significantly greater barriers than Massachusetts to enacting comprehensive reform. Most notable were its higher percentage of uninsured residents, a poorly funded safety net, and higher percentage of individuals in the individual health insurance market. California has the highest number of uninsured residents of any state in the nation; estimated at 6.5 million or 20 percent of the states population [UCLA Center for Health Policy Research, California Health Interview Survey, 2005].

The Governors plan was based on shared responsibility: the idea that individuals, employers, the government, insurers, and providers all have to put more resources into the system to achieve universal coverage. Not only did employers have a mandate to offer insurance, but individuals also were mandated to enroll. The plan called for subsidies to make insurance more affordable for individuals, as well as expansions in Medi-Cal (Californias Medicaid program) and Healthy Families (Californias State Childrens Health Insurance Program). Beyond the coverage expansion, the plan also contained aggressive steps for cost-containment, wellness, and prevention [Office of the Governor, Original Health Reform Plan, http://gov.ca.gov/pdf/press/Governors_HC_Proposal.pdf; the final version is available at <http://www.fixourhealthcare.ca.gov/plan>].

After vetoing an employer mandate bill in the fall sponsored primarily by the Assembly speaker, the Governor and legislative leadership agreed on a bill, officially designated Assembly Bill 1 of the First Extraordinary Session of the California Legislature in 2007 (AB X 1 1) called the Health Care Security and Cost Reduction Act (the Act). The Governors approach was popular among 60 to 70 percent of the population, as shown in several surveys by the Public Policy Institute of California and the Field Poll [Public Policy Institute of California Statewide Survey: Californians and Their Government, June 2007; The Field Poll, Large Majority Favors the Health Care Reform Package Making Its Way Through the Legislature, Dec. 21, 2007].

Yet, key interest groups greeted the plans announcement with skepticism [Allan Zaremborg, California Chamber of Commerce Press Release, Jan. 8, 2007, <http://www.calchamber.com/CC/News/Archive/2007/01082007PR.htm>]. In the Legislature, Republicans were negative [Dick Ackerman, Senate Republican Leaders press release, Jan. 8, 2007, <http://republican.sen.ca.gov/news/33/pressrelease4396.asp>; Tom Chorneau, *GOP lawmakers not on board with Schwarzenegger health plan; offer health savings accounts and tax breaks as alternative*, San Francisco Chronicle, March 14, 2007]. After a full year of work, the Assembly passed health reform only to watch the Act die in a bitter defeat in a Senate committee.

LEGISLATIVE POLITICS DECIDED THE FATE OF HEALTH REFORM

The legislative process was defined by several key characteristics that combined to create gridlock on health reform, in particular by isolating and alienating various members of the legislature, especially in the Senate. When it came time to vote, Senators were unprepared to take the bold step of moving health reform forward.

A Closed Process

While the Governor's initial health reform plan was crafted inside his administration, the plan evolved throughout 2007 in a series of closed meetings with stakeholders. The Governor's negotiation strategy was primarily one-on-one consultation with a broad range of stakeholders. Designed to create ample opportunity for stakeholders to freely share ideas and build support, the hope was that the significant stakeholder effort would develop a plan with broad backing prior to full engagement with the Legislature.

For much of 2007 while the stakeholder process continued, there was virtually no real role for legislators and the general public. There was only one informational hearing on the bill, which was held in mid-February. The Governor's plan was not released in legislative language as a bill until October -- well after legislative session typically ends. In an effort to spread distrust of reform and the process, opponents seized on the lack of a bill to assert that there was no way to know what the Schwarzenegger administration truly intended. The delay also created a perception that no legislator believed enough in the Governor's plan to introduce it. Unfortunately, the whole process was put on hold as the 2007 budget debate eclipsed the health care debate for several months during the summer of 2007 [Jordan Rau, *After long standoff, California lawmakers pass \$145-billion budget*, The Los Angeles Times, Aug. 22, 2007]. This delay to the closing of the debate would eventually prove a critical factor in why health care reform failed.

Tenuous Legislative Relations and Few Champions

At the beginning of the health care reform debate, the Republicans and Democrats in both legislative houses articulated their own health care reform plans. In December 2006, Assembly Speaker Fabian Nunez and Senate President Pro Tem Don Perata both released reform plans in what was widely considered to be an effort to get out ahead of the Governor's plan.

The Assembly plan was primarily an employer mandate, which eventually passed through the Assembly as AB 8 [AB 8, chapter 1, section 4800.01 subsection H, Assembly Speaker Fabian Nunez]. In contrast, the Senate leaders plan consisted more of a broad articulation of concepts in favor of reform. And in an even greater contrast, the Republican plans did not attempt to reach universal coverage [Tom Chorneau, *GOP lawmakers not on board with Schwarzenegger health plan; offer health savings accounts and tax breaks as alternative*, San Francisco Chronicle, March 14, 2007], which was what the Governor said was his top goal.

The tense relationship between the two legislative houses delayed the Senate's involvement. From the beginning, the Assembly Speaker appeared much more dedicated to health care reform than the Senate leader [Fabian Nunez, *Health care reform -- now; We can't let radicals stop my sensible plan for helping desperate Californians*, Los Angeles Times, Aug. 30, 2007]. Eventually, there was a formal agreement between the two leaders: the Assembly would lead on the health care debate while the Senate would take up a different topic -- water rights -- as its key issue. After it became clear that the water deal would fall apart, Senator Perata appeared even less amenable to working on health care reform [Mike Zapler, *Perata a surprise hurdle to health reform*, Oakland Tribune, Dec. 22, 2007]. The division of labor also meant that few if any Senators were engaged in health care reform and the marathon sessions that took place between the Speaker, Governor and stakeholders.

The one other figure in the Senate who was well positioned to offer leadership on reform was Senate Health Committee Chair Sheila Kuehl. While she held an informational hearing in February, Senator Kuehl has long been a single-payer advocate -- an approach not seriously taken into account in California's health care reform proposals. As a result, the Senator, a health care expert in her own right, opted not to play a constructive role in moving the reform effort forward. Prior to the final vote on health care reform in her committee, Senator Kuehl made it clear that she

would vote against any non-single payer reform plan [Shane Goldmacher, *Kuehl says health bill provides less help than advertised*, Capitol Alert from the Sacramento Bee, Dec. 20, 2007].

Even after Senator Perata, Speaker Nez, and the Governor reached an agreement in early December 2007, Perata quickly seemed to reverse course. After the Assembly passed the compromise Act, Senator Perata announced first that he would not call the Senate to order during the Christmas Holiday break [*Senate delays health care vote*, Capitol Weekly, Jan. 14, 2008]. Instead, he called for an analysis of the plan by the non-partisan Legislative Analysts Office (LAO) -- a step not taken for health care reform plans that had previously passed the Senate, such as the Speakers employer mandate and SB 840 (a single-payer bill, sponsored by Senator Kuehl, that the Governor vetoed in 2006). In addition, Perata used uncertainty about the size of the projected budget deficit -- and its implication for critical state health care programs -- as cover for opposing comprehensive reform measures [Editorial, *Perata's reasons for killing health bill: Huh? State Senate's leader leaves a sad legacy as historic opportunity dies on his watch*, Sacramento Bee, Jan. 30, 2008].

The closed process and legislative dynamics created a situation where there were precious few legislative leaders carrying the reform effort. Besides Speaker Nez, no other California legislator seemed to have been truly invested in the outcome of the reform process.

Divided Stakeholder Leadership

The common perception of health care reform is that labor and consumer groups will support the effort while employers and insurance companies (concerned about their profits) will oppose it. The California experience turns this paradigm on its head, showing that broad coalitions in support of health reform can be built over time -- and that labor and consumers can also challenge reform. But for the bulk of the legislative session, stakeholders continued to be divided as the policy was negotiated with the Administration and Legislature, and most of the Left-leaning organizations backed the Speaker and his employer-mandate approach.

Ultimately, there were important stakeholder endorsements. But the bulk of that support for the Governors plan did not come until the final months of the year. At the same time, there was always some level of opposition. The December 17, 2007 version of the Act as passed by the Assembly received letters of support or support if amended from 68 organizations and more than 700 individuals. Forty-two organizations and more than 350 individuals wrote in opposition to that version as well [ABX 1 1, Assembly Third Reading, Dec. 17, 2007, <http://www.leginfo.ca.gov>].

The Positions of the Stakeholders

This section assesses the political positions of stakeholders, with the final section of this commentary examining the policy details.

Consumer Groups and Unions. Few consumer groups supported the specifics of the Governors plan when it was announced. Eventually, most came to understand the political and policy reality that their long-time goals of coverage and guarantee issue could only be achieved in tandem with a mandate that individuals must obtain health insurance. Among the key supporters were Consumers Union, the American Association of Retired Persons (AARP), the State Employees International Union (SEIU), and Health Access, Californias major consumer advocacy group. The California State Council of Carpenters and the American Federation of State, County, and Municipal Employees Union (AFSCME) were also actively supportive of reform.

Some key labor groups also consistently opposed health care reform, such as California AFL-CIO and several of its key unions, including the Teamsters. Their primary concern was the affordability of health insurance that people would be required to purchase. The AFL-CIO was extremely critical during the autumn of 2007.

Insurance Companies. The Governor's Office had great success in building support with insurers. Many insurers, including Kaiser Permanente and Blue Shield of California, became vocal proponents. The holdout was Blue Cross of California, whose substantial profit margin in the individual market drove it to oppose health care reform altogether [*Blue Cross Earmarks \$2 Million To Fight Health Reform Plans*, California Healthline, May 25, 2007]. The Acts caps on insurer profits and requirements to offer insurance to all who want to buy it (two provisions originally proposed by the Governor) would cut at the heart of the Blue Cross profits.

Employer Perspectives. Employers were divided over health care reform. Steve Burd, CEO of Safeway, led the proponents, eventually helping to create an ad hoc group of mostly large employers that supported reform [Jonathan Cohn, *Whats the One Thing Big Business and the Left Have in Common?*, New York Times Magazine, April 1, 2007]. Other key employers and employer groups weighed in the affirmative as well, including the Los Angeles and San Diego Chambers of Commerce.

At the same time, other employer groups opposed reform, including the California Chamber of Commerce, the California chapter of the National Federation of Independent Businesses, and the California Restaurant Association. Their opposition focused on the burden of the employer mandate, particularly on small businesses [Marie-Anne Hogarth, *Business groups announce opposition to California health care bill*, Sacramento Business Journal, Jan. 10, 2008].

Providers: Institutional Supporters, Physician Neutrality. While initially skeptical, the strongest advocate from the provider community was the California Hospital Association, followed by the California Primary Care Association and the Public Hospital Association. Support from the hospitals hinged on the 4 percent provider revenue fee proposed by the Governor. Many hospitals initially viewed this fee negatively. However, the Governors intent was to use the fee to increase hospital rates under Medi-Cal (the states Medicaid program) and reduce the number of uninsured. Ultimately, hospitals saw the benefit [California Hospital Association, *The Clock Is Ticking: Action on Health Care Reform is Needed Now*, Press Release, Dec. 13, 2007].

In contrast, the California Medical Association started with a negative view of reform that changed only marginally over the year. There was significant resistance to the notion that all physicians should pay a 2 percent fee on their income to help expand health care coverage under the Governors vision of shared responsibility. Proposed increases to Medicaid reimbursements rates did not do enough to sway the organization, and the physician fee was dropped from consideration.

Counties and the Safety Net. In California, counties are integral to the health care safety net as well as critical political players. Under the expanded coverage from health care reform, counties and the safety net would be responsible for fewer uninsured people, but would also receive less of the subsidies currently generated by uncompensated care. This raised concerns about the financial viability of public hospitals. Eventually, the compromise Act offered guaranteed ongoing funding to public hospitals to give them a chance to transition to the new health system.

Big Tobacco. The tobacco lobby has always carried influence in the California Legislature [Daniel Weintraub, *The death of health care reform*, Feb. 10, 2008]. And its influence got a boost in 2006 following the defeat of a ballot proposition that would have tripled the states tobacco tax to pay for a number of health related efforts. It is difficult to

quantify the impact of the opposition, but most observers believe that the tobacco lobby played an important role [Anthony York, *Postmortem analysis of health care bill*, Capitol Weekly, Jan. 31, 2008].

Single-Payer Opposition. Single-payer advocates opposed the Governors and Legislatures efforts throughout 2007. California has several significant groups who either do or have supported single-payer approaches, such as the California Nurses Association and the Santa Monica-based Foundation for Taxpayer and Consumer Rights [Jamie Court, *Mandatory Health Insurance? No sale*, Los Angeles Times, Op-ed., Sept. 25, 2007]. Both groups were aggressive in their criticism.

No Republican Support

The Governor remained confident that he could secure Republican votes for his health care reform plan. Yet as a moderate, Gov. Arnold Schwarzenegger has had a tense relationship with the much more conservative Republican caucuses in both legislative houses [Evan Halper, *Schwarzenegger goes on offensive against GOP budget opponents*, Los Angeles Times, Aug. 14, 2007]. Ultimately, it became clear to all parties that no Republican votes for reform were to be forthcoming. In fact, the Republican budget-bunker even delayed the passage of the 2007-08 state budget by 52 days to try to prevent some programs from being funded. It was one of the longest delays in state history. The ideology of the Republican caucus against health spending could not be broken.

Two-Thirds Rule

California is one of less than a dozen states where a two-thirds vote is needed to raise revenue, and one of only three states that has a two-thirds requirement to approve the budget. The two-thirds requirement bestows significant power on the minority party. The reform plan raised revenue from within the state by implementing a hospital fee (designated officially as a tax), an employer fee on firms not offering insurance, and a cigarette tax as well as by new payments from previously uninsured individuals who would now pay insurance premiums.

As a result, there was an agreement between the Governor, the Speaker Nez, and Senator Perata to take a dual approach where the Legislature would pass out a reform plan, but voters would have to directly approve funding on a November 2008 ballot measure. Due to legal requirements, the bill was submitted in its final form at the end of December, before the Senate had agreed to take up health reform.

Consequently, when the Senate Health Committee met in January 2008, their only option was to vote up or down on the more than 200-page health plan. Several senators cited their inability to understand the full impact of the bill as well as their inability to offer amendments, as a reason for abstaining or voting no. Despite a years worth of work on health reform, several senators perceived that the bill was being rushed through their chamber. But the point was moot. With no Republican support for the bill, all but one Democratic vote was needed to move the bill forward. Senator Kuehl, the chair, was long understood to be a no vote. Days before the hearing, another Senator announced his opposition. Reports are mixed on the pressure that Senator Perata brought to bear to move the bill forward, but clearly key members of his caucus were acting contrary to his early December announcement in support of reform.

Tyranny of the Minority

As 2007 came to a close, all of the key legislative factors against reform collided. The closed process with few legislative champions made Senators feel isolated and un-invested in reform. And with no Republican support, and with a few Democrats dedicated only to single-payer reforms, that left little margin for error. There is a certain irony that the far Right and the far Left combined to stop health care reform. The lack of Republican support had a critical impact on the process in blocking the Democrats ability to fund health care reform because it forced the ballot initiative approach.

And by the time the bill arrived in the Senate committee, the ballot approach meant that the Senate would not be able to modify the bill, and left Senators feeling even more divorced from the health care reform process. Unsurprisingly, this is where the health care reform proposal in California ended.

POLICY CONTROVERSY

The controversy of the policy and budget issues certainly played a role in derailing health care reform. A broad and powerful coalition of supporters formed around the policy decisions. At the same time, those looking for reasons to oppose health care reform certainly found them. The plan was a work in progress, and it would have continued to evolve through implementation and beyond. But no single policy issue derailed reform. This section discusses the policy issues in detail while the next section discusses how the policy debate affected key stakeholders. In the appendix to this commentary, there is a detailed section-by-section analysis of the health reform bill [2007 Bill Text CA A.B. 1A].

Individual Mandate and Affordability

In January 2007, the Governor announced his plan calling for all Californians to purchase health coverage. The Governor pushed for the individual mandate as a way to achieve universal coverage. He felt that the only way to make sure that everyone has affordable health insurance is to be sure that everyone is in the insurance pool, spreading the risks and costs [Elizabeth Carpenter & Sarah Axteen, *Myths About the Individual Mandate*, New America Foundation, Feb. 18, 2008]. In addition, the Governor discussed at length the efficiencies universal coverage create by eliminating the hidden tax -- the higher premium costs the insured pay to cover the costs of the uninsured [Len Nichols & Peter Harbage, *Estimating the 'Hidden Tax' on Insured Californians Due to the Care Needed and Received by the Uninsured*, New America Foundation, May 21, 2007].

Initially, the individual mandate had virtually no support among Republicans, Democrats or most Left-leaning interest groups. Following lengthy negotiations, the Assembly Speaker and many critical stakeholders were able to reach a compromise with the Governor, which rested on resolving a number of issues, most significantly affordability and enforcement.

Affordability. Advocates raised immediate concerns that the Governor's plan did not do enough to make insurance affordable. The key to affordability lay in compromising on the size of the subsidies given to help individuals purchase insurance. After much debate between the Speaker and Governor, the two sides settled on a plan to limit premiums to 5.5 percent of family income.

Out-of-Pocket Costs. Opponents of the plan were concerned that there were no caps given for other cost-sharing and co-payments. Despite the fact that today's health system offers no such protection, there was a feeling that individuals could face an open-ended financial commitment for health insurance under the mandate without a cap.

Benefit Package. The minimum benefits needed to fulfill the mandate were left to be defined by the state in the future, raising concerns of the adequacy of the mandated coverage. Opponents stated that Californians would be required to purchase coverage without a clear sense of what benefits would be included for those in the statewide purchasing pool.

Enforcement. Regarding enforcement, the Governor eventually adopted an approach espoused by the New America Foundation that coverage should be seamless, meaning that every effort should be made to help people keep insurance [Peter Harbage & Len Nichols, *Coverage Without Gaps, Implementing Seamless Health Coverage in California*, New American Foundation, Sept. 2007]. Far from a punitive approach, the seamless concept is built on the idea that the government has a responsibility to take extraordinary steps to help people maintain coverage. The concept satisfied many who were concerned that the penalties could be harsh.

Guarantee Issue. The key issue in achieving compromise on the individual mandate was the guarantee issue. Today, underwriting rules prevent many people from obtaining insurance. Even worse are rescission policies that some insurance companies have used to drop coverage for those who need it once they start to make claims. Advocates saw the guarantee issue as a critical achievement, as it would allow all persons to have insurance.

Loss Ratios. Some advocates opposed the mandate because they said that it would be a boon to insurance industry profits. There were calls for rate regulation, which the Governor opposed. However, he did call for an 85 percent loss ratio. A loss ratio is a calculation of the percentage of the premium that is devoted to health care services. A loss ratio of 85 percent is an indication that 15 percent of premium dollars collected are on average dedicated to overhead and/or profits. The rate was reasonable for many insurers and gave a sense to many that price gouging would be prevented.

Employer Mandate

The Governor surprised observers by including an employer mandate in his original plan, calling for all but small employers (those with less than 10 employees) to pay 4 percent of payroll if they did not offer health insurance. In contrast, the Assembly plan would have required all employers to spend roughly 7.5 percent of payroll on health care. The two-sides agreed to a sliding scale of employer contributions between 1 percent and 6 percent, varying by firm payroll.

The policy remained controversial. Many employers were concerned about the fee, even at the lower 4 percent level. At the same time, many Democrats and unions kept up the pressure for higher employer participation, believing employers should have primary responsibility for offering health insurance. Neither side was entirely happy with the compromise [Julie Appleby, *California health reform gets sticky*, USA Today, Oct. 17, 2007].

Beyond the level of the fee, another key concern was the federal law limiting the ability of states to regulate health insurance benefits. Under the federal Employee Retirement Income Security Act (ERISA), there was concern that any fee on those firms not offering benefits would not be legal. A complex law with little history of judicial review, ERISA Section 514 [29 U.S.C.S. § 1144] is broadly interpreted to void all state regulation to the extent it relates to employer-sponsored health plans. Many Democrats and the Governor argued that the fee would be allowed by federal law. The County of San Francisco has been thus far successful in repelling the pending ERISA challenge to its health reform approach, which relies on an employer mandate for funding [Bob Egelko, *Appeals court lets S.F.'s universal health care law go forward*, San Francisco Chronicle, Jan. 9, 2008]. However, opponents pointed to cases in other jurisdictions where the federal courts intervened to stop reform from proceeding. [Amy Lynn Sorrel, *Federal court overturns Md. employer mandate*, Amednews.com., Aug. 14, 2006]. The lack of clear precedent created significant uncertainty in the debate around whether ERISA would pre-empt the employer mandate.

Funding Sources

The funding sources caused controversy in a number of ways.

Cigarette Tax. The Governors original plan had no cigarette tax, while the Speakers called for a \$2 per-pack increase. To help fund health reform, AB X 1 1s related ballot initiative, the Secure and Affordable Health Care Act of 2008, would have raised the cigarette tax by an additional \$1.75 per pack above the current \$0.88 rate, to a total tax of \$2.62 per pack [see The Secure and Affordable Health Care Act of 2008, Initiative #07-0103, Dec. 2007, available online at http://alankatz.files.wordpress.com/2007/12/health_careinitiative-20071228.pdf; see also State Board of Equalization, Staff Analysis of the Secure and Affordable Health Care Act of 2008, available online at <http://www.boe.ca.gov/legdiv/pdf/CigTaxInitiative.pdf>]. The cigarette tax proposal raised all the standard concerns. For example, much was made of a cigarette tax as a declining source of revenue. The inclusion of a cigarette tax also brought the opposition of big-time political player tobacco into the political discussion around reform.

Role of the Federal Government. There was significant controversy around whether the federal government would participate as a funding source. Despite statements by U.S. Health and Human Services Secretary Leavitt early in 2007 that funding would be available, public skepticism continued. Adding fuel to the concern that the federal government would oppose any increases in state health spending was President Bush's veto of the State Children's Health Insurance Program (SCHIP) renewal and expansion bill in October and again in December of 2007 [Kathy Robertson, *Bush veto hurts Schwarzenegger's health plan*, San Jose Business Journal, Oct. 3, 2007].

A key federal concern was the 4 percent tax on hospital revenues. The tax would have been used to draw down federal dollars for hospitals by increasing Medi-Cal reimbursement rates. The majority of California hospitals would be net winners because the increases would go to those seeing Medicaid patients. However, the state had signed an agreement in 2005 that would prohibit using hospital revenue for this purpose. Given the public statements of the Bush administration in support of this aspect of the plan, the Governor argued that federal government would allow the state to go forward despite that 2005 agreement.

In addition, federal permission would be needed to implement the proposed plan in other areas, including:

- A new Medicaid Section 1115 waiver to cover low-income childless adults;
- State plan amendment or waiver to expand Medi-Cal and the Healthy Families Program (HFP) eligibility;
- Elimination of the asset test in Medi-Cal; and,
- Approval to redirect certain federal funds from supporting the safety net to the purchase of insurance coverage.

Finally, there was concern about the call to use federal funds to expand California HFP to 300 percent of the federal poverty level (FPL), operated under the federal State Children's Health Insurance Program (SCHIP). After President Bush's repeated vetoes of an SCHIP expansion, Congress only passed a funding extension of the program through March 2009 that contains enough for existing programs -- not program expansions. Also, the federal government issued a directive in August 2007 that restricted states' ability to expand SCHIP at higher income levels. [Peter Harbage, *Assessing California's Ability to Comply with New Federal SCHIP Rules*, The California Health Care Foundation, Oct. 5, 2007].

Budget Impact and Budget Scoring. In the final stages of the health debate in December, a \$14-billion budget shortfall was announced. After reports of the budget situation began to circulate in December, Senator Perata called for the non-partisan LAO to determine the impact the Act would have on the state budget. Released in January 2008, the LAO report had sufficient information in it to serve the political purposes of both supporters and detractors [Health Care Reform, report by the California Legislative Analysts Office, Jan. 22, 2008, <http://www.lao.ca.gov/laoapp/PubDetails.aspx?id=1697>].

Although the report validated most of what the Governor and Speaker Nez had been saying with regard to costs, the LAO also offered alternative assumptions about the plan's costs to show how the plan may not work [Health Care Reform, report by the California Legislative Analysts Office, Jan. 22, 2008, <http://www.lao.ca.gov/laoapp/PubDetails.aspx?id=1697>].

The most significant of these raised the estimated monthly costs of providing health insurance to individuals from \$250 per person to \$300. At the higher cost, the state was projected to have an operating deficit of more than \$1.5 billion dollars in the fifth year of operation. Opponents also effectively leveraged this finding in conjunction with news reports of Massachusetts health reform budget overruns [Alice Dembner, *Subsidized care plan's cost to double: Enrollment is outstripping state's estimate*, The Boston Globe, Feb. 3, 2008].

Questions Regarding State Implementation

As with most pieces of legislation, the Act left operational details for state officials to develop later. However, opponents used the lack of details to question the state's ability to implement the complex law and prompt an important

policy debate. A few of the most significant concerns are discussed here.

Tax Credit Process. Reform would have used advanceable tax credits to help defray the cost of insurance for certain persons. Some questioned the ability of the state to screen for eligibility in advance.

Individual Mandate Enforcement Process. Many called into question the states ability to enforce the mandate, particularly the need to design a process for hardship exemptions. Opponents argued that a case-by-case approach to granting exemptions would have required considerable resources both in administrative time and expenses to create a new process for which California had no experience.

Employer Mandate Enforcement Process. To operationalize the employer mandate, the state would need to develop a payroll reporting and employer fee collection process. The operational details for this process, including the states ability to levy penalties for noncompliance and a budget for this process, were not specified.

Negotiation of Insurance Payment Rates for the State Pool. The plans authors argued that \$250 per member per month (PMPM) was in line with the states experience with Medi-Cal Managed Care, an average negotiated rate. However, the LAOs report raised concerns regarding the states ability to achieve a \$250 PMPM cost in the state purchasing pool. The LAO argued that just a 20 percent increase in the PMPM would significantly increase costs to the state.

Immigration. The Governors policy called for all persons to be insured, but left the coverage mechanism for immigrants as the counties responsibility. The issue left questions about the status of the undocumented simmering for those on both sides of the political spectrum. It is reasonable to assume that if health reform had proceeded further, immigration would have become a more contentious issue.

LESSONS

The 2007 experience in California holds three primary lessons for the broader health reform effort: how to find policy compromises; how to build broad coalitions of support and; how the pursuit of the ideological perfect can block the good.

Finding Policy Compromises

The ultimate California compromise legislation was a feat of balance between individual and collective responsibility, between affordability for individuals and sustainability for governments and employers. The Republican Governor and Democratic legislative leadership were also able to find balance and compromise in the details on cost-sharing, eligibility limits, employer contribution levels and a myriad of other aspects. This shows that a comprehensive reform plan allows room for building a plan that offers something for everyone.

Building a Broad Coalition of Support

It was just that feat of balance and compromise in the process of working out the final reform plan that allowed it to build such broad support among stakeholder groups as diverse as major employers, insurers, consumer groups and labor. Coalitions can be built that support comprehensive health care reform.

Pursuing the Perceived Perfect Can Block the Good

The Democrats in the California Senate who opposed or abstained from voting were in fact casting a vote for the status quo of the broken system. They did so for a variety of reasons, but the most compelling was that the compromise

plan was not their first perfect choice of reform single-payer for forces on the Left or a more open market for forces on the Right.

Thus, the most important national lesson from California is the need for leadership to unite not just moderates, but voices from the Right and the Left. Everyone must seek not their first choice, or their second choice of the status quo, but the harder third choice that will help Americans better afford and access health care now.

CONCLUSION

Barring extraordinary circumstances, it is unlikely California will achieve comprehensive health reform in 2008. An initiative has been put forward to cover all children, and there are other areas of possible interest around improving transparency and quality in the health care system.

California showed that health reform tried on a state level opens the process to a series of state-specific challenges and opportunities. While states cannot wait for the federal government, it is clear that a national solution is the best way to pursue health reform, in order to provide the resources and opportunity to truly solve our system crisis.

The national health debate will continue. Success in California would have brought additional momentum to the national debate, but given that the reasons for failure are California-specific, it is not clear that Californias failure will reduce national momentum. Senator Clintons plan bears strong resemblance to the California approach, as does Senator Obamas. Senator McCain has the beginning of a reform plan, and given the strength of the debate on the Democratic side, he will likely face the need for a higher standard in the general campaign. But whoever enters the White House in January of 2009 will be presented with the opportunity to lead the nation on this vital issue.

Appendix

Section-by-Section Analysis

This appendix provides a section-by-section analysis of the January 16, 2008 version of the Health Care Security and Cost Reduction Act, Assembly Bill 1 of the First Extraordinary Session of the California Legislature in 2007 [2007 Bill Text CA A.B. 1A]. While this appendix considers the bill, it does not examine the language that had been submitted for the accompanying ballot initiative and the financing measure. This appendix is written in the present tense not past tense as the bill still rests in the California Senate Health Committee but is in inactive status.

Section 1 names the legislation the Health Care Security and Cost Reduction Act.

Section 2 specifies the goals of this Act, which is to provide universal health care and establish a plan to do so. The steps include: (1) ensuring all Californians have access to affordable, comprehensive health insurance; (2) leveraging federal funds through existing programs; (3) maintaining the strength of the private health insurance system, while improving the availability and affordability of private coverage by reforming the private insurance market, enhancing access to preventive health services and chronic disease management programs, promoting cost-effective technologies, and implementing system-wide cost-containment strategies; and (4) early and ongoing evaluation of the reform implementation.

Section 3 expands the scope of practice of medical assistants to administer medications and perform other tasks, under the authorization of a nurse practitioner, nurse midwife or a physician assistant in any setting.

Section 4 left blank.

Section 5 establishes a nine-member task force to develop a recommended scope of practice for nurse practitioners by June 30, 2009. It specifies membership of this task force, and requires the Director of Consumer Affairs (DCA) to promulgate regulations that adopt the recommended scope of practice by July 1, 2010. This section becomes inoperative on July 1, 2011 and repealed as of January 1, 2012, unless a later enacted statute deletes or extends these dates.

Section 6 left blank.

Sections 7 to 10 specify provisions related to electronic prescribing, including defining the term electronic prescribing. By January 1, 2012, this section requires all prescribers and pharmacies in California to be able to transmit and receive prescriptions electronically. It gives the State Board of Pharmacy and other specified licensing boards authority and responsibility to ensure compliance, and requires prescribers to offer patients a written receipt containing specified information.

Electronic prescription systems must comply with national data exchange standards or be accredited, allow real-time verification of individual eligibility for benefits, and meet state and federal confidentiality and data security requirements, as well as state record retention and reporting requirements. In addition, this section expressly prohibits these systems from interfering with a beneficiary's freedom to choose a pharmacy or make prescribing decisions at the point of care.

Section 11 amends the Education Code to permit, but not require, school districts to distribute an information sheet to parents or guardians of specified students regarding health insurance requirements, based on a template to be developed by the California Department of Education (CDE). It also tasks CDE, in conjunction with the Managed Risk Medical Insurance Board (MRMIB) and the California Department of Health Care Services (DHCS), to develop a standardized template for this purpose, as specified, and to make the template available online or by written request. Both requirements have an effective date of January 1, 2010.

Section 12 codifies the individual mandate by amending the Insurance Code to require all California residents to enroll and maintain a minimum level of health insurance coverage for themselves and dependents as of July 1, 2010. Dependents are defined as a spouse or registered domestic partner, minor child of the subscriber, or a child over the age of 18 who is dependent on the subscriber.

This section requires MRMIB to establish, by regulation, the definition of minimum creditable coverage by March 1, 2009, as well as to establish standards for minimum creditable coverage that, at a minimum, apply to the individual market.

This section also provides the following exceptions to the individual mandate. MRMIB may grant exceptions to individuals if MRMIB determines that:

- The minimum level of coverage is not affordable or constitutes an undue hardship for that individual or family;
- The individual or family has an income at or below 250 percent of the FPL; or

- If premiums for that coverage exceeds 5 percent of the individuals or families income.

The mandate does not apply to people residing in the state for less than six months who, on that basis, are ineligible for guaranteed-issue health insurance.

This section also specifies that compliance with the individual mandate would not go into effect until several provisions of this bill are implemented, including implementation of the bills coverage expansions, purchasing pool provisions, and tax credit provisions.

Section 13 requires the California Health and Human Services Agency (CHHSA), after consulting with the California Public Employees Retirement System (CalPERS) and other affected provider groups, to develop performance benchmarks for quality measurement and reporting to create a common pay-for-performance model that will be offered in all state-administered health programs and promoted as a statewide framework for health care quality measurement and improvement.

Section 14 requires the Secretary of CHHSA, in collaboration with other relevant state agencies and an advisory body, to track and assess the impact of health care reform, including assessments of the sustainability and solvency of the pool, access, and affordability of health care, and the health care coverage market. The assessment must consider the impacts on the cost of health care to the state, employers, and local governments; the availability of insurance products; changes in employment and insurance markets; changes in racial and ethnic health disparities; and the overall health care delivery system, including capacity of providers and county safety-net systems. The Secretary is also required to submit the assessment to the Legislature by March 1, 2012 and every two years thereafter.

Section 15 requires CalPERS, by January 1, 2010 to provide its enrollees with an electronic personal health record (PHR) that, at a minimum, provides access to real-time, patient-specific information regarding benefit eligibility and cost-sharing requirements. It may also include additional patient health information available at the option of the enrollee. The PHR must adhere to national standards for interoperability, privacy, data exchange or be certified by a nationally recognized certification body. They must also comply with state and federal confidentiality and data security requirements.

Section 16 requires the creation of a Healthy Action Incentives and Rewards Program, as described in later sections.

Section 17 establishes the California Health Benefits Service Program (CHBS) within DHCS to expand cost-effective public health coverage options. By January 1, 2009, the CHBS must identify and report to the Legislature barriers and incentives to facilitating geographic expansion of, or the establishment and maintenance of, joint ventures between health plans that contract with, or are governed, owned, or operated by: a county board of supervisors, a county special commission, a county organized health system or a county authority. The report must also identify barriers that may inhibit the expansion of services by existing local health plans or by the County Medical Services Program (CMSP) into counties where there is not a local health initiative or county organized health plan.

The bill would require the CHBS to provide technical assistance to local health care delivery entities, such as local health initiatives or county organized health systems, to support joint ventures and other efforts to expand services to other geographic areas and populations, including technical assistance to contract with providers.

The section authorizes DHCS to contract with the joint ventures described above to provide health services to specified populations. This section also authorizes local health plans to form joint ventures to create integrated networks of public health plans that pool risk and share networks, and in doing so, would require participating health plans to seek contracts with public hospitals and other safety-net providers. All the joint ventures must obtain licensure under the Knox-Keene Act [Cal. Health & Safety Code §§ 1340 et seq.]. This section also creates a Program Stakeholder Committee within CHBS, comprised of 10 members as specified, who would meet quarterly to help CHBS fulfill its mission. DHCS must report on the implementation and progress of CHBS to the Legislature by November 1, 2009, as

well as make recommendations.

Section 18 establishes a prohibition on hospitals from balance billing. It prohibits non-contracting hospitals, as defined, from billing a covered patient for non-emergency services and post-stabilization care, other than applicable co-pays and cost shares. These requirements do not apply to non-contracting treating physicians who can continue billing patients for the difference.

Section 19 specifies that health care service plans that participate in the Medi-Cal managed care program are subject to filing, reporting, monitoring and survey requirements as established by the Department of Health Care Services. This section also specifies that the Department of Managed Health Care (DMHC) and DHCS are to develop a joint filing and review process for medical quality surveys.

Section 20 provides the director of DMHC with regulatory and program flexibility to facilitate new, modified, or combined licenses of local health initiatives, county organized health systems or the CHBS seeking licensure for regional or statewide networks to contract with MRMIB and to participate in the California Cooperative Health Insurance Purchasing Program (Cal-CHIPP), or to provide coverage in the individual or group markets. It requires the director to ensure all public health plans established meet essential financial, capacity and consumer protection requirements of the Knox-Keene Act.

Section 20.5 states legislative intent to establish mechanisms by which the state can defray costs of an enrollees public program participation by helping enrollees first take advantage of other non-state coverage opportunities. This section requires DHCS to consult with DMHC and DHCS to determine how to implement enhanced premium assistance programs and to report these findings to the Joint Legislative Budget Committee by July 1, 2009.

Section 21 prohibits private individual health insurance plans, except insurance explicitly defined as short-term limited duration, from refusing renewal of a policy except under the following circumstances:

- The policyholder failed to pay the premiums as established in the contract;
- The policyholder intentionally misrepresented themselves;
- The policyholder moves outside the service area; or
- The plan ceases to operate and gives 180-days notice to the state agency and the policyholder.

A plan that ceases to sell individual health insurance is barred from doing so in California for five years. If a plan withdraws an individual health benefit, it must notify the director and policyholder at least 90 days in advance and offer the individual choice of all benefit plans offered to businesses regardless of health status.

Section 22 prohibits health plans and insurers from canceling individual health coverage. The section lays out these limited exceptions:

- The individual fails to pay even after being given 15-days notice of failure to pay;
- The individual commits fraud or deception by using services of another health plan or knowingly permits such fraud or deception by another; or
- Good cause, as agreed upon in the contract.

This section establishes a process for individuals to appeal if they believe their policy was canceled or not renewed because of their health status. An individual may request a review by the DMHC, and if the complaint is found to be valid, the health plan or insurer will be notified. The coverage carrier then has 15 days to request a hearing or to reinstate the individuals benefits. If after the hearing the DMHC believes the cancellation was unlawful, the plan will have to reinstate benefits retroactively to the time of cancellation or failure to renew, and pay all incurred medical expenses from the date of cancellation or nonrenewal. Contracts established prior to the Acts adoption are not repealed.

Section 22.7 defines comparable benefits as any health plan contract in the same coverage choice category.

Section 23 requires health care service plans providing prescription drug benefits to make their most current

formularies available electronically to licensed prescribers and pharmacists by January 1, 2010.

Section 24 requires all health care service plans, except Medicare supplemental plans, to include a Healthy Action Incentives and Rewards Program (Rewards Program) after January 1, 2009 to help engage people in their health care. The Rewards Program will offer a health assessment tool to gauge overall health status and risk factors including smoking, alcohol and or drug abuse, and nutrition and physical activity practices. The program will provide access to a health care provider to review the assessment, and where appropriate, offer follow-up through a Web-based tool or nurse hotline.

The program will offer incentives and rewards to engage people and help them make good health choices, such as getting immunizations, proper screening services, doing the health risk assessment and participating in healthy lifestyle programs, such as smoking cessation, physical activity and good nutrition. Incentives may include but are not limited to health premium reductions, cash or gym memberships. If a health plan offers a premium reduction, it must be a uniform reduction offered after the program is completed.

The Rewards Programs must be priced consistently across all groups, potential groups and individuals without regard to health status, prior claims experience or risk profile. The same goes for the design of the incentives programs. Granting a health benefits plan cannot be conditional on enrollment in the Rewards Program. The programs must be pre-approved by the director of MRMIB, who has the power to suspend or withdraw any program that allows a health plan to market, sell or price health coverage for healthier, lower-risk groups. If any portion of this section is found noncompliant with federal law, the entire section will cease operation.

Section 25 requires the Office of Patient Advocate (OPA) to develop, and maintain on its Website, Office of Statewide Health Planning and Development (OSHPD) reports and data to help the public choose health plans, hospitals, medical groups and other providers.

Section 26 requires insurance carriers on or after July 1, 2010 to spend no less than 85 percent of after-tax revenues on health care benefits, as specified, excluding administrative fees. DMHC and the California Department of Insurance (CDI) are required to jointly adopt regulations to implement the requirement. Health plans and insurers must average costs across all products when calculating this medical loss ratio (MLR), including products of affiliated companies, regardless if they are under the jurisdiction of DMHC or CDI. DMHC and CDI can exempt new products in the first two years from the MLR if they are substantially different from the carriers previously existing products.

Section 27 allows health plans and insurers to communicate with enrollees electronically, under specified conditions.

Section 27.3 prohibits health plans and insurers from tying employees or contracted workers compensation to the percentage of the amount a claim is reduced for payment, the number of claims, or the cost of services for which the employee denied authorization or payment. The section sunsets on January 1, 2009 unless a separate statute extends it.

Section 27.5 repeats section 27.3.

Section 28 prohibits health plans and insurance carriers from establishing performance goals or quotas or providing additional compensation based on the number of people whose coverage is rescinded or the financial savings associated with the rescission of coverage to any person it employs or contracts with.

Section 28.5 specifies provisions regarding individual market reform and guarantee issue. This section institutes several reforms to the individual health insurance market. All health insurance carriers that sell individual private coverage must offer, accept and renew such coverage to all applicants within their service area. Guarantee issue is contingent on the individual mandate requirement.

This section establishes premium-rating rules for individual coverage. Individual rates must be based on geographic

location and perceived health risk (risk adjustment factors), as determined by the health plan. The geographic rating categories are limited to nine or fewer regions statewide, and it restricts how the regions are designed similar to the geographic rating limits currently imposed on small employer guaranteed-issue coverage. It also limits age rating to 12 categories, compared with the seven age range categories currently allowed for small employer coverage.

Health plans are prohibited from offering coverage on or after March 31, 2009 that provides less than minimum creditable coverage as defined by MRMIB. CDI and DMHC are prohibited from approving new products after the deadline that do not meet the defined minimum. Health plans, however, can indefinitely continue offering pre-existing plans that do not meet the criteria to those enrolled before the deadline. By July 1, 2010, all products a health plan markets, sells and approves must comply with the established minimum credible coverage.

Health plans may require individuals to provide information on health status and health history as necessary to apply the risk adjustment factors permitted, but they must use a standardized form and evaluation process that DMHC develops. Health plans also may ask individuals to provide that information voluntarily after coverage is issued for the purpose of providing care management services.

Notwithstanding those exemptions, health plans may reject an application for coverage from people meeting the following criteria: (1) new residents in the state for the first six months, unless they are eligible for coverage under the federal Health Insurance Portability and Accountability Act (HIPAA) [104 Pub. L. No. 191, *110 Stat. 1936 (1996)*] or can demonstrate at least two years of prior coverage; (2) individuals who are exempt from the individual mandate because of their income level, unless they can demonstrate prior creditable coverage or because they have received affordability or hardship exemption from MRMIB.

Pre-existing condition exclusions, waived conditions, or enrollment waiting periods are prohibited once guarantee issue is implemented, except for those people who fail to comply with the individual mandate for more than 62 days. For those people, the health plan can impose a pre-existing condition exclusion for up to 12 months, as specified.

The CDI and DMHC must by April 1, 2009 jointly develop and consistently enforce a system to categorize all health plan contracts and health insurance policies into five coverage choice categories with varying levels of coverage.

These categories must:

- . Provide a reasonable continuum of coverage;
- . Permit reasonable variation in the benefits to allow for a diverse market within each category;
- . Be enforced consistently between health plans and health insurers in the same marketplace regardless of licensure; and
- . Include one standard health maintenance organization (HMO) and one standard preferred provider organization (PPO).

To help consumers comparison shop, the carriers must offer coverage in all five choice categories, including at least one standard product in each category, and if the plan or insurer offers a specific type of benefit plan in one category a HMO, PPO, exclusive provider organization (EPO), or point of service they must offer the same type in all five categories. The Office of the Patient Advocate is to develop and maintain on its Website a matrix of the uniform benefits of all the individual health plan contracts and insurance policies arranged by coverage choice category.

Prices must reflect a reasonable continuum between the coverage choice categories and health plans cannot set price products at a rate lower than a product offered in a lower coverage category. The lowest choice category must offer the mandatory minimum creditable coverage, as determined by MRMIB.

Effective January 1, 2009, every health plan and health insurance policy must offer a Healthy Action Incentives and Rewards Program in each coverage category. A time frame for individual coverage to begin after health plans or insurance carriers receive payment for the first premium will be established. DMHC or CDI can force a plan to cancel contracts if it is determined to be financially insolvable.

Health plans that do not have sufficient health care delivery resources, as specified, and meet specified conditions are exempt from the guarantee issue requirement, as are health plans that do not offer coverage to individuals in the commercial market and whose membership and revenues are primarily from people eligible for Medicare or Medi-Cal.

The law would regulate how and when individuals can change coverage categories. Individuals can only move up to a higher coverage choice category on the anniversary date of the contract and if certain qualifying events occur (such as the death of the subscriber, marriage, divorce, birth of a child, etc.) and they can only move up one choice category per year.

Renewable private health insurance plans cannot refuse to renew a policy except under the following circumstances:

- Failure to pay;
- The policyholder engaged in material misrepresentation;
- The policyholder moves outside the service area; or
- The plan ceases to operate and gives 180-days notice to the state agency and the policyholder.

A plan that ceases to sell individual health insurance is barred from doing so in California for five years. If a plan withdraws an individual health benefit, it must notify the director and policyholder at least 90 days in advance and offer the individual the choice of all benefit plans offered to businesses regardless of health status. On or after July 1, 2010 health plans are prohibited from rescinding an individuals health benefits.

Premium rates must be in effect for no less than 12 months and must guarantee renewal, with specified exceptions, such as when a policyholder moves, fails to pay or engages in fraud or misrepresentation. When determining the premium for more than one subscriber, the rate should be based on the age of the youngest spouse or domestic partner.

For the first two years of the program, health plans can use the risk adjustment factor (rate increases or discounts for health status or health risk) to charge premium rates no more or less than 20 percent of the standard average rates. After the first two years, rates must be no more or less than 10 percent of the applicable standard risk rate. After four years, risk adjustment factors can no longer be used.

CDI and DMHC are required to jointly establish a maximum limit on the ratio between rates for individuals in the 60 to 64 years category and those in the 30 to 35 years category. DMHC, in consultation with the Insurance Commissioner and MRMIB, is to develop by March 1, 2009 a standardized form and uniform evaluation to be used by all carriers in how they determine any risk adjustment factor.

Insurance carriers and their agents or brokers must make specified disclosures related to individual rights, guarantee issue and renewal requirements and other specified regulatory requirements.

Health plans must demonstrate their compliance with the law to DMHC, must provide 20-days notice if they plan to change their benefit packages, and must file an amendment notifying changes to their standard risk rates before selling plans at the new rate. Specified information should be filed with DMHC if a health plan changes its offerings or standard risk rate.

DMHC and CDI, in consultation with outside actuaries and health plans participating in the individual market, are to develop a mechanism, as specified, by July 1, 2010 that helps health plans and insurers manage the risk of providing health coverage on a guarantee issue basis. No later than two years following implementation of guarantee issue, the director of DMHC and the insurance commissioner must make a finding related to the relative risk profile in individual

coverage, compared to the risk profile in Cal-CHIPP, and establish a reinsurance program, as specified, if specific risk profile differentials are identified. Reinsurance to compensate for adverse risk selection of more than 5 percent and up to 10 percent will be paid through a broad-based assessment on carriers, and risk selection differentials of more than 10 percent will be paid, subject to appropriation.

Section 29 requires the Department of Public Health (DPH) to maintain the existing California Diabetes program, contingent upon appropriation of state funds. This program provides information on diabetes prevention and management.

This section also establishes the California Comprehensive Diabetes Services Program (CDSP) within the Department of Health Care Services (DHCS). The DPH-run California Diabetes program will offer technical assistance to Medi-Cal regarding the scope of benefits provided through CDSP, which provides diabetes prevention or management services to specified fee-for-service Medi-Cal enrollees diagnosed with pre-diabetes or diabetes.

DHCS is authorized to define CDSP services, which may include diabetes screening, visits by certified practitioners, culturally and linguistically appropriate life-style coaching and self-management training, and regular and timely laboratory evaluations by the primary care physician. DHCS is also required to develop and implement incentives to encourage participation by Medi-Cal fee-for-service eligible beneficiaries and providers.

This section also requires DHCS to collect specified data to monitor health outcomes of participating Medi-Cal beneficiaries and to contract with an independent organization to evaluate the program, including short-term and long-term cost savings to expand CDSP to private or commercial insurance markets, and report on health outcomes and cost savings.

This section requires DHCS to secure all federal approvals to implement and fund CDSP, and permits the program to be implemented to the extent that federal financial participation is obtained. Implementation is also contingent on annual appropriation of state funds.

Section 30 requires DPH, in consultation with DMHC, DHCS, MRMIB and the Department of Insurance, to annually identify smoking cessation benefits provided by the 10 largest providers of health care coverage in the state (based on enrollment) and make this information available online.

To the extent funds are appropriated, DPH is required to increase the capacity of the California Smokers Helpline and expand public awareness of the helpline and other existing smoking cessation benefits. DPH will evaluate changes in awareness concerning the availability of smoking cessation benefits by beneficiaries and providers, based on changes of beneficiary awareness and use indicators, such as smoking rates, and changes in coverage for smoking cessation, resulting from the helpline expansion.

Section 31, contingent upon an appropriation, establishes the Community Makeover Grant Program within DPH to award grants to local health departments that act as local lead agencies in promoting active living and healthy eating. The grants would be based proportionally on population and given for specific purposes, including among other things, the creation of community infrastructure, coordination among local agencies, and local grants to promote physical activity in children, improve access to healthy foods and improve use of community recreation facilities. DPH must issue guidelines to local health departments on how to prepare a local plan to promote active living and healthy eating in order to prevent obesity and other related chronic diseases.

This section also requires DPH to track and evaluate obesity-related health indicators, including physical activity, diet, and community environment, as specified, to direct the most efficient allocation of resources for obesity prevention and to measure the extent to which funded programs promote the goals identified under the California Obesity Prevention Plan. These indicators will enable evaluation and comparison of obesity projects and programs, and the health and economic consequences of obesity.

Also, DPH is tasked to develop a public education campaign known as California Living, to the extent funds are appropriated. The purpose of the campaign is to stress the importance of obesity prevention that also frames active living and healthy eating in accessible, as well as culturally- and linguistically-appropriate, formats. The campaign is to be linked to community-level efforts, assist schools in promoting fresh foods and whole grains, and provide technical assistance to help employers that integrate wellness policies and programs into employee benefit plans and worksites.

Sections 31.1 to 31.6 make changes to the California Health & Safety Code regarding clinic funding under the Expanded Access to Primary Care (EAPC) program. This includes a program expansion by increasing income eligibility requirements for EAPC beneficiaries from 200 percent to 250 percent of the poverty level, but limits eligibility to individuals who lack private or employer-based coverage and who do not qualify for public health care coverage programs. Beneficiaries would be required to select a clinic as their medical home and, at the time their eligibility is determined, would be issued an ID card for use at that clinic.

This section, among other things, also requires DHCS to develop an electronic application process that also verifies annual income and issues ID cards upon eligibility determination by July 1, 2010. This section provides DHCS with the authority to contract with other entities, or use existing provider enrollment and payment processes. DHCS is also required to maximize federal funds available for these services.

Section 32 requires the Office of Statewide Health Planning and Development (OSHDP), beginning January 1, 2010, to collect and publish risk-adjusted outcome reports. Procedures and conditions required to be reported are to be divided among medical, surgical, and obstetric conditions. The office must publish the risk-adjusted outcome reports for surgical procedures, including for coronary artery bypass graft surgery and percutaneous coronary interventions (angioplasty and insertion of stents into blood vessels). OSHPD must compare risk-adjusted outcomes by hospitals and physicians, with specified exceptions.

This section also directs OSHPD to include in the annual reports, or make available separately at cost to the person requesting it, data assessing the statistical significance of hospital or physician data at 99%, 95% and 90% confidence levels. OSHPD will consult with the clinical advisory panel to report these results by hospital annually and by physician biannually.

Section 32.5 tasks OSHPD to obtain data necessary to complete risk-adjusted outcome reports from hospitals. It also establishes a process for the appointment of nine-member clinical panels to review and approve reports on risk-adjusted outcomes of hospital performance.

Section 33 establishes a 16-member California Health Care Cost and Quality Transparency Committee (Transparency Committee). The Transparency Committee is to represent specified areas of the health care system and consist of 10 people appointed by the Governor and six by the Legislature. It will meet once every two months, and develop, update and submit to the Secretary of CHHSA a detailed health care cost and quality transparency plan designed to provide public reporting of health care safety, quality and cost information, and to monitor implementation of the plan.

The committee must make its recommendations within one year of its first meeting, and review the plan every three years. The plan must include, but is not limited to, strategies to measure and collect data related to health care safety, quality, utilization, health outcomes and the cost of health care services from plans, insurers, medical groups, hospitals, etc. The Act requires the plan to collect data from health plans and insurers, medical groups, health facilities, licensed physicians, and other health care professionals, and include a process to assess compliance with data collection requirements, as well as a recommended fee schedule to fund implementation. Within 60 days of receiving the plan, the Secretary of CHHSA must accept the plan and develop regulations to implement it, or send it back to the Transparency Committee for further changes. The Secretary of CHHSA is responsible for seeing the plan implemented after its approval.

This section also requires OSHPD to identify a fee schedule for users of collected data and other financial resources to implement this provision. Proposed fees must be approved by the Governor and Legislature in the annual budget. Fees imposed on hospitals are specifically capped at 0.6 percent of operating costs, as specified. The Secretary must report to the Legislature every six years after the plans implementation, commencing on January 1, 2014, as to whether the Transparency Committee should continue or if changes are necessary.

Section 34 requires DHCS to identify best practices related to e-prescribing modalities and standards, and to make recommendations for statewide adoption of e-prescribing by January 1, 2009. This section also requires DHCS to develop a Medi-Cal e-prescribing pilot program contingent on the availability of federal funds or grants. DHCS may provide necessary e-prescribing technology, including equipment and software, to participating Medi-Cal prescribers.

Sections 34.3 to 34.7 repeat the language of Section 27.3 and Section 28 by prohibiting health plans from tying compensation or establishing performance quotas for employees of health insurance plans that are related to the percentage of the amount a claim is reduced for payment, the number of claims or the cost of services for which the employees denied authorization or payment.

Section 35 repeats the regulations of Section 26 establishing a Medical Loss Ratio of 85 percent on or after July 1, 2010.

Section 36 repeats Section 27, allowing health plans and insurers to communicate with enrollees electronically under specified conditions.

Section 37 amends the California Insurance Code in the same manner as Section 24, requiring all health care service plans, except Medicare supplemental plans, to include a Healthy Action Incentives and Rewards Program after January 1, 2009 to help engage people in their health care.

Section 38 amends the California Insurance Code in the same manner as Section 22.7. Specifically, it defines comparable benefits as any health plan contract in the same coverage choice category.

Section 39 amends the California Insurance Code in the same manner as a subdivision of Section 28.5 and prohibits all renewable private health insurance plans from refusing to renew a policy except under specified circumstances.

Section 42 amends the California Insurance Code to reform the individual insurance market in the same manner as Section 28.5 by requiring guarantee issue and renewal of individual coverage. The section specifies how health plans and insurers can create their rating systems and calls for the creation of five coverage choice categories.

Section 43 amends the California Insurance Code regarding family premium contributions for the Healthy Families Program (HFP). This section specifies what qualifies as family contribution, establishes a sliding scale for family contributions, and caps the monthly family premium contributions to the HFP to \$25 per child with a maximum of \$75 for families earning more than 250 percent of the FPL but less than 300 percent of the FPL, as of July 1, 2009. It also specifies discounts that can be applied to family premium contribution requirements for families meeting certain requirements.

Section 44 allows MRMIB, to the extent funds are made available, to provide or arrange for the provision of electronic PHRs for HFP enrollees. At a minimum, the records must provide real-time, patient-specific information about benefits and cost sharing via a Web-based system. The records may, but are not required, to include additional information, including laboratory results, prescription histories, claims histories and other information authorized by the enrollee. The PHRs must adhere to national standards for interoperability, privacy, data exchange or be certified by a nationally recognized certification body. They must also comply with state and federal confidentiality and data security

requirements.

Section 45 prohibits anyone administering or providing health benefits under the Healthy Families Program from eliciting information from an enrollee other than what is required to carry out the provisions of the law as applicable.

Section 46 establishes confidentiality rules for the Healthy Families Program and the Medi-Cal program.

Section 47 states nothing should preclude MRMIB from seeking voluntary feedback regarding the adequacy of the private and public health care delivery systems.

Section 48, among other things, amends the California Insurance Code to increase the income limit for HFP participants from 250 percent of the FPL to 300 percent of the FPL, effective July 1, 2009.

Section 49 amends the California Insurance Code to expand Healthy Families eligibility to children who otherwise meet program requirements regardless of immigration status, effective July 1, 2009.

Section 50 amends the California Insurance Code to specify that children or their uninsured parents or legal guardians who are qualified aliens cannot be determined ineligible solely based on their date of entry into the U.S. It makes these provisions contingent upon funding in the state budget.

Section 51 amends the California Insurance Code to specify when establishing a child's eligibility for Medi-Cal or Healthy Families, a parent or caretaker must sign under the penalty of perjury a form attesting that the child is not described in any of the categories for which federal financial participation for providing full-scope services is available.

Section 53 adds a new section to the California Insurance Code regarding the California Cooperative Health Insurance Purchasing Program (Cal-CHIPP). It establishes Cal-CHIPP as the state purchasing program or health insurance purchasing pool to be administered by MRMIB for the purpose of providing health care coverage to those eligible through participating health insurers, regulated by the CDI, or through health care service plans, regulated by the DMHC. MRMIB is given broad authority to operate Cal-CHIPP beginning January 1, 2009 and to begin providing health coverage through Cal-CHIPP on July 1, 2010.

Eligibility standards for enrollment and disenrollment in Cal-CHIPP are established, as well as the rights and remedies of those enrolled into two categories of Cal-CHIPP: Cal-CHIPP Healthy Families Program (CCHFP) enrollees and those who are not eligible for CCHFP.

The plans must adhere to the benefit requirements of the Knox-Keene Act [Cal. Health & Safety Code §§ 1340 et seq.], as well as provide prescription drug coverage. Enrollee cost-sharing levels must stay within levels that promote prevention and health maintenance, including appropriate cost sharing for physician office visits, diagnostic laboratory services and maintenance medications to manage chronic diseases. MRMIB must consider whether cost-sharing levels would deter an enrollee from obtaining appropriate and timely care when setting them.

The benefits offered to the purchasing pool will include at least three different coverage options:

1. A plan that offers the same benefits as the minimum coverage for the individual market;
2. A mid-range coverage product (defined as category three of the five coverage choice categories for the individual market);
3. A high-range, comprehensive benefit plan (category five). MRMIB may offer dental and vision coverage if specified conditions are met.

Premiums for these coverage options will equal the full cost of the coverage choice made by the enrollee. Enrollees eligible for the state health care tax credit may reduce their premiums by the value of the credit. MRMIB may provide

an additional contribution equal to 20 percent of the premium of a minimum benefit product to employees with incomes at or above 250 percent of the FPL whose employers pay into the California Health Trust Fund.

If MRMIB offers prescription drug coverage to Cal-CHIPP enrollees it may use bulk purchasing. If MRMIB decides to do so, it is allowed participation in other state or local government bulk purchasing programs, pursuant to collective bargaining with a labor organization. Health care service plans participating in such prescription drug arrangements and licensed by the DMHC must meet all the related Knox-Keene requirements.

MRMIB must collect and disseminate information on the quality and cost-effectiveness of Cal-CHIPP participating health plans and insurers. Confidentiality standards for Cal-CHIPP participants are established, as are the administrative duties of MRMIB in carrying out the purchasing pool program. Health plans and insurers participating in the program may contract with agents or brokers, at their own expense, to provide marketing and servicing of Cal-CHIPP health benefits.

Cal-CHIPP premiums must vary by income level. Individuals with a family income less than or equal to 150 percent of the FPL will have no premiums or out-of-pocket costs. Individuals with a family income above 150 percent of the FPL and less than or equal to 250 percent of the FPL will have premiums that cannot not exceed 5 percent of the familys net income.

As of January 1, 2010 through December 31, 1014, individuals and families with incomes between 250 and 400 percent of the FPL (\$43,000 to \$69,000 for a family of three) who receive coverage under Cal-CHIPP are eligible for a tax credit if their share of cost for a mid-range product exceeds 5.5 percent of their family income. The tax credit is limited to a specified maximum amount for a family based on family size and age. This credit phases down as income increases.

To be eligible for CCHFP coverage an individual must meet all of the following criteria:

- . Be a legal resident of the state;
- . Be 19 years of age or older;
- . Have family income between 101 and 250 percent of the FPL; and
- . Not be offered employer-sponsored insurance or have been offered coverage from an employer that does not make any financial contribution to the premium.

Eligibility for residents who do not qualify for Cal-CHIPP Healthy Families must meet all the following criteria:

- . Work for or be the dependent of an employee who works for an employer who elected to pay into the California Health Trust Fund;
- . Be an employee paying the full costs of coverage through an employee tax savings plan where the employer designates Cal-CHIPP in the cafeteria plan; and
- . Be eligible for the state health coverage tax credit established in this bill.

The Department of Health Care Services, in consultation with MRMIB, should convene a stakeholder group to develop an outreach and enrollment process for members of the pool program that is cost-effective and coordinated with Medi-Cal and the Healthy Families Program to ensure seamless access to coverage for all eligible Californians.

The initiative would establish a California Health Trust Fund for receipt of revenues from these sources, and would deem them to be revenues that are not subject to Proposition 98, the school funding initiative, and the Gann limit [i.e., various limits on government spending in California].

Section 54 makes changes to the California Insurance Code and addresses issues related to minimum creditable coverage. It begins by requiring MRMIB to establish regulatory standards for minimum creditable coverage that, at minimum, apply to the individual market and for purposes of the individual mandate by March 1, 2009. Minimum coverage must at least include coverage for physician, hospital and preventative services and be inclusive of existing coverage requirements under law. It then provides guidance on the development of these standards as well as specifying issues MRMIB must consider when defining minimum coverage, including the scope of services, enrollee and dependent deductibles, copayment requirements, and coverage of services outside the deductible.

This section also provides guidance to MRMIB on the development of a process for considering and granting requests for exemptions based on affordability and hardship. This includes specifying what criteria MRMIB must use when developing and reviewing affordability and hardship standards by which an individual may be exempt, establishing a process and timelines whereby individuals or families must obtain coverage after their exemption expires, identifying and tracking the number of individuals with exemptions, and reporting that information to the Legislature and Director of DMHC for establishing reinsurance mechanisms.

In addition, MRMIB must maintain an active statewide education and awareness program to inform all California residents of their obligation to obtain coverage and options for meeting the individual mandate. The language provides guidance on who MRMIB must work with to establish point-of-service methods to facilitate enrollment of individuals who do not have or maintain minimum coverage.

This section then requires MRMIB to develop an enforcement mechanism to ensure that uninsured individuals obtain the minimum creditable coverage, including informing non-covered individuals of the methods available to them to obtain affordable coverage. MRMIB must do so by employing, to the extent possible, existing state reporting processes used to collect information on employment and tax status of individuals. MRMIB must pay the cost of health care coverage on behalf of a previously uninsured individual who is enrolled by MRMIB in minimum creditable coverage after being uninsured for at least 62 days, and establish methods to recoup costs from these individuals. MRMIB may also enter into agreements with other state agencies or departments to perform activities related to the enforcement mechanism, and must report to the Legislature on the means and processes used to enforce the individual mandate by March 15, 2010.

Implementation of this section is contingent on appropriation of funds in the annual state budget.

Sections 55 and 56 establish unfair labor practices to prohibit employers from referring an employee or dependent of an employee to Cal-CHIPP for the purpose of separating that employee or dependent from the employers group health coverage. It also prohibits the employer from changing the employer-employee share-of-cost ratio or making modifications of coverage so the employees or their dependents enroll in Cal-CHIPP.

Section 57 allows employers to provide health coverage that includes a Healthy Action Incentives and Rewards Program, as specified. This section also allows an employer-offered program to include monetary incentives and premium cost reductions for non-smokers and smoking cessation.

Sections 57.1 to 57.7 amend the current California Revenue and Taxation Code to create the health care tax credit program.

Section 57.1 allows qualified taxpayers to receive an annual tax credit equal to the health coverage premium costs for qualified plans that are greater than 5.5 percent of the taxpayer's adjusted gross income. The amount of the credit is reduced by 1 percent for every 2 percent the taxpayers gross income exceeds 300 percent of the FPL. No one earning more than 400 percent of the FPL qualifies for the credit. Maximum monthly credits are also established.

Section 57.2 establishes the legislative intent to allow advances on the tax credit.

Section 57.3 states that the tax credits may be given to individuals between the ages of 50 and 64 whose income exceeds 400 percent of the FPL. This is limited by and contingent on available funding and cannot exceed \$50 million annually.

Section 57.4 creates a penalty in the tax code for individuals who fail to determine eligibility for the refundable credit. The penalty is \$1,000 for each failure.

Section 57.5 states MRMIB may share information with the Franchise Tax Board about individuals who purchased a health care plan that year.

Section 57.6 allows the Franchise Tax Board to share information with MRMIB in order to verify income, filing status and number of dependents.

Section 57.7 states all the Trust Fund monies must be spent each year and that the Franchise Tax Board is authorized to transfer the appropriate sum into the fund.

Section 58 requires the Employment Development Department (EDD) to establish a system to collect and report information related to employer health expenditures on behalf of their employees.

Section 58.5 establishes a system of fining employers who fail to maintain a cafeteria plan. The employers who fail without good cause will be fined \$100. The fine jumps to \$500 if the failure is willful.

Section 59 states that the Health Care Tax Savings Plan requires employers with one or more full-time employees to establish *Internal Revenue Code Section 125* accounts to allow employees to pay premiums for health coverage with pre-tax dollars.

Section 60 increases state funding that can be used for health care benefits for in-home supportive services (IHSS) workers by county or public authorities, which are entities who administer portions of the IHSS program in certain counties. This section provides three sequential 25 cent increases from the current 60 cents per hour, with two of three proposed increases contingent on estimated general fund revenues exceeding the prior years revenues by at least 5 percent. This section also specifies that, if the employee representative chooses, health benefits for IHSS workers can be provided through a trust fund.

Section 61, contingent on federal financial participation through a waiver, requires that Medi-Cal eligibility be simplified by eliminating the asset tests, which applies to certain Medi-Cal eligibility categories, and by no longer requiring Medi-Cal beneficiaries to file semi-annual status reports after July 1, 2010. They must file semi-annual address verification reports.

Section 62, effective July 1, 2010, extends coverage to the low-income caretaker relatives of the medically needy whose annual incomes are up to 250 percent of the FPL, as long as federal approval is obtained.

Section 63, effective July 1, 2010, extends coverage to medically needy 19- and 20-year olds with annual incomes up to 250 percent of the FPL, as long as federal approval is obtained.

Section 64 defines a benchmark benefits package for those Medi-Cal beneficiaries with net family income above

100 percent of the FPL as the same as the Cal-CHIP Health Families benefit package.

Section 65 requires DHCS to seek federal approval for a one-year eligibility test for those receiving benchmark benefits.

Section 66 tasks MRMIB with administering those benchmark benefits.

Section 67 specifies that children 19 and under will qualify for full-scope Medi-Cal benefits regardless of immigration status.

Section 68 establishes a new program to provide coverage to childless adults 21 and older who earn less than 100 percent of the FPL and do not qualify for Medi-Cal. Coverage in this program is limited to citizens, nationals or legal aliens who are not offered employer-sponsored health coverage. The covered benefits offered are the same as the Cal-CHIP Healthy Families plan, but also include long-term care, in-home supportive services and home and community-based services. Eligibility requirements for pregnant women and children will be used to determine eligibility for this new program, but the income disregards will not apply. Implementation of this program is contingent on a county share of cost.

Section 69 requires beneficiaries of this new program to file semi-annual status reports to update their eligibility status. The disabled, blind and aged, and those granted continuous eligibility are excused from this requirement.

Section 70 requires beneficiaries who are not required to make premium payments to file semi-annual address verification forms, starting July 1, 2010. If the beneficiary does not return the form, and follow-up by the county is unsuccessful, eligibility will be terminated. Exemptions from this provision are provided for the disabled, blind and aged, along with pregnant women and children 19 and younger.

Section 71 requires DHCS to maximize the availability of federal funding for the costs of providing Cal-CHIP Healthy Families to non-Medi-Cal beneficiaries.

Section 72 establishes baseline rates hospitals will be paid for caring for Medi-Cal beneficiaries if the expansions called for by this Act become inoperative. The rates are those which were in effect on June 30, 2010.

Section 73 specifies local coverage option (LCO) rules. Adults in the expanded Medi-Cal program, who live in a county where a LCO is available, will be covered exclusively by that LCO for the first four years it is available. After five years of operation of an LCO in a county, newly eligible individuals may enroll in the LCO, the county organized health system or one of the two-plan Medi-Cal managed care contractors in that county. LCOs are permitted to offer a limited network of providers with approval by DHCS and DMHC. DHCS must offer contract provisions to LCOs that limit the LCOs financial risk and provides for the state to share in profits or losses above or below the specified risk thresholds. Out-of-network emergency services providers for LCO enrollees must accept payments as payment in full if the rates comply with federal laws.

Section 74 requires DHCS to establish a Healthy Action Incentives and Rewards Program to be provided as a covered benefit under Medi-Cal. This section provides guidelines for this benefit, including, but not limited to, health risk appraisals, follow-up appointments with health care professionals to review findings of the appraisal, and incentives and rewards to engage individuals in their health. Implementing the program is contingent on DHCS seeking and obtaining federal financial participation and federal approvals, including any required state plan amendment or waiver.

Section 75 establishes the Comprehensive Diabetes Services Program to provide screening programs, lifestyle coaching and regular and timely lab tests to selected Medi-Cal beneficiaries. The program will only be implemented if state funds are allocated annually and if federal financial participation is available. CDHS must collect data to see if the

program improves health outcomes and saves money.

Section 76 establishes the Medi-Cal Hospital Stabilization Act and requires Medi-Cal to pay private and special district hospitals the maximum allowed under federal law. The payments would be adjusted annually by a cost escalator. The increased funds for the Medi-Cal rate increase would be generated by a 4 percent fee on hospitals. The collected fee would be matched with federal funds and paid back to hospitals in the form of a Medi-Cal rate increase. The hospitals would get a direct increase in rates for inpatient and outpatient fee-for-service Medi-Cal expansions.

In addition, Medi-Cal managed care plans would be paid more for the hospital services of those they cover, but the entire amount must be passed through to hospitals with the specific amounts subject to negotiation between the plans and the hospitals. In addition, hospitals will see an increase in revenue from coverage expansions.

The initiative provides for a new hospital fee of 4 percent of aggregate net patient revenue. According to Senate Health Committee analysis: Private and small public hospitals would pay the state approximately \$1.7 billion in fees in the first year of implementation, which would be almost doubled by obtaining federal matching funds. The total \$3.3 billion would then be paid to hospitals based on the formula in the Act. The hospitals would receive a rate increase of approximately \$1.5 billion for both inpatient and outpatient services. Six hundred million dollars would be paid to Medi-Cal managed care plans, which would pay the hospital. The specific amounts for individual hospitals are subject to negotiations between the plans and hospitals. Another \$600 million would be used for the hospital services paid for in the Medi-Cal and Healthy Families program expansions.

Public hospitals also would pay a new hospital fee. The rate increase for public hospitals would be different than for private hospitals as the state already provides the maximum funding allowed under state law. The funds raised by the fee on public hospitals would be used as general funding for ABX1 1. The state would provide a Medi-Cal rate increase for public hospitals with state funds, using state funds in lieu of local funds as the state match.

These funds would be matched with federal funds and then paid back to the hospitals, either directly or indirectly through increased payments from managed care plans and from payments for hospital services provided under the coverage expansions.

This section also requires \$25 million of the payments for public hospitals to be set aside for the Workforce Development Program Fund. This fund will be administered by the Office of Statewide Health Planning and Development (OSHPD), which will make allocations to counties exclusively for retraining health care workers in county hospital and clinic systems. Money in this fund is subject to legislative appropriation and can be rolled over for use in the following fiscal year.

The Act specifies that this section is only implemented to the extent that counties with designated public hospitals seeking reimbursement contribute toward the cost of care through a county share of cost.

Section 77 establishes the Medi-Cal Physician Services Increase Act to increase the Medi-Cal rates to physicians. The amount of the rate increase is not specified. Instead, this section would allow reimbursement to be established at a percentage of the amount paid by Medicare for the same services. The bill would also prohibit any reduction in Medi-Cal rates for physician services that are currently paid at or above the Medicare reimbursement rate. The amount of the increase in physician rates would be subject to appropriation in the annual state budget and would require obtaining federal matching funds. The bill would allow DHCS to set aside as much as 25 percent of the rate increase to be paid based on pay for performance measures.

Section 78 specifies that DHCS and MRMIB must take all reasonable steps to obtain the maximum amount of federal funds available to support the provisions in the Act.

Section 80 specifies that MRMIB may only expand Healthy Families to the extent funds are appropriated for those purposes in the annual State Budget or another statute.

Section 81 requires DHCS to work with the Department of Finance (DOF) to apply for amended federal waivers to maximize the availability of federal dollars and number of people eligible for federal cost sharing. This section provides DHCS with the flexibility to modify the Act to maximize federal funds. Specifically it may reduce eligibility for Healthy Families and Medi-Cal; increase cost sharing amounts; reduce benefits; and disadvantage applicants. Provisions of the Act are to be implemented as simultaneously as possible.

Section 82 establishes and lays out a plan to finance the Act, which is contingent on voter approval. The authors intent is for the Act to be funded by employers, individuals, federal, state and local governments, and health care providers. Specifically, (1) federal financial participation through Medicaid and S-CHIP; (2) county revenues from enrolling persons who would otherwise be eligible for county-funded care; (3) fees of 4 percent of patient revenues paid by acute care hospitals; (4) fees paid by employers; (5) premium contributions from employers and employees; (6) premium payments for individuals enrolled in publicly subsidized coverage and coverage in individual markets; (7) sales tax on cigarettes; and (8) other state funds made available through cost savings.

Section 83 requires the DOF to determine that the state has the necessary financial resources to implement the entire Act before it may go forward. The Act is to become operative the date the DOF files a finding with the Secretary of States office stating that sufficient state resources exist in the Health Care Trust Fund, the required federal approvals have been obtained, and that the required federal resources will be available.

Section 84 establishes the legislative intent for the state to develop and implement a transition plan by July 1, 2010 that will allow the state to use funding from the federal Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990 and other funding to pay for premiums and cost-sharing burdens. [See <http://hab.hrsa.gov/history.htm> for information on the CARE Act of 1990.]

Section 84.5 establishes that each provision of the Act is an integral part of health care reform and no provision should be severed from the remaining provisions. If any provision is determined to be invalid, the entire Act becomes inoperative.

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Enforcement of Arbitral Awards

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Enforcement of Arbitral Awards

By Publisher's Editorial Staff 2008

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SUMMARY: Reinsurance policies often involve parties of different nations. Most such parties prefer to submit disputes that arise under these policies to arbitrators with expertise in the type of matters under dispute, rather than to the uncertainties attendant with foreign courts and foreign laws. Among the many advantages of arbitration in the international setting is the relative ease in obtaining the enforcement of arbitral awards. This is due to uniform standards established in what is commonly known as the New York Convention, an international agreement ratified by over 140 nations. However, this commentary points out that several recent federal court decisions have allowed for non-statutory defenses and other impediment to the enforcement of foreign arbitral awards. The commentary analyzes these cases (some involving reinsurance), observing a split among the U.S. Circuit Courts on several pertinent issues. The commentary advises that this case law should be considered when drafting arbitration agreements and counseling client on the risks of international arbitration.

PDF LINK: Core Emerging Issues Commentary (\$)

ARTICLE: A large portion of reinsurance agreements involve international parties. When disputes arise under these agreements, they may be governed by complex and varied foreign laws. Most companies are reluctant to rely on foreign courts and unfamiliar laws to protect their interests and prefer instead to submit their international disputes to private arbitration. Arbitration has a number of advantages over litigation, including flexibility, informality, and the opportunity to select neutral decision-makers with relevant expertise. See SIA Researchers: Positive Outlook For International Arbitration, 17-3 Mealey's Litig. Rep. Reinsurance 10 (2006).

One of the most significant advantages of arbitration in the international context is the general ease of enforceability of arbitral awards. No major multilateral treaty exists relating to enforcement of foreign judgments, and the laws governing enforcement vary widely from country to country. See Honorable Engagement Among Countries -- Enforcing Arbitral Awards Abroad, 16-4 Mealey's Litig. Rep. Reinsurance 13 (2005). By contrast, arbitral awards are enforceable in most industrialized nations pursuant to uniform standards set forth in the Convention on the Recognition and Enforcement of Foreign Arbitral Awards of June 10, 1958, 21 U.S.T. 2517 (U.S.T. 1970) (the New York Convention). The Convention is considered a foundation instrument of international arbitration, and has been successful in achieving widespread uniformity in enforcement of arbitral awards around the world. See

United Nations Commission on International Trade Law, 1958 -- Convention on the Recognition and Enforcement of Foreign Arbitral Awards -- the "New York" Convention,
http://www.uncitral.org/uncitral/en/uncitral_texts/arbitration/NYConvention.html.

Complete uniformity has not been achieved, however, as demonstrated by several recent federal court decisions recognizing non-statutory defenses and other obstacles to enforcement of foreign arbitral awards. These decisions are significant, in that they reduce the finality of foreign arbitral awards and ultimately impact the cost, complexity, and reliability of international arbitrations.

Practice Insight: Corporate counsel need to be aware that their clients may face unexpected challenges in obtaining enforcement of foreign arbitral awards in the United States. These case law trends should be considered when drafting arbitration agreements and counseling clients on the risks of international arbitration.

Part One of this Article discusses the legal framework for enforcement of awards under the Convention, including the Convention's general provisions requiring enforcement of foreign arbitral awards, the exclusive statutory defenses to enforcement, and implementation of the Convention in the United States.

Part Two of this Article examines current legal issues in the judicial enforcement of foreign arbitral awards under the Convention and the practical implications of these issues. The decisions discussed in Part Two include a United States Circuit Court split concerning the applicability of domestic common law defenses to awards covered by the Convention but rendered in the United States, the use of personal jurisdiction and venue as defenses to enforcement and the treatment of annulled foreign arbitral awards.

PART ONE: THE NEW YORK CONVENTION

The New York Convention is considered one of the most successful treaties governing international commercial law. As of January 2007, it had been ratified by over 140 countries, including all of the world's major economies. The primary purposes of the Convention are to promote arbitration and establish uniform standards for enforcement and recognition of international arbitration agreements and awards. *See Scherk v. Alberto-Culver Co.*, 417 U.S. 506 (U.S. 1974).

In furtherance of these purposes, signatories agree to enforce international arbitral awards, according to the procedural laws of the enforcing country, unless one of seven specific defenses set forth in the Convention is established. *See* Article V of the Convention. Those defenses are:

1. (a) The parties to the agreement were, under the law applicable to them, under some incapacity, or the said agreement is not valid under the law to which the parties have subjected it or, failing any indication thereon, under the law of the country where the award was made; or
- (b) The party against whom the award is invoked was not given proper notice of the appointment of the arbitrator or of the arbitration proceedings or was otherwise unable to present his case; or
- (c) The award deals with a difference not contemplated by or not falling within the terms of the submission to arbitration, or it contains decisions on matters beyond the scope of the submission to arbitration, provided that, if the decisions on matters submitted to arbitration can be separated from those not so submitted, that part of the award which contains decisions on matters submitted to arbitration may be recognized and enforced; or
- (d) The composition of the arbitral authority or the arbitral procedure was not in accordance with the agreement of the parties, or, failing such agreement, was not in accordance with the law of the country where the arbitration took place; or

(e) The award has not yet become binding on the parties, or has been set aside or suspended by a competent authority of the country in which, or under the law of which, that award was made.

2. (a) The subject matter of the difference is not capable of settlement by arbitration under the law of that country; or

(b) The recognition or enforcement of the award would be contrary to the public policy of that country.

Because the Conventions "basic thrust [is] to liberalize procedures for enforcing foreign arbitral awards," courts have construed these statutory defenses very narrowly. *Karaha Bodas Co., L.L.C. v. Perusahaan Pertambangan Minyak Dan Gas Bumi Negara*, 190 F. Supp. 2d 936 (D. Tex. 2001) (citing *Parsons & Whittemore Overseas Co. v. Societe Generale de L'Industrie du Papier (RAKTA)*, 508 F.2d 969 (2d Cir. 1974)).

The Convention is implemented in the United States through Chapter 2 of the Federal Arbitration Act, 9 USCS § 1 et seq., and has broad application. Pursuant to § 202 of the Act, any agreement or award arising out of a legal relationship that is commercial in nature and involves a foreign party, relates to foreign property, or has some other reasonable relation to one or more foreign states falls under the Convention. An award falling under the Convention must be confirmed, upon application of a party within three years of the award, if none of the defenses enumerated in the Convention are established. § 207. The domestic provisions of the Federal Arbitration Act, contained in Chapter 1, also apply to foreign arbitral awards to the extent they do not conflict with the Convention or Chapter 2 of the Act. § 208.

Although the Convention purports to establish uniform standards for enforcement of arbitral awards, the case law trends discussed in Part Two illustrate that parties seeking enforcement of awards still face challenges.

PART TWO: CURRENT ISSUES IN ENFORCEMENT

Domestic Common Law Defenses to Arbitral Awards

Currently, there is a split among the United States Circuit Courts concerning whether non-domestic arbitral awards, i.e., awards that were rendered within the United States but that fall within the Conventions coverage due to a foreign connection, are subject to review under domestic common law standards, such as manifest disregard for the law and arbitrary and capricious. It had been well established that the statutory defenses are the exclusive grounds for relief from enforcement of a foreign arbitral award issued in another country. A number of federal courts have held, however, that non-domestic arbitral awards are subject to these common law defenses and all other defenses available under the Federal Arbitration Act.

The Second Circuit Court of Appeals was the forerunner among these courts, holding in the 1997 case *Yusuf Ahmed Alghanim & Sons, W.L.L. v. Toys "R" Us, Inc.*, 126 F.3d 15 (2d Cir. 1997) that domestic law applies to non-domestic arbitral awards. The parties in *Alghanim*, a domestic licensor and a Kuwaiti licensee, entered into arbitration before the American Arbitration Association to resolve a licensing dispute. The arbitrators found in favor of the licensee, which petitioned the trial court to confirm the arbitrators award. The trial court confirmed the award, and the Second Circuit affirmed. Citing Article V(1)(e), regarding awards that have been set aside in the forum country, the court noted that [t]he Convention specifically contemplates that the state in which, or under the law of which, the award is made, will be free to set aside or modify an award in accordance with its domestic arbitral law and its full panoply of express and implied grounds for relief. *Alghanim*, 126 F.3d at 23. Turning to the licensors domestic defense, the court concluded that in this case the licensor had not established that the arbitrators acted in manifest disregard of New York law or the parties agreement.

The Second Circuit reaffirmed this position recently in *Zeiler v. Deitsch*, 500 F.3d 157 (2d Cir. 2007). The award in

Zeiler resulted from an arbitration that took place in New York but that involved Israeli parties and property and Jewish law. The court, relying on the rationale in *Alghanim*, held that the trial court should have applied domestic arbitral law in reviewing the award, although it further held that domestic law would not have controlled the outcome as a practical matter.

Joining the Second Circuit and following *Alghanim*, the Sixth Circuit held in *Jacada, Ltd. v. Int'l Mktg. Strategies, Inc.*, 401 F.3d 701 (6th Cir. 2005) that domestic law applied in determining whether to vacate an award rendered in the United States against a British corporation. The Fifth Circuit and the District of Columbia Circuit have also indicated that they would follow *Alghanim* and recognize domestic defenses as grounds to refuse enforcement of non-domestic arbitral awards. *Termorio S.A. E.S.P. v. Electranta S.P.*, 376 U.S. App. D.C. 242 (D.C. Cir. 2007) (discussing arbitral award rendered in Colombia); *Karaha Bodas Co., L.L.C. v. Perusahaan Pertambangan Minyak Dan Gas Bumi Negara*, 364 F.3d 274 (5th Cir. 2004) (discussing arbitral award rendered in Switzerland).

The Eleventh Circuit has taken a contrary view, holding that awards covered by the Convention may be challenged only on the grounds set forth in Article V of the Convention. The award in *Industrial Risk Insurers v. M.A.N. Gutehoffnungshutte GmbH*, 141 F.3d 1434 (11th Cir. 1998) was rendered by a Florida arbitration panel in favor of a German manufacturer and against a domestic company in a complex commercial dispute involving business risk insurance. The domestic company filed a motion to have the award vacated, arguing that it was arbitrary and capricious. The trial court denied the motion, and the Eleventh Circuit affirmed. Strictly construing the language of Article V of the Convention, the court held its list of defenses was exclusive and therefore concluded that no defense against enforcement of an international arbitral award under Chapter 2 of the [Federal Arbitration Act] is available on the ground that the award is arbitrary and capricious, or on any other grounds not specified by the Convention. *Industrial Risk Insurers*, 141 F.3d at 1446.

The Eleventh Circuit applied the same reasoning in *Four Seasons Hotels & Resorts v. Consorcio Barr S.A.*, 377 F.3d 1164 (11th Cir. 2004), holding that non-statutory defenses were not to be entertained in an action to enforce an award rendered in Florida involving a domestic company and a Venezuelan company.

Although the other Circuits apparently have not yet ruled on the issue, a federal trial court in the Ninth Circuit considering the issue expressly rejected the reasoning of *Alghanim* and adopted the reasoning of *Industrial Risk Insurers*. *Woodchem v. D.B. W., Inc.*, 2001 U.S. Dist. LEXIS 25290 (D. Or. 2001).

Practice Insight: The practical implications of this unsettled issue are significant. Parties relying on arbitration in international disputes need to be aware that in many federal courts, non-domestic arbitral awards are subject to review on the merits. Counsel should consider reducing the risk of unpredictable judicial interpretations of the law by including governing law provisions within arbitration agreements and provisions limiting judicial review on the merits. These decisions also illustrate the importance of the place of arbitration whether it takes place abroad or within the United States and careful consideration should be given to forum selection clauses in arbitration agreements.

Jurisdiction and Venue Defenses

Enforcement of foreign arbitral awards that may otherwise be valid under the Convention has also been denied on personal jurisdiction and *forum non conveniens* grounds.

The Fourth Circuit refused enforcement of an arbitral award for lack of personal jurisdiction in *Base Metal Trading v. Ojsc Novokuznetsky Aluminum Factory*, 283 F.3d 208 (4th Cir. 2002). The arbitration in *Base Metal* took place in Russia and involved a dispute between a Guernsey, Channel Island corporation and a Russian corporation over dealings in aluminum materials. The Channel Island corporation, which prevailed in the arbitration, brought a confirmation proceeding in Maryland, based on the arrival of a shipment of the Russian company's aluminum products in Baltimore Harbor. The trial court dismissed the proceeding for lack of personal jurisdiction, and the Fourth Circuit affirmed. The

court explained that while the Convention conferred subject matter jurisdiction on the courts, the constitutional requirement of personal jurisdiction still had to be met. The court found that the Russian Company's single shipment to Maryland was too minimum a contact to support a finding of personal jurisdiction.

In a reinsurance case, *Monegasque De Reassurances S.A.M. (monde Re) v. Nak Naftogaz of Ukr.*, 311 F.3d 488 (2d Cir. 2002), the Second Circuit upheld the application of the *forum non conveniens* doctrine to an award covered by the Convention. The underlying dispute in *Monegasque* was an alleged breach of contract between two natural gas companies, one from Russia and one from Ukraine. A Monaco reinsurer, which ultimately had to pay for the loss, instituted arbitration in Russia against the Ukraine company and obtained an award. The award was confirmed by a Russian court. In the reinsurer's action to confirm the award in the United States, however, the Ukraine company successfully argued *forum non conveniens*. On appeal, the Second Circuit affirmed. Relying on the Convention's provisions that the forum country's procedural laws apply, the court concluded that the doctrine of *forum non conveniens* barred the action. The court explained that the parties and their transactions had no connection to the forum other than that the United States was a signatory to the Convention.

The District of Columbia Circuit also recently applied personal jurisdiction and *forum non conveniens* defenses to an international arbitral award, ultimately concluding that the defenses were not established. See *TMR Energy Ltd. v. State Prop. Fund of Ukr.*, 366 U.S. App. D.C. 320 (D.C. Cir. 2005); but see *TermoRio S.A. E.S.P. v. Electrificadora Del Atlantico S.A. E.S.P.*, 421 F. Supp. 2d 87, 89 (D.D.C. 2006), *affd*, 376 U.S. App. D.C. 242 (D.C. Cir. 2007) (dismissing an action to confirm a Colombian arbitration award on the merits and on the alternative ground that Columbia was the more appropriate forum).

It is questionable whether applying a forum's jurisdiction and venue rules as procedural rules to bar enforcement is consistent with the purposes of the Convention. Personal jurisdiction and venue rules may vary greatly from country to country, and they are not specifically listed as defenses in Article V of the Convention. In any event, these decisions state the law currently, at least in some Circuits, and counsel should consider reducing the risk of an unpredictable outcome by using forum selection and consent-to-jurisdiction clauses in arbitration agreements.

Annulled Awards

Another class of unenforceable foreign arbitral awards is those that have been set aside by authority in the forum country.

Both the Second Circuit and the District of Columbia Circuit have refused to confirm annulled foreign arbitral awards. In an early case addressing this issue, *Baker Marine, Ltd. v. Chevron, Ltd.*, 191 F.3d 194 (2d Cir. 1999), a trial court denied enforcement of a Nigerian arbitral award that had been annulled by a Nigerian court. The Second Circuit affirmed, relying on the provision in Article V(1)(e) recognizing the defense that an award has been set aside by an authority in the forum country.

A trial court likewise denied enforcement of a Colombian arbitral award recently in *Termorio S.A. E.S.P. v. Electranta S.P.*, 376 U.S. App. D.C. 242 (D.C. Cir. 2007) on the ground that the award had been annulled by Colombia's highest court as violative of Colombian law. The District of Columbia affirmed, holding that because the record did not indicate that the proceedings in the Colombian court were tainted or not authentic, the court had to respect the award pursuant to the Convention.

These cases appear to conflict with the District of Columbia's decision in *Chromalloy Aeroservices v. Arab Republic*, 939 F. Supp. 907 (D.D.C. 1996), which upheld an Egyptian arbitral award, despite its annulment by an Egyptian court, based on the United States' strong public policy in favor of arbitration. The *Baker* court distinguished *Chromalloy* in part on the ground that the arbitration agreement in the latter case precluded either party from appealing the arbitrator's decision.

Even if the more recent decisions in *Baker Marine* and *Termorio* are technically correct, insofar as the Convention recognizes a forum country's jurisdiction to set aside domestic awards under its laws, they create a number of practical and legal issues that may not have been anticipated. For example, it is unclear what effect annulment by a court in the forum nation may have if the award was first confirmed in the United States. It is also unclear what standards courts will use in determining whether the foreign court proceedings were tainted or authentic. These cases provide an additional reason for counsel to consider provisions limiting judicial review of arbitral awards.

CONCLUSION

Arbitration is the favored method of dispute resolution in international commercial disputes because of its many advantages over litigating in foreign courts. While the Convention has made enforcement of foreign arbitral awards relatively easy, as compared to enforcement of foreign judgments, it is important to understand that it is not hurdle-free.

Practice Insight: Corporate counsel should be aware of the anti-enforcement trends in the federal courts and should incorporate this information into their practice strategies in order to better serve clients engaged in international business.

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Stempel on N.Y. Embraces Consequential Damages in Bad Faith Claims

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New York Embraces Consequential Damages as a Remedy in Insurance Bad Faith Claims

By Jeffrey Stemple

March 13, 2008

SUMMARY: New York has historically been a friendly jurisdiction for insurers facing bad faith claims. It still is. But in a pair of late February 2008 decisions, *Bi-Economy Market, Inc. v. Harleysville Insurance* and *Panasia Estates v. Hudson Insurance*, the New York Court of Appeals, the states highest court, added a significant weapon to the arsenal of policyholders making bad faith claims. Taken together, these decisions permit policyholders, upon a showing of bad faith in refusing or delaying payment, to seek consequential damages flowing from the insurers failure to make timely, full payment under the policy.

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ARTICLE: In a pair of recent decisions, the New York Court of Appeals, normally a court embraced by insurers (New York law is frequently the choice of insurers in drafting dispute resolution and choice-of-law clauses in policies), ruled that under apt circumstances, policyholders may seek not only payment of policy proceeds from insurers but also pursue consequential damages in cases where the insurer has acted in bad faith toward the policyholder. *See Bi-Economy Market, Inc. v. Harleysville Insurance Co. of New York*, 2008 NY Slip Op 1418, 2008 N.Y. LEXIS 278 (N.Y. Feb. 19, 2008); *Panasia Estates, Inc. v. Hudson Ins. Co.*, 2008 NY Slip Op 1419, 2008 N.Y. LEXIS 275 (N.Y. Feb. 19, 2008). *See also* Lexis Insurance Law Center Insider Perspective (Comments of Jeffrey L. Kingsley, Esq., Feb. 25, 2008). Reading the reaction of the two judges dissenting from the Courts two 5-2 majority opinions, one might mistakenly get the impression that the insurance world was coming to an abrupt end and that the Court had massively deviated from traditional contract principles. On balance, however, the Court majority opinions appears completely consistent with traditional non-insurance contract law and hardly spell doom for insurers.

What makes both *Bi-Economy* and *Panasia* noteworthy is that they are a significant expansion of New York insurance law that has arguably been too protective of insurers. Even after these decisions, New York law remains distinctly less favorable to policyholder than the bad faith law of most states, which treats bad faith breach of an insurance policy as a tort that gives rises to the full array of tort damages, including potential punitive damages. By contrast, even after *Bi-Economy* and *Panasia*, New York appears to subject insurers to the risk of punitive damages only if they commit independent torts other than bad faith (e.g., fraud, conversion, defamation) against a policyholder. The emerging new regime in New York makes it look more like states that treat first-party insurance bad faith claims as a type of contract claim rather than a tort claim). *See, e.g., Beck v. Farmers Ins. Exch.*, 701 P.2d 795 (Utah 1985)

(however, Utah, like most states, treats bad faith by a third-party insurer as a tort).

If adhered to and applied logically in the future, the two decisions arguably presage a regime in which the economic playing field formerly tilted in favor of insurers in coverage litigation, will be closer to level for a wide range of insurance products but remains more protective of insurers than the law of most states. Insurers will undoubtedly attempt to turn back these decisions and their implicit tide. In response, policyholders will undoubtedly argue that the decisions are correct and that for too long, insurers in New York, who are supposed to have fiduciary-like duties beyond those of ordinary contracting parties, have largely been immunized in most bad faith cases from paying anything beyond the policy limits even where they have acted unreasonably in breaching the insurance contract.

To the extent these decisions usher in a new era in New York, there is a silver lining for insurers: a sufficiently compensatory regime of consequential damages, prejudgment interest, and attorney fee awards may as a practical matter supplant the efforts of aggrieved policyholders to style matters as punitive damages claims, reducing some of the pressure insurers undoubtedly feel from these types of claims notwithstanding the punitive-damage dampening effects of *State Farm Mut. Auto. Ins. Co. v. Campbell*, 538 U.S. 408 (2003), which set a presumptive cap of nine times compensatory damages in cases with substantial harm to policyholders.

Bi-Economy v. Harleysville

In *Bi-Economy*, a Rochester, New York meat market suffered a severe fire, resulting in the complete loss of food inventory and heavy structural damage to the building and business related equipment. Bi-Economy had commercial property insurance with Harleysville, including business interruption coverage and replacement cost coverage on the building and its contents in what was styled as a Deluxe Business Owners policy. Under the terms of the coverage, the insurer was obligated to pay the actual loss of business income resulting from the necessary suspension of the policyholders operations as during a period of restoration necessitated by a covered property loss. In addition, the policy covered continuing normal operating expenses incurred, including payroll. As is typical in such policies, the period of restoration was defined as beginning with the date of the physical property loss necessary to trigger coverage and ending on the dates when the property should be repaired, rebuilt or replaced with reasonable speed and similar quality. See 2008 N.Y. LEXIS 278, at *1-3.

Bi-Economy submitted a claim. Harleysville disputed it and was willing to advance a little over \$163,000 to the policyholder in the early aftermath of the fire and cessation of business operations. More than a year later, after resolution pursuant to the policy's ADR clause, Bi-Economy was awarded more than \$407,000. During the pendency of the dispute resolution, Harleysville offered to pay only seven months of . . . lost business income, despite the fact that the policy provided for a full twelve months of such coverage. See 2008 N.Y. LEXIS 278, at *3. The family-owned meat market went out of business and never resumed operations. It sued its insurer, alleging that as a result of Harleysville's breach of the policy and bad faith performance the business collapsed. In addition to seeking the full award of business interruption benefits available under the policy, Bi-Economy also sought consequential damages arising from the business's demise that allegedly resulting from the foot-dragging and resistance of Harleysville.

In response, Harleysville argued that it was not responsible for consequential damages because of the policy's consequential loss exclusion and because of the general rule that the measure of damages for breach of an insurance policy is payment of the amount of coverage owed under the policy. The argument was a winner with the trial court (counter-intuitively known as the Supreme Court in New York) and the intermediate appellate court (the Appellate Division). But Harleysville's winning streak ended before the Court of Appeals, which held that the lower court erred in dismissing its breach of contract claim seeking consequential damages for the collapse of its business resulting from [the insurers'] failure to fulfill its obligations under the contract of insurance and remanded the case for further proceedings. See 2008 N.Y. LEXIS 278, at *4.

The court reiterated the traditional rule that in breach of contract cases, the non-breaching party normally can recover general damages that are the natural and probable consequence of the breach (citing *Kenford Co. v. County of*

Erie, 73 N.Y.2d 312, 319, 537 N.E.2d 176, 540 N.Y.S.2d 1 (1989)). In addition, the non-breaching party can also seek consequential damages that do not directly flow from the breach if such damages are within the contemplation of the parties at the time of contracting. In other words, if the non-breaching party is damaged as a result of the breach for risks foreseen or which should have been foreseen at the time the contract was made, these amounts should be recoverable in a contract action if the consequential loss was foreseeable or probable (citing *Ashland Mgt. v. Janien*, 82 N.Y.2d 395, 403, 624 N.E.2d 1007, 604 N.Y.S.2d 912 (1993), *Restatement (Second) of Contracts* § 351, and *Farnsworth on Contracts* § 12.14). See 2008 N.Y. LEXIS 278, at *5-6. This basic rule of contract damages is most famously associated with the 19th Century British case *Hadley v. Baxendale*, 9 Ex. 341 [1854] which was embraced almost from its inception by American courts.

Following these traditional rules of contract damages, the Court of Appeals noted that the questions of foreseeability and probability were to be determined according to nature, purpose, and particular circumstances of the contract known by the parties . . . as well as what liability the defendant fairly may be supposed to have assumed consciously, or to have warranted the plaintiff reasonably to suppose that it assumed, when the contract was made. (quoting *Kenford Co. v. County of Erie*, 73 N.Y.2d 312, 537 N.E.2d 176, 540 N.Y.S.2d 1 (1989) and *Globe Ref. Co. v. Landa Cotton Oil Co.*, 190 U.S. 540, 544, 23 S. Ct. 754, 47 L. Ed. 1171 (1903)). See 2008 N.Y. LEXIS 278, at *6.

Under the circumstances of the Bi-Economy loss, the Court found it well within the contemplation of the parties (and the expectations of both policyholder and insurer) that an undue delay in providing business interruption insurance benefits or significant underpayment of these benefits might well result in the destruction of a relatively small, family-owned business such as Bi-Economy that purchased insurance for the purpose of protecting itself from just such circumstances and which was unlikely to have sufficient capital or cash reserves to weather this type of large loss and cessation of business in the absence of promptly receiving the full benefits of the insurance it had purchased.

The purpose served by business interruption coverage cannot be clearer to ensure that Bi-Economy had the financial support necessary to sustain its business operation in the event disaster occurred Certainly, many business policyholders, such as Bi-Economy, lack the resources to continue business operations without insurance proceedings. Accordingly, limiting an insureds damages to the amount of the policy, i.e., money which should have been paid by the insurer in the first place, plus interest, does not place the insured in the position it would have been in had the contract been performed.

* * *

Thus, the very purpose of business interruption coverage would have made Harleysville aware that if it breached its obligations under the contract to investigate in good faith and pay covered claims it would have to respond in damages to Bi-Economy for the loss of its business as a result of the breach.

* * * [T]he purpose of the contract was not just to receive money, but to receive it promptly so that in the aftermath of a calamitous event, as Bi-Economy experienced here, the business could avoid collapse and get back on its feet as soon as possible. Thus, this insurance contract included an additional performance-based component; the insurer agreed to evaluate a claim, and to do so honestly, adequately, and most importantly promptly. The insurer certainly knew that failure to perform would (a) undercut the very purpose of the agreement and (b) cause additional damages that the policy was purchased to protect against in the first place. * * * When an insured in such a situation suffers additional damages as result of an insurers excessive delay or improper denial, the insurance company should stand liable for these damages. This is not to punish the insurer, but to give the insured its bargained-for-benefit.

See 2008 N.Y. LEXIS 278, at *9-12 (citations omitted).

The court did not regard the policys limitation on payment for consequential losses as a contract provision abrogating the general rule that non-breaching parties can recover reasonably foreseeable consequential damages flowing from the breach. Consequential loss provisions in a commercial property policy often provide that the insurer

will not pay for the consequential losses flowing from non-covered initial injury but will pay for the consequences of covered property damage. (There may also be consequential loss provisions covering these types of losses even if they flow in part from an uncovered loss if covered causes are also in the mix). This limiting language in the policy cuts off a policyholders ability only to obtain damages resulting from property damage that stems from a non-covered cause even if a covered loss lies somewhere within the causal chain. It does not operate as an abrogation of the traditional *Hadley v. Baxendale* rule that foreseeable consequential damages may be obtained as a remedy for breach of the contract under appropriate circumstances hinging on the context of the contract and the understanding of the parties.

Panasia v. Hudson

In *Panasia Estates v. Hudson Ins. Co.*, the policyholder owned commercial rental property in Manhattan that was undergoing renovation covered under a Builders Risk policy. In a scene perhaps all too familiar to developers and homeowners alike, the construction crew opened the building in order to perform work and then apparently neglected to adequately protect it from the elements during construction. Inclement weather caused rain to enter the building through the roof opening, resulting in extensive damage to the property. See 2008 N.Y. LEXIS 275, at *1 (footnote omitted). Panasia gave prompt notice to its insurer, but Hudson failed to investigate or adjust the claim until several weeks later and then denied coverage three months later, claiming that the loss was the result of repeated water infiltration over time and wear and tear rather than from a covered risk.

Panasia sued seeking coverage and consequential damages, claiming that the delay and denial of its insurer elongated the renovation process, causing it to lose substantial rental income. The trial court and the Appellate Division rejected Hudsons argument that consequential damages were barred as a matter of law, certifying the matter to the Court of Appeals, which affirmed. Citing its companion decision in *Bi-Economy v. Harleysville*, the *Panasia* Court held that

consequential damages resulting from a breach of the covenant of good faith and fair dealing may be asserted in an insurance contract context, so long as the damages were within the contemplation of the parties as the probable result of a breach at the time of or prior to contracting. Here, the courts below failed to consider whether the specific damages sought by Panasia were foreseeable damages as the result of Hudsons breach. Because the record before us is not fully developed on that issue, such claim must be considered by [the trial court].

See 2008 N.Y. LEXIS 275, at *3-4, citing *Bi-Economy* and *Kenford Co.*, *supra*.

The Dissenting Judges Excessive Complaints

Judge Smith, joined by Judge Read, dissented in both cases, using essentially the same opinion for both dissents. In the main, the dissent argued that consequential damages are simply another form of punitive damages and that consequential/punitive damages are a bad idea that unnecessarily increases the cost of insurance. Left begging was the question of whether stronger remedies for policyholders really do translate into significant premium increases in a pricing world dominated by the underwriting cycle and changing investment performance. Also unaddressed was the core policy question of whether higher premium prices (if they are the inevitable result of full compensation for policyholders) are simply a fair price to pay to provide greater incentives to insurers to honor their policies and eschew opportunistic behavior. Although stronger remedies for policyholders cannot ensure that insurance is properly paid to policyholders, they at least provide greater incentive to avoid self-dealing, needless delay, and excessive frugality in adjusting claims or interpreting policies.

The dissent started conventionally enough, by correctly noting that punitive damages against an insurer are not available for mere breach of an insurance policy but can be awarded only if there is also egregious tortious conduct toward the policyholder and a pattern of similar conduct directed at the public generally. See 2008 LEXIS 275, at *4-5, citing *Rocanova v. Equitable Life Assur. Socy*, 83 N.Y.2d 603, 634 N.E.2d 940, 612 N.Y.S.2d 339 (1994) and *New York Univ. v. Continental Ins. Co.*, 87 N.Y.2d 308, 662 N.E.2d 763, 639 N.Y.S.2d 283 (1995). In addition, New York law requires an independent tort (not mere bad faith breach of the policy). Consequently, a policyholder like *Bi-Economy* or

Panasia can get punitive damages only if the insurer has also committed fraud or another tort against the policyholder no matter how much an insurers conduct in adjusting claims might reflect a pattern of egregious misconduct toward the public.

Unfortunately, the dissent conflates punitive damages with consequential damages in a manner that is without support in contract, tort, or insurance law. According to the dissent, *Bi-Economy* and *Panasia* improperly relabeled punitive damages so that [p]unitive damages are now called consequential damages, and a bad faith failure to pay a claim is called a breach of the covenant of good faith and fair dealing. See 2008 LEXIS 275, at *5. But notwithstanding the dissenters characterization, the substantive law of torts, contracts, and remedies has long and consistently distinguished punitive and consequential damages and the *Bi-Economy* and *Panasia* majorities are consistent with this historical understanding.

As most lawyers and judges learned during first-year contracts, a mere breach of contract, even if intentional, will not give rise to punitive damages unless the breach is accompanied by an independent tort (e.g., conversion, tortious interference, defamation, etc.). Insurance contracts are different because in this area of the law the covenant of good faith implied in every contract is taken more seriously and because policyholders, having already parted with premium dollars and a chance to buy coverage from another insurer, are highly dependent on the insurers reasonable, good faith performance of the policy/contract. As a result, most states treat bad faith breach as an independent tort that may give rise to tort damages, which are generally broader in scope than contract damages. For example, a policyholder victimized by insurer bad faith may be able to recover damages for mental anguish while the victim of non-insurance contract breach ordinarily can get such damages only if she also satisfies the elements of the independent tort of intentional infliction of emotional distress or an analogous cause of action.

And to perhaps state the obvious, consequential damages are different from punitive damages. Consequential damages are calculated based on actual losses a policyholder suffers as a proximate result of the insurers breach and in New York only a bad faith breach will give the policyholder a right to seek consequential damages. For example, the Bi-Economy meat market alleged that it failed because its capacity to operate was destroyed by fire and it was unable to rebuild, keep continuity, and retain business without the promised full insurance coverage that never came. It not only suffered the physical damage of the fire but also the consequential damage of lost business and failure. Panasia alleged that it not only suffered physical injury to its building as a result of contractor negligence and water intrusion but also that the insurers failure to provide coverage lengthened the time the building was out of service and unable to bring in rental revenue. These are classic consequential damages and bear no relation to punitive damages.

Punitive damages, by contrast, are not calculated based on any loss suffered by the policyholder but instead are set at an amount designed (however imperfectly by a jury) to punish the insurer for its egregious misconduct and to deter the insurer and others like it from engaging in such conduct in the future. States have developed an array of factors to consider in calculating a fair punitive damage award, including the wrongfulness of the misconduct, the wealth of the defendant, and the defendants history of such misbehavior and awareness of its conduct. The impact on the policyholder has an indirect influence in that some states consider the impact on the victims in calculating the limits of a punitive award and also require that punitive damages bear a reasonable relationship to compensatory damages.

In the aftermath of *BMW v. Gore*, 517 U.S. 559 (1996), *State Farm v. Campbell*, 123 S. Ct. 1513 (2003), and *Philip Morris USA v. Williams*, 127 S. Ct. 1057 (2007), there now is federal constitutional law setting some out limits on punitive awards based on the (1) reprehensibility of defendants conduct; (2) the relation of a punitive award to the compensatory damages awarded; and (3) the punitive awards relation to state fines and other punishments. Of these factors, only No. 2, the proportionality prong, bears any relation to the injuries incurred by the policyholder or other non-breaching contract party. In *Campbell*, the U.S. Supreme Court in essence set a 9:1 presumptive outer limit on punitive damages, at least in cases where compensatory damages are substantial (post-*Campbell* cases have occasionally permitted much higher ratios (e.g., 75:1) where the amount of compensatory damages was slight on the theory that adhering to the 9:1 ratio in such cases would provide insufficient deterrence to defendants.

The dissent attempts in part to make its strained punitive-consequential connection because *Bi-Economy* and *Panasia* permit awards of consequential damages not simply by a breach of contract, but only by a breach committed in bad faith. See

2008 N.Y. LEXIS 275, at *6. But one might legitimately ask what the dissent is complaining about? The rule set forth in *Bi-Economy* and *Panasia* is still highly protective of insurers and gives them more rights than ordinary contracting parties. Under these decisions, insurers appear to face the risk of consequential damages only if they act in bad faith in denying, delaying, or undervaluing a claim. Would the dissent rather that consequential damages routinely be available for innocent or negligent breaches by an insurer?

The dissent also makes another doctrinal and historical error by arguing that consequential damages are only available in cases where the contract in question involved more than merely a promise to pay money. This is incorrect. For example, consider a bank that extends a letter of credit, which is merely the promise for the payment of money upon proper demand. The borrower acts in reliance on the bank's promise and expends money, time, and effort setting up or expanding a business. If the bank breaches the agreement and fails to provide the promised funds, the borrower of course may pursue not only the amount of the loan but also any consequential damages (e.g., landlord or supplier penalties) as long as the borrower demonstrates that these sorts of losses were foreseeable to the lender. The dissent attempts to manufacture a distinction in the case law (money-vs.-performance) that does not exist as a matter of history or logic.

The dissent also argues that consequential damages are improper in insurance matters because in insurance contracts or other contracts for the payment of money, the parties have already told us what damages they contemplated; in the case of insurance, it is payment equal to the losses covered by the policy, up to the policy limits. See 2008 N.Y. LEXIS 275, at *7. Again, the simple example above of a borrower stiffed on a loan or letter of credit by a bank belies this assertion, as do the situations faced by the policyholders in *Bi-Economy* and *Panasia*. The dissent confuses insurance policy limits with a liquidated damages clause. They are not the same thing. For example, in a property insurance policy, the policy limits are the most the insurer will pay for coverage of an insured risk. But any injury inflicted on policyholders due to contract breach or tortious conduct logically are neither determined by nor limited to the policy limits.

According to the dissent, punitive damages can do serious harm and exact too great a cost in that they force insurers to overpay out of fear that juries will see even legitimate claim denial as insurer bad faith. See 2008 N.Y. LEXIS 275, at *5. The dissent's fear is overblown. Without doubt, juries overly sympathetic to policyholders are a constant concern for insurers. But conversely, policyholders must constantly fear jurors who fear increases in their own premiums, who see policyholders as greedy opportunists, or who simply misunderstand the nature of various insurance products or insurer duties.

There may indeed be a balance of terror in modern coverage and bad faith litigation. But the important point is that it is a balance. In my experience, for every jury too quick to second-guess an insurer is another jury insensitive to situations where an insurer sacrifices policyholder interests in favor of its own. The dissent sees it differently (2008 N.Y. LEXIS 275, at *9-11) but it cites no empirical evidence in support of its view that jurors are putty in the hands of policyholder counsel. This is a pretty weak reed for arguing that insurers should not be subject to something approximating the ordinary rules of contract law damages. If insurers are to be immunized or subjected to only limited damages on public policy grounds, the burden of persuasion should be on insurers who wish not to be held to the ordinary rules of contract remedies.

The dissent also does nothing to distinguish insurance cases from ordinary contract cases, although the judicial system has allowed jurors (subject to judicial supervision) to make consequential damage determinations in the latter for roughly 250 years. The same jurors the dissent finds too ignorant to make consequential damage determinations in insurance cases are permitted to do so in all manner of complex business cases involving alleged breach and incurrence of consequential damages. One might thus ask rhetorically: how can it then be so bad for juries to determine consequential damages in cases involving delayed renovation of buildings or the consequences of a devastating fire at a

meat market?

Further, the dissent fails to appreciate how protective the *Bi-Economy* and *Panasia* decisions are for insurers and how insurers continue to have it better, at least as regards consequential damages, than most contracting parties. To get consequential damages against an insurer, the policyholder must show not only injury within the contemplation of the parties but also bad faith conduct. To get consequential damages from any other entity with which it contracts, a policyholder need only show injury within the contemplation of the parties.

The dissent also fails to appreciate the practicalities of potential policyholder claims for consequential damages. Although the theory of both contract remedies and insurance indemnification is that one can be made whole through litigation, any sane person with some experience with the legal system knows that one is seldom fully compensated in a contract/insurance policy suit at least not if one calculates the lost time and opportunity cost, which one seldom recoups through a judgment under even the most liberal rules of contract remedies. In addition, the economics of litigation argue against bringing small claims (with small increasingly being defined upward). Even in jurisdictions that have substantial prejudgment interest and fee-shifting in favor of the prevailing party, sensible people don't sue if they don't have to.

The Likely Practical Limitations of the Decisions

Applied to losses a policyholder incurs because of insurer sluggishness in responding to a claim or chiseling behavior regarding claim value, the rational policyholder will usually simply lump such behavior as long as it receives basic out-of-pocket indemnity pursuant to the policy and receives enough of it fast enough to avoid substantial injury. Unless the policyholder incurs substantial consequential damage from insurer breach, the rational policyholder will probably correctly conclude that it is better off foregoing litigation if it can simply get what it is owed under a policy's scope of coverage for tangible property damage or business interruption payments that are close enough to adequate and that come soon enough so that the business is not imperiled even if it is inconvenienced.

Only in cases like *Bi-Economy* or *Panasia*, where the insurer failures are substantial and the harm to the policyholder is substantial will a rational policyholder be likely to bring consequential damages claims if the insurer is smart enough to pay roughly what it owes for property damage within a time frame that is not egregiously tardy. The case report does not reflect the magnitude of Panasia's rent loss, but it logically was substantial. And *Bi-Economy* lost everything. The dissents' fears of a flood of increased litigation simply because New York now is somewhat more receptive to consequential damage claims against insurers are probably overblown.

Although proving up foreseeability in order to obtain a consequential damages award may not be easy, it will be easier in many cases than proving up independent torts such as fraud and willful, wanton, reprehensible conduct by the insurer (directed at both policyholder and the public) which must be shown by the higher standard of clear and convincing evidence rather than a mere preponderance of the evidence. In addition, the de facto capping of punitives by *BMW v. Gore* and *Campbell* makes punitive damages less attractive to seek vis-à-vis compensatory damages. Policyholders and counsel may well conclude that it makes more sense to invest litigation resources pursuing consequential damages rather than chasing a punitive damages rainbow. To the extent this occurs, insurers may find themselves with a more predictable and calculable inventory of claims against them than existed prior to *Bi-Economy* and *Panasia*.

Future Issues and Arguments

Left undecided by these cases and awaiting further examination is the degree to which consequential damages will be available as a practical matter in different insurance contexts. *Bi-Economy* involved business interruption coverage while *Panasia* involved a builders risk policy. In both cases, the majority found it relatively easy to see how failing to pay business interruption benefits could imperil the survival of a business and how delay in covering destruction of a building under renovation could cost the policyholder rental income. But what about an all-risk property policy, a homeowners policy, an auto policy, a jewelers block policy, or various liability policies? Policyholder counsel can

argue with some force that in these contexts as well the parties are aware that the insured can easily suffer additional injury when there is unreasonable and significant refusal to pay, underpayment or delay, which may force the policyholder to incur the costs of substitute housing, or transportation.

For basic physical injury to tangible business property, even in the absence of business interruption coverage, it would seem to flow from *Bi-Economy* that the business could be damaged where an insurer fails to pay policy proceeds owed. Liability policies created different issues but policyholders would also seem to have a strong argument that the potential adverse consequences of litigation when an insurer wrongfully fails to defend or settle a claim are known to the parties at the time insurance is purchased. In turn, *Bi-Economy* and *Panasia* may lead to enhanced consequential damages remedies in the liability insurance arena as well.

In response to such arguments, insurer counsel will argue that the business interruption coverage of a small family business and the builders risk coverage for a major commercial property renovation presented particularly strong cases to alleging the reasonable foreseeability of damages and permitting a consequential damages claim. Insurers should be sure to emphasize that *Bi-Economy* and *Panasia* did not enter judgment for the policyholders but merely allowed consequential damages claims to proceed. Whether those claims are persuasive and supported by the evidence are separate questions. Most important, even if the policyholder suffered great consequential damages, these decisions only permit recovery if there was also insurer bad faith.

There is, of course, the question of whether New York might eventually conclude that consequential damages should be available even in the absence of insurer bad faith. The bad faith prerequisite is at odds with basic contract law and makes even less sense for insurance matters because of the insurers heightened duties to policyholders as compared to those of ordinary contracting parties. But New York has a long history of being hesitant to expand policyholder remedies against insurers. In the face of two heatedly dissenting votes, the Court of Appeals is unlikely to expand the potential reach of *Bi-Economy* and *Panasia* in the near future. But the logic of permitting consequential damages against an insurer on the same basis as against other contract-breaching parties is sufficiently strong that one might expect to see the argument in future policyholder briefs. However, the bad faith prerequisite to consequential damages against insurers is completely understandable considering the historical evolution of insurance litigation and remedies in New York. Having leveled the playing field a bit between insurers and policyholders, the Court of Appeals is unlikely to go farther for policyholders in the near future.

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Shidlofsky on Excess Underwriters v. Franks Casing

2008 Emerging Issues 1999

Shidlofsky on Excess Underwriters v. Franks Casing

By Lee H. Shidlofsky

March 6, 2008

SUMMARY: One pressing issue in insurance law is the extent to which an insurer has the right to seek reimbursement from its insured of defense costs and/or indemnity payments when it ultimately is determined that no coverage exists. A divided Supreme Court of Texas reversed its earlier decision and concluded that no such right exists. In doing so, the Court signaled the end of the right of recoupment by an insurer against its insured in Texas.

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ARTICLE: *Matagorda County--the first step on the way to *Franks Casing.** In 1993, three prisoners sued Matagorda County (and Sheriff Keith Gilgore) in federal court for damages arising out of assaults that occurred while they were incarcerated in the Matagorda County jail. [See *Matagorda County v. Tex. Assn of Counties County Govt Risk Mgmt. Pool*, 975 S.W.2d 782 (Tex. App.--Corpus Christi 1998, pet. granted).] Matagorda County tendered the defense of the claim to the Texas Association of Counties County Government Risk Management Pool (TAC), its law enforcement liability insurer. TAC contended that coverage was precluded because the county's policy included an exclusion for claims arising out of jail. Although it initially denied coverage, TAC ultimately defended Matagorda County under a reservation of rights, while also filing a declaratory judgment action seeking a declaration of no coverage under the policy.

In 1995, TAC was provided an offer to settle the underlying lawsuit for \$300,000, which was within policy limits. Although the county believed the offer was reasonable, its belief that the claim was covered caused it to refuse to fund the settlement. Thereafter, TAC issued a second letter reserving its rights. Therein, TAC informed Matagorda County that it was going to accept the settlement offer and later seek reimbursement of the full settlement amount, provided that the declaratory judgment action established that TAC was right and that the prisoners' claim was excluded from coverage. The county ignored TAC's letter. TAC settled the lawsuit as promised, and then amended its declaratory judgment action, requesting reimbursement of its defense and settlement costs.

At trial in the declaratory judgment action, the court granted TAC's partial summary judgment, finding that the jail exclusion precluded coverage for the prisoners' lawsuit. Trial proceeded on various defenses asserted by Matagorda County, and the jury returned a verdict finding that the county had accepted the jail exclusion and that it was estopped from claiming that it was unaware of its presence. Based on the verdict, the court awarded TAC its \$300,000 settlement payment and \$53,522.15 in attorneys' fees, which TAC paid in defense of the prisoners' lawsuit.

The county appealed, arguing that TAC had no right to reimbursement for either of the two amounts. In particular, Matagorda County argued that a right of reimbursement did not exist in the insurance policy and that such a right was not conferred in the unilateral reservation of rights letter issued by TAC. In fact, TACs reservation of rights letter never mentioned reimbursement. [See *Matagorda County*, 975 S.W.2d at 782.]

Relying, at least in part, on the Supreme Court of Californias decision in *Buss v. Superior Court*, 939 P.2d 766 (Cal. 1997), the Corpus Christi Court of Appeals rejected TACs claim for reimbursement of defense costs because TACs reservation of rights letter did not specifically notify Matagorda County that it would later seek defense costs. [See *Matagorda County*, 975 S.W.2d 782.] Although not holding such, the courts opinion strongly suggests that TAC at least would have had a quasi-contractual right to reimbursement of defense costs if it had specifically reserved its right to do so. The court noted that the Buss court found a quasi-contractual right of a liability insurer to collect from its insured reimbursement for defense costs of certain claims only if the insurer specifically reserved its right to seek reimbursement of defense costs at or before the time it provided a defense. [*Matagorda County*, 975 S.W.2d at 784.] Thereafter, the court held that reimbursement of settlement costs required a specific agreement by the insured to be bound by the settlement and to allow reimbursement to the insurer if the coverage issue is later determined against the insured . . . [Id. at 787.]

The appellate court decision left behind some unanswered questions. First, although implying that a unilateral reservation of rights would be sufficient to preserve a claim for reimbursement of defense costs, the court did not address whether Texas recognized such a claim. Second, although it held that a specific agreement was required for reimbursement of settlement costs under an equitable subrogation theory, the court did not elaborate as to whether anything but a bilateral agreement could trigger a claim for reimbursement under other reimbursement theories. The Supreme Court of Texas granted review of the case, but only to address the issue of reimbursement of settlement costs.

After noting that the issue before it was one of first impression in Texas, the Supreme Court began its analysis by examining the insurance contract. The Court noted that [i]t is undisputed that the insurance policy that defines the parties rights and obligations does not provide TAC a right of reimbursement; TAC first asserted such a right in its reservation-of-rights letter. It is similarly undisputed that the county did not otherwise expressly agree to reimburse TAC for the . . . settlement. [See *Tex. Assn of Counties County Govt Risk Mgmt. Pool v. Matagorda County*, 52 S.W.3d 128, 131 (Tex. 2000).] As such, the Court sought to determine whether Matagorda Countys consent to reimburse TAC may be implied or whether the circumstances presented warranted imposing, in law, an equitable reimbursement obligation.

The Court first considered whether an implied consent to reimbursement existed. TAC argued that the countys failure to respond to its second reservation of rights letter amounted to consent by acquiescence. The Court, however, disagreed. Relying on a Supreme Court of Wyoming decision, the Court held that a unilateral reservation-of-rights letter cannot create rights not contained in the insurance policy. [Id. (citing *Shoshone First Bank v. Pac. Employers Ins. Co.*, 2 P.3d 510, 515-16 (Wyo. 2000)).] Consequently, although silence by the insured after the insurer issues a reservation of rights letter implies agreement that the insurer will later contest coverage, the same silence cannot imply consent to additional obligations not contained in the insurance contract. [*Matagorda County*, 52 S.W.3d at 131.] Moreover, a meeting of the minds is an essential element of any implied-in-fact contract. [Id. at 133.] Thus, when an insurer attempts to add a reimbursement provision to the insurance contract, it only will be binding if first accepted by the insured. On the facts before the Court, TAC failed to get Matagorda Countys agreement, so no implied-in-fact contract existed and TAC could not seek reimbursement of the \$300,000 settlement. [Id. at 135.]

Because the Corpus Christi Court of Appeals did not actually issue a ruling as to whether Texas law recognized a right of reimbursement of defense costs and because that issue was not before the Supreme Court of Texas, the right of reimbursement of defense costs for those claims that are ultimately determined to be uncovered technically still is unclear in Texas. Nevertheless, technicalities aside, both the majority and the dissent in the Supreme Courts decision in *Matagorda County* unmistakably addressed the issue.

By relying upon the Wyoming Supreme Courts decision in *Shoshone*, the Court indicated how it would address the reimbursement of defense costs issue should it ever be squarely presented with it. The *Shoshone* court found that an insurer cannot unilaterally reserve its right to recoup defense costs. [*Id.* at 131 (noting that *Shoshone* reject[ed] the notion that the insurer could base a right to recover defense costs on a reservation letter).] The Courts also cited the Wyoming decision for the proposition that allowing reimbursement of defense costs via a unilateral reservation of rights would be tantamount to allowing the insurer to extract a unilateral amendment to the insurance contract. If this became common practice, the insurance industry might extract coercive arrangements from their insureds . . . [*Id.* at 133 (citing *Shoshone*, 2 P.3d at 516).] Thus, while not facing the issue head-on, the Courts statements and reliance on *Shoshone* strongly suggest that it would disallow any attempt by an insurer to unilaterally reserve its right to recoup defense costs for uncovered claims.

Even the dissent in *Matagorda County*, which discussed the defense costs issue at length, acknowledged that insurers should be on notice that todays decision may foreshadow how the court will decide the [defense costs] issue if it is presented. [*Id.* at 140 (Owen, J., dissenting).] Consequently, after the Supreme Courts decision in *Matagorda County*, a roadmap had been provided--albeit in dicta--for Texas trial courts and intermediate appellate courts. That is, while a unilateral reservation of rights likely is not sufficient to create a right of reimbursement of defense costs, such a reservation definitely is not sufficient to preserve an insurers right of reimbursement of indemnity payments.

Franks Casing I--Not quite Matagorda County. In *Excess Underwriters at Lloyds v. Franks Casing Crew & Rental Tools*, 93 S.W.3d 178 (Tex. App.--Houston [14th Dist.] 2002, pet. granted) (Brister, J.), Franks Casing Crew & Rental Tools, Inc. fabricated a drilling platform at its facility in Louisiana for ARCO. Several months later, the platform collapsed. As a result, ARCO sued Franks Casing and several other defendants. Franks Casing was insured under a primary policy with limits of \$1.0 million, as well as an excess policy with limits of \$10.0 million from Excess Underwriters. After being notified of the claim, Excess Underwriters issued a reservation of rights letter, stating that some of ARCOs claims against Franks Casing were not covered by the policies.

Before trial, ARCO offered a \$9.9 million settlement, but it was rejected by Franks Casing. Then, two weeks before trial began, Excess Underwriters contacted ARCO directly and attempted to settle the portion of the claim that it believed was covered, but no agreement could be reached. Subsequently, ARCO offered to settle all claims against all defendants for \$8.8 million, including a \$7.55 million contribution from Franks Casing. Because of the coverage issues that existed, Excess Underwriters offered to pay two-thirds of that amount if Franks Casing would pay the remaining one-third and agree to a waiver of all coverage issues. In the alternative, Excess Underwriters offered to pay \$5.0 million, leaving the coverage issues to be determined in arbitration. Franks Casing refused both options.

As the underlying lawsuit by ARCO proceeded to trial, it became obvious that Franks Casing was ARCOs target defendant. After the second day of trial, Franks Casings in-house counsel contacted ARCO and requested that it issue a settlement demand within the limits of the excess policy. In response, ARCO made a demand of \$7.5 million, which was immediately communicated to Franks Casings insurers. In communicating the settlement offer to Excess Underwriters, Franks Casing demanded that the carriers accept the settlement demand from ARCO. Agreeing that the case should be settled, Excess Underwriters stated that they would fund the settlement minus the primary limits but only if Franks Casing agreed to resolve the coverage issues at a later date. Franks Casing refused, sending a second letter to the carriers demanding that it accept ARCOs offer. Eventually, Excess Underwriters agreed to fund the settlement less any contribution from the primary carrier--but reserved its right to seek reimbursement from Franks Casing. The Excess Underwriters policy required approval of any settlement from its insured, which Franks Casing provided.

Before the settlement agreement was executed, Excess Underwriters filed a declaratory judgment action against Franks Casing. The trial court held that no coverage existed for ARCOs lawsuit, but, in interpreting *Matagorda County*, the court found that no right of reimbursement existed because Franks Casing had not expressly agreed that Excess Underwriters could seek recoupment. The appellate court affirmed, but it clearly was not happy about the decision. [See *Franks Casing*, 93 S.W.3d 178.] In recognition of that fact, the appellate court opinion--which was authored by Judge Brister before his rise to the Supreme Court--invited the Supreme Court of Texas to revisit the issue. [See *id.*]

Accepting the invitation, the Supreme Court of Texas initially concluded that *Matagorda County* did not control, finding it distinguishable from the facts before it. The Court noted that, in *Matagorda County*, it was concerned with the situation when an insurer has a unilateral right to settle and the insurer could accept a settlement that the insured considered out of the insureds financial reach. [See *Excess Underwriters at Lloyds v. Franks Casing Crew & Rental Tools*, 2005 Tex. LEXIS 418 (Tex. May 27, 2005) (*Franks Casing I*).] The Court viewed *Franks Casing I* in a different light:

The facts of the case before us today lead us to conclude that this concern is ameliorated if not eliminated in at least two circumstances:

- 1) when an insured has demanded that its insurer accept a settlement offer that is within policy limits; or
- 2) when an insured expressly agrees that the settlement offer should be accepted.

In these situations, the insurer has a right to be reimbursed if it has timely asserted its reservation of rights, notified the insured it intends to seek reimbursement, and paid to settle claims that were not covered.

[*Id.* at *3.] Having found those conditions satisfied in the case before it, the Supreme Court reversed the lower court, remanding the case to the trial court to render judgment in favor of Excess Underwriters. Notably, the Court concluded that [r]equiring an insured to reimburse its insurer for settlement payments if it is later determined there was no coverage does not prejudice the insured. [*Id.* at *4.] Moreover, the Court said that [t]he insurer should be entitled to settle with the injured party for an amount the insured has agreed is reasonable and to seek recoupment from the insured if the claims against it were not covered. [*Id.*] The Courts ruling had three concurring opinions and left many questions unanswered.

Franks Casing II--But on Second Thought. . . . *Franks Casing I* ignited a clash that was particularly loud between insureds and their defense counsel on one side of the fence and the insurance industry on the other. As evidence of that battle, a motion for rehearing was filed and an onslaught of *amicus curiae* briefs were filed on both sides. Insurers loved the result of *Franks Casing I*, whereas insureds and defense counsel strongly contested the result. Apparently, a similar battle existed between justices of the Supreme Court as well, as it took close to two years to issue a new opinion on rehearing.

In its new opinion, the Court, without ever mentioning its prior reasoning in the case, reversed itself, finding no exception existed to the rule set forth in *Matagorda County*. [See *Excess Underwriters at Lloyds London v. Franks Casing Crew & Rental Tools, Inc.*, 2008 Tex. LEXIS 92 (Tex. Feb. 1, 2008) (*Franks Casing II*).] In other words, no right of reimbursement exists after settlement if the insurer has not first obtained the insureds clear and unequivocal consent to the settlement and the insurers right to seek reimbursement. [*Id.* at *1.] Because *Franks Casing* had agreed only to first part--the settlement--but not the second part--the insurers right to seek reimbursement--the Court did not allow Excess Underwriters a right to reimbursement.

In support of its decision, the Court explained Texas law regarding reimbursement, beginning with its prior decision in *Matagorda County*. The majority explained that its analysis in that earlier case emphasized the dilemma faced by the insured and its insurer when a claimant presents a reasonable settlement offer, within policy limits, but coverage is unclear. If an insurer rejects such an offer, it faces significant potential liability for bad-faith insurance practices under Texas *Stowers* doctrine, if it eventually fails in its coverage contest against its insured. By refusing to allow a right of reimbursement, coverage in such cases is created even though it is ultimately determined not to exist. On the other hand, though, the insured in that same situation is forced to choose between rejecting a settlement within policy limits or accepting a possible financial obligation to pay an amount that may be beyond its means, at a time when the insured is most vulnerable. [*Id.* at *3 (quoting *Matagorda County*, 52 S.W.3d at 134).] The Court resolved that quandary, determining that the risk of coverage uncertainties was best placed with the insurer.

After discussing its reasoning in *Matagorda County*, the Court noted that several *amicus curiae* in *Franks Casing*

had warned that an implied right of reimbursement would create a significant conflict for defense counsel during settlement negotiations. Specifically, if the insured agrees that a settlement offer is reasonable, and the right of reimbursement is implied, defense counsels role in evaluating and recommending settlement possibly could advance the insurers interest over that of its insured. Thus, the *amici* argued, because defense counsel would be hindered, both the insured and insurer could be forced to retain settlement counsel to evaluate the case before it and formulate strategy for a future lawsuit regarding reimbursement. While it acknowledged that the fears may not be real, the Court noted that they foreshadow the significant distrust possible in the relationship between an insurer and its insured during settlement if the right of reimbursement were implied.

On a similar note, the Court discussed the concerns the *amici* held regarding the lack of incentive an insurer has for negotiating a favorable settlement for its insured when an implied right of reimbursement exists. In other words, because the insured likely will bear the obligation of paying a settlement if coverage is found to not exist, during settlement negotiations the insurer might shortchange the insured, curtailing attorneys fees and expenses, settling quickly at a high settlement amount, and avoiding any potential *Stowers* liability. Subsequently, any eventual litigation regarding reimbursement likely will be prolonged with the insured footing its own bill, effectively negating the insurance it purchased for the very purpose of hedging the risk and expense of future litigation. [*Id.* at *5.] The Court, finding that it had weighed these same concerns in *Matagorda County* and that the insurer was better positioned to handle them, the Court in *Franks Casing II* refused to overrule that earlier decision--even though it had done so in *Franks Casing I*.

The Court then addressed Excess Underwriters position that this case could be distinguished from *Matagorda County*. The carriers argued that, by actively requesting the settlement offer and demanding that its insurer settle the claim, Franks Casing impliedly had agreed to the right of reimbursement. The Court, however, failed to see how Franks Casings actions amounted to anything but an obvious demonstration that it believed the claim should be settled. Rather, both parties held firm in their respective coverage positions, including the existence (or not) of a right to reimbursement. The Court said, This is a far cry from impliedly consenting to reimbursement. . . . Given the parties explicit efforts to preserve their positions, it makes no more sense to say that Franks Casing impliedly agreed to reimburse the carriers than it would to say that the carriers impliedly agreed to waive their coverage position. [*Id.* at *5.] As such, because Franks Casings was consistent in its position that the insurers alone were responsible for the claims, its agreement to reimbursement could not be implied. Moreover, the Court did not believe the policys consent-to-settle language had anything to do with the Excess Underwriters right to reimbursement should they choose to negotiate settlement of a claim.

Excess Underwriters also alleged that the equitable theories of *quantum meruit* and *assumpsit* also favored the existence of a right of reimbursement. The same theories had been rejected by the Court in *Matagorda County*, but Excess Underwriters tried to distinguish that case because Franks Casing had sought The settlement demand from its claimant and specifically demanded that its insurer pay it. The Court determined that those distinctions failed to allay the concerns underlying its analysis in *Matagorda County*. The Court continued to be concerned that an insured would be forced to choose between rejecting a settlement within policy limits or accept a financial obligation in an amount that may be beyond its means. Accordingly, it refused to grant a right of reimbursement. Moreover, the Court refused to rewrite the parties contract or add to its language. In addition, the Court rejected a request that it overrule its decision in *Matagorda County* and follow opinions issued in California and Florida, both of which permitted a right of reimbursement.

In closing, the Court addressed the dissenting opinions of Justice Hecht and Justice Wainwright. Justice Hecht believed an equitable reimbursement obligation should have been imposed on Franks Casing. Justice Wainwright, on the other hand, thought Franks Casings acquiescence in the settlement meant Excess Underwriters should be entitled to an implied-in-fact right of reimbursement. The Court previously addressed these same arguments in *Matagorda County* and, once again, it refused to adopt either position. With regard to Justice Hechts opinion, the Court said that his approach would breed uncertainty and promote litigation rather than settle it. [*Id.* at *9.] That is, whether an insurer would be entitled to a right of reimbursement would depend upon the financial status of its insured. Those with less

economic heft than *Franks Casing* but more than Matagorda County might or might not be on the hook, depending upon how a court might view the equities presented. [*Id.*] Turning to Justice Wainwrights arguments, the Court again explained that *Franks Casings* could not be found to have agreed to the insurers right of reimbursement just because it stayed firm as to its position regarding coverage and demanded that the reasonable settlement offer be paid.

Commentary. The Courts holding in *Franks Casing II* is another in a growing line of favorable decisions for insureds in Texas, qualifying as one of the most significant decisions issued by the Supreme Court of Texas in recent years. Although never addressing its prior analysis in *Franks Casing I*, an opinion authored by Justice Owens who now is a judge on the U.S. Fifth Circuit Court of Appeals, the Court returned Texas law to its post-*Matagorda County* state. In other words, an insurer only is entitled to a right of reimbursement if the insurer: (1) obtains the insureds clear and unequivocal consent to a settlement offer; and (2) the insureds clear and unequivocal consent to the insurers right of reimbursement. This is significant in that defense counsel and/or coverage counsel for the insured are no longer constrained when a *Stowers* demand is received (Note: the Court assumed without discussing the issue that a demand within the policy limits of an excess policy qualified as a *Stowers* demand). Prior to *Franks Casing II*, a letter from defense counsel or coverage counsel stating simply that the settlement demand was reasonable might have subjected the insured to a right of recoupment. In light of the Courts ruling, however, defense counsel is free to evaluate the merits of the *Stowers* demand and coverage counsel is free to demand that the insurer accept the *Stowers* demand without fear of subjecting the insured to a right of recoupment. On the other hand, the insurer is left to weigh the extra-contractual risk of rejecting a settlement offer.

Whether this means that more insurers will be less likely to settle claims quickly on behalf of their insureds remains to be seen. Even with no guarantee of a right of reimbursement, however, insurers likely still will be willing to enter settlements when coverage is questionable in light of the continuing *Stowers* doctrine. Thus, even though it is not assured of a right to reimbursement, an insurer will think twice before rejecting a *Stowers* demand that could subject them to a significant financial obligation if they ultimately are wrong about coverage. That being said, a potential downside is that *Franks Casing II* likely will lead to more (and earlier) declaratory judgments in which insurers will attempt to obtain a declaration as to their rights and obligations when coverage under a policy is questionable. In fact, the Court basically encouraged insurers to seek prompt resolution of coverage disputes. Moreover, insurers may soon seek approval for amendatory endorsements specifically providing for a right of reimbursement from its insured.

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Manning on Sahli v. Woodbine Bd. of Education

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Manning on Sahli v. Woodbine Bd. of Education

By Diana C. Manning and Benjamin J. DiLorenzo

March 6, 2008

SUMMARY: In *Sahli v. Woodbine Bd. of Educ.*, 193 N.J. 309 (2008), the New Jersey Supreme Court held that counsel to local boards of education are not entitled to indemnification from the school district when sued in their capacity as counsel to the board. Given this bright line rule, practitioners representing boards of education are cautioned to review the terms of their professional liability coverage so that they are not left uninsured.

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ARTICLE: As noted by Justice Albin, concurring in part and dissenting in part in the New Jersey Supreme Courts recent Opinion in *Sahli v. Woodbine Bd. Of Educ.*, 193 N.J. 309, 324 (2008), attorneys representing the nearly 600 local boards of education in New Jersey may be surprised to learn that they do not hold a position in local government. While Ronald Sahli, Esq., the appointed attorney for the Woodbine Board of Education was not ultimately responsible for legal fees incurred in defending a suit filed by a former Board employee against both the Board and the Boards attorney, the Supreme Courts ruling serves as a warning to attorneys representing local boards of education to carefully select and review their professional liability insurance policies to avoid a pitfall that leaves them uninsured.

The *Sahli* decision involved interpretation of N.J. Stat. Ann § 18A:16-6, which requires local boards of education to defend and indemnify any person holding any office, position or employment under the jurisdiction of any board of education in any civil action or administrative proceeding brought against these individuals. Both the Woodbine Board of Education and its attorney were sued by a former employee of the school district who alleged violations of the Conscientious Employee Protection Act (CEPA). The challenged conduct related to the attorneys participation in executive session board meetings wherein decisions regarding the plaintiffs employment status were made. During these meetings, the board attorney was appointed to act as secretary *pro tem* because of concerns regarding the standing secretaries past breaches of confidentiality. While the trial court held that board counsel was entitled to indemnification under N.J. Stat. Ann. § 18A:16-6, the Supreme Court affirmed the Appellate Divisions holding that as an independent contractor, board counsel did not qualify as an individual holding an office, position or employment under the jurisdiction of the Board of Education entitled to indemnification. The Supreme Court did, however, find the attorney was entitled to indemnification to the extent he was acting as secretary *pro tem*, an office of the Board. Similarly, the Supreme Court found that because the board attorney did not satisfy the definition of insured under the school districts Joint Insurance Fund policy, he was not entitled to coverage.

Clarification of The Nature of Board Counsel. The *Sahli* decision leaves little doubt that board attorneys are not entitled to indemnification for actions undertaken in their role as counsel to the Board. The Appellate Division opinion, summarily affirmed by the Supreme Court, was based on both the statutes legislative history and prior precedent finding independent contractors of the Board to be beyond the scope of the indemnification statute. Specifically, *Hartmann v. Maplewood School Transp. Co.*, 109 N.J. Super. 497 (App. Div. 1970), the Appellate Division held that a bus driver employed by an independent bus company was not entitled to indemnification under the statute. As explained by the *Sahli* Court, the *Hartmann* decision supports the proposition that a third party whose relationship to a board of education is purely contractual is not a person holding any office, position or employment with a board of education. Similarly, the Appellate Division reasoned that the absence of any discussion of board counsel in the statutes long legislative history further supported its conclusion.

Much like Justice Albin, many practitioners may quarrel with the Courts equation of a bus drivers contractual relationship with a board of education to that of the intimate role board counsel plays in school district decision-making. Regardless, the *Sahli* decision makes clear that statutory indemnification is unavailable to board counsel because they do not hold a position under the jurisdiction of the Board.

Professional Liability Insurance Issues Implicated. Important to practitioners is the potential impact of the *Sahli* decision on their ability to seek defense and indemnification from their professional liability insurance carrier when they are sued in their capacity as counsel to a board of education. The *Sahli* opinion contains minimal discussion of professional liability insurance coverage issues other than to recognize that the boards counsel was defended by his professional liability carrier in the employees civil action. The underlying matter settled without any contribution from board counsel, and the claim at issue in *Sahli* was a subrogation action driven by the attorneys insurance carrier. Although the coverage issues were not discussed, the implication to practitioners representing local boards of education is significant.

Many professional liability policies contain an exclusion for claims arising out of the insureds services and/or capacity as: a public official, or an employee of a governmental body, subdivision, or agency. While the *Sahli* Court rejected characterizing board counsel as one holding a position on a board of education, its holding was limited to the meaning of position under the indemnification statute. Professional liability coverage issues were not at issue.

However, broader coverage that limits the scope of the exclusion is available in the marketplace. For example, some policies include the above language, but limit the exclusion by stating that it is applicable unless the Insured is deemed an employee solely by virtue of rendering Professional Services to such governmental body, the remuneration for which services inures to the benefit of the named insured. This language indicates that if the relationship between the attorney and the local governmental body is solely one in which legal services are rendered, the exclusion does not apply.

The *Sahli* decision serves as an important reminder to practitioners serving as board counsel to carefully select and review the scope of insurance coverage provided by their professional liability policies.

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Sonnenschein, Nath & Rosenthal, LLP on Wade v. EMCASCO Insurance Co.

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Sonnenschein, Nath & Rosenthal, LLP on Wade v. EMCASCO Insurance Co.

By William T. Barker

March 3, 2008

SUMMARY: Plaintiffs with claims exceeding defendants insurance policy limits have sought to remove those limits by setting up the insurer for bad faith claims. A common method has involved making time-limited settlement demands while withholding information important to settlement evaluation. An insurer could argue that its conduct was reasonable with the information available to it but could not attack the plaintiffs conduct in the attempted set-up.

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ARTICLE: [T]he doctrinal impetus for insurance bad faith claims derives from the idea that the insured must be treated fairly and his legitimate interests protected. . . . In other words, the justification for bad faith jurisprudence is as a shield for insureds--not as a sword for claimants. Courts should not permit bad faith in the insurance milieu to become a game of cat-and-mouse between claimants and insurer, letting claimants induce damages that they then seek to recover, whilst relegating the insured to the sidelines as if only a mildly curious spectator.

Peckham v. Continental Casualty Insurance Co., 895 F.2d 830, 835 (1st Cir. 1990).

On April 10, 2007, the United States Court of Appeals for the Tenth Circuit issued an opinion which gives insurers a new means of defending against bad faith claims manufactured by the conduct of plaintiffs. In *Wade v. EMCASCO Insurance Company*, n1 the plaintiff had made a policy-limits settlement offer, but then neglected to send the medical records and releases necessary for the insurer to evaluate the claim. When the insurer did obtain the necessary records and promptly authorized a policy-limits settlement, the plaintiff rejected the offer and brought a bad faith claim well in excess of the policy limits. The court in *Wade* ultimately rejected the bad faith claim, holding that it was the plaintiffs manipulative conduct that caused the failure to settle, not any bad faith on the part of the insurer. The below article lays out the problem surrounding bad faith set-ups, summarizes how prior cases have handled them, and then discusses the recent approach used in *Wade* to address them.

I. The Problem of Bad Faith Set-Ups

Since 1914, courts have began reading an implied duty of good faith and fair dealing into every insurance contract. n2 Actions arising out of this implied duty include claims against insurers for a bad faith failure to settle. n3 When an insured is held liable for a claim, the insurer is generally only obligated to pay up to the policy limits. n4 When,

however, an insurer has wrongfully rejected a settlement offer within the policy limits and the insured is subsequently held liable for an amount in excess of the limits, the insurer may be obligated to pay the full amount of the judgment.
n5

Such claims for a bad faith failure to settle are intended to protect the interests of the insureds who are presumed to be in an inferior financial and bargaining position to insurers. Courts have reasoned that if insurers are insulated from any liability in excess of the policy limits, they may be more willing to risk litigation and an obligation to pay the policy limits in the hopes of having to pay nothing. n6 By holding insurers liable for excess judgments when they have wrongfully refused a policy limits settlement, however, courts can better protect the interests of the insured who would otherwise have to pay the excess judgment.

The jurisprudence of bad faith claims is intended as a shield for insureds, protecting them from unnecessary excess judgments. n7 Instances of gamesmanship, however, have arisen in which third-party plaintiffs attempt to manufacture bad faith claims and use them as a sword. Insurers will generally be in a better financial position than their insureds, creating an incentive for an injured third-party plaintiff to find ways to hold an insurer liable for the entire judgment. To this end, plaintiffs have made attempts to induce insurers to stumble into bad faith claim traps. By using manipulative conduct such as settlement offers with unreasonably short deadlines, withholding information necessary to evaluate a claim, or arbitrarily withdrawing offers, claimants have been able to set traps for insurers in which any misstep may lead to a bad faith claim.

II. Prior Bad Faith Set-Up Cases

Because bad faith claims arise out of the insurers duty of good faith and fair dealing, much of the analysis has centered around whether the insurers conduct was reasonable. While this allows for arguments that a third-party plaintiffs conduct justified the refusal by the insurer, the focus in these cases is still squarely on the *insurers* conduct.

In *Brown v. Liberty Mutual Fire Insurance Company*, the third-party plaintiffs counsel made a request for the policy limits, but did not provide any information about the claimants medical condition and denied requests for authorization to obtain the medical records. n8 In affirming a summary judgment that the insurer did not act in bad faith, the court focused on whether the insurer had acted arbitrarily or in bad faith. n9 While the factors considered by the court included the nondisclosure of relevant factors by the insured, the court examined the factors in light of whether such conduct rendered the insurers conduct reasonable. n10 The court did not analyze the third-party plaintiffs conduct for independent culpability.

Similarly in *Safeway Insurance Company v. Botma*, the court focused on whether the insurer acted reasonably when it did not make a settlement offer until it received medical records. n11 Again, the claimant had delayed almost a year to forward medical records, but the ultimate consideration was whether this justified the insurers conduct. n12 In *Thomas v. Lumbermens Mut. Cas. Co.*, the claimants failure to deliver medical records was viewed in the light of whether the insurer conducted a reasonable investigation. n13

In *McCulloch v. Hartford Life & Accident Insurance Company*, the claimant (1) failed to provide a copy of her driver's license for several months and (2) submitted a physician statement from a doctor in Florida while she lived in Massachusetts, but these were given as justifiable reasons for the insurer refusing to pay, not as conduct to be analyzed separately as culpable. n14

While the court in *American Mutual Insurance Company v. Bittle*, described the deadline on claimants demand as arbitrary and unreasonable because it required the insurer to make a decision before having a chance to interview the investigating police officer, the court ultimately used this as a measure of the insurer acting in good faith. n15 In *Glenn v. Fleming*, the court affirmed a finding that the *insurer* had not acted in bad faith because the claimants settlement offer was premature and was only open for two weeks. n16

Even in a case in which the court felt the claimants conduct was a manipulative attempt to capitalize on a

miscommunication, the issue was still whether the insurers conduct had risen to the level of bad faith or not. n17

III. *Wade v. Emcasco Insurance Company*

Wade v. EMCASCO Ins. Co., 2007 U.S. App. LEXIS 8227 (10th Cir. 2007)

A. Factual Background. While all the preceding cases provided ways for an insurer to prove that its refusal of a settlement offer was reasonable, none took the approach found recently in *Wade v. EMCASCO Insurance Company*. In *Wade*, the Tenth Circuit shifted the paradigm and focused on the conduct that caused the refusal to settle, whether it be the conduct of the insurer, the insured, or the third-party plaintiff. n18 This sort of analysis opens up the possibility of analyzing the culpability of the third-party plaintiffs conduct independently, rather than just as a measure of how reasonable an insurers conduct was.

Counsel for the third-party plaintiff in *Wade* acted similarly to those in the cases discussed above. Ninh Nguyen was injured in a car accident with Jerry Wade, EMCASCOs insured. n19 Mr. Nguyen was in the hospital for a severe spinal cord injury, but there was some question as to whether or to what extent this injury had been caused by the accident. n20 An investigator was hired by EMCASCO to gather statements from the insured and witnesses to the accident, but the investigator had difficulty ever reaching the primary witness. n21

Mr. Nguyen retained Gary Patterson to represent him in the matter, and as early as March 29, 2001, Mr. Patterson had obtained a medical release from Mr. Nguyen. n22 Mr. Patterson requested an itemized list of medical expenses on April 6, 2001. n23 Despite repeated attempts by EMCASCO to obtain a copy of the emergency medical records and repeated promises from Mr. Paterson that he would send them, it would not be until October 30, 2001 that Mr. Patterson would forward the pertinent emergency medical records. n24

Despite this delay in providing medical information, Mr. Patterson made his first policy limits settlement offer to EMCASCO on May 1, 2001. n25 This offer *expired* a full two weeks before Mr. Patterson, himself, had even received Mr. Nguyens medical records from his time in the hospital following the accident. n26 Even once he received these records on June 28, 2001, Mr. Patterson waited four months before sending them to EMCASCO, and by that time all settlement offers had expired. n27 Mr. Patterson delayed the process in other ways as well. As early as May 21, 2001, Mr. Patterson had spoken with the key witness. n28 Though he knew EMCASCO was trying to reach the witness, Mr. Patterson only forwarded a copy of the witnesss statement on August 2, 2001, five weeks after he had received it. n29

Mr. Patterson made a second policy limits settlement offer on August 2, 2001. n30 Still without having sent the emergency medical records to EMCASCO, Mr. Patterson withdrew this offer on August 20, 2001. n31 In late October, frustrated with not having received the necessary medical records, David Cooper, counsel for EMCASCO, requested that Mr. Patterson supply EMCASCO with a release to obtain the records themselves. n32 Mr. Patterson promptly responded by sending a medical release, but signed it himself rather than have his client, the patient sign it; the medical release was not accepted by the hospital. n33

Finally after further prompting by Mr. Cooper, Mr. Patterson forwarded the necessary medical records on October 30, 2001, and EMCASCO, now able to evaluate the claim fully, authorized a policy limits settlement the very next day. n34 Having delayed EMCASCOs ability to evaluate the claim for at least four months, Mr. Patterson now felt that it was too late to settle for the \$100,000 policy limit and enlisted an attorney who specialized in bad faith claims to bring such an action against EMCASCO for \$3,000,000. n35

B. Discussion. The courts in the cases discussed above when presented with these facts may have reasoned that EMCASCO had acted reasonably in not settling before having received the necessary medical records. In affirming summary judgment in favor of EMCASCO, the Tenth Circuit in *Wade* did recognize this analysis of insurer conduct as important and considered the following factors established by *Bollinger v. Nuss*:

(1) the strength of the injured claimant's case on the issues of liability and damages; (2) attempts by the insurer to

induce the insured to contribute to a settlement; (3) failure of the insurer to properly investigate the circumstances so as to ascertain the evidence against the insured; (4) the insurer's rejection of advice of its own attorney or agent; (5) failure of the insurer to inform the insured of a compromise offer; (6) the amount of financial risk to which each party is exposed in the event of a refusal to settle; (7) the fault of the insured in inducing the insurer's rejection of the compromise offer by misleading it as to the facts; and (8) any other factors tending to establish or negate bad faith on the part of the insurer. n36

The *Wade* court, however, took the analysis further and wrote:

It is . . . necessary to take into consideration, in addition to the other pertinent *Bollinger* factors, relevant aspects of the third-party plaintiffs conduct, including any responsibility the plaintiff might have for the insurers lack of adequate information upon which to judge a proposed settlement offer and the reasons the plaintiff had for declining to entertain an offer after expiration of a deadline. n37

While the facts in *Wade* discussed above may have been enough to establish that EMCASCO acted reasonably, focusing on whether Mr. Petersons conduct was improper shifts the context of the facts and allows insurers greater leeway to argue that a bad faith claim should fail. The *Wade* court was convinced that Mr. Peterson had acted improperly and his conduct, not EMCASCOs, had caused the failure to reach a settlement and the excess judgment. n38

Furthermore, the court found that the undisputed evidence showed that Mr. Petersons sole reason for rejecting EMCASCOs settlement offer was so that he could pursue a bad faith claim. n39 In fact, Mr. Patterson had proceeded from the very beginning with a bad faith claim in mind. n40

The court believed that a finding of bad faith in such a situation would turn the law on its head and wrote:

The cause of action for failure to settle is meant to protect the interests of the insured by requiring the insurer to conduct the litigation, including settlement negotiations, as if the insurance contract had no policy limits. It is not meant to create an artificial incentive for third-party claimants to reject otherwise reasonable settlement offers that are within the policy limits. We would be turning the cause of action on its head by holding an insurance company liable where it eventually offered to settle the claim for the policy limits, but a claimant rejected the offer precisely in order to manufacture a lawsuit against the insurer for bad-faith refusal to settle. n41

Wade is a clear case of a third-party plaintiff attempting to set-up an insurer for a bad faith claim. Rather than just find that the insurer acted reasonably under these circumstances, the *Wade* court pointed the finger at the third-party plaintiff. Doing so opens up the possibility for insurers to mount successful attacks on third-party plaintiffs attempts to manufacture bad faith claims in the future. Rather than merely pleading innocence and defending their conduct, insurers in the future may be able to shift the analysis of blame to third-party plaintiffs improperly using an insureds shield as their sword.

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n1 . 2007 U.S. App. LEXIS 8227 (10th Cir. 2007).

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[2]. *Brassil v. Maryland Casualty Co.*, 210 N.Y. 235, 242, 104 N.E. 622, 624 (1914).

n3

[3]. See, e.g., *Torrez v. State Farm Mut. Auto. Ins. Co.*, 705 F.2d 1192, 1194 (10th Cir. 1982); *Liberty Mut. Ins. Co. v. Davis*, 412 F.2d 475, 477 (5th Cir. 1969).

n4

[4]. See *Rova Farms Resort, Inc. v. Investors Ins. Co. of Am.*, 65 N.J. 475, 478, 323 A.2d 495, 508 (1974).

n5

[5]. See, e.g., *Communale v. Traders & Gan. Ins. Co.*, 50 Cal. 2d 654, 660, 328 P.2d 198, 201 (1958).

n6

[6]. See *Bollinger v. Nuss*, 449 P.2d 502, 510 (Kan. 1969).

n7

[7]. *Peckham v. Continental Casualty Insurance Company*, 895 F.2d 830, 835 (1st Cir. 1990).

n8

[8]. 168 Fed. Appx. 558, 563 (5th Cir. 2006).

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[9]. *Id.* at 563-64.

n10

[10]. *Id.*

n11

[11]. 129 Fed. Appx. 355, 357 (9th Cir. 2005).

n12

[12]. *See id.*

n13

[13]. 424 So. 2d 36, 38 (Fla. Dist. Ct. App. 1982).

n14

[14]. 363 F. Supp. 2d 169, 178 (D. Conn. 2005).

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[15]. 338 A.2d 306, 309-10 (Md. Ct. Spec. App. 1975).

n16

[16]. 247 Kan. 296, 306, 799 P.2d 79, 86 (1990).

n17

[17]. *Matt v. Liberty Mut. Ins. Co.*, 798 F. Supp. 429, 434-435 (D. Ky. 1991).

n18

[18]. *See id.* at **44-45.

n19

[19]. *Id.* at *3.

n20

[20]. *Id.* at **5-6.

n21

[21]. *Id.*

n22

[22]. *Id.* at *6.

n23

[23]. *Id.*

n24

[24]. *Id.* at *11.

n25

[25]. *Id.* at *6.

n26

[26]. *Id.* at *7.

n27

[27]. *Id.*

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[28]. *Id.*

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[29]. *Id.* at *8.

n30

[30]. *Id.*

n31

[31]. *Id.* at *9.

n32

[32]. *Id.* at *10.

n33

[33]. *Id.* at *11.

n34

[34]. *Id.* at **11-12.

n35

[35]. *Id.* at **12-16.

n36

[36]. *Id.* at *23.

n37

[37]. *Id.* at *33.

n38

[38]. *See id.* at **44-47.

n39

[39]. *Id.* at **41-42.

n40

[40]. *Id.*

n41

[41]. *Id.* at **46-47 (citation omitted).

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Wildermuth on Subprime Mortgage Crisis and D&O Insurance, Part II of III

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Wildermuth on the Repercussions of the Subprime Mortgage Crisis on D&O Insurance, Part II of III

By Matthew R. Wildermuth

February 28, 2008

SUMMARY: Now that the subprime mortgage crisis has crashed the party of Wall Street, financial institutions everywhere are evaluating whether such losses are going to incite investors to bring suit against the institution. This article addresses the issues that should be at the forefront of general counsel's mind when evaluating how any directors and officers liability policy the company has in place may respond to claims and suits of this nature.

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ARTICLE: Introduction

To the extent there was any confusion about what it meant, the resounding thud heard on Wall Street during the first few weeks of January 2008 was the sound of the other shoe dropping. Despite previous assurances that the impact of the subprime mortgage meltdown was contained, on January 18, Merrill Lynch announced write-downs of \$14 billion attributable to subprime lending losses; Citigroup, not to be outdone, disclosed write-downs the same day totaling \$18 billion [Nick Timiraos, *Why Banks' Pain Could Continue*, Wall Street Journal (Jan. 19, 2008)]. At more than \$100 billion in losses across the financial institution industry (and still counting), the subprime-collateralized debt obligation fiasco is threatening to eclipse the havoc wreaked on the economy by the savings & loan crisis [*id.*].

It is beyond the scope of this commentary to address in any detail the causes, the viability of the proposed remedies or the ultimate fallout of the subprime mortgage crisis. For purposes of this commentary, suffice it to say that the deepening housing slump has adversely affected the value of the collateral securing individual mortgage loans and that this problem has been compounded exponentially by investment vehicles that packaged large pools of mortgages into a single block which was then used as collateral for other debt obligations. These aggregated packages were supposed to be insulated from wild swings in value by the diversity of the properties and rendered more stable by being secured with hard assets (the borrowers homes). Billions of dollars of losses later, it turns out neither proposition was true [*Finding Default*, The Economist, Jan. 17, 2008]. How Merrill Lynch, Citigroup, Bear Stearns and other financial experts others got into this mess (and took many of their equally sophisticated investors along with them) will be a critical part of the

analysis as the blame assessment process kicks into high gear (some of which has happened already) [Craig Karmin, *Springfield, Mass., Takes Aim at Merrill Over Subprime Losses*, Wall Street Journal, Jan. 19, 2008 at B1; Dan Levine, *Subprime Loans Could Yield Lots of Work for White-Collar Defense Lawyers*, The Recorder (Dec. 26, 2007)].

Because the losses at issue already exceed tens of billions of dollars, the conduct underlying these losses will be scrutinized in oppressive detail, not only by the investors seeking to recoup their losses but by the insurers to whom the accused entities will turn, seeking to maximize the coverage potentially available through the companies directors and officers liability policies (D&O policies). The stakes for all parties will be high and the battles over insurance coverage both for defense and indemnity costs will be bruising. Based on experience with other major meltdowns, lets look at what are expected to be three of the bloodiest battlegrounds as these disputes heat up.

The Insurers Attempt to Rescind the Policy Based on One or More Alleged Misrepresentations or Non-Disclosures in the Application Process

The key question here is whether the company made any misrepresentations or non- disclosures in its application for directors and officers liability insurance that are sufficiently material to the risk assumed or the terms and conditions under which coverage was provided that the insurer has grounds to deny coverage, whether based on fraud in the inducement or breach of the representation and warranty clause in the policy. Insurance practitioners are familiar with the "garden-variety" misrepresentation cases one often sees in life and medical insurance policies (failure to report existing conditions and prior procedures) and general liability policies (non- or under-disclosure of previous losses, current conduct presenting increased risk). In the D&O context, the lines are not so clearly drawn. The insurer seeking rescission must establish that the statements made (or omitted) in the application were (a) material and false at the time; and (b) actually contributed to the increased risk of loss under the policy [see Ostrager & Newman, *Insurance Coverage Disputes* (10th Ed.) § 20.02[a]]. This can be tricky given changes in the marketplace that happen daily that may impact a stocks value and the corporations bottom line. The court in *ClearOne Communications, Inc. v. Lumbermens Mut. Cas. Co.* [2005 U.S. Dist. LEXIS 26187, at *40 (D. Utah 2005), at *40], discussed in detail below, described the standard as follows:

A misrepresentation is material if it diminishes an insurers opportunity to evaluate or estimate risk. *Berger v. Minn. Mut. Life. Ins. Co.*, 723 P.2d 388 (Utah 1986); see also *Utah Power & Light v. Federal Ins. Co.*, 983 F.2d 1549, 1555 (10th Cir. 1993). The test for whether a fact is material to the risks assumed under an insurance policy is whether reasonable insurers would regard the fact as one which substantially increases the chance that the risk insured against will happen and therefore would reject the application [citations omitted]. A companys financial statements are indicative of its financial health and, therefore, generally evaluated by an insurer before issuing a policy. *Cutter & Buck, Inc. v. Genesis Ins. Co.*, 306 F. Supp. 2d 988, 1003 (W.D. Wash. 2004). In *Cutter & Buck*, the insurer sought to rescind a policy on the basis that the financial statements were materially misrepresented and it had relied upon them. The court noted the general principle that when an insurer asks for no information pertaining to a particular matter, it can be assumed that the matter is not material. *Id.* at 1003 [citation omitted]. But the court noted that the opposite is also true: This implies that when an insurer specifically asks information in regard to a certain matter, the presumption is that the matter is material. *Id.* [citing numerous non-Washington cases for this principle].

Given this focus on the content of the application and information provided in response, insurers continually have sought to improve the application form and incorporate new developments in the law.

One example of this is insurers incorporation of the reporting and certification obligations imposed under the Sarbanes-Oxley Act, which, among other things, requires C level executives to affirmatively seek out information within the corporation regarding the true financial picture and risks faced by the corporation. Specifically, the principal executive officer or officers and the principal financial officer or officers of a publicly traded entity must certify in each quarterly and annual report filed or submitted to the Securities & Exchange Commission that:

. he or she has reviewed the report;

. based on his or her knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

. based on his or her knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the issuer as of, and for, the periods presented in the report; [see Sarbanes-Oxley Act of 2002, 15 U.S.C. § 7241(a)(1)-(4).]

The certifying officers also must have disclosed to the corporation's auditors and to the audit committee of the board of directors any fraud, whether or not material, that involves management or other employees who have a significant role in the issuer's internal controls [*id.*].

D&O applications now routinely include statements the corporations make in their respective SEC disclosures as part of the representations and warranties constituting the policyholders formal insurance application. For example, a specimen wording comprising part of a Financial Institution Portfoliosm policy available from Chubb defines Application to mean:

All signed applications, including attachments and other materials submitted therewith or incorporated therein, submitted by the Insured to the Company for this coverage section or for any coverage section or policy of which this coverage section is a direct or indirect renewal or replacement. Application shall also include, for each Organization, all of the following documents whether or not submitted with or attached to any such signed application: (i) the annual report (including financial statements) last issued to shareholders before this policy's inception date; (ii) the report last filed with the Securities and Exchange Commission on Form 10K before the policy's inception; [quarterly statements, proxy statements, other SEC filings and the like].

[The referenced policy form, viewable at <http://www.chubb.com/businesses/csi/chubb2373.pdf>, is cited solely as an example and may or may not be the definition actually incorporated into any particular policy.]

Insurers thus obtain an extra measure of protection against material misrepresentations and omissions during the underwriting process. However, because the evidence pertinent to the insurers rescission claim now will be largely the same as the evidence the SEC, investors or others will employ to prove liability in the underlying action, sticky situations will develop as these competing interests come into conflict.

The *ClearOne* case illustrates how these issues may present in an actual case. [Although this case involved some claims that had already been resolved prior to the parties litigating the insurers rescission claim, it is one of the only rescission cases addressing the incorporation of Sarbanes-Oxley certifications in the application that has resulted in a dispositive decision.] In September 2002, ClearOne applied to National Union for a directors & officers liability policy. The application ClearOne submitted included the following statement in bold capital letters: All written statements and materials furnished to the insurer in conjunction with this application are hereby incorporated by reference into this application and made part hereof [2005 U.S. Dist. LEXIS 26187, at *5-12]. One of the application questions asked the applicant to either provide copies of its most recent SEC filings or direct National Union to an internet location where it could obtain them. ClearOne directed National Union to ClearOnes website for these documents and its CEO signed the application and certified the information provided therein was true and accurate [*id.*].

National Unions underwriters began evaluating the financial information and developed concerns about the manner in which ClearOne recognized revenues. The lead underwriter contacted ClearOnes broker to obtain confirmation that ClearOnes corporate officers had made the appropriate Sarbanes-Oxley disclosures to the SEC and requested the broker to have ClearOne expressly represent that ClearOnes revenue recognition practices had not previously resulted in any non-compliance notices from the SEC or any other regulatory officials [*id.*]. The broker made the requested inquiries

and reported back to National Union that ClearOne had executed the Sarbanes-Oxley statements and had not been the subject of any noncompliance notices. In reliance on these statements, National Union issued a D&O policy to *ClearOne* [2005 U.S. Dist. LEXIS 26187, at *11-12].

In early 2003, ClearOne notified National Union that it had been sued by various shareholders and that ClearOne and its CFO would be seeking coverage for their losses under the *Policy* [2005 U.S. Dist. LEXIS 26187, at *29]. During the course of those lawsuits, ClearOne acknowledged that its accounting practices in recording and recognizing revenues were not in compliance with generally accepted accounting principles and ultimately conceded that it had recognized revenue before the amounts charged to both distributors and nondistributors were considered fixed and determinable or reasonably collectible [2005 U.S. Dist. LEXIS 26187, at *25-26]. National Union responded to ClearOne's tender by directing ClearOne to the admissions it had made regarding its financial statements, stated that those financial statements were material to National Union's risk analysis and reminded ClearOne that National Union had relied on those financial statements in issuing the *Policy* [2005 U.S. Dist. LEXIS 26187, at *29]. Based on these misrepresentations, National Union sought to rescind the *Policy*.

The district court had little difficulty finding that ClearOne's financial statements were misstated but noted that rescission of an insurance policy requires proof of more than an innocent misstatement [2005 U.S. Dist. LEXIS 26187, at *40-42]. National Union argued that ClearOne's August 18, 2005 10K filing acknowledged that it inappropriately accelerated revenue in its 2001 and 2002 annual reports and SEC filings and admitted that its distributors did not have the financial resources to pay for ClearOne's products when delivered, thereby making the statements in its application incorporating those filings materially false as well [*id.*]. The district court ultimately agreed that ClearOne's representations could not be construed as being innocent:

The record, as discussed in the ClearOne's Business Practices section above, shows that ClearOne entered into Distributor Agreements with the stated policy of recognizing revenue when product shipped. But the common practice was that ClearOne did not require payment for product according to the terms of the Distributor Agreements and allowed the distributors to pay for product when it was sold. Additionally, ClearOne would ship product to the distributors without having received an order for that product. It is clearly these practices which gave rise to ClearOne's financial misstatements. ClearOne acknowledged that it was its business practices that caused the errors in its financial statements: We have a material weakness with respect to accounting for revenue recognition and related sales returns, credit memos, and allowances. Our accounting policies and practices over revenue recognition and related sales returns, credit memos, and allowances were inconsistent with generally accepted accounting principles in the U.S. (GAAP). ClearOne, through its practices, thus actually caused the inflated revenue figures. ClearOne, as an entity, was certainly aware of the conditions which gave rise to the misstated financial statements and had a reason to know that its financial statements were incorrect. Accordingly, the provision of those misstatements to National Union was not innocent [2005 U.S. Dist. LEXIS 26187, at *44-48].

The district court therefore granted summary judgment in favor of National Union, holding that the insurer had no obligation to provide coverage for the suits against *ClearOne* [2005 U.S. Dist. LEXIS 26187, at *50].

On appeal, the Tenth Circuit affirmed the district court's findings but remanded the case to address what the appeals court considered a factual dispute that, though easily addressed, had to be resolved through trial rather than on summary judgment [*ClearOne Communications, Inc. v. Nat'l Union Fire Ins. Co. of Pittsburgh*, 494 F.3d 1238, 1249 (10th Cir. 2007)]. The court found that the district court concluded that ClearOne, as an *entity*, clearly had knowledge of the revenue misrepresentations but did not address whether in fact whether the CEO (who signed the insurance application) had such knowledge [*id.*] Drawing all inferences in ClearOne's favor, the appeals court agreed that the record evidence regarding the CEOs actual knowledge of the misstatements in the 10-K was in conflict and thus not appropriate for resolution on summary judgment [494 F.3d at 1248-1250]. The court took pains to point out that

[o]n the other hand, whether she *should have known* about the misstatements is a different question, and perhaps an easier matter to establish. In the corporate context, corporate directors have a general obligation to know the financial

condition of their corporations. As a general rule an officer or director of a corporation is chargeable with knowledge of all matters relating to the affairs of the corporation which he actually knows or which it is his duty to know. Thus, in actions by strangers against an officer or director, the defendant will generally be charged with knowledge of all facts relating to the condition and business of the company which he might have known by the exercise of due diligence, whether actually known to him or not. *Gay v. Young Mens Consol. Coop. Mercantile Inst.*, *Gay v. Young Men's Consol. Coop. Mercantile Inst.*, 107 P. 237, 240 (Utah 1910); see also 2 Fletcher Cyc. Corp. § 465 ([T]he [corporate] officer is chargeable with the knowledge he or she should have had in the discharge of his or her duties.). Furthermore, under the Sarbanes-Oxley Act, the signing officer of a corporate 10-K (in this case, Flood) is required to certify the accuracy of the corporations financial statements and requires the officer to design[] . . . internal controls to ensure that material information relating to the [corporation] is made known to such officer[] by others within [the corporation]. 15 U.S.C. § 7241(a)(1)-(4) [494 F.3d at 1249].

In light of insurers express incorporation of Sarbanes-Oxley certifications into the representation and warranty provisions of the policy application, we can expect that insurers will be anxious to continue employing this new weapon in their arsenal to combat coverage for claims where the insured appears to have misrepresented material facts regarding its financial condition. As *ClearOne* illustrates, however, many of these disputes will require a full-blown trial to dispositively establish precisely what the policyholders directors and officers knew when. It is therefore an issue that will make policyholders and insurers nervous and in turn will send coverage litigators shopping for new cars.

Policy Exclusions for Fraud, Self-Dealing and Criminal Conduct

Adelphia Communications, Enron and TYCO, Inc. -- spectacular examples of corporations being used as the personal piggy banks of greed-driven corporate officers renewed the focus on the provisions in D&O policies barring coverage for fraud and profiteering from within the corporation [see, e.g., *In re Adelphia Communications. Corp.*, 298 B.R. 49, 53-54 (S.D.N.Y. 2003)]. To the extent this conduct does not trigger a suit by the insurer to rescind the policy as discussed above, the two policy exclusions most likely to come into play are the dishonesty and personal profit exclusions. We examine each in turn.

The Dishonesty Exclusion. A typical Dishonesty Exclusion in a D&O policy states:

the company shall not be liable to make any payment for loss in connection with any claims made against any of the insured persons brought about or contributed to by the dishonesty of such insured person if a judgment or other final adjudication adverse to such insured person establishes that acts of active and deliberate dishonesty or committing or attempting by such insured person with actual dishonest purpose and intent and were material to the cause of action so adjudicated [see Ostrager & Newman at § 20.20[f]].

As the court construed this language in *PepsiCo, Inc. v. Continental Cas. Co.* [640 F. Supp. 656, 660 (S.D.N.Y. 1986)], the insurer must await the outcome of the underlying litigation and is not permitted to put the directors and officers . . . on trial to determine whether or not they were, in fact, dishonest to the point that the policy will not cover them.

Significant for purposes of answering general counsels question regarding whether coverage may be available initially, this exclusion expressly requires a final adjudication of the alleged bad apples conduct, meaning the insurer cannot deny coverage based on the allegations of complaints, indictments or other documents [*id.* (exclusion for dishonesty applies only after a final judgment or other final adjudication); *In re WorldCom, Inc. Sec. Litig.*, 354 F. Supp. 2d 455, 460 (S.D.N.Y. 2005) (policy form entitling insured officers and directors to defense or advancement of defense costs requires insurer to fund such amounts pending adjudication that conduct falls within scope of exclusion)].

In the *Worldcom* coverage litigation, National Union provided the primary D&O coverage and Continentals policy was excess [354 F. Supp. 2d at 460]. The National Union policy contained the following provisions to which the Continental policy was deemed to follow form:

"NOTICE: . . . THE INSURER MUST ADVANCE DEFENSE COSTS PAYMENTS PURSUANT TO THE TERMS HEREIN PRIOR TO THE FINAL DISPOSITION OF A CLAIM."

. . .

This policy shall pay the Loss of each and every Director or Officer arising from a Claim first made against the Directors or Officers during the Policy Period or the Discovery Period (if applicable) and reported to the Insurer pursuant to the terms of this policy for any actual or alleged Wrongful Act in their respective capacities as Directors or Officers of the Company, except when and to the extent that Company has indemnified the Directors or Officers.

. . .

The Insurer shall, in accordance with and subject to Clause 8, advance Defense Costs of such Claim prior to its final disposition.

. . .

[Clause 8 of the policy provides:] Under both Coverage A and Coverage B of this policy, except as hereinafter stated, the Insurer shall advance, at the written request of the Insured, Defense Costs prior to the final disposition of a Claim. Such advanced payments by the Insurer shall be repaid to the Insurer by the Insureds or the Company severally according to their respective interests, in the event and to the extent that the Insureds or the Company shall not be entitled under the terms and conditions of this policy to payment of such Loss [354 F. Supp. 2d at 459].

After National Union entered into a settlement agreement with WorldComs bankruptcy trustee that was deemed to have exhausted the limits of the primary policy, WorldComs directors and officers turned to Continental and demanded that it advance defense costs in respect of the ongoing securities litigation [354 F. Supp. 2d at 459-460].

Continental then sought to have its excess policy rescinded based on an alleged misrepresentation in WorldComs application and argued that it had no obligation to provide defense costs or any other policy benefits to WorldComs officers and directors while its rescission claim was pending [354 F. Supp. 2d at 561-565]. The court rejected Continentals argument, holding that:

Until the issue of rescission is adjudicated, a contract of insurance remains in effect and the duty to pay defense costs is enforceable. In *Wedtech*, the Honorable Leonard Sand required an insurer to reimburse attorneys' fees as they were incurred by directors pending litigation of its right to rescind the policy as to each director. *Wedtech*, 740 F. Supp. at 221 (S.D.N.Y. 1990) (applying New York law). Relying on the policy's severability clause, the court found that the policy was not necessarily void *ab initio* with respect to each director. *Id.* at 218-19. Even more recently, the Honorable Helen Freedman held in insurance litigation arising from the criminal and civil lawsuits pending against Tyco officers that under New York law the duty to pay defense costs is unaffected by an unproven claim for rescission. *Tyco*, 2004 WL 583829, at *5. After surveying the law of several jurisdictions she found that where an insured has challenged the right of an insurer to rescind its policies and has sought an adjudication that the policies are binding, courts have enforced the obligation of the insurers to perform under the policies and to defend or to pay defense costs. *Id.* at *6. See also *PepsiCo*, 640 F. Supp. at 659, 664 (finding ongoing duty to pay defense costs where insurance company had asserted a right to terminate the policy at will) [354 F. Supp. 2d at 465].

The court therefore ordered Continental to immediately begin reimbursing the WorldCom directors and officers for defense costs as such costs were incurred [354 F. Supp. 2d at 470].

Based on the reports to date, the subprime losses appear to be less a product of affirmative dishonesty than a failure to perceive the real risk that the respective portfolios could reach their worst case scenario potential. That said, as time goes on, the issue of whether the marketers of these securities concealed information about the risk at the outset or as the adverse development materialized constitutes dishonesty as that term is used in the standard D&O policy exclusion will likely be litigated many times over.

The Personal Profit Exclusion. The standard D&O policy expressly excludes coverage for losses that arise out of or are attributable to the Insured or its directors and officers obtaining any personal profit or advantage to which the Insured was not legally entitled [see *Commercial Union Ins. Co. v. Auto Europe, L.L.C.*, 2002 U.S. Dist. LEXIS 3319 (N.D. Ill. 2002)]. The battle lines in respect of this provision initially were drawn at whether the exclusions use of the term *personal* profit indicated that it was intended to apply only to a natural person such as a director or officer, as a corporation does not have any personal rights [2002 U.S. Dist LEXIS 3319, at *8-10]. Because it can act only through its agents and is owned by its respective shareholders, the argument goes, it cannot obtain any personal profit or advantage [*id.*].

The court in *Auto Europe* ultimately relied upon, among other things, the Blacks Law Dictionary definition of person (a human being or an entity (such as a corporation) that is recognized by law has having the rights of a human being) to refute the policyholders contention [*id.*]. Because the complaint against the policyholder alleged that the corporation derived an improper benefit by overcharging its customers for value added tax on cars rented in Europe, the court found that the personal profit exclusion barred coverage for the corporation and its officers and directors as to both defense and indemnity [2002 U.S. Dist LEXIS 3319, at *11-13].

To date, little evidence has emerged that the large banks and brokerage houses have profited from the packaging of subprime loans into CDOs and related investments. To the contrary, the opposite seems to be true. There are, however, certain situations in which this issue is going to receive a lot of attention.

One such case is the opening salvo Barclays Bank launched through its December 18, 2007 complaint filed against Bear Stearns in the U.S. District Court for the Southern District of New York [Kate Kelly, *Barclays Sues Bear Over Failed Funds*, Wall Street Journal, Dec. 20, 2007 at C3. The complaint is available at <http://online.wsj.com/public/resources/documents/12192007barclays.pdf>]. While Barclays complaint is rife with allegations that Bear Stearns concealed and withheld information regarding the performance of the CDOs comprising the investment funds at issue, the complaint also alleges that Bear Stearns manipulated the fund to insulate itself from harsh losses and used multiple entities in the transaction chain to generate additional fees charged to Barclays or against the fund principal [see *Complaint* 53, 180-181]. Among other contentions, Barclays asserts that:

Bear Stearns ... used the Enhanced Fund as a place to unload excessively risky or troubled assets that could not be sold to other investors at the prices paid by the Enhanced Fund [*Complaint* 15];

Bear Stearns concealed the fund's falling net asset value from Barclays and investors in related feeder funds for as long as possible, instead of revealing the drop in value in, and the increased risk to, the Enhanced Fund, and instead of taking immediate and effective corrective action to correct problems with the Enhanced Fund [*Complaint* 5];

Bear Stearns and its management entity operated the fund deceptively, for their own or their conspirators gain, and bad faith, and in a grossly negligent manner, contrary to the duties that they owed Barclays [*Complaint* 105]; and

While the value of the fund was plummeting in February and March 2007, Bear Stearns senior manager Ralph Cioffi withdrew millions of dollars of his own money from the Enhanced Fund, while publicly making optimistic forecasts about the portfolio's prospects [*Complaint* 138].

Employing the personal profit formulation discussed in the paragraphs above, Barclays complaint clearly raises the

potential for Bear Stearns and its officers and directors to face potential liability for reimbursing its insurer(s) for any defense costs advanced pending a determination as to whether or not the conduct at issue constituted personal profit or advantage for which coverage would be barred. Because a meaningful portion of Barclays \$50 million investment and other amounts allegedly have been lost through the operation of the Enhanced Fund, the battles over whether Bear Stearns conduct was dishonest or constituted acts of personal profiteering will generate multiple rounds of trials and appeals.

Liability For The Corporate Entity

The astute general counsel will also want to investigate whether the corporation's policy provides protection to the entity itself, separate and apart from the individual directors and officers. Many insurers offer D&O policies affording optional coverage to protect the corporation itself against securities claims, sometimes along with the directors and officers and sometimes standing alone [David Gische, Directors & Officers Liability Coverage, at <http://library.findlaw.com/2000/Jan/1/241472.html>].

The addition of entity coverage for securities claims is a relatively new development, and addresses concerns and confusion raised by court rulings regarding allocation of policy proceeds between directors and officers, both as to indemnity and defense [see, e.g., *In re Adelphia Communications Corp.*, 298 B.R. 49, 53-54 (S.D.N.Y. 2003); *Nordstrom, Inc. v. Chubb & Son, Inc.*, 54 F.3d 1424 (9th Cir. 1995)].

The availability of entity coverage often generates disputes between various factions over the use of the policy proceeds, particularly when the entity is in bankruptcy. The corporate estate has an interest in preserving the policy proceeds for its own benefit; the directors and officers each have an interest in having the policy cover ongoing defense costs with respect to the claims and suits asserted against the company (which may or may not be subject to the automatic stay provisions of the Bankruptcy Code [11 U.S.C. § 362(a)]); and claimants whether shareholders, creditors or others also seek recovery for their alleged losses. Whether the corporation has priority in its claim for the use of these policy proceeds for its own defense ordinarily will be a function of how the provisions of the Insuring Agreements comprising the policy direct how those funds should be used [see Note, *In Re Adelphia Communications Corp.*, 49 N.Y.L. Sch. L. Rev. 1007-1018 (2005)].

Perhaps most significant for purposes of determining priority of payment of defense costs of the individual directors and offices is the extent to which the bankrupt corporation has a current property interest in the policy proceeds as opposed to a contingent obligation based on its obligation to indemnify directors and officers for reimbursable costs pursuant to the corporations bylaws. This was a critical issue in the *Adelphia* case, where, the corporate insured was in bankruptcy, the insurer was seeking to rescind the policy for material misrepresentations by the bad apples and the (relatively) innocent directors and officers were trying to fend off litigation already initiated against them [*In re Adelphia Communications Corp.*, 298 B.R. at 53-54. In reviewing the Bankruptcy Courts determination regarding the allocation of the policy proceeds, the District Court concluded that the corporate estates claim to the policy proceeds was not yet ripe:

Here, as far as I can tell, Adelphia does not have a property interest in the proceeds of the insurance policies yet. Although the D & O policies reimburses each estate to the extent that the estate advances funds because of the indemnification obligations in the charter or by-laws, see *Adelphia*, 285 B.R. at 592, "[i]t has not been suggested that any of the Debtors has made any payments for which it would be entitled to indemnification coverage, or that any such payments are now contemplated," *id.* at 587. Furthermore, "none of the Debtors [have] made or committed themselves to payments using their entity coverage." *Id.* Claiming the debtors now have a property interest in those proceeds makes no sense at this juncture. Such argument would be akin to a car owner with collision coverage claiming he has the right to proceeds from his policy simply because there is a prospective possibility that his car will collide with another tomorrow, or a living person having a death benefit policy, and claiming his beneficiaries have a property interest in the

proceeds even though he remains alive. No cognizable equitable and legal interest in the proceeds from the D & O policies has arisen here. Without legal and equitable interest in the proceeds, Adelpia's estate cannot be ascribed to hold a property interest in those proceeds [298 B.R. at 53-54].

Although some elements of the subprime mortgage industry will go or already have gone bankrupt, it is unlikely that any Wall Street titans such as Citigroup, Bear Stearns and Merrill Lynch, among others, will face such consequences. In some respects, that will make the battles over allocation all the more intense because real indemnification dollars could start flowing immediately as more suits like Barclays are filed and the long knives come out.

Conclusion

Whether the conflict first presents as a dispute over whether the corporate policyholder misrepresented information in its application (and the documents deemed incorporated in the application), whether the conduct of the policyholder or its directors and officers was dishonest or driven by personal profit, or whether the directors and officers defense costs will consume some or all of the coverage available to the corporate entity, the subprime mortgage crisis will spawn litigation over the parties respective rights and obligations under the operative D&O policies. Policyholders will sue insurers; insurers will sue policyholders; claimants will either participate directly in the litigation to protect their stake or will stand nervously on the sidelines cheering for whatever outcome provides them the greatest likelihood of recovery. In other words, this will be like most other significant financial, products-liability or natural crises encountered in the U.S. over the last two decades. While tremendous resources will be devoted to determining the origin of and blame for the underlying problems, more resources will be consumed answering what may now be the \$64 **billion** question: who ultimately is going to pay for it.

RELATED LINKS: For Further Discussion of the Insurance Coverage Implications of Subprime Mortgages, see
 • Mealey's Emerging Insurance Disputes 17 (2007)

For Discussion of State Responses to Subprime Mortgage Lending, see
 • Real Estate Financing Special Alert: More State Governmental Responses to Problems in the Subprime Mortgage Loan Origination Business

See also

- Clearone Communs., Inc. v. Lumbermens Mut. Cas. Co., 2005 U.S. Dist. LEXIS 26187 (D. Utah 2005);
- ClearOne Communications, Inc. v. Nat'l Union Fire Ins. Co. of Pittsburgh, 494 F.3d 1238 (10th Cir. 2007);
- PepsiCo v. Continental Casualty Co., 640 F. Supp. 656 (D.N.Y. 1986);
- In re WorldCom, Inc. Sec. Litig., 354 F. Supp. 2d 455 (D.N.Y. 2005);
- Commercial Union Ins. Co. v. Auto Eur., L.L.C., 2002 U.S. Dist. LEXIS 3319 (D. Ill. 2002);
- In re Adelpia Communs. Corp., 298 B.R. 49 (D.N.Y. 2003)

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Shaya B. Pacific v. Wilson, Elser, Moskowitz, Edelman & Dicker

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Milone and Lavella on Shaya B. Pacific v. Wilson, Elser, Moskowitz, Edelman & Dicker

By Richard D. Milone and Justin F. Lavella

February 26, 2008

SUMMARY: According to a decision of the New York Supreme Court, Appellate Division, Second Department, a lawyer hired to defend a client in a lawsuit or arbitration may be required to investigate the availability of insurance coverage and, if necessary, take steps to safeguard this asset as a fundamental component of the effective representation of a client. Moreover, the failure to take such steps could lead to a claim for legal malpractice.

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ARTICLE: Overview. When a lawyer is hired to defend a client in a lawsuit or arbitration, analyzing and pursuing the clients available insurance coverage is sometimes not expressly included in the scope of the attorneys engagement. However, according to a decision of the New York Supreme Court, Appellate Division, Second Department, investigating the availability of insurance coverage and, if necessary, taking steps to safeguard this asset, could be fundamental to the effective representation of a client, and the failure to take such steps could lead to a claim for legal malpractice.

That opinion, *Shaya B. Pacific, LLC v. Wilson, Elser, Moskowitz, Edelman & Dicker, LLP*, 38 A.D.3d 34 (N.Y. App. Div. 2006), denied a motion to dismiss by finding that it was an open question of fact whether a law firm, even one retained by a policyholders insurer, that failed to investigate the availability of insurance coverage exercised the reasonable skill and knowledge commonly possessed by a member of the legal profession. 38 A.D.3d at 41.

As a result of this ruling, it is incumbent upon any attorney defending a lawsuit or arbitration to take inventory of the insurance that might apply to that suit, and to take the steps necessary to preserve the insurance coverage. The harsh result for the law firm in the *Wilson Elser* case strongly encourages defense counsel to consider insurance issues, including the identification of applicable coverage and the noticing of actual or potential claims, at the outset of their engagement.

Background of the *Wilson Elser* Case. An individual who was injured on April 1, 2000, on the premises of the policyholder, Shaya B. Pacific, LLC (Pacific), sued seeking damages in excess of \$50 million. The policyholders primary insurance carrier, Certain Underwriters at Lloyds of London, hired the New York law firm Wilson, Elser,

Moskowitz, Edelman & Dicker LLP (Wilson Elser) to defend the underlying lawsuit on the policyholders behalf in July 2000. Approximately six months later, on January 21, 2001, the primary insurer -- but not the law firm -- advised the policyholder that because the underlying plaintiffs demand exceeded the primary policy's \$1 million limit of liability, the policyholder may wish to engage counsel of your own choice at your own expense to act on your behalf in regards to any potential excess judgment. The primary insurer also noted that the policyholder may wish to check with [its] insurance agent to determine if any excess insurance coverage is in force [and if so] to quickly notice any excess insurance carrier of this suit situation. *Id. at 36.*

In the liability phase of a bifurcated trial, the underlying plaintiff received a judgment finding the policyholder liable for his injuries. After this ruling, but before the awarding of damages, Wilson Elser placed an excess insurer, National Union Fire Insurance Company of Pittsburgh, Pa. (National Union), on notice of the claim. The National Union policy was not issued to the defendant, Pacific, but rather to a company named Greendel Developers, Ltd (Greendel). The record before the appellate court did not reveal the relationship between Pacific and Greendel, but presumably Pacific was either an additional named insured on Greendel's policy, or the two companies were related in some way that would give Pacific grounds to claim coverage under Greendel's policy.

This notice, which occurred more than two years after Wilson Elser's initial retention, sought coverage for any defense or indemnity costs exceeding the primary policy's limits. National Union denied coverage on two grounds. First, National Union asserted that there was insufficient proof that Pacific was entitled to insurance proceeds under Greendel's policy, and second, it asserted untimely notice. Under New York's strict law governing late notice, the failure to give prompt notice to an insurer can operate as a complete bar to coverage, regardless of whether or not the insurer suffered any resulting prejudice.

After the damages phase of the trial, the policyholder was ultimately found liable for more than \$6 million in damages, an amount well in excess of the primary policy's \$1 million limit of liability. Due to National Union's denial of coverage, no excess insurance coverage was available to cover the remainder of the damages award.

Pacific then sued Wilson Elser, alleging that the firm's failure to investigate the availability of excess coverage, and its failure to give timely notice to National Union at the time of its retention, constituted legal malpractice. The trial court dismissed the policyholders malpractice claim, but the appellate court reversed, finding that it could not conclude, as a matter of law, that Wilson Elser had no duty to advise its client concerning excess insurance coverage issues.

The New York Appellate Divisions Decision. The appellate division did not determine definitively that Wilson Elser had committed malpractice. It did, however, hold that a law firm in Wilson Elser's position has a duty to ascertain the existence of excess insurance coverage and, therefore, held that it was error for the trial court to have dismissed Pacific's complaint against Wilson Elser at the pleading stage.

The appellate court articulated a two-part inquiry. First, the court asked whether an attorney retained directly by a defendant in a personal injury action has any obligation to investigate the availability of insurance coverage for his or her client and to see that timely notice of claim are served. *Id. at 40.* And, second, if such an obligation exists [whether] it also binds an attorney who is retained to defend a personal injury action . . . by the defendant's carrier. *Id.*

The court answered the first inquiry in the affirmative. As support, the court stated that the policyholders case likely would turn on two questions: (1) what was the scope of the agreed representation and (2) did the attorney handling the matter, in light of all relevant circumstances, exercise the reasonable skill and knowledge commonly possessed by a member of the legal profession. *Id. at 41.* Because these questions were ones of fact, the court held that the policyholders legal malpractice action could not be dismissed on a pre-discovery motion. *Id.* (citing *Darby & Darby, P.C. v. VSI Intl, Inc.*, 95 N.Y.2d 308 (N.Y. 2000); *Firemans Fund Ins. Co. v. Farrell*, 289 A.D.2d 286 (N.Y. App. Div.

2001)).

The Effect of the Tripartite Relationship. The answer to the second question turned on the unique dynamics of the three-way relationship among a policyholder, its insurer, and its insurer-appointed defense counsel. Wilson Elser argued that, as a law firm hired by an insurer, it would place itself in a conflicted position if it were to provide advice to Pacific on insurance recovery issues.

Although recognizing that the tripartite relationship is fraught with potential conflicts of interest, and further acknowledging that it might raise conflict issues for Wilson Elser to advise Pacific with respect to its coverage rights against London (the primary insurer which was paying Wilson Elser's fees), the court found that identifying and preserving excess insurance coverage in this instance would not raise such concerns. A primary insurer is agnostic as to the existence of excess insurance sitting above its own policy, so Wilson Elser should have had no difficulty in assisting Pacific in preserving such coverage. Accordingly, Wilson Elser could not have breached any duty owed to the primary insurer by advising the policyholder on issues of excess coverage. The court thus refused to hold, as a matter of law, that Wilson Elser was excused from exploring the existence of excess coverage on the grounds that the primary insurer was paying its fees.

Observations on the Wilson Elser Decision. One lesson from the *Wilson Elser* decision is obvious: a defense lawyer, whether paid by the true client or by the client's insurer, must investigate and preserve applicable insurance.

The case also raises some additional, more subtle, questions.

First, how extensive is the duty of the law firm to investigate the existence and applicability of potential insurance? The facts of *Wilson Elser* indicate that the duty may be quite substantial. This was not a case where an excess insurance policy belonging to Pacific was handed to the law firm on a platter, and all that it needed to do was write a notice letter to National Union. Rather, the policy that Wilson Elser was accused of failing to preserve was issued to a separate company, Greendel, rather than Pacific. As a result, the Appellate Division declined to dismiss Pacific's claim that Wilson Elser had a duty to examine not only Pacific's own insurance program, but other parties' programs to the extent that Pacific might be entitled to claim under their policies. Unraveling the corporate history of a client and identifying other entities whose insurance might apply to the client's liabilities is a major undertaking. Under the *Wilson Elser* holding, it appears that defense counsel may be obligated to do so or risk malpractice liability.

Second, who pays for the time spent by defense counsel in identifying and preserving the client's potential sources of insurance recovery? The *Wilson Elser* opinion is silent on this point. Surely a law firm is not expected to perform this work at no cost. The policyholder will not want to pay fees out of its pocket after having been informed by its insurer that its legal fees are covered, particularly if the law firm was selected and directed by the primary insurer. The primary insurer, however, will likely contend that paying for insurance coverage advice is outside the scope of the duty to defend required by its insurance contract. It is a logical extension of the *Wilson Elser* decision, however, that a law firm must provide this service as part of providing a complete defense. Just as a good defense lawyer examines potential claims against third parties who may owe contribution or indemnity, *Wilson Elser* holds that it is incumbent on a defense lawyer to identify and secure applicable insurance. In the face of this holding, it is the view of these authors that a primary insurer's standard duty to defend, which includes all costs reasonable and necessary to the defense effort, must include the duty to pay for some insurance-related efforts on the part of defense counsel.

Third, one must wonder about the significance of the letter dated January 21, 2001, from the primary insurer, Lloyds, advising Pacific to engage independent counsel and consult with its insurance agent to determine if there was any excess insurance available. The letter, no doubt, was intended to assist Pacific, but at the same time was intended to provide cover to Lloyds itself, and potentially to Wilson Elser, in the event that excess insurance was needed and was not properly secured. While the letter may have given Wilson Elser a false sense of security, with hindsight it provided

no protection. Moreover, it raises the further question of whether Lloyds honored its own fiduciary duty to act in the best interest of its insured, Pacific. Perhaps Lloyds, having recognized that excess insurance may become necessary, should have done more than write one letter to Pacific and then wash its hands of the responsibility to make sure that excess coverage was preserved. If a law firm hired by an insurer to protect an insured will be charged with the duties outlined in the *Wilson Elser*, then it is reasonable to conclude that insurers must look closely at their own duties as well.

Finally, a tangential point is worth noting. Typically a policyholder is not permitted to sue either its attorneys or insurance broker for malpractice associated with the handling of insurance claims until its insurer has been legally absolved of any right to pay under its policy. The *Wilson Elser* opinion, however, does not state what became of Pacific's insurance coverage claim against National Union, other than to say that National Union denied coverage on two grounds. As a result, it is unclear whether Pacific litigated its coverage issues against National Union to conclusion or chose not to pursue its claim any further based on a view that New York's late notice rule was insurmountable. Nevertheless, it is debatable whether a mere denial from an insurer is sufficient proof that the coverage is truly lost, so that a malpractice claim against the policyholders' counsel would be justified.

Practice Tips for Legal Practitioners. Practitioners should consider several lessons from this cautionary tale.

First, tort defendants, insurers, and attorneys always should address insurance issues directly when defining the scope of the legal representation. As noted by the *Wilson Elser* court, the scope of the parties' retention agreement or engagement letter may indicate whether a duty to inquire about insurance exists. *Wilson Elser* would have had a solid defense to Pacific's malpractice claim if its retention letter had confirmed that its engagement did not include the duty to examine excess insurance. Law firms are wise to confirm in every engagement letter in which they represent a defendant in any kind of suit that their services will or will not include an examination of potentially applicable insurance.

Second, whether required by their retainer agreement or not, attorneys defending a lawsuit should take a close look at the availability of insurance at the outset of an engagement. Not only should the defendant's own insurance be considered, but also other parties' coverage under which the client may be an additional insured or otherwise have an ability to claim coverage rights.

Third, do not accept an insurer's denial of coverage at face value. Quite often insurers deny claims that they know are covered in the hopes that policyholders will not pursue them. Never assume that coverage is unavailable.

Fourth, if you are unable to perform a complete and thorough analysis of potentially available coverage, either due to an actual or perceived conflict, or due to lack of experience with insurance issues, consult with somebody who is in position to provide such an analysis.

Fifth, act quickly. Many times, decisions made at the outset of a representation may materially affect not only the amount but also the availability of insurance coverage. One such example is the decision to give notice. As noted in the *Wilson Elser* decision, under New York law, insurers will argue that coverage is forfeited if notice is not given within 30-60 days, and there is no requirement that the insurer prove that it was prejudiced by the delay. Most other states' laws are less strict, but nonetheless, late notice is an issue that can and should be avoided. In addition, most policies require policyholders to satisfy a number of other conditions or risk losing coverage. Such conditions include the duty to seek insurer consent, the duty to keep the insurer informed of developments, and the duty to cooperate.

Finally, defense counsel should not interpret *Wilson Elser* as creating an additional burden. The decision actually provides a new source of compensation for both the client and its defense counsel. While defense counsel in *Wilson Elser* was being paid directly by the primary insurer, in many instances a client may be paying such costs directly because it either ignored its insurance or was wrongly denied coverage by its insurer. Yet, under many policies, the insurer is required to pay its policyholders' legal fees directly.

If you have any questions about the *Wilson Elser* opinion or insurance coverage in general, please do not hesitate to contact the authors of this article.

For general information on insurance, see Appleman on Insurance Law and Practice (2d Ed. LexisNexis Matthew Bender).

For sample insurance policy forms, search Legal > Area of Law By Topic > Insurance > Search Forms & Drafting Instructions > ISO Policy Forms.

For annotated insurance policies and leading insurance cases, see Millers Standard Insurance Policies Annotated (Legal Research Systems Inc.).

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Clifford on Storek v. Fidelity Guaranty Insurance Underwriters, Inc.

2008 Emerging Issues 1957

Clifford on Storek v. Fidelity Guaranty Insurance Underwriters, Inc.

By Robert C. Clifford

February 26, 2008

SUMMARY: Robert C. Clifford discusses the issues raised by the U.S. District Court in *Storek v. Fidelity & Guaranty Insurance Underwriters, Inc.*, 504 F. Supp. 2d 803 (N.D. Cal. 2007) and the duty of an insurer to provide a defense to a claim against an insured. Although *Storek v. Fidelity & Guaranty* is a federal trial court decision, the well-reasoned opinion may be persuasive in California cases involving an insurers duty to defend.

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ARTICLE: *Introduction. Storek v. Fidelity & Guaranty Insurance Underwriters, Inc.*, 504 F. Supp. 2d 803 (N.D. Cal. 2007), involved the duty of an insurer to defend its insured. The claim arose out of a family dispute between three brothers about the management of a building owned by the family. The defendant insurer issued a policy providing coverage to two brothers to protect them against losses they might sustain in connection with their ownership of the property. The policy provided in part that the insurer was obligated to pay "those sums that the insured becomes legally obligated to pay as damages because of bodily injury, property damage, personal injury or advertising injury". The policy also provided that the insurer was obligated "to defend the insured against any suit seeking those damages". While the policy was in effect, a dispute arose within the family about management of the property. Two of the brothers filed an action against the third brother alleging mismanagement, conversion and fraudulent actions.

In response, the defendant brother filed a cross-complaint, asserting 12 causes of action including accounting, breach of fiduciary duty, conversion, wasting of trust assets, conspiracy, breach of contract, intentional interference with prospective business advantage, quantum meruit, equitable contribution and fraud. The cross-defendants then tendered the cross complaint to their insurer, asserting the insurer was obligated to provide a defense to the cross-complaint. The insurer declined to defend on the basis that the cross-complaint did not raise a potential for coverage. The two brothers then filed an action against the insurer alleging that the insurer breached its duty to defend. The court granted the insurer's motion for summary judgment, holding that neither the allegations of the cross-complaint nor extrinsic evidence established that the insurer had a duty to defend.

General Principles as to the Insurer's Duty to Defend. An insurer's duty to defend an insured extends beyond the specific claims set forth in the pleadings. The duty is so broad that the insurer is obligated to defend an action so long as

the complaint contains language that creates a potential for liability under the terms of a particular insurance policy. Remote facts buried within causes of action that may potentially give rise to coverage are sufficient to invoke an insurer's duty to defend. *Storek v. Fidelity & Guaranty* citing *Pension Trust Fund for Operating Eng'rs v. Federal Ins. Co.*, 307 F. 3d 944, 951 (9th Cir. 2002).

In California, the seminal case of *Gray v. Zurich Insurance Co.* (1966) 65 Cal. 2d 263, 276, 54 Cal. Rptr. 104 held that the insurer must defend the insured if there is any possible factual or legal basis on which the insurer may eventually be obligated to indemnify the insured under any provision contained in the policy. An insurer's duty to defend extends to all actions that raise the "possibility" or "potential" for coverage. Courts frequently recite the mantra that an insurer's duty to defend is broader than the duty to indemnify. Any doubt as to whether the facts give rise to a duty to defend is resolved in the insured's favor. *Storek v. Fidelity & Guaranty* citing *CNA Casualty of California v. Seaboard Surety Co.* (1986) 176 Cal. App. 3d 598, 607, 222 Cal. Rptr. 276.

Although *Gray v. Zurich* and its progeny broadened the duty to defend imposed on the insurer, this duty is not unlimited. An insurer is not obligated to defend every claim asserted against the insured regardless of the scope of coverage; rather, its duty to defend is generally limited to claims within the policy's scope of coverage. See *Lipson v. Jordache Enterprises, Inc.* (1992) 9 Cal. App. 4th 151, 153, 11 Cal. Rptr. 2d 271.

Application of the Principles. In applying the principles concerning an insurer's duty to defend, the court in *Storek v. Fidelity & Guaranty* followed the two-step coverage analysis developed by the California Supreme Court in *Horace Mann Ins. Co. v. Barbara B.* (1993) 4 Cal. 4th 1076, 17 Cal. Rptr. 2d 263. First, the court compared the cross-complaint's allegations to the terms of the policy and found that the allegations did not trigger coverage because they pertained solely to the financial management of the real property. *Storek v. Fidelity & Guaranty Insurance Underwriters, Inc.*, 504 F. Supp. 2d 803, 807 (N.D. Cal. 2007).

Here, the insureds (cross-defendants in the underlying action) had contended that the insurer owed a duty to defend because the cross-complaint contained facts which essentially stated a cause of action for defamation or slander. Specifically, they contended that the cross-complaint's allegations that the insureds had "inserted themselves into the [building] ownership relationship" and that they may have obtained their mother's authorization to make her trustee decisions implied that they had made slanderous statements about the cross-complainant during that course of conduct. The *Storek* court rejected the insureds' "tortured" analysis: "Simply put, there is nothing in the allegations set forth in the cross-complaint that even remotely suggests a potential for liability for personal injury, whether on a theory of wrongful eviction or on a theory of defamation, libel, or slander." *Storek v. Fidelity Insurance Underwriters, Inc.*, 504 F. Supp. 2d 803, 808 (N.D. Cal. 2007).

Recognizing that, under California law, an insurer's duty to defend is not limited to the face of the cross-complaint, the *Storek* court next focused on whether extrinsic facts gave rise to a duty to defend. *Storek v. Fidelity Insurance Underwriters, Inc.*, 504 F. Supp. 2d 803, 808 (N.D. Cal. 2007). The rationale of the extrinsic evidence rule is that neither the insured nor the insurer should be bound by the specific allegations advanced by a third party, when the circumstances of the case clearly establish, or eliminate, an insurer's obligation to provide a defense.

Here, the insureds contended that a series of pre-litigation e-mail exchanges between members of the *Storek* family supported a defamation cause of action, while post-litigation correspondence from the cross-complainant and his counsel complaining that the cross-complainant had been excluded from the property supported a cause of action for wrongful eviction, even though the cross-complainant had elected not to plead such a cause of action. Essentially, the insureds contended that California law required an insurer ". . . to provide a defense whenever extrinsic evidence raises the potential for liability." *Storek v. Fidelity Insurance Underwriters, Inc.*, 504 F. Supp. 2d 803, 811 (N.D. Cal. 2007). The *Storek* court disagreed, ruling that California law is not so expansive that it requires an insurer to undertake a defense as to claims that are both factually and legally untethered for the third party's complaint. *Storek v. Fidelity Insurance Underwriters, Inc.*, 504 F. Supp. 2d 803, 812 (N.D. Cal. 2007). Instead, the court found that ". . . an insurer owes no duty to defend based upon mere 'speculation' as to claims that a third party might have brought." *Storek v.*

Fidelity Insurance Underwriters, Inc., 504 F. Supp. 2d 803, 811 (N.D. Cal. 2007). Here, the court found no evidence to impose a duty to defend because the underlying lawsuit set forth neither the facts nor the legal claims necessary to bring the lawsuit within the terms of the insureds' policy.

Conclusion. One lesson to be learned from the Storek decision is that even if the duty to defend is extremely broad, nevertheless, there are definite limits to constrain the imposition of a duty to defend upon an insurer. Secondly, it is established that even though the complaint does not provide a basis for imposing a duty, California law allows, indeed requires, insurers to consider evidence extrinsic to the allegations set forth on the face of a complaint.

Strategic Point -- Plaintiff. Counsel representing plaintiffs or cross-complainants in business litigation should consider asserting a cause of action, or multiple causes of action, that will trigger the defendant's or cross-defendant's commercial general liability coverage. Examples of such causes of action would typically include libel, slander, wrongful eviction, or other form of wrongful conduct arising from negligence.

Strategic Point -- Insured. Counsel for an insured seeking to impose a duty to defend upon an insurer must carefully review the complaint's allegations to determine whether they support a cause, or causes, of action that will trigger coverage under the insured's liability policy. Secondly, counsel should thoroughly investigate the circumstances that form the basis of the lawsuit at issue to determine whether extrinsic evidence that supports covered causes of action exists.

Strategic Point -- Insurer. Counsel for an insurer should recognize that although the duty of an insurer to defend is certainly broad, the duty is not unlimited and an insurer owes no duty to defend based upon mere speculation as to claims that a third party might have brought.

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Cohen on Granite State Ins. Co. v. Ace American Reinsurance Co.

2008 Emerging Issues 1948

Cohen on Granite State Ins. Co. v. Ace American Reinsurance Co.

By Richard J. Cohen

February 25, 2008

SUMMARY: The follow the settlements principle refers to a duty of the reinsurer to follow the actions of the cedant in adjusting and settling claims. Subject to certain exceptions, it allows the cedant the right to decide what the scope of coverage actually is when the cedants policy is subject to more than one reasonable interpretation, and allows the cedant to make adjustments and settlements in conformity with that interpretation.

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ARTICLE: Simply stated, reinsurance is the act of insuring insurers for the risk of exposure the insurer takes on behalf of their own insureds. In concept, the insurer passes on to the reinsurer some of all of the risk it has underwritten. Reinsurance serves several purposes. In the first instance, it can increase the capacity of the insurer to accept risk, by providing to the insurer a partner with whom to share that risk. Relatedly, reinsurance can also strengthen the solvency of an insurer in order to satisfy and overcome any requirements that it operate under a certain solvency margin that is, the ratio of net premium income over capital reserves. Without reinsurance, capital reserves would be exhausted much earlier and it would limit the risk that the insurer could elect to take on thus limiting its capacity to insure. Reinsurance agreements are substantially less formal than the agreements between the re-insured (the cedant) and its insured. Under standard reinsurance industry practices, reinsurers are obligated to follow their ceding companys settlements with the cedants insureds so long as the settlements are made in good faith after reasonable investigation and do not involve *ex gratia* payments that is, one devoid of legal obligation. A following form clause found in a reinsurance contract provides that where there is a concurrence by and between that policy and the policy to be reinsured, the reinsurance policy will be construed as offering the same terms, conditions, and scope of coverage as exists in the cedants policy absent explicit language to the contrary. As a result, the policy of reinsurance indemnifies the reinsured policy for all payments made pursuant to its terms unless an exclusion is spelled out in the reinsurance policy. The follow the settlements principle refers to a duty of the reinsurer to follow the actions of the cedant in adjusting and settling claims. If the cedants loss settlement is not fraudulent, collusive or otherwise made in bad faith, and is not an *ex gratia* payment, the reinsurer, under the follow the settlements doctrine, cannot raise policy defenses against the cedant that might have been raised by the cedant against the original insured. The follow the settlements doctrine allows the cedant the right to decide what the scope of coverage actually is when the cedants policy is subject to more than one reasonable interpretation, and allows the cedant to make adjustments and settlements in conformity with that interpretation. For example, if the cedant enters into a settlement with its insured on the basis of a reasonable judgment that the insureds

challenge to the cedants coverage position would be sustained at trial, the reinsurer is required under the follow the settlement doctrine to indemnify the cedant for that exposure.

To just what lengths the cedant may go in deciding the scope of coverage and apportioning settlement dollars via agreement with its insured and still seek indemnity from its reinsurer may soon be put to the test. But while the final exam looms large on the horizon, the mid-term exam contained too many blanks so said New Yorks Appellate Division. In *Granite State Ins. Co. v. Ace American Reinsurance Co.*, 46 A.D.3d 436, 2007 N.Y. Slip. Op. 10464 (1st Dept., December 27, 2007), AIG, of which Granite State is an affiliate, issued excess umbrella liability policies to Castle & Cooke, Inc. (now known as Dole Foods Company), and then purchased facultative contracts of reinsurance from Ace American Re. In the early 1990s, Castle & Cooke was sued by thousands of its field workers in Central America and the Philippines for injuries allegedly suffered as a result of the workers exposure to Dibromochloropropane (DBCP), a pesticide. Through various of its affiliated companies, AIG had issued seven policies to Castle & Cooke, under which Castle & Cooke sought coverage for the DBCP claims. One of those policies was issued by Granite State in 1979. Relying on a DBCP exclusion, AIG ultimately disclaimed coverage under the Granite State policy, but agreed that its other policies did answer to the underlying claims. AIG and Castle & Cooke then entered into a future cost agreement setting forth which policies would provide defense and indemnity on an ongoing basis. After AIG realized it had paid more than the available limits with respect to defense and indemnity on one of its policies issued by affiliate National Union, its counsel advised it to move its overpayments to the Granite State policy, which, unlike the National Union policy, was reinsured by Ace. By addendum, AIG and Castle & Cooke then amended their future cost agreement to acknowledge that AIG had exhausted the applicable limits of its National Union policy and, to the extent any sums remained unpaid, they would become the responsibility of Granite State.

AIG then sent Ace a notice of loss based on the payment to Castle & Cooke that it had reallocated to the Granite State policy. Ace objected on two grounds: (1) that AIGs reallocation of the settlement to the Granite State policy was not in good faith and, alternatively, (2) that by doing so, AIG had made an *ex gratia* payment that was not covered by the Ace reinsurance contract. Granite State then brought action against Ace and Ace ultimately moved for summary judgment. The lower court denied the motion, and, on appeal, Ace argued that the lower court had conflated the two separate exceptions, thus requiring Ace to prove bad faith notwithstanding what Ace argued was an obvious *ex gratia* payment. The Appellate Division appears to have acknowledged that the court below failed to reach the issue of whether the payment was *ex gratia*. The appellate court, however, still affirmed the ruling below, finding a question of fact not only as to whether the reallocation of the settlement proceeds to the Granite State amounted to bad faith, but also as to whether the payment was, indeed, *ex gratia*.

This decision appears to have left some of the facts to the readers imagination. It certainly appears that AIG, advertantly or not, negotiated an agreement with its insured to move its obligation from a policy that may not have been reinsured, to a policy under which it had disclaimed coverage but which was reinsured. The decision is silent on what explanation AIG gave for doing so, as well as the basis for an argument on the part of the cedant that the payment under the Granite State policy was indeed an obligatory one. What is very interesting is that the court appears to have referred interchangeably to the follow the fortunes doctrine which requires the reinsurer to follow the cedants underwriting fortunes, and the related follow the settlements doctrine oftentimes referring to the fortunes doctrine as opposed to the settlement doctrine when describing the cedants actions in reallocating the settlement proceeds. The courts recitation of the relevant facts do not suggest any significant underwriting issue. AIG disclaimed under what the court referred to as a DBCP exclusion in the Granite State policy, and its insured did not challenge the disclaimer. Given the question of fact, however, the reader might surmise either that the basis for disclaimer may not have been so obvious after all, or, more significantly, that the court simply was not inclined to hold that the cedants actions were geared specifically and exclusively for purposes of passing the exposure on to the reinsurer and thus was either in bad faith or *ex gratia*. If the latter, we may be seeing the gradual expansion of the cedants discretion in managing its ultimate exposure. This certainly is a case to watch with interest, as it ultimately may provide guidance on just how much latitude a cedant may be granted in allocating its obligations in a way that allows it to seek recovery of its contribution through its reinsurance.

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Aylward on Emerging Exposures Imperil Excess Insurers

2008 Emerging Issues 143

Aylward on the Disappearing Safety Net: Emerging Exposures Imperil Excess Insurers

By Michael F. Aylward

February 25, 2008

SUMMARY: Excess insurers have long relied on the principle that they would have no duty to indemnify their insureds until the underlying primary insurance had been exhausted. However, recent decisions of the Eight and Tenth Circuits and some state courts have been receptive to insureds' contentions that in certain instances they should obtain excess coverage for catastrophic losses where the underlying insurance has not been exhausted.

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ARTICLE: Introduction

Traditionally, excess insurers have bound coverage and monitored claims with the comforting assurance that any obligations that they might owe to a policyholder will not arise until the underlying primary insurance had played its part. However, several recent opinions have made clear that this coverage "safety net" is increasingly threadbare and that excess insurers may, in fact, be held to owe coverage for risks far beyond what they may believe that they originally bargained for.

Two recent rulings from the U.S. Courts of Appeals for the Eighth and Tenth Circuits have opened the door to policyholder arguments that insureds can obtain excess coverage for catastrophic losses even if the stated underlying insurance is not exhausted. While some of these issues have been explored in the past in "drop-down" cases arising out of primary insurance insolvencies, these rulings point to new and potentially troubling (from the excess insurers' point of view) recovery strategies.

The Yaffe Companies, Inc. v. Great American Ins. Co.

In *The Yaffe Companies, Inc. v. Great American Ins. Co.* [499 F.3d 1182 (10th Cir. 2007), *reh'g denied*, No. 06-7057 (10th Cir. Nov. 20, 2007)], the owner of a scrap yard in Muskogee, Oklahoma sought coverage for nearly \$1.8 million that it had paid to settle bodily injury and property damage claims resulting from an explosion at its scrap yard. Yaffe sought coverage for these claims under a commercial general liability (CGL) policy issued by ACE American and an umbrella liability policy issued by Great American. The ACE CGL policy was written with limits of \$1 million per

occurrence and a general aggregate of \$2 million. Notably, however, the policy not only contained a \$10,000 deductible but the deductible was written on a "per claim" basis. Over that coverage was Great American's umbrella policy with a limit of \$25 million each occurrence and in the aggregate.

Ordinarily, one would not expect there to have been much of an issue with respect to the availability of coverage under the Great American policy as Yaffe's settlement payments clearly exceeded the \$1 million primary limit. In this case, however, because most of Yaffe's claim payments were for less than the \$10,000 deductible. As a result, ACE ultimately only paid \$497,999.10 -- less than half the total primary policy limit. Great American therefore contested Yaffe's demand that it pay the amount of \$785,986.89, the difference between the total amount of damages that it had paid and \$1 million.

In the ensuing coverage litigation, the U.S. District Court for the Eastern District of Oklahoma granted Great American's motion for summary judgment declaring that Great American's excess obligations only arose "when Yaffe becomes obligated to pay sums in excess of or, stated in another way, after exhaustion of, the \$1 million coverage provided by the ACE policy" [*Yaffe Cos. v. Great Am. Ins. Co.*, 2006 U.S. Dist. LEXIS 29482, at *10 (D. Okla. 2006)].

On appeal, Great American argued that the District Court had correctly found that its obligations did not arise until the ACE primary policy had become exhausted. The Tenth Circuit disagreed. It declared that the triggering event for Great American's coverage obligations was the point in time when the insured's liability exceeded \$1 million and did not depend on whether that amount was actually paid pursuant to the underlying insurance.

The Tenth Circuit focused on the insuring language in the Great American policy which stated that the insurer would pay on the insured's behalf "those sums in excess of the retained limit that the insured becomes legally obligated to pay by reason of liability imposed by law or assumed by the insured under an insured contract because of bodily injury, property damage, personal injury or advertising injury that takes place during the Policy Period and is caused by an occurrence happening anywhere."

The policy further stated that Great American would pay that portion of damages in excess of the "retained limit" which was the greater of:

1. the total amount stated as the applicable limits of the underlying policies listed in the Schedule of Underlying Insurance and the applicable limits of any other insurance providing coverage to the insured during the Policy Period; or
2. the amount stated in the declarations as self insured retention as the result of any one "occurrence" not covered by the underlying policies listed in the Schedule of Underlying Insurance or by any other insurance providing coverage to the insured during the Policy Period

And then up to an amount not exceeding the each occurrence limit as stated in the declarations.

Despite Great American's argument that it was unreasonable to trigger its coverage prematurely merely because the insured had saved premium by purchasing primary insurance with a "per claim" deductible rather than the more common "per occurrence" deductible term, the Tenth Circuit held that, "Yaffe's bargain with ACE should be irrelevant to the construction of the language of the Great American policy and that, in any event, any savings that Yaffe had achieved with respect to the premium that it paid to ACE was more than off-set by the fact that it ultimately paid half a million dollars in uninsured losses."

The court also distinguished Condition P in the Great American policy, which stated that coverage under this policy did not apply unless or until the insured or the underlying insurer is obligated to pay the retained limit, holding that this was merely meant to prevent the excess insurer from being obligated to drop down and was not inconsistent with this situation, where the primary insurance not only had been kept in effect but the actual retained limit had been paid by the insurers and the insured.

The Tenth Circuit concluded that the Great American policy was ambiguous and that summary judgment should not have been granted to Great American. The case was therefore remanded to the Oklahoma District Court for further findings with respect to whether Yaffe was, in fact, entitled to coverage. Although such a finding of coverage seemed likely, the Tenth Circuit declined to reach that conclusion as the Oklahoma District Court had precipitously granted summary judgment to Great American prior to Great American having had the opportunity to file an opposition to the insured's cross-motion for summary judgment.

This line of reasoning was disputed by Justice Brisco in a dissenting opinion. Brisco argued that the majority had erred in determining that the umbrella policy's reference to "the applicable limits in the underlying policies" merely set the threshold amount over which the umbrella policy would pay and failed to take into account the requirement that that \$1 million amount actually had been paid by the primary insurer. The dissent criticized the majority for ignoring the "key introductory language" of the policy which stated that Great American "will be liable only for that portion. . . in excess of the retained limit which is the greater of . . . \$1 million." While acknowledging that this language could perhaps be clearer, Justice Brisco held that its reference to "the applicable limits of the underlying policies" was obviously intended to mean that those policies had to be exhausted before coverage begins under the umbrella policy:

To conclude otherwise, as the majority does, effectively transforms the policy from its intended purpose as an excess policy into a primary insurance policy with a large deductible. If that is the proper interpretation, then one must ask why the policy repeatedly refers to the underlying policies and their applicable limits, and why the policy requires that those underlying policies be kept in full force and effect?

Justice Brisco also criticized the manner in which the majority had addressed the gaps in primary coverage resulting from the use of a "per claim" deductible. The dissent noted that deductibles cannot reasonably be considered to constitute a "gap" and that excess insurers were generally not responsible to reimburse policyholders for the amount of a primary policy deductible quoting other authorities to the effect that "the rationale for not including deductible payments as part of the limits of the underlying policy was grounded in the insured's decision to, in essence, become self-insured for the deductible amount as the result of a bargain reached with the primary insurer" [Couch on Insurance [otilde] 220:36 (3d ed.)]. Taking the policy as a whole, the dissent argued that summary judgment should have been affirmed for Great American.

Late in 2007, Great American moved for *en banc* reconsideration. This motion was denied by the full court on November 27, 2007. Interestingly, of the judges who considered the petition, only Justice Hartz, one of the two justices in the majority in the original panel, voted to grant *en banc* rehearing. It is unclear whether Hartz had doubts about the opinion he had joined or felt that it might have more influence and effect as restated as an opinion of the full court.

Yaffe should stand as an object lesson to excess underwriters of the perils not only of using "retained limit" language to define the threshold point at which the umbrella policy arises, but also of the danger of not fully taking into account the effect that certain features in a primary policy may have in prematurely triggering an excess insurer's obligations. One could easily conceive of similar issues arising where, unbeknown to the excess underwriter, the primary policy is written with burning limits. Similar issues have arisen in cases where certain types of coverage afforded under the primary policy have limits lower than are afforded by the policy as a whole, as is commonly the case nowadays with sexual abuse endorsements and employment practices liability (EPL) coverages. Over the years, insurers have found that including sub-limits of coverage are in many respects more effective than excluding coverage all together.

West Bend Mut. Ins. Co. v. Rosemont Exposition Services, Inc.

The potential peril presented by sub-limits was explored by the Illinois Appellate Court in its recent opinion in *West Bend Mut. Ins. Co. v. Rosemont Exposition Services, Inc.* [2007 Ill. App. LEXIS 1275 (1st Dist. 2007)]. In that case, Rosemont Exposition Services was sued by two former employees for defamation and retaliatory discharge. Rosemont tendered the defense of these claims to its general liability insurer (West Bend), which had issued both a \$1

million CGL policy and a \$5 million umbrella liability policy. The CGL policy contained an exclusion in the main body of the policy precluding coverage for employment practice liability claims. However, coverage was reinstated by endorsement with a separate limit of \$100,000. A similar EPL exclusion was contained in the umbrella policy.

West Bend duly accepted the defense of the underlying claims pursuant to the EPL endorsement in its CGL policy. However, after the limits of that became exhausted (defense costs were included within limits for this coverage), Rosemont demanded that West Bend continue to provide a defense pursuant to the main body of the CGL policy. Alternatively, Rosemont argued that the umbrella policy should drop down since the only available underlying insurance was now exhausted.

The Cook County Circuit Court agreed with West Bend, however, that neither the CGL nor the umbrella policy afforded coverage for EPL claims. These findings were affirmed by the Appellate Court. Having concluded that the underlying claims fell within the exclusion's definition of prohibited employment practices, the court ruled that it was clearly subject to the employment-related practices (ERP) exclusions in the CGL and umbrella policies.

Waste Management of Minnesota, Inc. v. Transcontinental Ins. Co.

Disputes with respect to the manner in which the retained limit may be deemed to be satisfied were also at the heart of the recent opinion from the U.S. Court of Appeals for the Eighth Circuit in *Waste Management of Minnesota, Inc. v. Transcontinental Ins. Co.* [502 F.3d 769 (8th Cir. 2007)]. In that case, a garbage truck loaded by Waste Management of Minnesota, Inc. and driven by one Chad Trenhile jumped a highway median and struck the car of Brian and Ellen Ross, injuring both the Rosses and Trenhile. The Rosses sued Waste Management, Trenhile and various trucking defendants. At the time, Waste Management had in place a \$1 million primary policy with Reliance Insurance Company which during the course of these proceedings was declared insolvent. Over the Reliance policy was an excess policy issued by Transcontinental.

The Ross claims were ultimately settled for \$2.3 million of which Transcontinental contributed slightly more than \$1.3 million. However, the Ross settlement did not resolve the pending Trenhile personal injury lawsuit against Waste Management and other parties. An issue arose, therefore, as to whether the \$1 million that other parties had paid to settle the Ross lawsuit satisfied the underlying \$1 million retained limit necessary to trigger Transcontinental's excess obligations as regards the Trenhile claim.

The Ross lawsuit had been settled through a combination of \$555,000 paid by the Minnesota Insurance Guaranty Association (on behalf of the insolvent Reliance Insurance Company), \$250,000 paid by the Rosses uninsured motorist's carrier (MSI), \$150,000 paid by Waste Management itself and an agreement on the part of the Rosses to reduce their judgment by \$30,000. Since the total payments by the insured and the Guaranty Association only came to \$705,000, Transcontinental disputed any obligation to accept coverage for the Trenhile claims as the \$1 million underlying retained limit had not been satisfied.

In the ensuing coverage litigation, the U.S. District Court for the District of Minnesota held that the Ross settlement payments had, in fact, exhausted the \$1 million underlying limits thereby triggering Transcontinental's duty to defend and indemnify Waste Management for the Trenhile claim [*Waste Management of Minnesota, Inc. v. Transcontinental Ins. Co.*, 2006 U.S. Dist. LEXIS 59864 (D. Minn. 2006), *aff'd*, 502 F.3d 769 (8th Cir. 2007)]. On appeal, the Eighth Circuit affirmed.

As a preliminary matter, the Eighth Circuit rejected Transcontinental's argument that the District Court's decision violated the Financial Impairment condition in its policy, which stated that the bankruptcy of an underlying insurer would not increase the excess insurer's obligations. The court observed that, had Reliance been solvent, it would have paid its full \$1 million limit with the result that Transcontinental would have paid exactly the same amount towards the \$2 million settlement as it ultimately did through the assistance of other parties. As a result, the court ruled that the District Court's decision was "true to the mandate" of the anti drop-down language in the policy and did not either

relieve or increase Transcontinental's obligation as an excess insurer of Waste Management. The court declared, therefore, that this argument was a "red herring."

The court next turned to Transcontinental's argument that only payments actually made by the underlying insurer or its policyholder counted against the underlying limits necessary to trigger its excess obligations. The Eighth Circuit noted, however, that the Transcontinental policies called for the excess carrier to pay any "ultimate net loss" in excess of the Reliance policy limit and that "ultimate net loss" was defined not as the amounts paid by Reliance or Waste Management but as the damages for which Waste Management was "legally obligated to pay." In keeping with its earlier opinion in *Reliance Ins. Co. in Liquidation v. Chitwood* [433 F.3d 660, 664 (8th Cir. 2006)] the court held, therefore, that exhaustion does not require an insurer to pay the full dollar value of a policy but only requires the insured to prove that the claims aggregating the full amount of the specific policy have been settled thereunder.

The court also rejected Transcontinental's argument that this analysis was contrary to the exhaustion clause in its policy which stated that the excess policy would continue in place of the exhausted amount of scheduled underlying insurance in the event exhaustion occurred by reason of payments of a combination of covered settlements or judgments. The Eighth Circuit held that this language did not require that the underlying insurers had actually paid their excess policies as long as their obligations to do so had been finally determined.

Having rejected all of Transcontinental's arguments, the Eighth Circuit concluded that Waste Management clearly became "legally obligated to pay" the \$2.3 million balance of the Ross judgment. The court found that, "[a] contrary ruling would result in the Reliance insolvency relieving Transcontinental of its preexisting contractual duties as an excess insurer, contrary to the Financial Impairment policy provision."

As with the Tenth Circuit's opinion in *Yaffe*, *Waste Management* reflects the ongoing tension between excess insurer arguments that their policies should not come into play until primary policies have actually been paid and policyholder claims that such language is either ambiguous or is in any event satisfied once their liabilities are determined to exceed the retained limit. Although not reflected in either opinion, excess insurers have argued in cases of this sort that the primary insurer acts as a kind of gatekeeper and that excess insurers rely on this gatekeeping function to ensure that any resulting determination of liability or judgment has fairly been disputed and adjudicated. What seems ultimately to have been determinative in the *Waste Management* case, however, was the fact that such safeguards likely already existed as the result of the arbitration and litigation process and that Transcontinental was left in no worse off position, not having been obligated to "drop down" to act as a primary insurer, than would have been the case had Reliance remained solvent. To the contrary, the court suggested that Transcontinental would in fact have obtained a windfall by being relieved of any payment obligations if its arguments had prevailed.

Allmerica Financial Corp. v. Certain Underwriters at Lloyd's, London

The interrelationship between primary and excess policies was also recently construed by the Supreme Judicial Court of Massachusetts. The issue in *Allmerica Financial Corp. v. Certain Underwriters at Lloyd's, London* [449 Mass. 621 (2007)] was whether "following form" language in an umbrella liability policy bound the excess insurer to follow not only the terms of the primary policy but the primary insurer's understanding and claims decisions with respect to those terms.

Allmerica, a life insurer, had been sued in a class action brought by policyholders who alleged that Allmerica had acted unfairly and deceptively in selling them various "vanishing premium" life insurance policies. Allmerica tendered the defense of this claim to its general liability insurer, Columbia Casualty. Columbia Casualty agreed to advance the cost of defending Allmerica pursuant to a reservation of rights. Although Columbia Casualty never accepted coverage for the claims, it ultimately agreed to pay its full \$20 million policy limit pursuant to a Settlement Agreement and Release towards the cost of settling the underlying class action. The Agreement specified that Columbia Casualty's payment was not to be construed as "an admission of coverage or lack of coverage for the claim for coverage submitted by Allmerica"

During the pendency of the class action settlement discussions, Allmerica also contacted Certain Underwriters at Lloyd's, London, which had underwritten the excess coverage over Columbia Casualty's primary policy. Several months later, Underwriters disputed any obligation to provide coverage for the claims in light of a wrongful acts exclusion.

In the ensuing coverage litigation, Allmerica contended that as the Lloyd's policy followed form to the underlying Columbia Casualty policy, Lloyd's was bound by the primary insurer's decision to settle and could not rely on exclusions that Columbia Casualty had chosen not to assert. In effect, Allmerica argued that the "following form" language extended not only to the terms of the underlying policy but the understanding and actions of the underlying insurer as regards those terms. Thus, coverage would extend not only to the written terms of the policy but its actual application to a claim.

While acknowledging that the issue was one of first impression in Massachusetts, the Supreme Judicial Court found authority in its prior rulings with respect to whether and when excess insurers were required to "drop down" due to the insolvency of primary insurers. The court found that these "drop down" cases demonstrated a basic point, namely that excess insurance is separate and distinct from primary insurance.

An insurance program involving a primary policy and one or more excess policies divides risk into distinct units and insures each unit individually. The individual insurers do not (absent a specific provision) act as co-insurers of the entirety of the risk. Rather, each insurer contracts with the insured individually to cover a particular portion of the risk.

The Supreme Judicial Court found that this analysis was not changed by the inclusion of "following form" language in the excess policies. Rather, the court declared that the follow form clause allowed policyholders to have coverage for the same set of potential losses (with the same set of exceptions) in each layer of the insurance program and did not bind the insurers to a form of joint liability should coverage in a prior layer fail. Rather, the court found that the "layer of risk each insurer covers is defined and distinct."

Furthermore, the court declared that excess insurers are "strangers" to primary contracts and that primary and excess insurers act independently of each other with respect to decisions about their policies, including coverage determinations and settlements. Relying on opinions of the Indiana Supreme Court and the U.S. Court of Appeals for the Third Circuit [*Allstate Ins. Co. v. Dana Corp.*, 759 N.E.2d 1049 (Ind. 2001); *Keystone Shipping Co. v. Home Ins. Co.*, 840 F.2d 181 (3d Cir. 1988)], the Supreme Judicial Court declared that, consistent with its own analysis of "drop down" cases, given the independent roles played by primary and excess insurers, excess insurers were not bound by the claims decisions of primary insurers. "In sum, absent an explicit contractual commitment to do so, an insurer is not bound by the settlement another insurer makes for the same claim, even if the language of the non-settling policy follows the form of the settling policy. The underwriters were entitled to make a determination concerning the merits of the underlying class action settlement and coverage under its policy independent of that made by Columbia Casualty."

In fact, this victory proved to be short lived for Underwriters. The court proceeded to find that although Underwriters was free to raise the prior claims exclusion and other defenses, those defenses were ineffective. As a result, the court ultimately concluded that the trial court had erred in granting summary judgment for Allmerica and remanded the case for further findings in keeping with its determination that the various Lloyd's exclusions did not apply nor were these claims uninsurable as a "known loss."

RELATED LINKS:

- *The Yaffe Companies, Inc. v. Great American Ins. Co.*, 499 F.3d 1182 (10th Cir. 2007);
- *The Yaffe Companies, Inc. v. Great American Ins. Co.*, 2006 U.S. Dist. LEXIS 29482 (E.D. Okla. 2006);
- *West Bend Mut. Ins. Co. v. Rosemont Exposition Services, Inc.*, 2007 Ill. App. LEXIS 1275 (2007);
- *Waste Management of Minnesota, Inc. v. Transcontinental Ins. Co.*, 502 F.3d 769 (8th Cir. 2007);
- *Allmerica Financial Corp. v. Certain Underwriters at Lloyd's, London*, 449 Mass. 621, 871 N.E.2d 418 (2007);
- *Allstate Ins. Co. v. Dana Corp.*, 759 N.E.2d 1049 (Ind. 2001);
- *Keystone Shipping Co. v. Home Ins. Co.*, 840 F.2d 181 (3d Cir. 1988)

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Thomas on Emerging Issues for Terrorism Insurance

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Emerging Issues for Terrorism Insurance

By Jeffrey E. Thomas

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SUMMARY: The federal Terrorism Risk Insurance Program Reauthorization Act of 2007 became law on December 26, 2007. It extended the Terrorism Risk Insurance Act ("TRIA") through the end of 2014 and made other changes to the Act. This Emerging Issues Analysis sets forth the basic principles and provisions of TRIA and the changes that were enacted in the 2005 and 2007 extensions of the Act.

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ARTICLE: On December 26, 2007, President Bush signed the Terrorism Risk Insurance Program Reauthorization Act of 2007 into law. That Act extended the Terrorism Risk Insurance Act ("TRIA"), as modified, for another seven years. It also made a number of changes to the Act. This commentary will briefly outline the main principles of TRIA, the changes that were adopted in the extensions of the Act in 2005 and 2007, and then will identify significant emerging issues regarding the program. n1

I. TRIA Principles

Most fundamentally, TRIA is intended to supplement the market mechanism for insurance. After approximately \$36 billion in insured losses n2 that insurers paid without having collected any specific premiums for that risk, n3 insurers changed their attitude about the insurability of terrorism risk. Because of the unpredictable nature of terrorism risk and uncertain amount of associated damages, insurers were reluctant to provide terrorism coverage, n4 at least in any comprehensive way at prices that policyholders were willing to pay.

To address insurer reluctance to provide insurance, a plan was devised to pool the high-end risk through a industry-government partnership. This pooling was known as a federal "backstop" for terrorism insurance. A "backstop" is a statutory mechanism that provides federal government reimbursement of a significant portion of terrorism claims and then seeks reimbursement of some or all of those payments from the industry. It allows the market to function because the insurers still bear a significant amount of risk giving them market incentives and because the government does not provide insurance directly to consumers, instead relying on insurers to do so. The program does not set a price for this insurance (although states continue to regulate pricing after a brief, temporarily preemption by the program).

The program works as follows. Insurers for those lines covered by the Act are required to offer terrorism coverage

on the same conditions as coverage for non-terrorist losses under the policy. n5 If a policyholder chooses to buy terrorism coverage, in the event of a terrorist loss covered by the Act, the government will reimburse the insurer for 90% of the losses n6 after the insurer pays enough claims to satisfy and insurer deductible. This deductible is based on a percentage of direct earned premiums of the insurer in the previous year. n7 After making payments to reimburse insurers, the government must impose a tax on eligible insurance policies to recoup a specified "industry retention" amount, n8 and may recoup more than the industry retention if conditions are considered appropriate by the Secretary of Treasury, up to a maximum of 3% of premiums. n9 The maximum covered by the program was \$100 billion in a year. n10

Originally, the program only covered terrorism committed "by an individual or individuals acting on behalf of any foreign person or foreign interest." n11 The definition of what constituted terrorism is broad, n12 but to be covered by the Act the event must cause insured damages above a specified threshold n13 and must be certified by the Secretary of Treasury n14 (which is not subject to judicial review). n15 The lines of insurance included in the Act were commercial property and casualty insurance, including excess insurance, workers compensation insurance and surety insurance. n16

II. Amendments to TRIA

TRIA was extended in 2005 (for two years), n17 and then again in 2007 (for seven years). n18 The extensions also included some modifications. The most significant change was that the scope of the program was broadened to include domestic terrorism. n19 The amendments also made some changes to the lines of insurance that were covered. n20 In addition, the trigger for an event to be a covered "terrorist" event was raised to \$100,000,000, n21 the insurer deductibles were raised to 20% of direct earned premium, n22 and the industry retention (also known as the mandatory recoupment amount) was raised to \$27.5 billion. n23 The government's reimbursement rate was lowered from 90% to 85% (after insurer deductibles). n24 To address concerns about the cost of the program, the mandatory recoupment was changed to 133% of the difference between the industry retention (\$27.5 billion) and the amount that insurers paid for their deductibles and copayments. n25 The Secretary also was given discretion to charge up to 3% of premiums to help recover the money spent on the program. n26

III. Emerging Issues

Although the extension of the program addressed the most significant issue, whether we would continue to have the program, there are a number of important issues that remain. The issues addressed below are whether the program will become permanent; whether nuclear, chemical, biological and radiological risks should be included; whether the program sufficiently protects insurer solvency; the scope of the coverage for terrorism losses; and how allocation issues will be addressed.

A. Will the Program Become Permanent?

One of the major issues during the extension debate was the appropriate duration. The Democratically controlled House wanted a longer duration, or even permanent program. The President, however, has consistently maintained that this program was temporary until the insurance market could respond to terrorism risk. The President threatened to veto a bill that would have extended the program for 14 years; the seven year extension approved by the Senate was a compromise that the administration was willing to accept.

At the heart of this debate is the question of whether the market will be able to respond without governmental assistance. Terrorism is more difficult to predict and model than other kinds of risks. Terrorism is perpetrated by human actors who have the intention of causing harm. In order to generate greater fear and alarm, terrorists may act in ways that are unexpected. n27 The religious or political fervor of some terrorists and their willingness to commit suicide is another consideration that makes it difficult to model or prevent terrorist behavior. n28 Modeling is also complicated

by a lack of information. The historical data are limited and the wide variety of cultural and operational contexts for terrorist events makes much of the data incomparable. n29 Access to information is limited because of national security and law enforcement concerns.

Because of the unpredictability of a terrorist attack and the amount of losses caused by such an attack, insurers who plan for the worst have an incentive to not insure terrorism events or to charge a high premium to reflect the unpredictability of a terrorism event. Consequently, one of the questions is whether the market can provide terrorism insurance at a price that consumers are willing to pay.

TRIA, by reducing the amount of risk to be borne by insurers at the high end, has helped stabilize the price for terrorism insurance. In the first nine months after the adoption of TRIA, rates declined between 50 and 75%, and they continued to fall in 2003. By the third quarter of 2004, the typical price for terrorism coverage was about 4% of total premium for property coverage, compared to 10% a year before. n30 As prices declined, more policyholders purchased terrorism coverage. n31 According to a study conducted by Wharton Risk Management and Decision Processes Center at the University of Pennsylvania, "about 50% of commercial enterprises have purchased TRIA-line terrorism insurance." n32

Under the present market circumstances, the availability of terrorism insurance would have decreased if TRIA had been permitted to expire. n33 Without a federal backstop, it is expected that prices for terrorism insurance would increase, n34 which may result in consumers being unwilling to purchase the coverage. In addition, although reinsurers have re-entered the market for terrorism risk, they have only indicated a willingness to provide up to approximately \$5 billion to \$6 billion in coverage. n35 This is only a fraction of the \$27.5 billion industry aggregate in the current program year, and is less than one-fourth of the estimated \$30 billion in individual insurer retentions. Survey data show that reinsurers are not likely to significantly increase the coverage available for terrorism. n36 Without access to reinsurance or TRIA, many primary insurers would take actions to avoid underwriting terrorism risk as they did in the aftermath of September 11th. The Treasury Department study included a survey of insurers which found that nearly 50% of insurers responding reported that they did not plan to write terrorism coverage if TRIA expired. n37

It may be that over the next seven years the market will develop sufficiently to provide terrorism insurance without the federal program. Consultants and insurers continue to work on modeling of terrorism risk, and as those models are refined, reinsurers may become more willing to share the risk with primary insurers. On the other hand, critics of the program suggest that it amounts to "free" reinsurance, which undermines the ability of the reinsurance market to compete. The program, however, leaves significant risk on the insurers through the insurer deductible (20% of direct earned premiums) and the insurer co-pay (15% of insured losses after the deductible), which leaves an incentive to buy reinsurance.

B. Will the Program Be Expanded to Nuclear, Biological, Chemical and Radiological Attacks?

A second major issue that was debated during the 2007 extension was whether the program should be expanded to cover nuclear, biological, chemical and radiological (sometimes referred to as "NCBR") attacks. At the present, there is little insurance coverage available for such attacks. Although TRIA requires that insurers offer terrorism insurance to their policyholders, they are only required to offer terrorism insurance on the same terms and conditions as property and casualty coverage for non-terrorism losses. n38 Because most property insurance policies have long specifically excluded losses from nuclear events and for release of contaminants, which would likely exclude coverage for chemical, biological and radiological materials, TRIA does not require terrorism insurance to cover such events. n39

The absence of coverage for NCBR attacks represents a significant gap in insurance coverage for terrorism. The use of NCBR materials for a terrorist attack is a serious risk. According to RAND, "al Qaeda has long expressed an interest in the offensive employment of NBCR materials." n40 Although al Qaeda has yet to demonstrate any such capability in

an actual attack, they have made efforts to develop it. n41 Models have shown that a large-scale biological attack, such as with anthrax, could generate as much as \$90 billion in losses. n42 Nuclear or radiological attacks could have an even more severe impact. A "dirty bomb" could contaminate an area as large as ten square miles requiring demolition on a massive scale and astronomical losses. The RAND study concluded that the "most profound risk" of uninsured losses is in the area of a NCBR attack. n43 There failure to address NCBR risk in TRIA is therefore a significant limitation.

The 2007 extension recognized this issue by requiring a study. The Comptroller General is to study the availability and affordability of insurance covering NBCR risk, the outlook for such insurance in the future, and the capacity of private insurers and state workers compensation funds to manage NBCR risks. n44 This report is to be submitted to House and Senate committees not later than a year after enactment of the extension, and is to include a detailed statement of findings and recommendations for legislative, regulatory, administrative or other actions at the federal, state or local level. n45 Consequently, it is possible that this gap may be closed at some point in the future.

C. Does the Program Adequately Protect Insurer Solvency?

The insurer deductibles and co-payments leave a significant amount of risk for the insurers. On one hand, this creates an incentive to buy reinsurance. On the other hand, if primary insurers are unable to purchase reinsurance, the program may create a risk of insolvency unless the insurers can accumulate sufficient reserves to pay their share of terrorism claims. TRIA mandates that insurers offer terrorism coverage to their customers. Some insurers may charge a price that customers are unwilling to pay, which could limit the insurers' exposure. But insurance prices are regulated by the states, which have kept them artificially low from an actuarial standpoint. Moreover, regulation of workers compensation regulations precludes the exclusion of terrorism coverage, so those insurers cannot avoid the risk. This section will outline the insolvency risks of the current program.

One way of gauging the insolvency risk is to compare a risk to company surplus. Although the data are now somewhat dated, the Wharton study showed that insurer deductibles under the program created some insolvency risk. As a general matter, rating agencies generally require that no single risk account for more than 10% of an insurer's surplus. Yet at the 20% of direct earned premium level, terrorism risk would exceed 10% of surplus for eight out of the top 10 and 18 out of the top 30 insurers. n46

One reason for this problem is that direct earned premiums do not necessarily represent an insurer's ability to pay a loss. Certain lines of insurance and some companies may have less capital available even though they have significant premium income. One way to address this limitation would be to move to a deductible system more directly connected to an insurer's ability to pay. This has not been part of the debate about extension of the program, however, so it does not seem very likely to occur.

A second issue related to insolvency is pricing. Historically, price regulation of insurance was adopted to help insurers develop sufficient surplus to be able to pay claims in the long run. Thus, while consumers generally want lower prices, regulation should set prices high enough that insurers can create a sufficient pool to pay claims when they occur. Because of the uncertainty of terrorism risk, it is difficult to know how big the pool needs to be in order to pay claims after an event. Nevertheless, the Insurance Services Office developed a methodology to price terrorism risk, and suggested that a price of \$0.10 per \$100 of value for property coverage would be appropriate in high risk cities. Regulators in New York and District of Columbia, however, approved only \$0.03 and \$0.018, depending on the property. n47 Other states have also kept down the rates for terrorism insurance. n48 None of the states has adopted pricing at the level that was suggested by the Insurance Services Office. Some states used regulatory authority to lower the price requested by insurers, while others used their regulatory power to negotiate adjustments to the proposed pricing model. n49

By keeping the prices for terrorism insurance low, state regulation reduces the ability of insurers to build surplus to pay claims. In addition, state regulation interferes with the market mechanism. Artificially low prices interfere with the ability of insurers to buy reinsurance, which reduces the demand for reinsurance. The Wharton study found that "there is

relatively little private insurance to cover portions of losses below the TRIA deductible in urban areas and/or the price of reinsurance is prohibitively high relative to the premium that insurers can charge for coverage to commercial firms." n50 Although TRIA preempted the states' pricing and approval regulation when it was first adopted, this preemption was temporary. n51 Perhaps as more sophisticated models are developed or as the market for insurance softens the regulators will allow the pricing to be closer to the value of the risk, but if they do not, unless insurers have additional surplus generated from other insurance premiums, artificially low prices for terrorism could contribute to the risk of insolvency.

D. What Is the Scope of Terrorism Coverage Supported by the Program?

Although TRIA in theory supports the market mechanism to provide insurance coverage for terrorism, the question is the extent to which terrorism events are actually covered by insurance policies that are in compliance with the Act. It is important to keep in mind that while the Act requires that terrorism insurance be *offered*, it does not mandate that consumers purchase such insurance. While many are buying terrorism coverage, a substantial number of consumers are electing not to buy it. In those cases, coverage is unlikely (though as we will see below, not completely impossible). The following subsections discuss the definition of terrorism, the alignment of terrorism definitions between the program and insurance policy forms, transition issues created by the most recent extension, the impact of the requirements of standard fire coverage, and whether insufficient offering of terrorism or related notices could create insurance coverage.

1. Definition of Terrorism

Terrorism "is a phenomenon that is easier to describe than to define." n52 Although it has been a subject of considerable interest since the 1970s, there is no consensus as to how "terrorism" should be defined. n53 TRIA approaches this problem by using a very broad definition of terrorism combined with certification by the Secretary of Treasury. n54 The essence of the definition is a violent or dangerous act that is dangerous to human life, property or infrastructure, that causes damage in the U.S. undertaken "as part of an effort to coerce the civilian population of the U.S. or to influence the policy or affect the conduct of the U.S. Government by coercion." n55 To trigger coverage by the act, the insured losses must exceed \$100 million. n56 The Secretary's decision on certification is not subject to judicial review. n57

This approach raises one potential coverage problem because of the threshold requirement. Terrorist attacks that cause relatively small losses, less than \$100 million, are not covered by the program. Those policies that explicitly track the scope of the program therefore would not provide coverage. Although \$100 million is a relatively small loss compared to \$36 billion (the amount of insured damages from September 11th), a loss of that magnitude would be catastrophic for many policyholders.

A second coverage problem comes from the certification process. Although the use of a certification approach has the benefit of certainty for establishing that an event was a terrorist attack (and also reduces the transaction costs associated with that determination), it may not have the benefit of accuracy. It is possible that what is, in fact, a terrorist attack may not be certified by the Secretary of Treasury. The program does not allow any recourse to dispute the Secretary's decision. As a result, coverage to a certain extent depends on the decision of the Secretary. As a practical matter, a terrorist attack may create strong political incentives for the Secretary to certify that a catastrophic event was a terrorist act, which could make it easier for policyholders than having to prove an event was caused by terrorists.

2. Alignment of Terrorism Definitions

Even though the Secretary certifies that an event was caused by an act of terrorism, it is at least a theoretical possibility that policies with their own definition of terrorism could be construed more narrowly than a decision by the

Secretary. While some policy forms are careful to track the definition of terrorism used in the Act, others use the definition of terrorism developed by ISO before TRIA was adopted. n58 Insurers with their own definition of terrorism could decide that a certified act of terrorism does not meet the policy definition. That outcome, however, seems somewhat unlikely given that certification triggers a right to reimbursement under the program. On the other hand, the reimbursement program, as noted above, still leaves a substantial risk on insurers which may be enough of an incentive to deny claims.

The reverse of this scenario could benefit policyholders. Under policies with their own definition of terrorism, a policyholder might have coverage for losses that were not due to a certified act of terrorism. Some policies define terrorism to include disruption of an electronic, communication, information, or mechanical system and the advancement of political, ideological or religious objectives. n59 If insurance coverage is determined to be broader than that provided by the program, this would put the insurer at risk of having to pay for claims on its own without reimbursement under the program.

In addition to the broader definition itself, some policies have their own quantitative threshold requirements before coverage applies. For example, some policies require that there be at least \$25 million in insured property losses or 50 or more injured persons before the coverage applies. n60 As a result, while terrorism coverage could appear to exist based on the nature of the act, it may be necessary to measure the overall damages before coverage applies. Not only is this difficult to do, it creates the risk of a coverage gap when total losses are less than \$25 million and where there are fewer than 50 people injured. Like the program threshold, the individual policy thresholds may not seem significant in comparison to the losses from September 11th, but losses behold these thresholds could be significant to individual policyholders.

3. Transition Coverage Issues

Another coverage concern arises from the amendment of the statutory definition in the 2007 extension. To the extent that policy forms specifically incorporate the statutory definition, they will continue to be in harmony with the Act. But if the form has a definition that draws a distinction between foreign and domestic terrorism, it creates a transition issue until the policy is amended, or new insurance with the proper definition is purchased. TRIA requires that terrorism insurance be provided on the same terms and conditions as non-terrorism coverage. Where the statutory definition has been amended to include domestic terrorism, but the policy has not been amended, the policy is no longer in compliance with the Act. Because the policy excludes domestic terrorism, which is now covered by the Act, it offers coverage that is less than that required by the Act.

It is not clear how this conflict would be resolved. On the one hand, the policy was in compliance at the time it went into force, so it is arguably enforceable. On the other hand, the Act's extension was intended to expand the scope of TRIA's protection to include domestic terrorism. If a domestic terrorism takes place, TRIA's intention is that it should be covered. But by the terms of the policy it would not be covered even though the insurer could have access under the Act to reimbursement. The cleanest way to address this problem would be to amend policies so that domestic terrorism is included. This requires significant paperwork (approval of an amendment, and then delivery to policyholders), and may warrant charging some additional premium for the additional risk. Another possibility is that a court might use public policy or a doctrine like reasonable expectations to construe the policy as covering domestic terrorism even though by its terms it only applies to foreign terrorism. Should a court take this approach, it would raise the question of whether the federal government would be required to reimburse the insurer in light of the fact that the policy did not comply with the mandatory offering requirement.

4. Mandatory Coverage for Ensuing Fires

There is one situation where it may appear that there is no coverage, but under operation of state law coverage would apply. Some states mandate coverage for ensuing fire losses even though the fire was caused by an excluded peril. At the time of the September 11th attacks, 29 states required commercial property insurance to conform to the coverage of the so-called "standard fire insurance policy." n61 This mandates that property insurance provide coverage for fires that ensue from a terrorist event even if other damages from the terrorist events are specifically excluded by the policy. n62 After TRIA was adopted, 12 states modified their statutes to exclude in various ways ensuing fire coverage caused by acts of terrorism. n63 As of 2005, ensuing fire coverage for terrorism events was still mandated in 17 states.

5. Adequacy of Mandatory Offering and Related Disclosures

Another way that a policyholder might have terrorism coverage without electing to buy it could be due to an inadequate mandatory offering and/or disclosure. TRIA requires that terrorism insurance be offered and that certain disclosures be made explicitly, such as the possibility of proportional coverage in the event that a terrorism event exceeds the TRIA cap. The Act, however, does not do much to enforce these requirements. Although the Act includes civil penalties for noncompliance, n64 it seems unlikely that these penalties would be applied to inadequate offerings in individual cases. The Act also includes the penalty of non-reimbursement of claims for inadequate disclosures, n65 but this also seems unlikely to provide much help in individual cases. Courts handling individual claims after a terrorism event may be tempted to grant coverage based on the inadequacy of offerings and disclosures. When faced with terrorism losses that are excluded from coverage, policyholders are likely to argue that they did not have sufficient disclosure of their options and the consequences of their particular election. Such arguments are quite common with Uninsured and Underinsured Motorist Insurance, which many states require be offered to consumers. A body of law has developed giving Uninsured and Underinsured Motorist coverage as a matter of law when the insurer does not properly offer the coverage, disclose the options and consequences, and/or fails to properly document the election. n66 Courts may use a similar argument to find terrorism coverage based on inadequate offerings or disclosures, or, alternatively, may rely more generally on public policy or a doctrine such as reasonable expectations to find terrorism coverage.

E. How Would Losses Be Allocated If the Cap Is Exceeded?

The last group of emerging issues to be addressed relates to allocation. The program is quite clear that the cap for federal reimbursement is \$100 billion, and that insurers do not have any obligation to pay for terrorism losses once that cap has been met. n67 If the cap is exceeded, insurers are to pay a pro rata share of the insured losses. n68 For example, if there were \$150 billion in losses, insurers would pay 100/150, or 2/3 of the losses. This raises the possibility that the losses will need to be allocated among the policyholders.

To make this system work, of course, the insurers must know what their pro rata share will be prior to paying claims. If insurers pay claims and then learn that the cap is going to be exceeded, they would start reducing payments, but that would be unfair to those whose claims took longer to pay. While theoretically, insurers could ask those insured who have received claims checks to return a portion of the payment, it is hard to imagine that policyholders would cooperate voluntarily. To help address this situation, the 2007 extension requires that the Treasury Secretary report to Congress within 15 days after a terrorism event whether "the Secretary estimates that aggregate insured losses will exceed \$100,000,000,000." n69 (It is difficult to believe that the estimate made within 15 days of the event can be very accurate.) This estimate will put the parties on notice that the allocation system according to Treasury regulations will apply. The 2007 extension requires that such allocation regulations be adopted within 240 days after enactment of the extension, n70 with a report to Congress to be made within 120 days of enactment describing the process to be used for determining the allocation. n71 It is hard to envision an allocation system that will not be fraught with problems, but perhaps the Treasury can come up with a workable set of regulations.

A related problem would arise in the case of multiple events in a single program year. The program is designed

with an annual cap. n72 If the cap is exhausted by an attack early in the year, what will happen in the event of a second attack a few months later? Suppose, for example, the first attack results in losses of \$75 billion, and that a second attack causes another \$50 billion in losses. If \$75 billion is allocated to the first attack, that would only leave \$25 billion for the second, leaving those policyholders with only 50% coverage. It would make sense to allocate the losses for the year in the same pro rata way as if there were a single event that exceeded the cap, but the timing of notices, calculations of estimates, and payment of claims may not allow this. Perhaps the regulations adopted by Treasury will be sufficient to deal with this scenario, or perhaps it will never need to be addressed, but the statute does not provide any guidance.

V. Conclusion

TRIA has been successful in reducing the price for terrorism insurance and increasing its availability through the backstop mechanism. The program has been in operation for five years, and has now been extended for another seven, so it will continue to provide support for terrorism insurance.

A number of emerging issues arise from TRIA and its extension. Will the program be extended again or become permanent? It may be that the nature of terrorism risk will not allow the market to fully respond to that risk. On the other hand, as we learn more about the risk and continue to develop modeling techniques, perhaps the market will be prepared to address the risk without the federal backstop.

Will the program be extended to nuclear, chemical, biological and radiological risks? Those risks are significant and are not currently covered by the program. The 2007 extension requires that the Comptroller General study this issue and make recommendations, so perhaps they will be covered in the future.

Does the program sufficiently protect insurer solvency? The program includes insurer deductibles and copayments to create an incentive for the market, but the amounts are not based on the insurers' ability to pay. An insurer's ability to charge an actuarially sound price is limited by state regulation, which interferes with the insurer's ability to buy reinsurance. If the reinsurance market does not expand and a major terrorist attack occurs, some insurers may be put in financial jeopardy.

What is the scope of the coverage provided by the program? If policyholders elect not to buy terrorism insurance, they probably will not be covered. However, they may nonetheless have property coverage for damages due to an ensuing fire in those states that follow the "standard" fire insurance requirements that have not created an exception for terrorism. Alternatively, courts might be tempted to find coverage as a matter of law if the offering and disclosures were found to be inadequate. For those policyholders who buy the insurance, their coverage may turn on whether the threshold requirement has been met (\$100 million in insured losses) and whether the Secretary of Treasury certifies the event as caused by terrorists. Some policies may, however, provide somewhat broader or narrower coverage if they do not explicitly follow or reference the statutory definition. For the next year or so, policies that cover foreign terrorism may create a transition issue because of the amendment to expand the definition of terrorism to include domestic groups.

How will losses exceeding the \$100 billion cap be allocated? In theory, the losses are to be paid proportionately. It is hard to imagine how the information will be available to do this accurately, but Treasury has been charged with developing regulations to address this allocation problem. A related problem is multiple events within a single program year, which would also require some kind of allocation. Perhaps the regulations will address this problem as well, though the statutory extension does not specifically mention the multiple event scenario.

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n1 Work on this commentary has been influenced by work done by the author as the Reporter to the Task Force on Federal Involvement in Insurance Regulation Modernization for the Tort Trial and Insurance Practice Section of the American Bar Association. The author acknowledges the input and participation of Task Force members, which has been beneficial, but notes that the views presented here are his alone and not those of the Task Force or any other member of the Task Force.

n2 See Robert P. Hartwig, *9/11 and Insurance: The Five Year Anniversary* (September 2006) (available at http://server.iii.org/yy_obj_data/binary/773375_1_0/September%2011%20Anniversary.pdf). This figure does not include losses that were paid through the Victim's Compensation Fund, which might have been covered under liability insurance had the claimants pursued their tort remedies rather than electing to be compensated through the fund.

n3 See Munich Re, 11th September 2001, 3.3-3.4 (2001).

n4 See *What Makes Terrorism Different?*, 23 Viewpoint No. 3, Winter 2002 (available at <http://www.aais.org>).

n5 Terrorism Risk Insurance Act of 2002 103(c), 15 U.S.C. 6701 note.

n6 Terrorism Risk Insurance Act of 2002 103(e)(1)(a), 15 U.S.C. 6701 note.

n7 Terrorism Risk Insurance Act of 2002 102(7), 15 U.S.C. 6701 note.

n8 The industry retention was \$10 billion in the first year, \$12.5 billion in the second year, and \$15 billion in the third year. See Terrorism Risk Insurance Act of 2002 103(e)(6), 15 U.S.C. 6701 note.

n9 Terrorism Risk Insurance Act of 2002 103(e)(7)-(8), 15 U.S.C. 6701 note.

n10 The "cap" provides that payments made by the Secretary of Treasury under the program are limited to no more than \$100 billion for a program year. If that amount is likely to be exceeded, the Secretary is to notify Congress, which is to determine the procedures for any sources of any additional payments beyond the \$100 billion amount. *See* Terrorism Risk Insurance Act of 2002 103(e)(2), 15 U.S.C. 6701 note. Some have characterized this limit as a "soft cap" because it contemplates that Congress will authorize additional reimbursement.

n11 Terrorism Risk Insurance Act of 2002 102(1)(A)(iv), 15 U.S.C. 6701 note.

n12 A terrorist act is defined as "a violent act or an act that is dangerous" to human life, property or infrastructure, Terrorism Risk Insurance Act of 2002 102(1)(A)(ii), 15 U.S.C. 6701 note, that causes damage in the U.S. or to an U.S. air carrier or vessel or mission, Terrorism Risk Insurance Act of 2002 102(1)(A)(iii), 15 U.S.C. 6701 note, "as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion," Terrorism Risk Insurance Act of 2002 102(1)(A)(iv), 15 U.S.C. 6701 note.

n13 The original threshold was \$5 million. *See* Terrorism Risk Insurance Act of 2002 102(1)(B)(ii), 15 U.S.C. 6701 note.

n14 Terrorism Risk Insurance Act of 2002 102(1)(A), 15 U.S.C. 6701 note.

n15 Terrorism Risk Insurance Act of 2002 102(1)(C), 15 U.S.C. 6701 note.

n16 Federal crop insurance, private mortgage insurance, financial guaranty insurance, insurance for medical malpractice, health and life insurance, flood insurance, and reinsurance were excluded from coverage. *See* Terrorism Risk Insurance Act of 2002 102(12), 15 U.S.C. 6701 note.

n17 Terrorism Risk Insurance Extension Act of 2005, 109 P.L. 144, 119 Stat. 2660 (2005).

n18 Terrorism Risk Insurance Program Reauthorization Act of 2007, 110 P.L. 160, 121 Stat. 1839 (2007).

n19 Terrorism Risk Insurance Program Reauthorization Act of 2007, 2, *110 P.L. 160, 121 Stat. 1839 (2007)*.

n20 Directors and officers liability insurance was added, and commercial automobile, burglary and theft insurance, surety insurance, professional liability insurance and farm owners multiple peril insurance were removed from coverage. Terrorism Risk Insurance Extension Act of 2005 3, *109 P.L. 144, 119 Stat. 2660 (2005)*.

n21 Terrorism Risk Insurance Extension Act of 2005 6, *109 P.L. 144, 119 Stat. 2660 (2005)*.

n22 Terrorism Risk Insurance Extension Act of 2005 3(c), *109 P.L. 144, 119 Stat. 2660 (2005)*.

n23 Terrorism Risk Insurance Extension Act of 2005 5, *109 P.L. 144, 119 Stat. 2660 (2005)*.

n24 Terrorism Risk Insurance Extension Act of 2005 4, *109 P.L. 144, 119 Stat. 2660 (2005)*.

n25 Terrorism Risk Insurance Program Reauthorization Act of 2007, 4(e), *110 P.L. 160, 121 Stat. 1839 (2007)*.

n26 See Terrorism Risk Insurance Program Reauthorization Act of 2007, 4(c), 4(e)(1)(B), *110 P.L. 160, 121 Stat. 1839 (2007)*.

n27 See Wharton Risk Management and Decision Process Center, *TRIA and Beyond* 52-53 (2005).

n28 Peter Chalk, Bruce Hoffman, Robert Reville & Anna-Britt Kasupski, *Trends in Terrorism: Threats to the United States and the Future of the Terrorism Risk Insurance Act* 26-29 (2005).

n29 See Wharton Risk Management and Decision Process Center, TRIA and Beyond 58 (2005).

n30 Peter Chalk, Bruce Hoffman, Robert Reville & Anna-Britt Kasupski, Trends in Terrorism: Threats to the United States and the Future of the Terrorism Risk Insurance Act (2005).

n31 Peter Chalk, Bruce Hoffman, Robert Reville & Anna-Britt Kasupski, Trends in Terrorism: Threats to the United States and the Future of the Terrorism Risk Insurance Act (2005).

n32 Wharton Risk Management and Decision Process Center, TRIA and Beyond 2 (2005).

n33 Peter Chalk, Bruce Hoffman, Robert Reville & Anna-Britt Kasupski, Trends in Terrorism: Threats to the United States and the Future of the Terrorism Risk Insurance Act 10 (2005); Wharton Risk Management and Decision Process Center, TRIA and Beyond 168 (2005).

n34 See Wharton Risk Management and Decision Process Center, TRIA and Beyond 28 (2005).

n35 Wharton Risk Management and Decision Process Center, TRIA and Beyond 27 (2005).

n36 Wharton Risk Management and Decision Process Center, TRIA and Beyond 27-28 (2005).

n37 U.S. Department of Treasury, Assessment: the Terrorism Risk Insurance Act of 2002 at 6 (2005).

n38 Terrorism Risk Insurance Act of 2002 103(c)(1), 15 U.S.C. 6701 note.

n39 Peter Chalk, Bruce Hoffman, Robert Reville & Anna-Britt Kasupski, Trends in Terrorism: Threats to the United States and the Future of the Terrorism Risk Insurance Act 6-7(2005); Wharton Risk Management and Decision Process Center, TRIA and Beyond 81 (2005). It should be noted that workers compensation insurance is a notable exception to this because of the mandatory scope of coverage of workers compensation insurance. Wharton Risk Management and Decision Process Center, TRIA and Beyond 81 (2005).

n40 The RAND study cites a news interview of bin Laden in which he "specifically asserted that acquiring weapons of mass destruction (WMD) was a religious duty for all Muslims." Peter Chalk, Bruce Hoffman, Robert Reville & Anna-Britt Kasupski, Trends in Terrorism: Threats to the United States and the Future of the Terrorism Risk Insurance Act 30 (2005).

n41 Peter Chalk, Bruce Hoffman, Robert Reville & Anna-Britt Kasupski, Trends in Terrorism: Threats to the United States and the Future of the Terrorism Risk Insurance Act 31-32 (2005).

n42 Wharton Risk Management and Decision Process Center, TRIA and Beyond 50 (2005).

n43 Peter Chalk, Bruce Hoffman, Robert Reville & Anna-Britt Kasupski, Trends in Terrorism: Threats to the United States and the Future of the Terrorism Risk Insurance Act xii (2005).

n44 Terrorism Risk Insurance Program Reauthorization Act of 2007, 5(a), *110 P.L. 160, 121 Stat. 1839* (2007).

n45 Terrorism Risk Insurance Program Reauthorization Act of 2007, 5(a), *110 P.L. 160, 121 Stat. 1839* (2007).

n46 Wharton Risk Management and Decision Process Center, TRIA and Beyond 126-27 (2005).

n47 American Insurance Association, How the Free Market Fails (April 2005).

n48 American Insurance Association, *How the Free Market Fails* (April 2005).

n49 Wharton Risk Management and Decision Process Center, *TRIA and Beyond* 84-88 (2005).

n50 Wharton Risk Management and Decision Process Center, *TRIA and Beyond* 19-20 (2005).

n51 Terrorism Risk Insurance Act of 2002 106(A)(2)(B), 15 U.S.C. 6701 note.

n52 *Public Report of Vice-President's Taskforce on Combating Terrorism*, in *What is Terrorism, Opposing Viewpoints Pamphlets* 17 (1986).

n53 See Jeffrey E. Thomas, *Exclusion of Terrorist-Related Harms from Insurance Coverage: Do the Costs Justify the Benefits?*, 36 *Ind. L. Rev.* 397, 413 (2003). For a thorough discussion of the definitional problems, see Bruce Hoffman, *Inside Terrorism* 13-44 (1998) and Brian Michael Jenkins, *The Study of Terrorism: Definitional Problems* (Dec. 1980).

n54 See Terrorism Risk Insurance Act of 2002 102(1)(A), 15 U.S.C. 6701 note.

n55 Terrorism Risk Insurance Act of 2002 102(1)(A), 15 U.S.C. 6701 note.

n56 Terrorism Risk Insurance Extension Act of 2005 6, 109 *P.L.* 144, 119 *Stat.* 2660 (2005).

n57 Terrorism Risk Insurance Act of 2002 102(1)(C), 15 U.S.C. 6701 note.

n58 See Jeffrey E. Thomas, *Exclusion of Terrorist-Related Harms from Insurance Coverage: Do the Costs Justify the Benefits?*, 36 *Ind. L. Rev.* 397, 404-07 (2003).

n59 See, e.g., Limited Terrorism Exclusion (Other Than Foreign Terrorism); Cap On Foreign Terrorism Losses, ISO Form CG 21 92 01 06; see also Jeffrey E. Thomas, *Exclusion of Terrorist-Related Harms from Insurance Coverage: Do the Costs Justify the Benefits?*, 36 *Ind. L. Rev.* 397, 406 (2003).

n60 See, e.g., Limited Terrorism Exclusion (Other Than Foreign Terrorism); Cap On Foreign Terrorism Losses, ISO Form CG 21 92 01 06.

n61 Wharton Risk Management and Decision Process Center, TRIA and Beyond 85 (2005).

n62 New York State Insurance Department, General Counsel Opinion Regarding Commercial Property Insurance Terrorism Limitation for Fire Following, June 26, 2003, available at <http://www.ins.state.ny.us/rg030627.htm> [last visited Nov. 4, 2005].

n63 Wharton Risk Management and Decision Process Center, TRIA and Beyond 85 (2005). Amendments are under consideration in additional states.

n64 See Terrorism Risk Insurance Act of 2002 104(e), 15 *U.S.C.* 6701 note.

n65 See, e.g., Terrorism Risk Insurance Act of 2002 103(b)(2), 15 *U.S.C.* 6701 note.

n66 See, e.g., Alan I. Widiss & Jeffrey E. Thomas, 1 *Uninsured and Underinsured Motorist Insurance* 2.6 (LexisNexis rev. 3d ed. 2005).

n67 See Terrorism Risk Insurance Act of 2002 103(e)(2), 15 *U.S.C.* 6701 note, as amended by Terrorism

Risk Insurance Program Reauthorization Act of 2007 4(a), *110 P.L. 160, 121 Stat. 1839 (2007)*.

n68 See Terrorism Risk Insurance Act of 2002 103(e)(2)(B), *15 U.S.C. 6701* note; Terrorism Risk Insurance Program Reauthorization Act of 2007 4(c), *110 P.L. 160, 121 Stat. 1839 (2007)* (providing for regulations to determine the pro rata share).

n69 Terrorism Risk Insurance Program Reauthorization Act of 2007, 4(b)(1), *110 P.L. 160, 121 Stat. 1839 (2007)*.

n70 Terrorism Risk Insurance Program Reauthorization Act of 2007, 4(c)(2), *110 P.L. 160, 121 Stat. 1839 (2007)*.

n71 Terrorism Risk Insurance Program Reauthorization Act of 2007, 4(c)(2)(iii), *110 P.L. 160, 121 Stat. 1839 (2007)*.

n72 See Terrorism Risk Insurance Act of 2002 103(e)(2), *15 U.S.C. 6701* note.

RELATED LINKS:

- 15 USCS § 6701;
- 109 P.L. 144;
- 110 P.L. 160

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Morrison Mahoney LLP on Plastics Engineering Co. v. Liberty Mutual Insurance

2008 Emerging Issues 1900

Morrison Mahoney LLP on Plastics Engineering Co. v. Liberty Mutual Insurance

By Michael F. Aylward

February 12, 2008

SUMMARY: Although the Wisconsin Supreme Court had clearly adopted an actual injury approach to the issue of trigger of coverage in its 2004 opinion in *American Girl* ending years of controversy with respect to the appropriate trigger for long-tail claims, uncertainty continues to persist with respect to whether an insurers defense and indemnity duties in cases involving ongoing injuries or damage should be allocated in some respect and whether, insofar as such claims triggered both insured and uninsured periods, the insurers obligation should be correspondingly pro rated.

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ARTICLE: Despite its landfills, industrial facilities and Superfund sites, Wisconsin has lagged behind neighboring states such as Minnesota in the evolution of case law affecting long-tail claims for pollution or mass torts. To some extent, this paucity of precedents reflects the deep freeze that pollution coverage litigation went into between 1994 and 2003 when the declared law of Wisconsin was the most environmental clean up costs were not damages. n1 Despite the flood of new and re-opened claims since the Wisconsin Supreme Court reversed that view in *Johnson Controls*, litigants have found few and conflicting precedents to guide them, however, with respect to the key questions of how any covered damages should be allocated among insured and uninsured periods and how many policy limits may be triggered in such cases. This period of uncertainty may soon come to a close with a recent opinion of the U.S. Court of Appeals for the Seventh Circuit certifying key coverage issues to the Wisconsin Supreme Court.

The claims in *Plastics Engineering Co. v. Liberty Mut. Ins. Co.*, 2008 U.S. App. LEXIS 1194 (7th Cir. January 22, 2008) arise out of asbestos bodily injury claims brought against a manufacturer of molding compounds in Sheboygan, Wisconsin. Plenco, which has been in business since 1934, began manufacturing products with asbestos-containing components in 1950 and continued to do so until 1983. For much of this period, Plenco was insured by Liberty Mutual. n2

In 2004, Liberty Mutual which until that point in time had paid all of Plencos defense costs, settlements and judgments for its asbestos claims, advised its insured that it would henceforth only pay a proportionate share of reasonable and necessary defense costs. Liberty Mutual has, however, continued to pay all of Plencos defense costs, settlements and judgments albeit now under a reservation of rights. Nevertheless, Plenco sued Liberty Mutual in 2004 seeking a declaration that it was in fact obligated to pay all of its defense costs and judgments. In response, Liberty Mutual sought a declaration that it was not obligated to pay certain defense costs or indemnity corresponding to

uninsured periods and was entitled to a refund for overpaid amounts. In October 2006 a lower courtⁿ³ found that each individual claim against Plastics Engineering was a separate occurrence and that Plastics Engineering was entitled to recover under Liberty Mutuals primary policies under an all sums basis. Liberty Mutual appealed.

Although the Wisconsin Supreme Court had clearly adopted an actual injury approach to the issue of trigger of coverage in its 2004 opinion in *American Girl*ⁿ⁴ ending years of controversy with respect to the appropriate trigger for long-tail claims,ⁿ⁵ uncertainty continues to persist with respect to whether an insurers defense and indemnity duties in cases involving ongoing injuries or damage should be allocated in some respect and whether, insofar as such claims triggered both insured and uninsured periods, the insurers obligation should be correspondingly *pro rated*.

Several opinions of the Wisconsin Court of Appeals had suggested that insurers might allocate defense costs between covered and non-covered claims if there was a rational basis for doing so.ⁿ⁶ However, none of these cases involved long-tail claims. Meanwhile, the Seventh Circuit had adopted a time on the risk approach to allocation in several Wisconsin cases, although not always on the basis of Wisconsin law.

In the face of such conflicting case law, Wisconsin policyholders have waged an aggressive lobbying campaign in the state legislature to adopt all sums theories by law. To date, however, such efforts have been defeated by the insurance industry.ⁿ⁷

Wisconsin courts have also had relatively little occasion over the years to visit the issue of whether separate injuries giving rise to multiple claims against a policyholder trigger one or multiple occurrence limits. Indeed, outside of the conventional set of auto cases,ⁿ⁸ there is little or no occurrence case law in Wisconsin.

On appeal from the District Courts ruling in *Plenco*, Liberty Mutual urged the Seventh Circuit to apply a *pro rata* approach to its claimed defense and indemnity obligations. Liberty Mutual argued that its indemnity duties were limited not only by the express terms of its policies, but pursuant to the cause approach on the basis that the insureds liability arose out of a single occurrence.

Addressing the occurrences issue, the Seventh Circuit found that prior Wisconsin state court opinions failed to provide sufficient guidance to allow it to decide this issue. The court took note of *Society Ins. v. Town of Franklin*,ⁿ⁹ in which the Court of Appeals had ruled that damage to surrounding property emanating from the insureds landfill was held to involve a continuous occurrence triggering numerous limits of coverage. The Seventh Circuit noted, however, that the Court of Appeals had not addressed whether these claims involved separate occurrences in each policy year, however. Similarly, the continuous trigger analysis adopted by the Court of Appeals in *Wisconsin Electric Power Co.*,ⁿ¹⁰ in which the court had addressed issues involving claims against a power utility brought by farmers whose herds had been damaged by stray voltage, looked only to the issue of trigger of coverage, not the number of occurrences. The court found that such cases differed from the instant case in that the damage stemmed from exposure that happened at one geographic site whereas in this case the insured had manufactured asbestos at its Wisconsin plant that had allegedly caused injury to plaintiffs throughout the country as the result of the incorporation of the insureds product into other manufacturers products.

In light of this uncertainty and the significance of the issue, the Seventh Circuit elected to certify the occurrences issues to the Wisconsin Supreme Court. The Seventh Circuit also asked the court to advise whether a non-cumulation clause in Liberty Mutual policies were as being contrary to the requirements for other insurance wordings set forth in Wisconsin Statute Section 631.43(1).ⁿ¹¹ In this case, Liberty Mutual had argued that certain of its policies contained a variation of a non-cumulation clause wherein the insureds right to recover under the policy should be diminished by any payments received under earlier insurance for the same occurrence. Whereas Liberty Mutual had argued that this statute applies only to clauses that are expressly designed as other insurance terms, *Plenco* argued that it should also apply to non-cumulation clauses given their similar effect. *Plenco* argued, therefore, that the district court had incorrectly held

that Section 631.43(1) applies only to concurrent insurance policies rather than cases of this sort involving consecutive policies.

Finally, the Seventh Circuit agreed to certify the issue of whether Liberty Mutual had a right to *pro rate* its obligations to Plenco, either as regards defense costs or indemnity. In keeping with cases such as *Grube*, the Seventh Circuit agreed that Wisconsin law generally requires insurers to defend suits in their entirety. On the other hand, the court allowed that, This issue may become more complicated if Wisconsin courts follow a pro rata allocation approach for indemnification liability. In that event, If damages are allocated between insurers based on the percentage of the injury that happened in each policy period, the same principles of pro-rata may support allocation of defense costs. Given this uncertainty, the Seventh Circuit concluded that it was appropriate to certify this case to the Wisconsin Supreme Court under Circuit Rule 52 which allows a federal court to certify to the states highest court questions of state law that will control the outcome of a pending case.

The Seventh Circuits interest in certifying this question to the Wisconsin Supreme Court is all the more interesting in light of the fact that unlike several circuits, notably the Fifth and Eleventh Circuits, the Seventh Circuit only rarely certifies questions of state law. As a result, the Seventh Circuit has from time to time come into direct conflict with contrary rulings of state appellate authorities in cases involving the identical issue of state law. n12 It remains to be seen whether the Seventh Circuit feels chastened by its recent experience with Illinois courts or whether it is sensitive to the acute political ramifications of this issue in Wisconsin and prefers to shift the political burden of resolving this issue to the state Supreme Court. In either event, a great deal will ride on the ultimate outcome of this opinion if the Wisconsin Supreme Court agrees to accept review.

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n1 . In 1994, the Wisconsin Supreme Court ruled 4-3 in *City of Edgerton v. General Cas. Co.*, 517 N.W.2d 463 (Wis. 1994) that environmental cleanup costs are not covered damages. Despite a series of confusing and conflicting opinions in the ensuing years, it was not until July 2003 that the Supreme Court ruled in *Johnson Controls, Inc. v. Employers Ins. of Wausau*, 665 N.W.2d 257 (Wis. 2003) that it had made a mistake in adopting such a narrow and technical interpretation of damages.

n2 . The parties stipulated to the fact that Liberty Mutual was defending under primary policies issued between February 1968 and January 1989 and umbrella policies issued between May 1970 and January 1984 and January 1986 to January 1998.

n3 . *Plastics Engineering Co. v. Liberty Mutual Ins. Co.*, 2006 U.S. Dist. LEXIS 78622 (E.D. Wis. October 27, 2006).

n4 . *American Family Mut. Ins. Co. v. American Girl, Inc.*, 673 N.W.2d 65 (Wis. 2004).

n5 . Early Wisconsin cases such as *Kremers-Urban Co. v. American Employers Ins. Co.*, 351 N.W.2d 156 (Wis. 1984) and *Lund v. American Motorists Ins. Co.*, 797 F.2d 544 (7th Cir. 1986) had suggested that it was the date of the insureds negligent act, not the time of the resulting damage, that was the trigger of coverage.

n6 . See *Sauk County v. Employers Ins. of Wausau*, 550 N.W.2d 439 (Wis. Ct. App. 1996) (holding that insurers obligation to pay defense costs (allowing allocation of legal fees between cost of defending lawsuit and cost of prosecuting counterclaim) and *Loosmore v. Parent*, 613 N.W.2d 923 (Wis. Ct. App. 2000) (holding that insurer had no obligation to pay for cost of cross-claim against co-defendant). On the other hand, in *Grube v. Dawn*, 496 N.W.2d 106, 122 (Wis. App. 1992), the Court of Appeals had ruled that apportionment would not be permitted where it was neither practical nor desirable and that an insurer must provide a complete defense even if only some of the claims against the insured were covered. See also *Lockwood Intl v. Volm Bag Co.*, 273 F.3d 741, 743 (7th Cir. 2001), the Seventh Circuit declared that if defense costs are readily apportionable between the covered and the uncovered claims, the insurance company need pay only for the former.

n7 . In 2005, for instance, insurer opposition helped to kill Assembly Bill 222 (Senate Bill 137), that had been promoted by Wisconsin paper and pulp companies that face significant environmental liability exposures as the result of the contamination of the Fox River.

n8 . See *Olsen v. Moore*, 202 N.W.2d 236 (Wis. 1972) (successive auto collision held to involve a single occurrence); *Welter v. Singer*, 376 N.W.2d 84 (Wis. Ct. App. 1985) (claims against trucker who ran over a bicyclist and then backed up into a car triggered a single occurrence limit); and *Danielson v. Gaspar*, 623 N.W.2d 182 (Wis. Ct. App. 2000) (various different theories of liability arising out of insureds negligent entrustment of vehicle held to only trigger a single occurrence limit).

n9 . *Society Ins. v. Town of Franklin*, 607 N.W.2d 342 (Wis. Ct. App. 2000).

n10 . *Wisconsin Electric Power Co. v. California Union Ins. Co.*, 419 N.W.2d 255 (Wis. Ct. App. 1987).

n11 . Wisconsin Statute Section 631.43(1) provides that:

When two or more policies promise to indemnify an insured against the same loss, no other insurance provisions of the policy may reduce the aggregate protection of the insured below the lesser of the actual insured loss suffered by the insured or the total indemnification provided by the policies if there were no other insurance

provisions.

n12 . Compare *Eljer Manufacturing Co. v. Liberty Mutual Ins. Co.*, 972 F.2d 805 (7th Cir. 1992)(holding that incorporation of defective product triggers coverage even if actual injury to third-party property does not occur until after the policy) with *Travelers Ins. Co. of Illinois v. Eljer Manufacturing, Inc.*, 757 N.E.2d 481 (Ill. 2000)(holding that coverage is not triggered until third-party property damage actually occurs) and *American States Ins. Co. v. Capital Associates*, 392 F.3d 939 (7th Cir. 2004)(holding that the issue of whether junk faxes trigger coverage for invasion of privacy is not even close) with *Valley Forge Ins. Co. v. Swiderski Electronics, Inc.*, 860 N.E.2d 307 (Ill. 2006)(finding coverage for TCPA claims).

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Michael F. Aylward is a senior partner in the Boston office of Morrison Mahoney LLP where he chairs the firms complex insurance claims resolution group. For nearly 25 years, Mr. Aylward has represented insurers and reinsurers in coverage disputes around the country concerning the application of liability insurance policies to commercial claims involving intellectual property disputes, environmental and mass tort claims and construction defect litigation. He is a frequent lecturer on insurance issues and has authored portions of various insurance treatises and is a frequent contributor to scholarly publications on legal issues. Mr. Aylward has taken a leadership role in legal organizations including the Defense Research Institute (Board of Directors (2000-2003); past Chair, Insurance Law Committee and Law Institute (2004-2006); and the International Association of Defense Counsel (Chair, Reinsurance, Excess and Surplus Lines Committee, Board of Editors, Defense Counsel Journal). He presently serves as the chair of the Reinsurance, Excess and Surplus Lines Committee of the Federation of Defense and Corporate Counsel.



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Gerber & Biggie:Natl Union Fire Insurance Co. v. Underwriters at Lloyd's London

2008 Emerging Issues 1899

Gerber & Biggie:Natl Union Fire Insurance Co. v. Underwriters at Lloyd's London

By Daniel W. Gerber and Brian R. Biggie

February 11, 2008

SUMMARY: Notice of a receivership action and civil action seeking specific performance does not constitute notice of a derivative action by share-holders. It is not up to the insurer, under a Directors and Officers policy, to scroll through documents received from the insured and determine whether notice has been provided. The obligation to comply with notice provisions remains with the insured, and Courts are reluctant to require an insurer to speculate as to the consequences that may result from specific wrongful acts on the part of the insured.

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ARTICLE: For Every Policy And Every Potential Claim, Insureds and Insurers Must Be Conscious Of Whether Notice Is Necessary, and If So, Whether The Notice Requirements In The Policy Were Satisfied

While variations exist, insureds under Directors and Officers policies are required to provide prompt notice of a potential claim in order to be entitled to coverage. Policy provisions dictate to the insured what information is required and the manner such information must be submitted. The difficulty for the insured, is determining what constitutes a 'potential claim' and what 'wrongful acts' may give rise to a civil action.

Analysis

In *National Union Fire Insurance Company of Pittsburgh v. Underwriters at Lloyd's London*, So.2d , 2007 Fla. App. LEXIS 18750 (Fla. App. 3 Dist. 2007), PCA was a Miami based publicly traded health care company. PCA procured D&O coverage through Lloyds for the period of April 7, 1996 to September 8, 1997. National Union's policy provided coverage for the period of September 8, 1997 to September 8, 2003. In 1996, PCA and Sierra Health Services began discussing a merger. PCA's representatives disclosed to Sierra that it was under-reserved by \$100 million, which was in violation of Florida's insurance law. Despite this, the two companies continued with their merger.

PCA later disclosed that it was in fact under-reserved by \$130 million. This number was outdone by an audit that revealed PCA was in fact, under-reserved by \$190 million. As a result of the mounting deficits, the Florida Insurance Department filed a complaint seeking receivership, causing a court order effectively freezing PCA's assets. In March

1997, Sierra rescinded its agreement with PCA. In turn, PCA filed suit in federal court seeking specific performance of the agreement and Sierra filed an action seeking a declaration that it rightfully rescinded the agreement.

On April 29, 1997 PCA sent Lloyds a letter enclosing the Sierra complaint and the receivership pleadings from the Florida action and put Lloyd's on notice of a "potential claim brought by Sierra." Lloyds advised that the notice presented only a "potential claim situation" because no director or officer of PCA was named as a defendant. Lloyds stated that if a director or officer were added as a defendant then notice would be deemed given the date the Sierra letter was sent.

In November 1997, several shareholders filed suit against a number of PCA's directors and officers. PCA tendered the claim to Lloyds, which disclaimed coverage stating that notice of the Sierra complaint did not constitute notice of the shareholder action. The shareholder class action was settled with a contribution from PCA and National Union, resulting in a claim against Lloyds. National Union and PCA argued that Lloyds should have provided defense and indemnity in the shareholder action. The court disagreed.

The court stated, "[T]he essence, then, of a claims-made policy is notice to the carrier within the policy period." *Id. citing Gulf Ins. Co. v. Dolan, Fertig & Curtis*, 433 So.2d 512, 514 (Fla. 1983). Pursuant to the terms of the policy, proper notice required the following information, 1) the specific wrongful act; 2) the consequences which have resulted or may result therefrom; and 3) the circumstances by which PCA first became aware. The court held that the letter that enclosed the Sierra complaint and receivership pleadings did not put Lloyds on notice of a subsequent shareholder action filed against the directors and officers of PCA. The court went on to state,

Even if we assume that *In re PCA* asserted claims "arising out of" the wrongful acts alleged in the Sierra lawsuit, we conclude that the Sierra complaint and attached receivership pleadings did not adequately describe the consequences that resulted from PCA's wrongful acts and the circumstances of PCA's discovery of those wrongful acts. *Id.*

Notably, the court stated that it is the *insured* who is in the better position to evaluate the claim and its possible consequences. The court went on to state, "[I]ts obligation to provide notice cannot be shifted to the insurer to speculate as to the consequences that may result from specific wrongful acts by sifting through voluminous documents identified in the Sierra complaint and receivership proceedings." *Id.*

The *National Union* case is certainly not the first time an insured misinterpreted its obligations under a notice provision. In *National Union*, the insured believed that notice of a one claim (rescission and receivership actions) would be construed as notice of a separate subsequent claim (shareholder action). In contrast, the insured in an unreported 5th Circuit decision, chose not to forward notice of a potential claim because the insured did not believe notice was necessary. *Precis Inc. v. Federal Ins. Co.*, 184 Fed.Appx. 439 (5th Cir. Tex. 2006).

In *Precis*, the insured obtained a policy providing coverage for "written demands asserted against the insured's Directors and Officers. The insured's general counsel received letters demanding "consideration and adjustment" for damages the author stated were the result of the actions of the company and its general counsel. The insured did not believe that the letters constituted demands for monetary damages and therefore, did not promptly forward the letters to the insurer. When the letters were eventually sent to the insurer, nine months later, coverage was denied based on late notice. The court upheld that insurers disclaimer and stating that the letters triggered the insured obligation to provide notice.

Practice Tip

In the end, it is the insured who must decide whether to provide notice and if so, what information to include. General Counsel, Officers and Directors cannot assume forwarding pleadings or a letter alone, will satisfy a policy's requirements. Similarly, the decision not to forward information regarding a potential claim must be made with caution. In this decision, perhaps more than any other, that will determine an insured's entitlement to coverage.

General Counsel, Officers and Directors must be certain that the notice provided is specific and details the consequences of the alleged wrong acts. It is a mistake to assume an insurer will glean such information from demands for damages or even a complaint. By providing an explanation of the possible consequences of a wrongful act, insureds will be able to place an insurer on notice of claims that may not be readily apparent. This is essential given that it is unlikely a court will place such a burden on the insurer. Lastly, if there is ambiguity as to whether an occurrence constitutes a potential claim consider the nature of the occurrence and the potential resulting exposure in order to determine whether the insurer should be put on notice.

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The Impact of the Illinois Supreme Court's Decision in Kajima

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Meckler Bulger and Tilson LLP on the Impact of the Illinois Supreme Court's Decision in Kajima

By Meckler Bulger and Tilson LLP, Scott Seaman and Jason Schulze

February 8, 2008

SUMMARY: In their analysis of the Illinois Supreme Court's recent decision in *Kajima*, prominent insurance law and commercial litigators, Scott M. Seaman and Jason R. Schulze of the firm Meckler Bulger and Tilson LLP, address important issues relating to the targeted tender rule on concurrent coverage cases and Illinois law on allocation of losses in long-tail coverage cases.

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ARTICLE: Introduction

The Illinois Supreme Court's recent decision in *Kajima Construction Services, Inc. v. St. Paul Fire and Marine Ins. Co.* [227 Ill. 2d 102 (2007)] involves the interplay between Illinois' "targeted tender" or "selective tender" rule and the requirements of "horizontal exhaustion." In this single, cogent opinion, the Illinois Supreme Court set proper limits on Illinois' targeted tender rule and provided clarity with respect to Illinois law on allocation. The decision makes clear that a targeted tender does not preempt the fundamental requirement of horizontal exhaustion. Further, the decision properly limits the application of the targeted tender rule to "circumstances where concurrent primary insurance coverage exists for additional insureds."

The decision also has implications with respect to long-tail claims and consecutive policies beyond making clear that the targeted tender rule has no application to such matters. Indeed, the decision further establishes that Illinois is a *pro rata* or horizontal exhaustion jurisdiction, not an "all sums" or "vertical exhaustion" jurisdiction.

This is the Illinois Supreme Court's first substantive foray into allocation-related issues since *Zurich Ins. Co. v. Raymark Indus. Inc.* [118 Ill. 2d 23 (1987)] ("*Raymark*") decided over 20 years ago. Notwithstanding substantial decisional authority demonstrating that Illinois is a *pro rata* jurisdiction, policyholders for years have used the *Raymark* decision to argue that Illinois is an "all sums" or "vertical spike" jurisdiction. The *Kajima* decision, at a minimum, limits the application of *Raymark* in the long-tail claim context to primary policies -- as many decisions applying Illinois law already have recognized -- and actually establishes that Illinois is a *pro rata* jurisdiction.

We begin with an overview of Illinois' targeted tender rule. Next, we examine Illinois jurisprudence on allocation spanning from *Raymark* to *Kajima*, visiting numerous Illinois appellate and trial court decisions and providing guidance to practitioners along the way. We then discuss the *Kajima* decision. Finally, we consider the impact of this decision both on the targeted tender rule and on the broader subject of allocation.

The "Targeted Tender" or "Selective Tender" Rule in Illinois

There is a line of cases specific to Illinois law that, under certain circumstances, allows a policyholder to tender its defense to one of its primary insurers (but not another) and thereby nullify the defending insurer's rights of equitable contribution as to both defense and indemnity against the non-selected insurer. Simply stated, where applicable, it allows a policyholder covered by multiple primary liability insurance policies to select or target which insurer will defend and indemnify it with regard to a specific claim and to make its selection stick.

This "targeted tender" or "selective tender" rule originated in *Institute of London Underwriters v. Hartford Fire Ins. Co.* [234 Ill. App. 3d 70 (1st Dist. 1992)] in the context of concurrent insurance contracts. The case arose out of a construction accident on the premises of an insured property owner. The property owner had coverage available to it both under its own insurance contract (under which it was a named insured) and under a contractor's insurance contract (under which it was an additional insured). The property owner tendered the underlying suit to the contractor's insurer and "notified [its own insurer] of the claim but unequivocally stated that [its own insurer] should not respond to the loss, but that the [contractor's insurer] was to provide the defense and indemnification for it under the [contractor's policy]" [234 Ill. App. 3d at 73].

The contractor's insurer defended the property owner in the underlying action. Fourteen months after the underlying action was filed, and against the wishes of the property owner, the contractor's insurer sent a letter requesting that the property owner's insurer contribute to a settlement of the underlying action. The property owner's insurer refused. The contractor's insurer subsequently settled the underlying action on its own and brought an equitable contribution action against the property owner's insurer [234 Ill. App. 3d at 72-73].

The appellate court held that the doctrine of equitable contribution "did not apply" on the facts of that case, even though the contractor's insurance and the property owner's insurance were co-primary. The court held that, where two insurance contracts potentially apply to a loss, the policyholder has the "right" to select which insurer is to defend and indemnify it by tendering its defense to one insurer and not the other, thereby foreclosing the selected insurer's right of contribution from the "excused" insurer [234 Ill. App. 3d at 78-79].

The court pointed out that the contractor's insurance contract, unlike the property owner's contract, did not contain an "other insurance" clause. The court refused to allow the contractor's insurer to claim any benefit from the "other insurance" clause of the property owner's contract, claiming that to do so would "elevate" the status of the contractor's insurer to that of a third-party beneficiary under the property owner's insurance contract [234 Ill. App. 3d at 77].

The appellate court concluded that the property owner's own insurance was never triggered. The property owner never tendered its defense to its own insurer (and, in fact, specifically instructed its insurer not to get involved in the defense or the indemnification of the claim). Further, the letter from the contractor's insurer to the property owner's insurer requesting that the latter contribute to the underlying settlement did not amount to a tender of the defense. As such, the property owner's insurer had no duty to respond to the underlying action in any way. As a result, the contractor's insurer was barred from seeking contribution from the property owner's insurer. The court believed that the property owner's concern that attributing the loss to the policy under which it was the named insured could result in an increase in premiums or cancellation of the policy justified allowing the property owner to have the right to select which policy participated [234 Ill. App. 3d at 78-79].

Subsequent to the appellate court's decision in *Institute of London*, the Illinois Supreme Court discussed the targeted tender rule in *Cincinnati Cos. v. West American Ins. Co.* [183 Ill. 2d 317 (1998)]. The issue in that case was

whether a primary insurer's duty to defend arose upon receipt of actual notice of the suit against its policyholder or upon the policyholder's tender of its defense to the insurer. The court held that actual notice triggered the duty to defend. In the course of the decision, the court commented favorably on the targeted tender rule and the policyholder's right to forgo coverage under a policy in order to protect itself against an increase in premiums or policy cancellation [183 Ill. 2d at 326]. The court also recognized that the targeted tender rule is not a one-way street. In other words, the policyholder may choose to forgo an insurer's involvement in the defense by instructing the insurer not to participate in the litigation. The court stated that the insurer would then be relieved of its obligation to the policyholder with regard to that claim [183 Ill. 2d at 326]. The court did not address whether or not the "selected" insurer would be precluded from pursuing a claim for equitable contribution against the "excused" insurer. [See also *Bituminous Cas. Corp. v. Royal Ins. Co. of Am.*, 301 Ill. App. 3d 720 (3d Dist. 1998) (applying the targeted tender rule and holding that it is only where its policy is triggered that the insurer becomes liable for the defense and indemnity costs of a claim and it becomes necessary to allocate loss according to the terms of the "other insurance" clauses of the policies).]

Targeted tender also was at issue in *Alcan United, Inc. v. West Bend Mut. Ins. Co.*, [303 Ill. App. 3d 72 (1st Dist. 1999)]. The *Alcan* case was a declaratory judgment action between two insurers, Reliance National Insurance Company and West Bend Mutual Insurance Company. Alcan United, Inc. was a named insured under the Reliance contract and an additional insured under the West Bend contract. Both the Reliance and West Bend contracts contained "other insurance" clauses. The *Alcan* court held that an "other insurance" clause merely governs apportionment of "available" insurance and, as such, does not "come into play" unless other coverage is "available" (i.e., the policyholder also tenders to another insurer) [303 Ill. App. 3d at 82], citing *Employers Ins. v. James McHugh Constr. Co.*, 144 F.3d 1097 (7th Cir. 1998)(applying Illinois law)]. As such, an "other insurance" clause does not prevent a policyholder from selectively tendering its defense to only one of its insurers, thereby precluding the "selected" insurer from obtaining equitable contribution from other insurers that also provide coverage.

The Illinois Supreme Court considered whether the presence of an "other insurance" clause precludes the application of the targeted tender doctrine in *John Burns Const. Co. v. Indiana Ins. Co.* [189 Ill. 2d 570 (2000)]. Burns, a general contractor, entered into a subcontract with a paving company that required the subcontractor to name Burns as an additional insured under its policy with Indiana Insurance Company. Burns sought to have Indiana defend and indemnify it in a subsequent slip and fall case. Indiana refused and Burns had its own insurer, Royal Insurance Company, defend. Burns and Royal filed an action seeking a declaration that Indiana had the exclusive obligation to defend and indemnify Burns. The trial court held the two insurers must contribute equally to the defense and indemnity of Burns. The appellate court affirmed, holding that Burns' initial tender to Indiana triggered the "other insurance clause" provision of the Indiana policy, which in turn activated Royal's duty to defend [189 Ill. 2d at 573].

The Illinois Supreme Court, in reversing the appellate court's holding that an "other insurance" clause provides a selected insurer the right to seek equitable contribution from another insurer, ruled that the presence of an "other insurance" clause in the insurance contract was "irrelevant" to the application of the targeted tender rule. The court began its analysis by reaffirming the principle that a policyholder has the right to choose which of its insurers will be required to defend and indemnify it. Addressing Indiana's argument that it could seek equitable contribution from Royal even though the insured had tendered to Indiana alone, the Court stated:

Indiana attempts to distinguish *Institute [of London]* by noting that the policy issued by Institute did not contain an "other insurance" provision and, therefore, Institute did not have a contractual right to involve Hartford. It was irrelevant that the Institute policy did not contain an "other insurance" clause, however. As the appellate court noted in *Institute [of London]*, the purpose of an "other insurance" clause is not to trigger coverage but to provide a method of apportioning coverage that would be triggered otherwise. [Citation omitted].

* * *

We . . . conclude that Indiana may not take advantage of the other insurance provision in its policy. The insurance provided by . . . Royal was not "available," in the language of the other insurance provision, for [John Burns] had

expressly declined to invoke that coverage. Moreover, we do not believe that the presence of the "other insurance" provision in the Indiana policy serves by itself to trigger the coverage afforded by Royal's policy. An "other insurance" provision does not in itself overcome the right of an insured to tender defense of an action to one insurer alone.

[*John Burns*, 189 Ill. 2d at 577-78.] Holding that Indiana should not benefit as the result of its own refusal to defend Burns, the Illinois Supreme Court also rejected Indiana's argument that Royal's policy was triggered when it took over the defense of Burns after Indiana rejected it [189 Ill. 2d at 578]. Accordingly, after *Burns*, it was settled law in Illinois that the selective tender doctrine could be applied in that type of concurrent coverage situation regardless of the presence of an "other insurance" clause in the policy of the selected insurer.

A couple of cases allowed a policyholder to "deactivate" a tender previously made under some circumstances "for purposes of invoking exclusive coverage with another carrier" [*Alcan*, 707 N.E.2d at 695; see also *Legion Ins. Co. v. Empire Fire & Marine Ins. Co.*, 354 Ill. App. 3d 699 (1st Dist. 2004), *appeal denied*, 215 Ill. 2d 598 (2005)]. The issue of the extent to which a policyholder may deactivate a tender or must renounce coverage under other policies likely will be the subject of future decisions.

The targeted tender rule generally has been applied in the context of claims involving concurrent primary insurance contracts in which the insured (often a general contractor) has its own policy and is named as an additional insured under policies issued to another (often a subcontractor who names the general contractor as an additional insured pursuant to a contractual obligation).

The targeted tender rule has not gained acceptance outside Illinois. In fact, the rule has been subject to considerable criticism as being an improper way to address an issue that could better be addressed -- as some courts have done -- by holding that co-insurers' "other insurance" clauses have no impact on their respective rights and obligations when the underlying parties' hold harmless and indemnity agreements address how the risk of loss is to be borne [see, e.g., *Am. Indem. Lloyds v. Travelers Prop. & Cas. Ins. Co.*, 335 F.3d 429, 436 (5th Cir. 2003) (applying Texas law) (noting "an indemnity agreement between the insureds or a contract with an indemnification clause, such as is commonly found in the construction industry, may shift an entire loss to a particular insurer notwithstanding the existence of an 'other insurance' clause in its policy"); *Hartford Cas. Ins. Co. v. Mt. Hawley Ins. Co.*, 123 Cal. App. 4th 278 (Cal. Ct. App. 2004) (holding that one primary insurer could not seek equitable contribution from another primary insurer based upon the indemnity provisions in the underlying construction contract)]. In addition, at least prior to *Kajima*, there has been some concern that policyholders may seek to have the doctrine applied outside its intended scope of concurrent policies under which the policyholder is the additional insured.

Illinois Case Law on Allocation of Losses

In 1987, the Illinois Supreme Court issued its decision in *Zurich Ins. Co. v. Raymark Industries, Inc.* [118 Ill. 2d 23 (1987)]. The court in *Raymark* primarily was focused on the issue of trigger of coverage in the context of asbestos-related claims under primary commercial general liability policies. The court ruled that, under the plain language of the policies "an insurer must provide coverage for a claim if the claimant sustained 'bodily injury' or 'sickness' or 'disease' during the policy period." In affirming the appellate court, the Illinois Supreme Court applied a "triple trigger," holding that the policies were triggered at the initial exposure, when the disease manifested itself, and at any interim time when the claimant manifested some sickness. The court further noted that, between the time exposure to asbestos ceases and the time an asbestos-related disease becomes diagnosable, there is no continuous injury. The court stated that "sickness" may take place in the period before clinical manifestation of the disease and whether and when a claimant suffered sickness must be determined on a case-by-case basis [*id.* at 29]. n1

After having fully analyzed the trigger issue and having rejected the application of a continuous (or exposure) trigger used in *Insurance Co. of North America v. Forty-Eight Insulations, Inc.*, [633 F.2d 1212 (6th Cir. 1980), *aff'd on rehearing*, 657 F.2d 814 (6th Cir.), *cert. denied*, 454 U.S. 1109 (1981)], the court simply held:

Having rejected the premise underlying the *pro rata* allocation approach adopted in *Forty-Eight Insulations*, we conclude that the appellate court did not err insofar as it declined to order the *pro rata* allocation of defense and indemnity obligations among the triggered policies.

[*Raymark*, 118 Ill. 2d at 57.]

The above quote constitutes the entirety of the court's consideration of the issue of allocation. The Illinois Supreme Court simply concluded that the appellate court did not commit reversible error insofar as it declined to order the *pro rata* allocation of defense and indemnity obligations among the triggered primary insurance policies on the facts of the case before it. The Illinois Supreme Court did not promulgate a rule governing allocation in Illinois and provided no indication whatsoever that it intended its refusal to reverse the lower court's allocation holding in *Raymark* to apply in any other case or context. Of course, the *Raymark* decision is 20 years old and predated a wealth of cases in Illinois and across the country specifically analyzing and addressing the important issues of allocation.

Post-Raymark Horizontal Exhaustion/Pro Rata Decisions

Since *Raymark*, there have been numerous cases applying Illinois law that have addressed issues regarding allocation of losses. A majority of appellate court decisions in Illinois have recognized the very limited nature of the *Raymark* decision on the issue of allocation and have concluded that: (1) horizontal rather than vertical exhaustion is required; (2) in the absence of a reliable method to prorate the loss based upon the claim-specific facts, a time-on-the-risk allocation applies; and (3) the policyholder is responsible for periods where it is self-insured or has no available insurance or insufficient insurance available for whatever reason. These cases have recognized that many policies with "all sums" language expressly limit coverage to injuries or damages "during the policy period" and have considered the requisite equities associated with a fair allocation.

In *U.S. Gypsum Co. v. Admiral Ins. Co.* [268 Ill. App. 3d 598 (1st Dist. 1994), appeal denied, 161 Ill. 2d 542 (1995)], the appellate court addressed the issue of allocation in the context of asbestos property damage claims. The court rejected the policyholder's vertical exhaustion argument because it would "blur the distinction between primary and excess insurance" and allow the policyholder "to effectively manipulate the source of its recovery, avoiding difficulties encountered as the result of its purchase of fronting insurance and the liquidation of some of its insurers" [*id.* at 654].

The appellate court decision in *Outboard Marine Corp. v. Liberty Mut. Ins. Co.* [283 Ill. App. 3d 630 (2d Dist. 1996), appeal denied, 167 Ill. 2d 617 (1997)] is particularly instructive. The case involved coverage for environmental property damage claims and was authored by the current Chief Justice of the Illinois Supreme Court, Robert Thomas, when he was a justice sitting on the appellate court. Justice Thomas rejected the policyholder's argument that *Raymark* required vertical exhaustion, noting that the case did not involve a claim for property damage or coverage for excess insurance. Justice Thomas wrote: "[t]his is the only fair approach. While the insurers agreed to indemnify OMC for 'all sums,' it had to be for sums incurred during the policy period. *Gypsum* supports the notion that OMC cannot shift its responsibility for uninsured years to its excess carriers" [*id.* at 642]. The court saw no justification to. Instead, the court applied a *pro rata* time-on-the-risk allocation with the policyholder being held responsible for uninsured periods.

In *Missouri Pacific R. Co. v. International Ins. Co.*, [288 Ill. App. 3d 69 (2d Dist. 1997), appeal denied, 174 Ill. 2d 567 (1997)], the appellate court ruled on the issue of allocation in the context of noise-induced hearing loss ("NIHL") and asbestos bodily injury claims. The court rejected the policyholder's argument that an "all sums" ruling was required by *Raymark* and the policy language, noting:

[w]e read nothing in *Zurich* as precluding the application of the *pro rata*, time-on-the-risk allocation method announced in *Outboard Marine* to the case at bar. *Zurich's* rejection of a *pro rata* approach was based on the narrow facts of the case before it, namely, that it had rejected the trigger analysis set forth in *Forty-Eight Insulations*. The court did not adopt a general rule forever precluding the application of a *pro rata* approach. As we explained in *Outboard*

Marine, such an approach is appropriate where, as here, a single continuous occurrence results in an unallocable loss implicating successive policy periods.

[*Id.* at 79.] The court rejected the policyholder's "all sums" argument, noting it ignored the requirement that such sums "must be on account of personal injuries that occur during the policy period" [*id.* at 77]. The court reversed the grant of summary judgment in favor of the policyholder and ruled that, on remand, the parties should be given the opportunity to present evidence that NIHL and asbestos claims may be measured and allocated, to a reasonable degree of medical and scientific certainty, to particular policy periods. If the injuries cannot be measured and allocated to particular policy periods, the *pro rata* time-on-the-risk allocation of damages approach used in *Outboard Marine* would be applied [*id.* at 78]. The court held that horizontal exhaustion is required and that the insured is responsible for uninsured periods [*id.* at 82].

Practice Insight: The foregoing language in the decision affording the parties an opportunity to make a factual showing about when injuries or damages took place should serve as an important reminder for practitioners to consider a fact-based allocation in the appropriate case. The most accurate allocation method -- and the one that most closely adheres to the requirements of most insurance policies -- is to determine precisely what injury or damage took place during each policy period or each uninsured period and allocate the loss accordingly. In many long-tail claims, the inability to make such a determination or the litigation costs associated with attempting to make such a showing has caused parties to advocate and courts to apply either a *pro rata* proxy or an all sums fiction for apportioning losses. Nonetheless, practitioners should consider with respect to a given claim whether factual evidence and/or expert testimony could be developed that would provide a meaningful basis to allocate losses consistent with the portfolio interests of the client.

The appellate court once again rejected the "all sums" argument and required horizontal exhaustion in *AAA Disposal Systems, Inc. v. Aetna Cas. and Surety Co.* [355 Ill. App. 3d 275 (2d Dist. 2005), appeal denied, 213 Ill. 2d 275 (2005)]. In that case, which involved environmental property damage, the court applied a *pro rata* time-on-the-risk allocation. Moreover, it held that the period of October 1, 1985 to June 24, 1988 must be included in the allocation notwithstanding the court's acknowledgement that no insurance coverage was available to the insured during that period. In addition, the court determined that the period in which coverage was provided by an insolvent insurer must be included in the allocation period [see also *Roman Catholic Diocese of Juliet, Inc. v. Interstate Fire Ins. Co.*, 292 Ill. App. 3d 447 (1st Dist. 1997) (applying a *pro rata* allocation in a sexual abuse case); *Illinois Cent. R.R. v. Accident & Cas. Co.*, 317 Ill. App. 3d 737 (1st Dist. 2000), appeal denied, 193 Ill. 2d 586 (2001) (ruling in favor of the horizontal exhaustion of policies and a *pro rata* allocation of losses in a case involving employment discrimination that took place over a period of years)]. n4

As the case histories demonstrate, over the years the Illinois Supreme Court repeatedly has declined to review appellate court decisions providing a *pro rata* or horizontal approach to allocation and requiring that the policyholder bear responsibility for periods of no insurance. In particular, the Illinois Supreme Court denied review in *Outboard Marine*, *Missouri Pacific*, and *AAA Disposal Systems, Inc.* n5

Post-Raymark All Sums/Vertical Exhaustion Decisions

Policyholders argue that a couple of Illinois appellate court decisions have sided with them by looking to the "all sums" language in some policies in a vacuum and by considering *Raymark* as requiring an "all sums," "pick and choose," or "vertical spike" allocation at least at the primary insurance level. One such decision is *Benoy Motor Sales, Inc. v. Universal Underwriters Ins. Co.* [287 Ill. App. 3d 942 (1st Dist. 1997)]. *Benoy* involved one insurer's obligation to 10 automobile dealerships in connection with various claims asserted by the Illinois Environmental Protection Agency and the United States Environmental Protection Agency at a single polluted site.

In *Benoy*, the appellate court reversed the trial court's ruling that held the insurer was required to pay each dealer only that part of the settlement amount and defense costs that relate to shipments of oil to the site while the policy was in effect and not to shipments made during gaps in coverage. The *Benoy* decision cites with approval to the *Raymark* decision and noted that an analogy to the facts of *Benoy* (which involved environmental contamination) to *Raymark* was "apt." The portion of the *Raymark* decision endorsed by the appellate court in *Benoy*, however, was the adoption of a triple trigger for asbestos bodily injury claims [*Benoy*, 287 Ill. App. 3d at 948]. Yet, the appellate court actually applied a continuous trigger and remanded the case for a determination of how much the insurer was obligated to pay on behalf of each policyholder [*id.*]. Accordingly, as another appellate court decision specifically found, *Benoy* simply "did not reach a decision regarding *pro rata* allocation" [AAA *Disposal*, 355 Ill. App. 3d at 287; *see also John Crane Inc. v. Admiral Ins. Co.*, No. 04CH8266, 2006 WL 1010495, *30 (Cir. Ct., Cook Cty., Ill. April 12, 2006) (noting that *Benoy* is "not applicable" because it "did not reach a decision regarding *pro rata* allocation")].

In a subsequent opinion authored by Justice Wolfson, the same appellate justice who authored *Benoy*, the court refused to hold that Illinois law required an "all sums" allocation [*Maremont Corp. v. Cont'l Cas. Co.*, 326 Ill. App. 3d 272 (1st Dist. 2001), *appeal denied*, 198 Ill. 2d 617 (2002)]. *Maremont*, like *Benoy*, was an environmental property damage coverage action. The trial court found the continuing pollution required it to apply a "continuous trigger" in determining coverage for a single occurrence. Because the policyholder could not prove the amount of damages that occurred during the years that Continental and London insured it, the court allocated damages to the various policies in proportion to the period of time each was on the risk. The trial court further found *Maremont* was required to horizontally exhaust all primary insurance before it could reach the Continental and London excess policies. Because the pro rated damages did not exceed the liability limits of the primary policies, the trial court ruled Continental and London could not be held liable, and granted their motions for summary judgment.

Although the appellate court opinion suggests that Justice Wolfson continues to believe that the "during the policy period" language does not serve as a limitation on the promise to pay "all sums," the court ultimately did not accept the policyholder's argument that *Outboard Marine* and the other *pro rata* decisions in Illinois ran contrary to *Raymark*. The court stated, "[w]hether *Zurich's no pro rata* holding applies to the kind of case before us is an issue that awaits another day" [*Maremont*, 325 Ill. App. 3d at 279]. In fact, the appellate court recognized that Illinois law required horizontal, rather than vertical, exhaustion and affirmed the decision of the trial court.

Practice Insight: As demonstrated in the previous section, most of the Illinois decisions appreciate that the "all sums" language found in many commercial general liability ("CGL") policies does not support vertical exhaustion because it cannot be read in isolation from the "to which this policy applies" qualifier and the express language limiting coverage to damages or injuries "during the policy period." In advocating any particular allocation methodology, it is important for the practitioner to understand the language in the subject insurance policies as well as the legal precedent in the relevant jurisdiction. Many excess policies are written on an "ultimate net loss" or "loss" basis and do not contain "all sums" language. Indeed, the Insurance Services Office ("ISO") replaced the "all sums" language with "those sums" language beginning with the 1986 CGL form. Most of the cases that have held in favor of an "all sums" or vertical exhaustion allocation -- which remains the minority view -- have placed their reliance mostly or entirely on a so-called promise to pay "all sums." Accordingly, practitioners representing insurers seeking a *pro rata* allocation with respect to policies that do not contain "all sums" language should forcefully point out the absence of any contractual basis to support an "all sums" ruling. [See generally Scott M. Seaman and Jason R. Schulze, Allocation of Losses in Complex Insurance Coverage Claims [otilde][otilde] 4.2 and 4.3 (2d Edition, Thompson West Legalworks 2006, 2007 Supp.) for a discussion of the various allocation theories and the arguments supporting them.]

A recent unpublished appellate court order addressed the issue of liability for defense costs associated with asbestos bodily injury claims [*Caterpillar, Inc. v. Century Indem. Co.*, No. 03-06-0181 (Ill. App. 3d Dist. Feb. 2, 2007), *reprinted in* 21-14 Mealey's Litig. Rep. Ins. 1 (Feb. 13, 2007) (unpublished decision), *appeal denied*, 225 Ill. 2d 629 (2007)]. The court in *Caterpillar* rejected the insurer's argument that the "during the policy period" language limited its obligation to pay a *pro rata* share of defense costs. The court held "there is nothing in the language of [the insurer's] policies that permits a *pro rata* reduction in its obligation to pay 'all sums' and defend 'any suit.'" In particular, the court

found that "*Raymark* is on all fours with the instant case" in that both cases involved a primary insurer's obligation to pay defense costs for asbestos bodily injury claims. The *Caterpillar* court held that "the policy language, as well as the precedent set forth in *Raymark*, direct an all sums allocation of defense costs." It appears that the factual similarity to *Raymark* drove the court's decision on defense costs.

The *Caterpillar* decision is of limited utility to policyholders. First, as an unpublished order, it is not precedential and may not be cited by any party except to support contentions of double jeopardy, *res judicata*, collateral estoppel, or law of the case [see Ill. Sup. Ct., R 23]. Second, the decision was issued prior to *Kajima*. Third, the holding relates only to primary policies in the context of asbestos claims. Finally, this case only involved policies issued by a single insurance company.

In seeking a "vertical exhaustion" result, policyholders often are relegated to citing the decision of the Massachusetts Appellate Court in *Chicago Bridge and Iron Co. v. Certain Underwriters at Lloyd's London* [59 Mass. App. Ct. 646 (2003)]. The allocation issues in *Chicago Bridge* involved nine years of successive policies issued by the only insurer defendant in that case [59 Mass. App. Ct. at 647]. Thus, because the environmental contamination spanned at least 50 years, the central argument was whether that insurer, as the lone defendant in the action, could limit its obligation to pay defense and indemnity for the environmental losses at multiple sites at issue on a *pro rata* basis, i.e., 9/50ths of the total loss at issue. The Massachusetts Appellate Court ruled that the insurer was obligated to pay the entire loss on the basis of an "all sums" allocation methodology. Although purporting to apply Illinois law, the Massachusetts Appellate Court relied mostly upon its own prior allocation ruling under Massachusetts law. Indeed, the Massachusetts Appellate Court specifically noted twice that an "all sums" ruling was consistent with Massachusetts law under that court's earlier decision in *Rubenstein v. Royal Ins. Co. of America* [44 Mass. App. Ct. 842 (1998), review granted, 428 Mass. 1109 (1998)]. Thus, *Chicago Bridge* appears to be more of a reflection of the court's view of Massachusetts law, than a true reflection of Illinois law.

In sum, the weight of pre-*Kajima* authority -- and certainly the better reasoned decisions -- support a horizontal exhaustion or *pro rata* allocation under Illinois law.

The Facts in the *Kajima* Case

Kajima, a general contractor, entered into a subcontract with *Midwestern Steel Fabricators* in connection with a construction project. The subcontract required *Midwestern* to maintain CGL coverage for *Kajima* as an additional insured. *Midwestern* subcontracted a portion of its contract to *Up-Rite Steel*. *Thomas Jones*, an employee of *Up-Rite*, was injured while working on the project and filed a personal injury suit against *Kajima* and *Midwestern*. *Kajima* had its own CGL policy with *Tokio Marine and Fire Insurance Company* with limits of \$1 million per occurrence. Pursuant to the requirements of the subcontract, *Kajima* also was an additional insured under a \$2 million primary policy and \$5 million umbrella policy issued to *Midwestern* by *St. Paul*. *Kajima* made a "targeted tender" to *Midwestern* and *St. Paul* to provide the exclusive defense and indemnification with respect to the *Jones* case [*Kajima Constr. Servs. v. St. Paul Fire & Marine Ins. Co.*, 227 Ill. 2d 102, 2007 Ill. LEXIS 1702 (2007), reprinted in 22-6 Mealey's Litig. Rep. Ins. 1 (2007)]. When *St. Paul* initially did not accept the tender, *Kajima* requested that *Tokio* handle the matter and pursue the defense and indemnity owed to *Kajima*. *St. Paul* later accepted the tender under a reservation of rights, but it refused *Tokio's* demand that *St. Paul* settle the *Jones* suit by paying \$3 million. Ultimately, the *Jones* case did settle for \$3 million, with *Tokio* paying its primary limits of \$1 million and *St. Paul* paying its primary limits of \$2 million [2007 Ill. LEXIS 1702, at *3].

Kajima and *Tokio* then filed a declaratory judgment action against *St. Paul* seeking reimbursement of the \$1 million paid by *Tokio*. On cross-motions for summary judgment, *Kajima* and *Tokio* argued that, based upon the targeted tender rule, *St. Paul* should have contributed an additional \$1 million from its umbrella policy because it was solely responsible for the defense and indemnification of *Kajima* without contribution from *Tokio*. *St. Paul* argued it was not required to contribute any of its umbrella limits because *Tokio* provided primary coverage and Illinois law requires that all primary policies be exhausted prior to an excess policy being implicated (i.e., horizontal exhaustion). The trial court

agreed with St. Paul, granting its motion for summary judgment and denying the motion of *Tokio/Kajima* [2007 Ill. LEXIS 1702, at *4]. The appellate court affirmed, holding "the selective tender rule should be applied to circumstances where concurrent insurance coverage exists for additional insureds" [2007 Ill. LEXIS 1702, at *4-5]. Nonetheless, to the extent "defense and indemnity costs exceed the primary limits of the selected insurer, the deselected insurer or insurers' primary policies must answer for the loss prior to invoking coverage under an excess policy" [2007 Ill. LEXIS 1702, at *23]. The Illinois Supreme Court subsequently allowed the petition of *Kajima* and *Tokio* for leave to appeal.

The Illinois Supreme Court's Decision in *Kajima*

The unanimous decision authored by Illinois Supreme Court Chief Justice Robert Thomas included a general discussion of horizontal exhaustion and the targeted tender rule. The court made clear that horizontal exhaustion requires not only that collectable primary insurance must be exhausted before excess insurance is impacted, but that the policyholder must also satisfy its responsibility for periods of fronting insurance, insolvent insurers, and self-insurance.

First, the court cited to *Gypsum* and quoted to the following language from *Gypsum* criticizing vertical exhaustion as allowing the policyholder to:

[e]ffectively manipulate the source of recovery, avoiding difficulties encountered as the result of its purchase of fronting insurance and the liquidation of some of its insurers. This would permit *Gypsum* to pursue coverage from certain excess insurers at the exclusion of others. Such a practice would blur the distinction between primary and excess insurance [citations omitted], and would allow certain primary insurers to escape unscathed when they would otherwise bear the initial burden of providing indemnification [*Gypsum*, 268 Ill. App. 3d at 654].

[2007 Ill. LEXIS 1702, at *6.]

Second, the court stated that, following *Gypsum*, "the appellate court continued to apply horizontal exhaustion to require an insured to first exhaust all available primary insurance coverage, *including self-insured periods*, before an excess policy can be reached" [2007 Ill. LEXIS 1702, at *7]. (Emphasis added.) n6

The court noted that its prior decisions addressing targeted tender are not entirely on point as those cases did not involve excess insurance policies [2007 Ill. LEXIS 1702, at *16]. Although the requirement of horizontal exhaustion originated in cases involving a continuous tort or long-term environmental and hazardous waste claims, the court ruled that the application of horizontal exhaustion was not limited to those types of claims. The court stated "[g]iven that the crux of horizontal exhaustion is the difference between primary and excess insurance, we see no reason to depart from horizontal exhaustion in this case" [2007 Ill. LEXIS 1702, at *18.]. In determining that the targeted tender rule does not prevail over horizontal exhaustion, the court relied upon the fundamental "difference between primary and excess insurance" and found Justice Freeman's discussion in *Roberts v. Northland Ins. Co.* [185 Ill. 2d 262 (1998)] (Freeman, C.J., concurring in part and dissenting in part, joined by Miller and McMarrow, JJ) (*quoting* S. Seaman & C. Kittredge, *Excess Liability Insurance: Law and Litigation*, 32 *Tort & Ins. L.J.* 653, 656 (1996)) to be "particularly instructive" [*Kajima Constr. Servs. v. St. Paul Fire & Marine Ins. Co.*, 227 Ill. 2d 102, 2007 Ill. LEXIS 1702, at *19 (Ill. 2007)].

In finding that the targeted tender rule does not preempt horizontal exhaustion, the Court stated:

[g]iven the clear distinctions between primary and excess insurance coverage, we decline to extend the targeted tender doctrine to require one insurer to vertically exhaust its primary and excess coverage limits before all primary insurance available to the insured has been exhausted. Extending the targeted tender rule to require an excess policy to pay before a primary policy would eviscerate the distinction between primary and excess insurance Consequently, we find that the better rule is that set forth by the appellate court -- that targeted tender can be applied to circumstances where concurrent primary insurance coverage exists for additional insureds, but to the extent that defense and indemnity costs exceed the primary limits of the targeted insurer, the deselected insurer or insurers' primary policy must answer for the loss before the insured can seek coverage under an excess policy. This holding preserves the distinction between

primary and excess insurance policies.

[2007 Ill. LEXIS 1702, at *22]. The court found that, despite Kajima's targeted tender to St. Paul, Kajima was required to exhaust its primary policies before invoking St. Paul's excess coverage [2007 Ill. LEXIS 1702, at *23]. The court, therefore, found it unnecessary to address St. Paul's alternative argument that the targeted tender rule does not apply in this case because Kajima did not knowingly forgo coverage from *Tokio* [2007 Ill. LEXIS 1702, at * 24].

The Impact of *Kajima* on Targeted Tender

The *Kajima* decision is significant in the context of concurrent coverage cases because it does not allow a targeted tender to trump the requirement of horizontal exhaustion. Accordingly, all primary coverage must be exhausted before an excess policy is required to respond regardless of whether the policyholder purports to make a targeted tender to implicate excess coverage.

The decision also is significant because the Illinois Supreme Court properly limits the application of the targeted tender rule to "circumstances where concurrent primary insurance coverage exists for additional insureds" [2007 Ill. LEXIS 1702, at *5]. Accordingly, a policyholder may not make a targeted tender to select insurers in the context of long-tail claims and consecutive policies. Such a limitation is entirely sound and may moot much of the criticism directed toward the targeted tender rule. Essentially, with this proper limitation, the targeted tender rule produces the same result as the law in those states that hold that "other insurance" clauses have no impact on co-insurers' respective rights and obligations where the underlying parties' indemnity agreements address how the risk of loss is to be borne. In other words, the properly limited targeted tender rule can be said to effectuate the intent of general contractors and subcontractors (or similar entities) where they agree that the former should be named as an additional insured under the latter's policy in connection with work and materials supplied by the latter under the subject construction contract. Under such circumstances, the naming of a general contractor as an additional insured under the subcontractor's policy is specifically done so that the general contractor may call upon the subcontractor's insurer to respond to a claim arising from the subcontractor's work or acts.

An insurer may exercise a degree of control of the situation in the underwriting process by agreeing or not agreeing to issue the policy or to restrict who may be named as an additional insured. In addition, an insurer also could include specific language in the policy that overrides a targeted tender. In *American Country Ins. Co. v. Kraemer Bros., Inc.* [298 Ill. App. 3d 805 (1st Dist. 1998)], the court upheld an endorsement that was drafted specifically to deal with the doctrine of targeted tender in Illinois. The endorsement required, in pertinent part, the policyholder to "[p]romptly tender the defense of any claim made or 'suit' to any other insurer which also has available insurance for a loss which we cover." [298 Ill. App. at 808]. The court held the provision was enforceable and was not against public policy. It noted that the Illinois Department of Insurance had specifically accepted and approved American Country's "cooperation" endorsement. n7

Targeted tender simply has no place in the context of excess policies, consecutive coverage, or long-tail claims. The concerns regarding policy cancellation and increase in premiums under policies in force that served as the justification for allowing a targeted tender in the first instance do not exist with respect to historic consecutive policies. The Illinois Supreme Court's decision in *Kajima* appropriately delineates the limited circumstances to which the targeted tender rule applies -- some circumstances involving concurrent primary coverage for additional insureds.

When faced with a purported targeted tender, the selected insurer must evaluate the claim and whether, and to what extent, the targeted tender rule applies. This involves consideration of applicable choice of law rules to determine in the first instance whether Illinois law applies as well as the facts and coverage issues presented. The insurer should confirm that it is subject to a targeted tender by communicating with the policyholder or its counsel directly, as opposed to relying upon communications with a putative de-selected insurer. The targeted insurer should take the appropriate steps to preserve any rights and contribution claims available to it. In appropriate circumstances, it may defend or pay under a reservation of rights. If there is a dispute regarding coverage or the targeted tender, the insurer may be well-served by

instituting a declaratory judgment action given Illinois law on estoppel.

Practice Insight: The de-selected insurer would be well-served by communicating with its insured and confirming in writing the insured's directions that the insurer not provide defense or indemnity for the subject claim. Recalcitrance on the part of the targeted tender may result in the de-selected insurer having to participate in the defense or indemnity on behalf of the insured and in instituting an action against the targeted insurer as was the case in *Kajima*.

One important issue that the Illinois Supreme Court did not address in *Kajima* is the extent to which the policyholder must forego or renounce coverage under the non-selective party in order to invoke the targeted tender rule. It is unlikely that a selected insurer will be able to avoid the impact of the targeted tender rule under circumstances in which the policyholder is required to seek defense or indemnity from another insurer because of the refusal by the targeted insurer to defend or indemnify it. Yet, a fundamental element of the targeted tender rule is that the policyholder must seek coverage under the *targeted* insurer's policy, not those of multiple insurers. Accordingly, the rule should not be used as a mechanism for gamesmanship, negotiation, or pursuit of multiple recoveries by the policyholder. Accordingly, the issue of renouncing or forgoing insurance under other policies likely will be subject to future decisions.

The Impact of *Kajima* on Allocation of Losses in Illinois

The *Kajima* decision also has implications with respect to long-tail claims and consecutive policies, in addition to making clear that the targeted tender rule has no application to such matters. The Illinois Supreme Court recognizes that horizontal exhaustion is required under Illinois law in the context of long-tail claims and consecutive policies as well as instances of concurrent coverage. Application of horizontal exhaustion is completely incompatible with an "all sums" or "vertical spike" allocation that policyholders have argued is required by *Raymark*. Allowing a policyholder to "vertically spike" would eviscerate the distinction between primary and excess insurance in the context of long-tail claims and consecutive policies just as it would in the context of concurrent primary policies. *Raymark* already has been determined to be limited to its facts and to primary policies by multiple decisions. At a minimum, *Kajima* supports this limitation.

Yet, the Illinois Supreme Court's holding regarding horizontal exhaustion, its citation with approval to decisions such as *Gypsum*, *AAA Disposal*, *Missouri Pacific*, and *Outboard Marine*, its quotation from *Gypsum*, and its statement regarding horizontal exhaustion applying to self-insured periods strongly suggest that Illinois law requires a *pro rata* allocation in all instances involving concurrent coverage, including cases limited to primary policies. Further, the decision supports prior decisions holding that the policyholder is responsible for all periods of self-insurance or periods where insurance is unavailable. Although the court did not discuss the merits of a time-on-the-risk as opposed to a time-on-the-risk and limits *pro rata* methodology, it did cite cases that employed the time-on-the-risk methodology and that was the methodology employed by Chief Justice Thomas in his appellate court decision in *Outboard Marine*. Accordingly, in the aftermath of *Kajima*, Illinois should be viewed as a horizontal exhaustion, *pro rata* allocation jurisdiction.

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ⁿ¹ Recently, Cook County Judge Dorothy Kinnaird held an evidentiary hearing in the John Crane asbestos coverage case to determine whether medical advances over the past 20 years may require application of a continuous trigger or a trigger ruling other than the "triple trigger" ruling in *Raymark*. After hearing the medical

testimony, Judge Kinnaird concluded that the evidence was insufficient to prove that injury from exposure to asbestos is continuous from the time of exposure to the time of manifestation of disease. Instead of evidence of revolutionary medical developments that require revisiting the *Raymark* decision, Judge Kinnaird found the testimony supported the ruling in *Raymark*. See *John Crane Inv. v. Admiral Ins. Co.*, No. 04 CH 8266 (Cir. Ct., Cook Cty. Ill.) reported in 22-10 Mealey's Litig. Rep. Ins. 10 (2008).

n2 The court also held that the primary policies at issue did not obligate the insurers to assume the costs of defending actions against Raymark after their duty to indemnify has been discharged by the payments of judgments or settlements and they have made an orderly withdrawal from Raymark's defense.

n3 Football fans may recognize Chief Justice Thomas from his prior vocation. Prior to beginning a distinguished legal career, Justice Thomas was a place kicker. In college, he kicked the winning field goal to lead the Notre Dame Fighting Irish to a victory over the Alabama Crimson Tide in the 1973 Sugar Bowl and the 1973 National Title. He later played in the National Football League for the Chicago Bears.

n4 Various other courts applying Illinois law have found that Illinois law requires a *pro rata* allocation. See, e.g., *Great Lakes Dredge & Dock Co. v. City of Chicago*, 260 F.3d 789 (7th Cir. 2001), cert. denied, 535 U.S. 1012 (2002) (holding that "the Supreme Court of Illinois did not establish a principle that transcends the text of the insurance contracts. At least two appellate decisions in Illinois since *Zurich Insurance [Raymark]* have concluded that the Supreme Court of Illinois does not require joint and several liability independent of policies' language. [citations omitted]. Like the intermediate appellate courts in *Missouri Pacific* and *Outboard Marine*, we think that, when faced with the question, the Supreme Court of Illinois will follow the better reasoned (and more numerous) decisions that make policies' language the benchmark for [the allocation issue]."); *Illinois Central Railroad Co. v. Stonewall Ins. Co.*, Civil Action No. CV-99-3525 (Cir. Ct., Mobile Cty., Ala. June 2, 2006) (relying upon *Missouri Pacific* and noting that Illinois courts reject the "pick and spike approach" because insurers provide coverage for property damage that occurred "during the policy period" and the insured railroad was not entitled to select one policy period that provides full indemnification); *CBS Operations, Inc. v. Admiral Ins. Co.*, No. L-1739-99 (Super. Ct. Somerset Cty., N.J. Dec. 21, 2006) (holding that "the current state of Illinois law is that in environmental property damage cases with a continuous trigger on which coverage is based, such as in this case, Illinois courts are currently applying the *pro rata* time-on-the-risk allocation methodology.").

n5 Although policyholders may point out that the Illinois Supreme Court also denied review of the *Caterpillar* decision discussed in the next section, the Court's decision in *Kajima* was in the pipeline at the time.

n6 The Court cited several of the cases discussed previously in this article, including *AAA Disposal*, *Maremont Corp.*, *Missouri Pacific*, and *Outboard Marine*.

n7 In *Employers Ins. v. James McHugh Constr. Co.*, 144 F.3d 1097 (7th Cir. 1998) (applying Illinois law), the United States Court of Appeals for the Seventh Circuit rejected an insurer's argument that a standard "cooperation" clause required its policyholder to tender its defense to all insurers to protect the defending insurer's rights of contribution against other carriers. The court held that the "cooperation" clause was inapplicable to the enforcement of a claim against another insurer because the decision in *Institute of London* specifically allows a policyholder to choose one insurance company to provide the "whole defense" to an underlying action. The Seventh Circuit explained that the "cooperation" clause did not apply in the *McHugh* case because, after the policyholder chose to tender only to Wausau instead of its other insurers, "Wausau [was] the only insurer who was liable, period." 144 F.3d at 1106. Thus, Wausau's rights were extinguished by its policyholder's refusal to tender the defense to its other insurers.

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Shidlofsky on PAJ, Inc. v. Hanover & XL Specialty v. Financial Industries Corp.

2008 Emerging Issues 1844

Shidlofsky on PAJ, Inc. v. Hanover and XL Specialty v. Financial Industries Corp.

By Lee H. Shidlofsky

January 29, 2008

SUMMARY: In Texas Calculus, does PAJ + XL = Prejudice? Recent action by the Supreme Court of Texas may provide the answers. The notice-prejudice rule is a nationwide trend whereby an insurer is sometimes forced to prove that it was prejudiced by an insured's failure to timely notify it of a claim or lawsuit before the insurer can preclude coverage. On January 11, 2008, the Supreme Court of Texas issued an opinion on the matter in *PAJ, Inc. v. Hanover Insurance Co.*, 2008 Tex. LEXIS 8 (Tex. Jan. 11, 2008). That court also accepted a certified question from the *United States Fifth Circuit Court of Appeals. XL Specialty Ins. Co. v. Financial Indus. Corp.*, 2007 U.S. App. LEXIS 29373 (5th Cir. Dec. 19, 2007). The Courts efforts represent a step toward clarification of the notice-prejudice rule in Texas jurisprudence with respect to both occurrence-based and claims-made policies.

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ARTICLE: The Background of PAJ. Hanover Insurance Company (Hanover) insured PAJ, Inc. (PAJ), a jewelry manufacturer and distributor, under a CGL policy that provided coverage for personal and advertising injury (a/k/a Coverage B). In 1998, PAJ was sued for copyright infringement by Yurman Designs, and, unaware that its policy covered the dispute failed to provide notice to its insurer until four to six months after the *Yurman* suit began. After notifying its insurer, PAJ filed a declaratory judgment action seeking a declaration that Hanover owed it a defense and indemnity in relation to the *Yurman* matter. For purposes of that action, PAJ and Hanover stipulated that the insured failed to provide its insurer with notice of the *Yurman* lawsuit as soon as practicable, as the policy required. In addition, the parties agreed that the failure to provide timely notice did not prejudice Hanover. Both parties then moved for summary judgment on the notice issue. At the trial court, Hanover's motion was granted and PAJ's was denied because that court held that Hanover could preclude coverage under the policy without first demonstrating that it somehow was prejudiced by its insured's late notice. That decision was affirmed by the Dallas Court of Appeals.

On appeal to the Supreme Court of Texas, Hanover posited that the prompt-notice requirement in its insurance policy was a condition precedent to coverage, which, if not adhered to, defeats coverage irrespective of prejudice to the insurer. PAJ, on the other hand, alleged that the prompt-notice provision is merely a covenant and therefore Hanover's performance under the policy is excused only if the breach of that covenant is material. Further, PAJ claimed, even if the requirement is a condition precedent to coverage, Texas law requires Hanover to prove that the untimely notice by

its insured caused it prejudice. Siding with PAJ, the Supreme Court of Texas held that only a material breach of the timely notice provision will excuse Hanovers performance under the policy. [*PAJ, Inc.*, 2008 Tex. LEXIS 8, at *3*4.]

The Supremes Reject *Cutaia*, Follow *Hernandez*. Hanover relied almost entirely upon the Texas high courts 1972 decision in *Members Mutual Insurance Co. v. Cutaia*, 476 S.W.2d 278 (Tex. 1972). In that case, the insurance policy at issue required the insured to immediately forward to its insurer any suit papers and stated that no action shall lie against the [insurer] unless, *as a condition precedent thereto*, there shall have been full compliance with all of the terms of this policy. [*PAJ, Inc.*, 2008 Tex. LEXIS 8, at *4 (citing *Cutaia*, 476 S.W.2d at 27879) (emphasis in original).] The insurer and its insured stipulated that the insurer was not prejudiced by the insureds failure to forward suit papers to it until five months after they were received, which the parties agreed was a violation of the policy's prompt-notice requirement. Under those facts, the Supreme Court of Texas agreed with the insurer that it did not need to prove that it was prejudiced by the insureds failure to comply with the policy's condition before barring coverage.

Importantly, though, the PAJ Court noted that in its *Cutaia* decision it had emphasized the apparent injustice which results in this particular case and deferred the issue to the Legislature or the State Board of Insurance. Following the courts advice, a year later, the State Board of Insurance issued Board Order 23080, which required the addition of the following language to CGL policies:

As respects bodily injury liability coverage and property damage liability coverage, unless the company is prejudiced by the insureds failure to comply with the requirement, any provision of this policy requiring the insured to give notice of action, occurrence or loss, or requiring the insured to forward demands, notices, summons or other legal process, shall not bar liability under this policy.

[*Id.* at *5 (citing State Board of Insurance, *Revision of Tex. Standard Provision for General Liability Policies-Amendatory Endorsement-Notice*, Board Order No. 23080 (Mar. 13, 1972)).] Notably, when Board Order 23080 was issued, coverage for personal and advertising injury--the coverage at issue in PAJ--did not yet exist in a CGL policy. In light of that fact, the Board Order did not mention personal and advertising injury. As a result, Texas courts were split as to whether a prejudice requirement existed for such Coverage B cases. [See, e.g., *Gemmy Indus. Corp. v. Alliance General Ins. Co.*, 190 F. Supp. 2d 915 (N.D. Tex. 1998), *affd without opinion*, 200 F.3d 816 (5th Cir. 1999); *McCutchin v. Trinity Universal Ins. Co.*, 1999 Tex. App. LEXIS 7394 (Tex. App.--Dallas Oct. 6, 1999, no pet.) (noting the Boards failure to subsequently amend the endorsement language to include personal and advertising injury). *But see St. Paul Guardian Ins. v. Centrum G.S. Ltd.*, 383 F. Supp. 2d 891, 90001 (N.D. Tex. 2003) (holding that prejudice is required irrespective of the nature of the claim).]

Two decades after the Board Order was issued, the Supreme Court of Texas issued its decision in *Hernandez v. Gulf Group Lloyds*, 875 S.W.2d 691 (Tex. 1994), in which that court found that one partys material breach of an insurance contract excused the other partys performance under the contract. In PAJ, the Court explained that its *Hernandez* decision made clear that courts must consider, among other things, the extent to which the nonbreaching party will be deprived of the benefit that it could have reasonably anticipated from full performance. [*PAJ*, 2008 Tex. LEXIS 8, at *7.] Looking at the insurance policy's settlement-without-consent provision, the Supreme Court of Texas, in *Hernandez*, held that, irrespective of whether a provision is a condition precedent or a covenant, an insurer could not avoid coverage under the policy because of an immaterial breach of the settlement-without-consent provision by the insured.

The PAJ court recognized that, since its *Hernandez* decision, Texas commonly has been referred to as a notice-prejudice state (i.e., an insurer must be prejudiced by late-notice before it can escape coverage). Supporting that acknowledgement, the court cited the U.S. Fifth Circuit Court of Appeals decision in *Ridglea Estate Condominium Association v. Lexington Insurance Co.*, 415 F.3d 474, 480 (5th Cir. 2005). In *Ridglea*, that court relied upon *Hernandez* while holding that Texas requires prejudice for late notice of a claim or suit, including in first-party

commercial property policies, even in those policies that were not subject to Board Order 23080.

In *PAJ*, the majority criticized the dissents belief that *Hernandez* somehow made a distinction between conditions precedent and covenants in regard to the notice issue. Rather, the Court said, the policy language in *Hernandez* was the same as the language before the Court in *PAJ*, and it never distinguished between conditions and covenants in reaching its conclusion that an insurer must first show prejudice before it could preclude coverage. The *PAJ* majority also questioned the dissents fundamental premise that the timely notice provision before us creates a condition precedent rather than a covenant. [*PAJ*, 2008 Tex. LEXIS 8, at *16.] While the *Cutaia* policy provision at issue was specifically characterized as a condition precedent, that very language was removed from the standard CGL language and, more importantly, was not included in *PAJ*s insurance policy. Moreover, when *PAJ* and Hanover bargained for the occurrence-based insurance contract, which is quite different from a claims-made policy, timely notice was not a central theme. [*Id.* at *17 (citing *Matador Petroleum Corp. v. St. Paul Surplus Lines Ins. Co.*, 174 F.3d 653, 658 (5th Cir. 1999)).] The dissent, by focusing on the type of coverage rather than the type of policy, entirely disregards this important distinction. [*Id.* (emphasis in original).] The *PAJ* Court then said:

Finally, and perhaps most disturbingly, the dissent's analysis of the policy language would impose draconian consequences for even *de minimis* deviations from the duties the policy places on insureds. The policy in this case requires, in the same section at issue, not only notice of suit as soon as practicable, but also that *PAJ* immediately send . . . copies of any demands, summonses or legal papers. Thus, under the dissent's construction, an insured's failure to promptly forward a deposition notice or a certificate of conference would work a forfeiture of coverage, even when the insurer is not at all harmed. This is precisely the result that Board Order 23080 attempted to avoid and we rejected in *Hernandez*.

[*Id.*] Accordingly, the Court held that an insured's failure to timely notify its insurer of a claim or suit does not defeat coverage if the insurer was not prejudiced by the delay. [*Id.*]

The Court Accepts XL on Certified Question. On the very day it issued its *PAJ* opinion, January 11, 2008, the Supreme Court of Texas also accepted a certified question from the U.S. Fifth Circuit Court of Appeals. [*XL Specialty Ins. Co. v. Financial Indus. Corp.*, 2007 U.S. App. LEXIS 29373 (5th Cir. Dec. 19, 2007).] In *XL*, the Court will address a claims-made, management liability policy, which requires Financial Industries Corporation (FIC) to notify XL Specialty Insurance (XL) of any claim against it as soon as practicable after it is first made. The policy makes that requirement a condition precedent to payment. FIC was sued in Texas state court for breach of contract and fraud, but did not notify XL of the suits until seven months later. Importantly, FIC's notice to XL was provided within the claims-made policy period. Further, as in *PAJ*, the parties stipulated that the late notification was a breach of the policy's prompt-notice provision but the breach did not prejudice XL in any way.

After receiving notice of the lawsuits against its insured, XL sought a declaration from the federal district court that the claims-made policy at issue did not cover FIC because it failed to provide timely notice. On motion for summary judgment, the district court found in XL's favor, holding that Texas law does not mandate that an insurer show it was prejudiced before precluding coverage to its insured under a claims-made policy. In fact, no Texas court had recognized the existence of any sort of prejudice requirement in claims-made policies. [See, e.g., *Fed. Ins. Co. v. CompUSA, Inc.*, 319 F.3d 746 (5th Cir. 2003); *EmCode Reimbursement Solutions, Inc. v. Nutmeg Ins. Co.*, 510 F. Supp. 2d 603 (N.D. Tex. 2007); *Hirsch v. Tex. Lawyers Ins. Exch.*, 808 S.W.2d 562, 565 (Tex. App.--El Paso 1991, writ denied) (To require a showing of prejudice for late notice would defeat the purpose of claims made policies, and in effect, change such a policy into an occurrence policy.).] FIC appealed the federal district court's ruling to the Fifth Circuit.

Discussing the Supreme Court of Texas decisions in *Cutaia* and *Hernandez*, the Fifth Circuit noted that the *Hernandez* opinion arguably was broad enough to encompass policy provisions other than the consent-to-settle provision because it reasoned that [i]nsurance policies are contracts, and as such are subject to rules applicable to

contracts generally, including the rule that a breach must be material--i.e., cause prejudice--to excuse performance by the non-breaching party.

That court also recognized that, as of December 19, 2007, four cases related to the notice-prejudice rule were before the Supreme Court of Texas. [See, e.g., *Prodigy Commcns Corp. v. Agric. Excess & Surplus Ins. Co.*, 195 S.W.3d 764 (Tex. App.--Dallas 2006, pet. granted).] In *Prodigy*, which also addressed a claims-made policy, the Dallas Court of Appeals upheld a summary judgment finding for an insurer where it denied coverage to its insured for violating the policy's prompt-notice requirement even though notice still was provided within the policy's reporting period. (Notably, on January 11, 2008, the Supreme Court accepted the petition in *Prodigy* and oral arguments are set for April 1, 2008.) In light of *Prodigy* and the other cases pending before the Supreme Court of Texas, the Fifth Circuit was hesitant to follow its earlier precedent that required a showing of prejudice for occurrence-based policies but not for claims-made policies. Accordingly, it certified the following question to the Supreme Court:

Must an insurer show prejudice to deny payment on a claims-made policy, when the denial is based upon the insured's breach of the policy's prompt-notice provision, but the notice is nevertheless given within the policy's coverage period?

[2007 U.S. App. LEXIS 29373, at *7*8.] Again, as noted, the Supreme Court accepted that certified question on January 11, 2008.

Discussion

The Supreme Court of Texas decision in *PAJ* is another victory for insureds. With the Court's 5-4 decision, insurers face an additional obstacle in denying coverage to insureds--now they must show that any late notice of a claim actually caused them prejudice. In *PAJ*, the insurance policy at issue was an occurrence-based policy, providing coverage for, among other things, personal and advertising injury. The Court, though, relied upon *Ridglea*, a decision that had extended the *Hernandez* ruling to a first-party commercial property policy. That reliance raises questions as to the continued validity of two other opinions in which courts held that prejudice was not required for first-party homeowners policies. [See *Chiles v. Chubb Lloyds Ins. Co.*, 858 S.W.2d 633 (Tex. App.--Houston [1st Dist.] 1993, writ denied) (refusing to apply a prejudice requirement because the Board Order was limited to CGL policies); *Flores v. Allstate Texas Lloyds Ins. Co.*, 278 F. Supp. 2d 810, 816 (S.D. Tex. 2003) (refusing to extend the prejudice requirement to a homeowners policy because the Board Orders promulgated by the Texas Department of Insurance, which require a showing of prejudice, are restricted to automobile and CGL insurance policies).] In essence, the Court has implied that all occurrence-based policies, not just those discussed in Board Orders promulgated by Texas Department of Insurance, inherently require a showing of prejudice before an insurer can bar coverage. Moreover, by its reasoning, it appears that the Court will apply a prejudice requirement beyond just notice and consent-to-settle policy requirements.

In the same vein, with *XL* and *Prodigy* now before it, the Supreme Court of Texas has an opportunity to clarify whether a prejudice requirement applies to claims-made policies when the notice, while late, still is within the claims-made policy period. Logic dictates that the same prejudice reasoning should apply in that situation, as long as the notice is made within the policy period.

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Post-Claim Underwriting

2008 Emerging Issues 7

Post-Claim Underwriting

By Publisher's Editorial Staff 2008

January 9, 2008

SUMMARY: The insurance companies' practice of post-claim underwriting, most commonly seen in group health insurance policy handling, has led to: a California law prohibiting it; a class action suit against it; a Mississippi Supreme Court ruling allowing a jury to consider punitive damages for it; an administrative fine against Blue Cross of California; and a revision in a health insurance application form.

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ARTICLE: Post Claim Underwriting Defined

Once an insured fills out an insurance application, an underwriter conducts a risk assessment to determine whether or not the insurance company should make the insured an offer of insurance. Underwriting usually occurs before an insurance policy is issued. With post-claim underwriting, an insurance company does not begin the underwriting process until after an insured files a claim. Instead of conducting its risk assessment before a policy is issued, the insurer begins its investigation after the claim is filed often in order to find reasons for denying coverage on the ground that the insured committed fraud, misrepresentation, or concealment when filling out the application.

It is important for counsel to recognize whether or not an insurer has engaged in post-claim underwriting because an insured may have a cause of action against an insurance company for fraud and/or bad faith settlement practices. In some cases, an insured may even be able to recover punitive damages.

Identifying Post-Claim Underwriting

An insurance company engages in post-claim underwriting when it rescinds or cancels an insurance policy after an insured submits a claim, without proving that the insured willfully misrepresented his or her health status on an insurance application. The insurer conducts its risk assessment after a claim has been submitted, as opposed to when the insurance application was made. It denies coverage on the ground that the policy should not have been issued in the first place. The practice of post-claim underwriting is most common in the group insurance context. See Thomas C. Cady & Georgia Lee Gates, *Post Claim Underwriting*, 102 W. Va. L. Rev. 809 (Summer 2000). Counsel can identify a potential post-claim underwriting case through three insurance company practices.

Claim Sent Directly to Underwriting Department

Counsel can determine whether post-claim underwriting has occurred by noting that an insured's claim was submitted to the underwriting department of an insurance company, rather than being processed through its claims department. The underwriting department will have the insured sign a release for his or her medical records. It will review the medical records and attempt to identify an omission or inconsistency between the records and the insured's insurance application. The insurance company will then deny the insured coverage on the basis of misrepresentation, concealment, or fraud in the application. See Thomas C. Cady & Georgia Lee Gates, *Post Claim Underwriting*, 102 W. Va. L. Rev. 809, 813 (Summer 2000).

Application Process

Counsel may also be able to recognize if an insurance company is engaging in post-claim underwriting by looking at the insurance application. An oversimplified application, which does not ask about the applicant's health or only asks whether the applicant is in good health, provides a clue that post-claim underwriting is occurring. No medical examination will be required. An underwriting investigation will not be completed until after a claim is filed. Also, counsel should be aware that when an insurance company engages in post claim underwriting, the insurance application is issued immediately after the application is completed and the premium is paid. See Thomas C. Cady & Georgia Lee Gates, *Post Claim Underwriting*, 102 W. Va. L. Rev. 809, 814 (Summer 2000).

Delay in Processing Claim

A third clue counsel should be aware of is an unusually long delay between the insured's act of filing a claim and the insurer's notice of rescission of the policy. This indicates the practice of post-claim underwriting because the insurer is preparing its file thoroughly in order to support its decision to cancel the policy. See Thomas C. Cady & Georgia Lee Gates, *Post Claim Underwriting*, 102 W. Va. L. Rev. 809, 814 (Summer 2000).

Insurer's Bad Faith

Duty of Good Faith and Fair Dealing

Insurers owe insureds the duty of good faith and fair dealing. When an insurer engages in post claim underwriting and improperly denies a claim for insurance benefits an insured can file a cause of action against it for fraud or bad faith. Bad faith occurs if an insurer knowingly or recklessly denies a claim for insurance benefits without having a reasonable basis for doing so. This may involve failing to investigate an insured's health prior to the issuance of coverage. It has been stated that the practice of post-claim underwriting is illegal per se. See *Post-Claim Underwriting: A Life and Health Insurer's Boon or Bane*[dagger], Federation of Defense and Corporate Counsel Quarterly (Fall 2004).

Punitive Damages

When post-claim underwriting frustrates an insured's reasonable expectation of coverage, the insured is entitled to pursue a cause of action against an insurer under a theory of bad faith settlement practices and seek compensatory damages and, in the appropriate case, punitive damages. See Thomas C. Cady & Georgia Lee Gates, *Post Claim Underwriting*, 102 W. Va. L. Rev. 809, 816 (Summer 2000). In *Lewis v. Equity Nat'l Life Ins. Co.*, 637 So. 2d 183 (Miss. 1994), an insured filed suit in Mississippi against an insurer for its refusal to pay her benefits under an intensive care policy. The insured sought compensatory and punitive damages, alleging that the insurer denied her claim without performing an adequate investigation. A jury found that the insurer was liable to the insured for contractual damages. The trial court granted the insurer's motion for partial summary judgment on the insured's claim for punitive damages.

The Supreme Court of Mississippi reversed, holding that the trial court erred in refusing to place the issue of punitive damages before the jury. *See Lewis v. Equity Nat'l Life Ins. Co.*, 637 So. 2d 183, 184 (Miss. 1994). It stated that an insurer had an obligation to do its underwriting when a policy application was made and not after a claim was filed. *See Lewis v. Equity Nat'l Life Ins. Co.*, 637 So. 2d 183, 188-189 (Miss. 1994). The issue of punitive damages could go to the jury despite an arguable reason for denying a claim. *See Lewis v. Equity Nat'l Life Ins. Co.*, 637 So. 2d 183, 187 (Miss. 1994). The Supreme Court of Mississippi found that there were questions of fact regarding the adequacy of the insurer's investigation of the insured's claim and that a jury should have considered those questions. *See Lewis v. Equity Nat'l Life Ins. Co.*, 637 So. 2d 183, 187 (Miss. 1994).

California

Cal. Health & Safety Code § 1389.3 provides that: "No health care service plan shall engage in the practice of postclaims underwriting." It states that "postclaims underwriting" means the rescinding, canceling, or limiting of a plan contract due to the plan's failure to complete medical underwriting and resolve all reasonable questions arising from written information submitted on or with an application before issuing the plan contract." *Id.* Health insurers cannot cancel an individual policy unless an insured willfully misrepresents his or her health status or commits fraud in filling out an insurance application.

In California, insureds filed a class action against Blue Cross of California, which is a subsidiary of Wellpoint Health Networks, Inc., alleging claims of breach of contract and bad faith for cancelling coverage after the insureds filed medical claims. *Lawsuits Allege HMO Insurer Used Post-Claim Underwriting To Deny Health Benefits*, 10-7 Mealey's Man. Care Liab. Rep. 20 (2006). The parties settled the action. Under the settlement agreement, Blue Cross agreed to stop retroactively canceling an individual's health insurance coverage unless it could show that the insured intentionally misrepresented information on his or her insurance application. The settlement also included a new insurance application that was intended to reduce mistakes. *Blue Cross of California Settles Class Action Suit Over Policy Cancellations*, BestWire (May 15, 2007). The California Department of Managed Health Care fined Blue Cross \$1 million for rescinding policyholders' coverage after they filed a health insurance claim or received medical treatment in violation of state law. *State Regulators Fine Blue Cross of California \$1 Million for Routinely Rescinding Policyholders' Coverage*, BestWire (Mar. 23, 2007).

Conclusion

Insureds and their counsel should be aware of the practice of post-claim underwriting and know how to identify it. If an insured has been the victim of post claim underwriting, his or her counsel should realize that a cause of action could be filed against the insurer for bad faith. The insured may be able to recover punitive damages as well as compensatory damages.

Some states, like California, have laws that deter insurance companies from engaging in post-claim underwriting. Courts are also condemning the practice as unfair. The traditional sequence of underwriting and completing the underwriting process before a policy is issued permits the insurer to reduce the risk played by guesswork in assessing the risk it agrees to assume under the contract of insurance and also protects the insured's reasonable expectations of coverage. *See Thomas C. Cady & Georgia Lee Gates, Post Claim Underwriting*, 102 W. Va. L. Rev. 809, 868 (Summer 2000).

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The National Insurance Act of 2007

2008 Emerging Issues 9

The National Insurance Act of 2007

By Publisher's Editorial Staff 2008

January 9, 2008

SUMMARY: A bill that would revolutionize insurance law and the insurance industry is pending before Congress. It would allow insurance companies to choose to be federally chartered or licensed by the federal government rather than by individual states. They then would deal with one group of regulators and one set of regulations rather than those of the several states.

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ARTICLE: Introduction

Insurance companies have historically used the same information and statistics to set rates for various types of policies. In 1944, the U.S. Supreme Court, in *United States v. South-Eastern Underwriters Ass'n*, 322 U.S. 533 (U.S. 1944) held that rate setting involved interstate commerce and the use of standard rates and forms could violate the Sherman Antitrust Act. In response, Congress enacted the McCarran-Ferguson Act, which provided limited antitrust exemptions to insurance companies in using standard forms, setting rates, and exchanging risk information. "The calls for the repeal of McCarran, perhaps coupled with federal regulation of the insurance industry in place of the current state regulatory scheme, are gaining in intensity and momentum." Ruth T. Dowling, Patricia A. Sullivan and Marc S. Voses, *Antitrust Enforcement In The International Insurance Industry: How The EC's Examination Of The Block Exemption May (And Should) Inform The U.S. Debate Over The Future Of McCarran Ferguson*, 2-6 LexisNexis Antitrust Rep. NewsBrief 21 (2007). One response is the introduction by Senators John Sununu and Tim Johnson of 2007 S. 40, the National Insurance Act of 2007 in the Senate and by Rep. Melissa Bean (D-IL) and Rep. Ed Royce (R-CA), in the House.

The National Insurance Act is a proposal to allow insurance companies to be chartered by the federal government rather than by individual states. It also permits insurance brokers and agents to be federally licensed. In discussing the bill, Senator Johnson stated:

Since Gramm-Leach-Bliley, Congress has modernized the regulatory schemes for every part of the financial services industry except insurance. We have a responsibility to promote a balanced regulatory system that will allow the insurance industry to meet the highest standards of performance, innovation and progress; I believe the National Insurance Act of 2007 will achieve this.

Press Release, Senator John Sununu, SUNUNU, JOHNSON: MARKETPLACE DEMANDS INSURANCE REGULATORY REFORM, *Senators re-introduce "National Insurance Act" to respond to the needs of America's insurers and consumers*, May 24, 2007.

This commentary will examine some of the more important provisions in the proposal and some of the issues raised by it.

Reason for the Bill

At the current time, insurance is regulated state by state. Each state charters each individual insurance company permitted to underwrite insurance in its state. Each state regulates methods of insurance company bookkeeping, how premiums are to be invested, and minimum reserves to pay claims. States are actively involved in approving policy forms and rates, what must be included in different types of insurance policies, and payment of claims. There are insurance companies that underwrite insurance in every state and find it onerous to deal and comply with different regulations, particularly where they are writing insurance for entities that also have facilities nationwide.

In a press release when introducing the bill, Rep. Bean stated:

Regulatory obstacles currently discourage insurance innovation and nimble product development to capitalize on emerging growth markets. Eliminating the need to coordinate with 51 state regulators and accelerating the time to market potential will foster greater industry innovation and agility.

BEAN/ROYCE: BI-PARTISAN DEMAND FOR INSURANCE REGULATORY REFORM, *First bipartisan House version of National Insurance Act would offer insurance consumers and providers with much-needed regulatory alternative*. July 25, 2007.

Those supporting the bill believe it is market driven by the need for uniformity to enable insurers to work with one set of regulations and one group of regulators while writing insurance for companies located across the nation.

Provisions of the Bill

Optional nature

Under the proposal, no insurance company or producer would be required to be federally chartered or licensed. The regulations would parallel those established by the states, in the same manner that federal banks are chartered by the federal government, while still permitting states to charter banks and savings and loan associations. States would retain responsibility to charter and license insurers and producers and to regulate their activities.

Large nationwide insurance companies and producers might like the fact that they are dealing with one group of regulators and one set of regulations, when writing insurance for facilities in every state. Large companies, such as retail chains, multi-state manufacturers, delivery services, restaurant chains, real estate holding companies, or utilities may find it less costly and cumbersome to purchase insurance and to determine what is best for them.

On the other hand, states would be reluctant to give up their power to mandate minimum standards or to oversee insurers and producers to make sure that they perform or risk losing their ability to do business in the state. The National Association of Mutual Insurance Companies (NAMIC), through their president, John Bykowski, in testimony before the Committee on House Financial Services Subcommittee on Capital Markets, Insurance and Government Sponsored Enterprises, INSURANCE REGULATION CQ Congressional Testimony, Oct. 3, 2007, stated:

Notwithstanding the need to improve state-based regulation, NAMIC believes the decentralized system of state-based insurance regulation has inherent virtues that would be lacking in a national insurance regulatory system. State insurance regulation has the capacity to adapt to local market conditions, to the benefit of consumers and

companies, and affords states the opportunity to experiment and learn from each other.

Office of National Insurance

The proposal would create a new Office of National Insurance to promulgate regulations and oversee federally chartered and licensed insurance companies and producers. The ONI would be an independent agency located in the Department of the Treasury, with a Commissioner appointed to a five-year term by the President with the advice and consent of the Senate. The Commissioner is given six months to issue initial regulations concerning federally chartered and licensed insurance companies and producers. The powers of the Commissioner are to extend not just over federally chartered insurer and licensed producers, but also to any registered insurance self-regulatory organization. If enacted, the Commissioner would have up to two years in which to issue regulations governing the registration and operations of insurance self-regulatory organizations.

Chartering of Two Types of Insurance Companies

Title II of the proposed act covers the organization, incorporation, operation, and regulation of national insurance companies and national insurance agencies. Both life insurance companies and property/casualty insurance companies could choose to become federally chartered. While a holding company may own both, each would be separately regulated. Non-United States insurance companies may transact insurance in the United States through a United States branch by qualifying and licensing the branch to do business as a national insurer under the Act.

A life insurance company, at the time of its chartering as a National Insurance Company, may elect to adhere to participating policy procedures of the relevant law of the State in which its main office is located; or adhere to the participating policy procedures established by regulation of the Commissioner.

Property/casualty insurers will be subject to federal regulations and states are preempted from taking any action that would establish an asset or reduce its liability as a result of insurance ceded to a national insurer or a federally licensed reinsurer.

Licensing of Agencies and Producers

Title III of the proposed Act covers the licensing of insurance agencies and producers. A federally licensed agency or producer could sell insurance from a nationally chartered insurer in every state. A state licensed producer could sell insurance on behalf of any insurer, including National Insurers, operating within the state in which the producer holds a license.

Conversion Between State and Federal Charters

The bill provides for conversion of a state chartered insurer to one federally chartered and the right to convert back to state charter.

Applicable State Law

While federal law will control the operations of federally chartered insurers, state law will still apply in respect to state tax laws, liability of directors and officers, residual market mechanisms designed to make insurance available to those unable to obtain insurance, compulsory coverage of workers' compensation or motor vehicle insurance, and contract law.

Regulatory Powers

The Commissioner is required to issue financial regulations which are consistent with the statutory accounting practices promulgated by the National Association of Insurance Commissioners (NAIC) in its "Accounting Practices and Procedures Manual". Auditing, investing, risk-based management, and other accounting practices should also

follow model acts promulgated by the NAIC.

In respect to life insurance, the Commissioner is required to establish regulations consistent with the provisions of the Act. In respect to property and casualty insurance, the Act does not authorize the Commissioner to require a national insurer to use any particular rate, rating element, price, or form.

The Commissioner is required to issue regulations establishing standards for licensing agencies and producers, including such items as education, lines of insurance, and examination of producers. The Commissioner is also required to promulgate regulations concerning sales and marketing of insurers and producers to prevent unfair trade practices and fraud.

Enforcement Power

The Commissioner has the authority to conduct an investigation and to suspend or revoke a charter or license. In addition, those who violate a law, rule, or regulation may be fined up to a maximum of \$1 million.

Consumer Protection

The Senators and Representatives who introduced the bill have stated that the bill provides for a Division of Consumer Protection within the Office of National Insurance. Section 1105 of the bill calls for the creation of a Division of Consumer Affairs, with the duty to "support the Commissioner in the implementation and enforcement of the market conduct Regulations." The Commissioner is to issue regulations which address the advertising, sale, and administration of the insurance policies issued by national insurers, as well as claims under such policies and products. Those who are opposed to the bill contend that national insurers would not be subject to state imposed consumer protections, such as time limits in which claims must be paid.

Self-Regulatory Organizations

Self-regulatory organizations may also elect to be federally chartered. For such organizations, the Commissioner may review, approve, abrogate, modify, or add to the operating rules of an insurance self-regulatory organization. The Commissioner may also remove, suspend, or bar an individual from serving as an officer or director of an insurance self-regulatory organization, and may spend or revoke the registration of an insurance self-regulatory organization.

Other Powers of the Commissioner

The Commissioner has the authority to license reinsurers and non-United States insurers. Before any acquisition or merger with a nationally chartered insurer may take place, the Commissioner must approve of such transaction.

In the event a nationally chartered insurer cannot meet its financial obligations, the Commissioner must be named receiver and has the power to resolve or liquidate the financial matters of a national insurer. Regulations governing receiverships are to be based upon the Uniform Receivership Law adopted by the Interstate Insurance Receivership Compact Commission in September 1998.

State Guarantee Funds

State guarantee associations provide coverage to insureds when a state chartered insurer goes into receivership. Where state guarantee associations meet the levels of protection established by the NAIC, national insurers are required to participate in state associations in each state in which they offer insurance. To the extent a state does not provide the level of protection equivalent to NAIC model standards, a national insurer must join the National Insurance Guaranty Corporation, under the National Insurance Act, which will provide such protections to policyholders.

Antitrust Implications

Except in respect to standard insurance policy forms and § 3 of the McCarran-Ferguson Act, 15 USCS § 1013, the Sherman Act (15 USCS § 1 et seq.), the Clayton Act (15 USCS § 12 et seq.), the Federal Trade Commission Act (15 USCS § 41 et seq.), and the Robinson-Patman Antidiscrimination Act (74 P.L. 692), will be applicable to national insurers, national agencies, and federally licensed insurance producers to the same extent as other businesses are subject to such laws.

Responses to the Bill

Former Maine Insurance Superintendent Alessandro Iuppa, the National Association of Insurance Commissioners' most recent former president, testified before a House panel. He claimed that the U.S. market "demands far more dramatic action than the states alone are able to provide. . . . The need to operate within the state patchwork of regulation in the U.S. hinders insurers with risk issues confronting clients who operate on national and international bases." *Former NAIC Chief Touts Federal Regulator*, BestWire, Oct. 30, 2007.

Others supporting the bill include John Castellani, president of Business Roundtable, who sees the need for innovation and regulatory modernization in light of the global economy. *Business Roundtable Joins Federal Charter Campaign*, BestWire, Dec. 07, 2007. Treasury Secretary Henry M. Paulson Jr. sees the initiative as one to improve the global competitiveness of U.S. capital markets. The American Insurance Association supports the proposal creating a dual system, similar to that in banking.

Insurance industry groups are not uniformly in favor of the proposal. The National Association of Mutual Insurance Cos. (NAMIC), the Independent Insurance Agents & Brokers of America and the National Association of Professional Insurance Agents all oppose the measure.

NAMIC is urging Congress to strongly consider the issue before uprooting a system that has been in existence more than 150 years and has the support of property and casualty companies, and insurers alike. NAMIC contends the federal charter would create a cumbersome and over-regulated system, to the detriment of both policyholders and insurance companies. *NAMIC: Optional Federal Charter Would Hurt Consumers and Insurers*, NAMIC Online, (May 24, 2007).

Indiana Insurance Commissioner Jim Atterholt favors an interstate compact over the federal charter, even though federal oversight would not usurp the state's regulatory system. *Parties Choose Sides over Federal Insurance Oversight; Indiana Commissioner, Indianapolis-based National Association of Mutual Insurance Companies Favor Compact*, Indianapolis Business Journal, Aug. 20, 2007

While the bills apparently have bipartisan support and were introduced by bipartisan sponsors, there are political considerations. There is bound to be opposition to the bill because it creates a new bureaucracy. "John Bykowski, chief executive officer of Secura Insurance, said while the rate deregulation the NIA proposes has been long-sought by the industry, many fear the federal bureaucracy it creates could one day morph into something more onerous than what currently exists at the state level." *Subcommittee Chairman Maps Long and Winding Road to Regulatory Reform*, Best's Insurance News, Oct. 4, 2007.

Conclusion

Passage of the National Insurance Act will not be fast or easy.

Hearings on solvency protection. Hearings on enforcement systems. Hearings on product approvals. Hearings on best practices. Hearings on property/casualty and life, on agents and companies, on systems of federal charter, federal standards and regulatory federalism. Hearings, hearings, hearings, break-out sessions, hearings, bipartisan task forces. Oh, and some more hearings.

Such was the legislative plan laid out by Rep. Paul Kanjorski, chairman of the House Financial Services Subcommittee on Capital Markets and Insurance, as he convened the first in what is expected to be a lengthy series of

inquiries into ways to reform the U.S. insurance regulatory system.

Subcommittee Chairman Maps Long and Winding Road to Regulatory Reform, Best's Insurance News, Oct. 4, 2007. Although this was the second time this proposal has been introduced, (it was introduced in 2006 by Senator Sununu) its complexity will require careful consideration.

While large insurance companies and nationwide entities may welcome the uniformity presented by a nationally chartered insurer, state officials, and smaller insurers believe that it is far better for insureds that policies focus on the needs of the local community.

"Current inefficiencies in the insurance marketplace are driven by excessive rate and form regulation, which hamper competitive pricing, inhibit product and service innovation, and delay product delivery. Consistency, while desirable and cost effective, will not in and of itself lessen the marketplace inefficiencies resulting from regulatory models that do not uphold competitive economic principles," NAMIC President and Chief Executive Officer Charles M. Chamness said in a statement.

Treasury Review Sparks Comments on Federal Charter, Best's Insurance News, Nov. 26, 2007. The National Governors Association and the Independent Insurance Agents and Brokers of America have both opposed the creation of a dual regulatory system. *Insurance Groups Seek Governor Backing In Battle Over Optional Federal Chartering*; *Flurry of letters from opposing industry associations push to get or keep state chiefs on their side*, National Underwriter Property & Casualty/Risk & Benefits Management Edition, Sept. 17, 2007.

Another complicating factor is the decision in *Watters v. Wachovia Bank, N.A.*, 127 S. Ct. 1559 (U.S. 2007), which held that state consumer protection laws were preempted by the National Bank Act, 12 USCS § 1 et seq. There have been many comparisons to the banking industry where both federal and state chartered banks are allowed. Nevertheless, it is unclear to what extent state consumer protection laws affecting insurance companies would apply to nationally chartered insurers.

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Cope on Coverage for Interrelated Wrongful Acts: Pivotal Concept A Moving Target

2008 Emerging Issues 1749

Cope on Coverage for Interrelated Wrongful Acts: Pivotal Concept A Moving Target

By Carrie Cope

January 7, 2008

SUMMARY: Whether wrongful acts are related is a pivotal concept in professional liability insurance policies for purposes of triggering coverage and the application of exclusions and other policy provisions. However, not all policies define terms that are significant in this context and the ultimate analysis of whether claims are related is extremely fact specific. A recent Ninth Circuit decision examines coverage for potentially related claims under policies that define the term interrelated wrongful acts, holding that the insureds acts were not related and recovery was not barred simply because multiple investors received advice from the same financial advisor.

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ARTICLE: By far, the majority of professional liability policies issued in the U.S. marketplace are written on a claims-made basis and provide coverage for an insureds wrongful acts. The term wrongful acts is typically defined very broadly to include acts, errors or omissions of the insureds. Given that coverage is triggered under such policies by the filing of a claim against an insured, another, often pivotal, issue arises when more than one claim has been made against an insured and the claims are related in some way. Many professional liability policies contain provisions requiring that related claims or claims involving interrelated wrongful acts be treated as a single claim under the policy. This can be a crucial concept under many circumstances. For example, an insured may receive coverage for a claim filed after the end of the policy period (for which it would not have coverage if the operative policy was not renewed) if it is related to an earlier claim filed during the policy period. In another situation, if two claims are treated as a single claim for purposes of coverage under one policy, they would be subject to one aggregate limit of liability but also would typically be subject to one retention. Depending on the scope of the applicable policy's coverage, the treatment of a matter as a single claim or multiple claims may have a dramatic effect on the amount paid by the insurer under the policy and, if the policy contains a retention, deductible or coinsurance provision, it can impact the amount contributed by the insured as well. For example, if the insured has two consecutive policies with a \$10 million limit of liability and little or no retention, the insured may fight hard to have the insurer treat arguably related claims as two separate claims. On the other hand, if two consecutive policies have \$500,000 retentions, the same insured may argue that two claims should be treated as one claim. Whether potentially related claims will be treated as one or multiple claims depends not only on the policy language at issue, or lack of it, but very much on the facts of the particular case.

There is not a tremendous amount of case law addressing the meaning and scope of what constitutes interrelated wrongful acts in insurance policies. Policies drafted in recent years tend to address the concept by defining interrelated

wrongful acts, related wrongful acts or related claims. However, even if a policy does not specifically define such terms, some courts have found similar terms to be unambiguous.

In *Bay Cities Paving & Grading v. Lawyers' Mut. Ins. Co.*,ⁿ¹ the California Supreme Court addressed the issue of related acts in the context of a professional liability policy, holding there must be a logical and causal connection for acts to be related.ⁿ² The court reasoned that even though the word related can be broadly construed, it is not necessarily ambiguous, even if undefined within the policy. There is no single definition of related, appropriate in all cases, rather the word must be looked at in the context of the policy and particular circumstances involved.ⁿ³ Criteria used by the court to determine whether acts were related such that they constitute a single or multiple claims include:

- . whether the claims arose out of the same transaction;
- . whether they arose as to the same client; and
- . whether they were committed by the same party and resulted in a single injury.ⁿ⁴

A recent decision out of the Ninth Circuit addressed the scope of related wrongful acts in an exclusion. In *Fin. Mgmt. Advisors, LLC v. Am. Int'l Specialty Lines Ins. Co.*,ⁿ⁵ Financial Management Advisors (FMA) purchased an investment management policy from American International Specialty Lines Insurance Company (AISLIC) to cover claims made for wrongful acts related to investment advisory services. Two policies were issued with policy periods running from May 2002 through May 2003 and from May 2003 through May 2004, each subject to a \$2 million liability limit. The first policy contained an endorsement stating:

If written notice of a Claim has been given to the Insurer . . . then a claim subsequently reported to the Insurer alleging, arising out of, based upon or attributable to the facts alleged in the Claim for which such notice has been given, or alleging any Wrongful Act which is the same as or related to any Wrongful Act alleged in the Claim of which such notice has been given, shall be considered made at the time such notice was given.ⁿ⁶

The second policy contained the exclusion:

Any claim arising out of the facts alleged, or arising out of the same or related Wrongful Acts alleged or contained, in any claim which has been reported, or in any circumstances of which notice has been given, under any policy of which this policy is a renewal or replacement or which it may succeed in time.

Based on a joint reading of the endorsement and exclusion, the court noted that a claim brought under the second policy arising out of the same or related acts as a claim brought under the first policy would be treated as having been brought under the first policy, and would only receive coverage to the extent that the limit of the first policy was not exhausted by the earlier claim.ⁿ⁷

FMA and Malamed (FMA Parties) sought coverage under the policies for two separate lawsuits brought by unrelated investors, the Sitricks and Stein. The first suit was brought by the Sitricks, who invested in traditional equities and fixed income products managed by FMA, including several CBO funds. In December 2002, when the investments declined, the Sitricks filed suit against the FMA Parties alleging that Malamed made misrepresentations to dissuade the Sitricks from liquidating their equity investments, and Malamed misrepresented the risk involved in the CBOs managed by FMA to induce the Sitricks to invest in those funds. The FMA Parties tendered the claim to AISLIC and AISLIC agreed to assume the defense of the claim. In May 2004, the Sitricks and the FMA Parties reached a settlement, exhausting the limit of the first policy. Steinman filed the second suit in September 2004. Steinman, relying on Malamed's advice, invested in CBO II, which subsequently significantly declined in value. In his complaint, Steinman alleged that Malamed misrepresented the investment risk in CBO II and that FMA breached its contract with him given that Steinman's investment was placed in a higher risk category than what he had agreed to invest in. Again, FMA tendered the suit to AISLIC, who compared the two claims and ultimately denied coverage of the Steinman claim on the ground that it arose out of the same wrongful acts or wrongful acts related to the Sitricks claim.

In coverage litigation, the Ninth Circuit ultimately held that the two claims did not arise out of the same or related wrongful acts. ⁿ⁸ The court noted that the Sitricks and Steinman were unrelated investors with different investment objectives, were given investment advice at separate meetings on separate dates, and each had different investment packages. Further, the court found that both clients alleged different wrongful acts, the Sitricks' case largely based on misrepresentations concerning their equity investments and Steinmans case largely based on misrepresentations in the written materials of the underwriter and the commitment letter sent by FMA. Even with regard to the CBO II fund, the court found that both parties alleged different wrongful conduct relating to that fund. The court therefore reversed summary judgment in favor of AISLIC and remanded the case to the district court for proceedings consistent with their opinion.

Practice Tip. Generally speaking, in analyzing whether wrongful acts are related, courts tend to consider whether the construction of such terms ultimately result in the granting or denial of coverage for a claim. The issue commonly arises in more than one context in any given policy since it affects coverage triggers and exclusions, as well as deductibles and retentions. Consequently, it is not surprising that court decisions are sometimes inconsistent in their application of these terms.

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ⁿ¹ . 5 Cal. 4th 854, 873 (1993).

ⁿ²

[2]. *Bay Cities Paving & Grading v. Lawyers' Mut. Ins. Co.*, 5 Cal. 4th 854, 873 (1993)..

ⁿ³

[3]. *Bay Cities Paving & Grading v. Lawyers' Mut. Ins. Co.*, 5 Cal. 4th 854, 868 (1993)..

ⁿ⁴

[4]. *Bay Cities Paving & Grading v. Lawyers' Mut. Ins. Co.*, 5 Cal. 4th 854, 873 (1993).

ⁿ⁵

[5]. 506 F.3d 922 (9th Cir. 2007).

n6 . *Fin. Mgmt. Advisors, LLC v. Am. Int'l Specialty Lines Ins. Co.*, 506 F.3d 922, 2007 U.S. App. LEXIS 25724, at *2-3 (9th Cir. 2007).

n7 . *Fin. Mgmt. Advisors, LLC v. Am. Int'l Specialty Lines Ins. Co.*, 506 F.3d 922, 2007 U.S. App. LEXIS 25724, at *3 (9th Cir. 2007).

n8

[8]. *Fin. Mgmt. Advisors, LLC v. Am. Int'l Specialty Lines Ins. Co.*, 506 F.3d 922, 2007 U.S. App. LEXIS 25724, at *7 (9th Cir. 2007).

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Cope on Storm Clouds on the Horizon: New Assessment Concerns Florida Insurers

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Cope on Storm Clouds on the Horizon: New Assessment Concerns Florida Insurers

By Carrie Cope

January 7, 2008

SUMMARY: Some Florida insurers are facing new assessments in the event the Citizens Property Insurance Corporation sustains a budget shortfall in the coming years. This is the result of the Florida State Legislatures expansion of Florida Statute § 627.351, to apply to all property and casualty premiums with limited exceptions. Depending on the weather, some insurers and their policyholders could face years of additional assessments which could ultimately test the solvency of the Florida insurance market.

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ARTICLE: Debris is only one of countless problems Floridians and their insurers have had to deal with after a series of catastrophic hurricanes hit Florida in recent years. On one hand, increasingly alarmed homeowners have been faced with widespread policy rate increases and nonrenewals. On the other hand, burdened insurers, who have been attempting to cope with the detrimental effects of catastrophic claims, have been prohibited from raising rates and, in some cases, withdrawing their books of business from the State. In 2002, the Florida Legislature responded to the turmoil by enacting Florida Statute § 627.351, which combined the Florida Residential Property and Casualty Joint Underwriting Association and the Florida Windstorm Underwriting Association and created the Citizens Property Insurance Corporation (Citizens). Citizens was designed to provide insurance to homeowners in high-risk areas and to others who could not find coverage in the open market. However, the impact of a series of hurricanes in 2005 created major difficulties for Citizens.

As a result of the severe 2005 hurricane season, Citizens incurred more than \$2.6 billion in losses stemming from 168,377 claims. The severity of the losses combined with insufficient premiums left Citizens with a staggering \$1.7 billion deficit. The Legislature came to the rescue by providing \$715 million to offset the \$1.7 billion shortfall. The balance of the shortfall was paid by assessment which was collected from insurers in proportion to their net direct premium for insurance in the State for the year preceding the assessment. This reduced an estimated \$920 million regular assessment against property insurers to about \$205 million, thereby reducing an estimated average 11 percent regular assessment to about 2.04 percent for property insurance policyholders in the State (including Citizens policyholders). As the \$1.7 billion deficit exceeded the amount allowed as a regular assessment, for the first time, insurers were assessed both a regular and an emergency assessment. If billed in one year, the remaining \$800 million of the deficit would have required an 8 percent emergency assessment for specified lines. However, the Legislature determined that the amount should be amortized and collected from policyholders over a 10-year period at a rate of

1.4%.

Recognizing the potential severity of the problem, a special session of the Florida State Legislature in January 2007 addressed concerns over potential future deficits by broadening the assessment base to include more insurance lines. Florida Statute § 627.351, was amended to apply to all property and casualty premiums except for workers compensation and medical malpractice premiums. The result has some insurers outraged. While it seems logical to some that insurers writing property insurance coverage for hurricane claims should share in the assessments, it also seems inequitable that other insurers who do not write such coverage should be impacted as well. For example, why should an insurer writing animal, elevator, or entertainment coverage be subject to the assessments merely because the coverage is offered in Florida?

While there are some exemptions from participating in regular assessments, they are quite limited. For example, a company writing less than .5% of the statewide aggregate direct written premium is exempt for the first three years they are doing business in the State. An insurer may request a deferment of the regular assessment under dire circumstances. If payment of the assessment would impair the company (meaning that its surplus would fall below \$4 million or 10% of business), or render it insolvent (meaning that its surplus would fall below zero), the company could seek a deferment. Another option is that an insurer may qualify to be a limited apportionment company. If the criteria set forth for this status is met, the payment can be spread out over a 12-month period rather than paid within 30 days of its receipt from the policyholder.

There is also concern among insurers over the conditions under which an assessment may be levied. No criteria exist for when an assessment is levied, other than Citizens need for additional funds. The assessment can apply if there is a catastrophic event or if there are other budgetary issues. Although there is great concern among some insurers writing property and casualty policies in Florida, the impact on many insurers may not be substantial unless the deficit sustained by Citizens is extremely high or Citizens sustains deficits over an extended period so that the assessments overlap. The amount of assessments a company will be subject to will be in direct proportion to the amount of business it writes in the State. For example, if an insurers direct premiums for insurance written in Florida in 2007 was \$6 million, and the total gross direct premiums written by all companies that are subject to these assessments was \$32.6 billion, the insurer would be responsible for .0184% of the regular assessment. Based on the 2005 deficit amount, the insurer would be assessed \$37,720. The impact of an assessment of this size depends, of course, on the size and solvency of the company subject to the assessment. While emergency assessments may be passed on directly to the policyholders, regular assessments may be recouped from them. This can impact the insurers in various ways. For example, in some circumstances the insurers may not be able to recoup these assessments from their policyholders which may impact them financially. Currently, experts are forecasting an above average hurricane season for 2008. n1 In the event insurers and their policyholders are subject to multiple overlapping assessments, the result could ultimately test the solvency of the Florida insurance market. However, if history is any indication of how the Florida Legislature will respond if that occurs, it is likely to come up with a long-term solution.

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n1 . Jim Waymer, Hurricane Forecast: Above Average Season, Florida Today, www.florida.com (Dec. 7, 2007); Ken Kaye, Experts Already Predicting 3 Intense 'Canes in 2008, Sun Sentinel, www.sun-sentinel.com (Dec. 7, 2007); 2008 Hurricane Season Forecast Out, www.baynews9.com (Dec. 7, 2007).

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Impact of Hurricane Katrina on Insurance Law

2008 Emerging Issues 8

Impact of Hurricane Katrina on Insurance Law: Update on Recent Developments

By Publisher's Editorial Staff 2008

January 2, 2008

SUMMARY: The lessons and long-term consequences of Hurricane Katrina are beginning to emerge, as there is now underway: many key cases guiding litigation; several recently introduced bills in Congress with potentially far-reaching consequences; and emerging trends in new state regulations. The insurance practitioner needs to be aware of these emerging developments as they may well have a nationwide impact on the practice of insurance law.

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ARTICLE: BACKGROUND

On August 29, 2005, Hurricane Katrina roared ashore in the Gulf Coast, causing widespread destruction that decimated the coastline and left thousands of people homeless. After digging out of the rubble, many policyholders were thankful they had a homeowner's or commercial property policy that could help them rebuild. However, they were surprised to discover that many of the risks they thought they were protected from were specifically excluded by their policies. Coverage denials and small payouts have driven policyholders to turn the courts to challenge the language of their policies where they had some initial successes, prompting David Rossmiller, a partner with Dunn, Carney, Allen, Higgins & Tongue and an expert on Hurricane Katrina litigation who was interviewed for this article, to state that for him:

[T]he greatest issue to emerge from Katrina litigation is one that is related to litigation but is really independent of it. That issue is public and political perception of the strength of one's case, which as we have seen in Katrina litigation, can be just as important, or even far more important, than real strength. Lawyers tend to like to conduct litigation without outside interference; they do not often feel comfortable reaching out to the traditional media, new media like blogs, and the community. But as policyholder lawyers proved, these are among the most potent weapons in litigation. Insurers were slow to understand and react, some never did. Others showed the ability to adapt, learn from past mistakes and embrace a sophisticated strategy of combining litigation and public relations. Any method of communication that is effective in communicating your side of the story is a method lawyers need to respect, understand and make use of.

Insurance companies have added to their negative public and political perceptions by pulling out of the hurricane-prone coastlines or dramatically raising premiums, which has put pressure on Congress to step in and resolve what has been referred to as a "crisis" in the property and casualty insurance industry. Allegations of bad faith and fraud

in the settlement of Katrina property damage claims is intensifying the call for widespread reform of the way insurance companies do business. States are also attempting to avoid the chaos and ill-will that followed Katrina with regulations designed to protect policyholders.

Though it is too early to definitively say what the lessons and long-term consequences to the insurance industry will be, there are several key cases guiding litigation, recent bills making their way through Congress, and trends in state regulation that the insurance practitioner should be aware of as they could have a nationwide impact on the practice of insurance law.

LEGAL ISSUE 1: LITIGATION

Katrina teaches us what we already know, that insurance is a natural fall guy anytime it doesn't pay a suffering human being. When you combine this with a jury pool also heavily affected by the disaster, you are looking at a circumstance very favorable to ambitious policyholder litigation and to taking a case to a jury. With Katrina, there were too many cases for them all to be tried, so test cases were pushed forward, and juries struck out at insurers for what they perceived to be lack of human compassion, which is not necessarily the same thing as saying insurers should just pay regardless of what the policy says, but can be the same. In such a situation, one has to question whether any defense will work with an inflamed jury pool.-David Rossmiller

The course of Hurricane Katrina litigation bears out Mr. Rossmiller's comments. Many policyholders, particularly along the hardest hit coastal regions, were dissatisfied with the small payouts or denials of their property damage claims based on the insurers' insistence that the water damage to their property was caused by flooding, and thus, specifically excluded from coverage. The policyholders have turned to the courts in suits challenging the flood exclusion and anti-concurrent causation clauses in standard homeowners' and commercial policies. These actions are beginning to make their way through the court system with cases coming out of the Fifth Circuit being among the first to shape the course of Katrina-related litigation. Initially, district court cases out of both Louisiana and Mississippi seemed to be supporting the policyholders' arguments, but recent decisions by the United States Court of Appeals in the Fifth Circuit have upheld the language of the insurers' policies.

Flood Exclusions Upheld

The standard homeowner's policy includes an exclusion for flood damage, which states that the policy excludes loss resulting directly or indirectly from water damage caused by "flood, surface water, waves, tidal waves, overflow of a body of water, spray from these, whether or not driven by wind." *In re Katrina Canal Breaches Consol. Litig.*, 2006 U.S. Dist. LEXIS 85779 (D. La. 2006). In the wake of Hurricane Katrina, insureds have challenged this exclusion as ambiguous.

In a case out of the Southern District of Mississippi, the issue of whether damage caused to property from water inundation as a result of Hurricane Katrina's "storm surge" was a flood within the meaning of the standard exclusion was quickly put to rest. In *Buente v. Allstate Prop. & Cas. Ins. Co.*, 2006 U.S. Dist. LEXIS 23742 (D. Miss. 2006), the plaintiffs suffered damage to their property as a result of water inundation from Hurricane Katrina. They argued that this damage was caused by a "storm surge," which was not specifically listed as a peril in their homeowners' policy. *Id.* The *Buente* court found that the water that entered the plaintiffs' home was tidal water from the Mississippi Sound and concluded that the inundation was a flood as that term is ordinarily understood. *Id.* Thus, the flood exclusions in Allstate's policy were unambiguous and enforceable.

A case out of the Eastern District of Louisiana, *In re Katrina Canal Breaches Consol. Litig.*, 2006 U.S. Dist. LEXIS 85779 (D. La. 2006), gave the insurance industry pause when the district court concluded that the language of the standard flood exclusion was ambiguous and did not include an "inundation of water" from a man-made cause such as the breach of the levees due to negligent design and maintenance. However, the United States Court of Appeals for the Fifth Circuit eased insurers' fears of a billion-dollar payout resulting from these alleged ambiguously worded exclusions

with its recent decision in *Vanderbrook v. Unitrin Preferred Ins. Co. (In re Katrina Canal Breaches Litig.)*, 495 F.3d 191 (5th Cir. 2007), which overturned the district court, stating:

By definition, whenever a levee ruptures and fails to hold back floodwaters, the result is a more widespread flood. That a levee's failure is due to its negligent design, construction, or maintenance does not change the character of the water escaping through the levee's breach; the waters are still floodwaters, and the result is a flood. *Id.*

Although noting that the Louisiana Supreme Court had not interpreted the standard flood exclusion in the context of the breached levees, the *Vanderbrook* court made an *Erie* guess in determining how it would resolve the issue, finding that "inundation of water" was a flood that was unambiguously excluded from the plaintiffs' all-risk coverage. *Id.*

Though it appears that the standard flood exclusion clause and its commonly understood definitions will be upheld in Hurricane Katrina litigation, it is wise to keep in mind that there have been no decisions from the state supreme courts interpreting this clause under each state's insurance law. However, Mr. Rossmiller finds it likely that the Louisiana Supreme Court will agree with the Fifth Circuit, stating that "for flood exclusions, the mass of court opinion nationwide agrees with the Fifth Circuit."

Wind vs. Water Litigation and the Anti-Concurrent Causation Clause

"Wind vs. Water" is a catchy phrase that was coined to indicate that the typical homeowners' insurance policy generally covers damage from wind and rain, but not damage from flooding. As Hurricane Katrina's winds of up to 175 miles per hour lashed the coastal areas that were later inundated with flood waters from the storm surge or the breached levees, whether or what percentage of damage was caused to an insured property by wind has become a hot topic of litigation. Cases out of Mississippi have begun to define "Wind vs. Water" litigation.

In *Guice v. State Farm Fire & Cas. Co.*, 2006 U.S. Dist. LEXIS 57571 (D. Miss. 2006), the United States District Court for the Southern District of Mississippi held that class action lawsuits were not favored for determining causation. The plaintiff had sought to certify a class of insured homeowners whose property was totally destroyed during Hurricane Katrina and who had been denied full coverage under their policies because the damage was caused by both wind and water. *Id.* The court denied the motion, finding that the nature and extent of the property damage the homeowners sustained would vary depending on the location and condition of the property before the storm struck and what combinations of forces caused the damage. *Id.* Thus, a class action was not a suitable method for resolving the homeowners' losses. *Id.* The court re-affirmed its position in denying Plaintiff's Motion to Reconsider the Issue of Class Action Certification in *Guice v. State Farm Fire & Cas. Co.*, 2007 U.S. Dist. LEXIS 34148 (D. Miss. 2007). Thus, practitioners should be prepared to try property damage claims on a case-by-case basis on the issue of causation.

In *Broussard v. State Farm Fire & Cas. Co.*, 2007 U.S. Dist. LEXIS 2611 (D. Miss. 2007), another case out of the Southern District of Mississippi, the court found that the evidence established that the plaintiffs' home was damaged by wind and that, ultimately, their home was a total loss. *Id.* State Farm claimed that the loss was the result of the storm surge, and therefore, excluded from coverage under the plaintiffs' homeowner's policy. *Id.* The court found that once the plaintiffs had established their prima facie case, the burden was on State Farm to prove, by a preponderance of the evidence, what portion of the total loss was attributable to flood damage, and therefore, excluded from coverage under the policy. *Id.* The court entered a directed verdict for the plaintiffs, stating that:

I find, as a matter of law, that State Farm has not met its burden of proof as to the segregation of this total loss into wind damages, which are covered, and water damages which are excluded from coverage. State Farm has also failed to establish or to offer evidence that would support a finding that the insured property sustained no wind damage. *Id.*

State Farm has appealed the directed verdict. When asked about the likelihood of the *Broussard* decision being affirmed on appeal, Mr. Rossmiller states that:

I am fairly certain at least some portion of the case will be reversed. Although Judge Senter focused on the statement of a probability of some small damage in directing the verdict and giving a bad faith instruction, the same wind expert said that the wind could not have damaged more than those few shingles and that storm surge is what destroyed the Broussards' home. State Farm also had a wave expert who testified that the storm surge was nine to 11 feet inside the home. The Broussards' expert, of course, testified the home was destroyed by a tornado. The jury could have been allowed to pick between the two interpretations. It will be interesting to see how the court rules on the burdens of allocation of proof.

Mr. Rossmiller believes it is likely that Judge Jones, who wrote the Fifth Circuit's decision in *Leonard v. Nationwide Mut. Ins. Co.*, 499 F.3d 419, 431-432 (5th Cir. 2007) will say that State Farm met its burden of proof.

While awaiting the Fifth Circuit's decision in *Broussard*, practitioners should be prepared to shoulder the burden of proof in segregating out what damage was caused to a policyholder's property by an excluded peril and a covered peril, once a prima facie case has been established.

Mississippi recognizes the efficient proximate cause doctrine as the default rule of causation when dealing with losses from a covered and an excluded peril under an insurance policy. *Leonard v. Nationwide Mut. Ins. Co.*, 499 F.3d 419, 431-432 (5th Cir. 2007). The doctrine provides that to recover under a policy, such as a homeowner's policy, the insured has to show that the covered peril was the proximate or efficient cause of the loss, regardless of whether an excluded peril contributed to the damage. *Id.* Insurers have found a way to protect themselves from the efficient proximate cause doctrine by the inclusion of anti-concurrent causation (ACC) clauses in standard homeowners' and commercial policies. The ACC clause denies coverage whenever a covered peril and an excluded peril combine to cause damage to a dwelling or personal property. Because most homeowners' policies cover damage from wind but not from water, many policyholders who suffered losses from Hurricane Katrina are challenging the validity of the ACC clause.

Mr. Rossmiller offers some observations on the Wind vs. Water debate and ACC challenges, stating that:

The wind versus water debate actually had several components. One was the false doctrine that damage from a force like a hurricane involves multiple causation of loss merely because two forces, one covered and one uncovered, cause damage to a structure. In reality, in Katrina, no one has been able to point me to a single example where specific damage to a particular portion of a house resulted from a combination of forces. Instead, where a house was damaged by wind and water, these forces caused separate property damage, and did not combine to cause precisely the same loss to property as that term is understood in insurance contracts. If they had, anti-concurrent cause language would have been implicated, but it was not, because separate damage was caused by separate single forces. The notion that anti-concurrent cause language was vital or even necessary to a determination of coverage for Katrina damage is entirely false. The great irony of Katrina litigation is that anti-concurrent cause language was relentlessly attacked by the media, policyholder lawyers, politicians and consumer groups, and the result of those attacks is that anti-concurrent cause language has been upheld on appeal by the Fifth Circuit and even arguably extended by those appellate decisions beyond where it was originally intended to go. These Fifth Circuit decisions are not without their own errors in understanding causation, and the ultimate result will be a resounding victory for insurers, who got more from the court than they should have expected.

The cases Mr. Rossmiller is referring to are *Tuepker v. State Farm Fire & Cas. Co.*, 2007 U.S. App. LEXIS 25786 (5th Cir. 2007) and *Leonard v. Nationwide Mut. Ins. Co.*, 499 F.3d 419 (5th Cir. 2007). When the matter was before the district court in *Tuepker v. State Farm Fire & Cas. Co.*, 2006 U.S. Dist. LEXIS 34710 (D. Miss. 2006), it held that because the plaintiffs' policy carried a Hurricane Deductible Endorsement, it was intended to cover damages sustained from the effects of the hurricane. The court concluded that to the extent that State Farm argued the hurricane relieved it of duty, "the policy is ambiguous and its weather exclusion therefore unenforceable in the context of losses attributable to wind and rain that occur during a hurricane." *Id.* However, the United States Court of Appeals for the Fifth Circuit disagreed. In *Tuepker v. State Farm Fire & Cas. Co.*, 2007 U.S. App. LEXIS 25786 (5th Cir. 2007), it found that the ACC clause clearly provided that the indivisible damage caused by both the covered and excluded was not covered

under the plaintiffs' policy. *Id.* The court specifically stated that "the Hurricane Deductible Endorsement ... [did] not in any way render the ACC Clause ambiguous." *Id.*

In *Leonard v. Nationwide Mut. Ins. Co.*, 438 F. Supp. 2d 684 (D. Miss. 2006), the court found that because a windstorm was a weather condition covered by the policy, the ACC clause was ambiguous because reading the policy as a whole allowed for windstorm coverage, while excluding such coverage if the windstorm occurred at the same time as a flood. *Id.* The court concluded that the most reasonable interpretation of the policy provided coverage for damage from windstorms, and such coverage was "not negated merely because an excluded peril (in this case storm surge flooding) occur[red] at or near the same time." *Id.* However, the Fifth Circuit also reversed *Leonard's* holding on appeal in *Leonard v. Nationwide Mut. Ins. Co.*, 499 F.3d 419 (5th Cir. 2007), finding that the ACC clause was unambiguous and that Nationwide's use of the ACC clause to supplant the efficient proximate cause doctrine was not forbidden by state law, statutory law, or public policy. *Id.*

Mr. Rossmiller offers his opinion that:

Tuepker was a much better decision than *Leonard*. Some relatively minor errors in causation were present in *Tuepker*, but nothing big. In *Leonard*, on the other hand, Judge Jones' analysis of causation was not nuanced and, in many particulars, wrong. Having written on anti-concurrent cause language a great deal, it was not surprising to me that the court upheld the language, but the simplest and best way of dealing with that language was for the court to point out that Judge Senter in the underlying decisions improperly ruled on anti-concurrent cause language, because it was not at issue. As I've mentioned, neither the damage to the *Tuepker* home nor the *Leonard* home involved multiple causes -- every bit of the loss was caused by single forces acting separately to cause different, single damage. Judge Jones gave an example in *Leonard* in which she said the anti-concurrent cause language would apply, and not even insurers in Katrina trial courts had said it would apply in such an example. I was distressed to see this, because it will cause mischief down the road and further muck up the understanding of anti-concurrent cause language. It appears to me the *Tuepker* panel did not agree fully with Judge Jones analysis, but what are they going to do, overrule the Chief Judge on a case with similar facts and similar policy language? It would have been better had *Tuepker* been the first case of the two, and *Leonard* had to adapt itself to *Tuepker's* analysis, rather than vice versa.

Mr. Rossmiller's comments indicate that some confusion about the ACC clause continues. However, as it now stands, the ACC clause has been upheld by the Fifth Circuit as unambiguous, enforceable, and not against public policy.

LEGAL ISSUE 2: LEGISLATIVE RESPONSE

Because of the slow recovery process and constituents' continuing outrage at the handling of insurance claims in the areas hit by Hurricane Katrina, the 110th Congress has been active in introducing bills that insurers and practitioners should follow as they could create massive changes in the insurance industry. Different legislative measures seek to end the wind vs. water debate, improve the health of the property and casualty insurance markets, and reform the insurance industry.

The Flood Insurance Reform and Modernization Act of 2007

The wind vs. water debate has been taken up by Congress in the form of a bill initially introduced as the *Multiple Peril Insurance Act of 2007*, 2007 H.R. 920, by Representative Gene Taylor (D-MS). The bill sought to amend the *National Flood Insurance Act of 1968*, 42 USCS § 4001 et seq., to make multiperil coverage for damage resulting from windstorms or floods available under the National Flood Insurance Program (NFIP). However, insurance industry leaders, FEMA, and the Bush Administration made it clear that the *Multiple Peril Insurance Act of 2007* was not favored in hearings before the House Financial Services Committee. The major concerns were that government insurance would displace policies available in the private market, that it would undercut incentives for people to mitigate risks, that it would displace state initiatives for addressing wind risk through private markets, and what the cost of expanding the federal program to taxpayers would be. *Flood Insurance: Hearing Before the Subcomm. on Housing*

and Community Opportunity of the H. Comm. on Financial Services, 110th Cong. (2007) (statement of David I. Maurstad, Assistant Administrator Mitigation, Federal Emergency Management Agency).

The provisions of the *Multiple Peril Insurance Act of 2007* were made a part of a bill introduced by Representative Maxine Waxman (D-CA), the *Flood Insurance Reform and Modernization Act of 2007*, 2007 H.R. 3121. The *Flood Insurance Reform and Modernization Act of 2007* sought to restore financial solvency to the NFIP and states that one of its purposes is to allow the NFIP to provide multiperil insurance coverage against loss of real or personal property from a windstorm or flood. The bill passed the House of Representatives by a vote of 263 to 146. 2007 Bill Tracking H.R. 3121.

However, in recent developments, multiperil coverage under the NFIP appears to be an issue that, if not dead, has been tabled for the time being. Senator Christopher Dodd (D-CT) introduced the *Flood Insurance Reform and Modernization Act of 2007*, 2007 S. 2284, to the Senate on November 1, 2007. The bill before the Senate does not contain the provisions that were once in the *Multiple Peril Insurance Act of 2007*. While Mr. Rossmiller states that "I was ready to listen about the wind coverage," he does add that "it was unsettling that no one could put a price tag on it. In the end, it appeared to have the makings of a boondoggle. Adding a boondoggle to a flood program badly in need of revamping is no solution."

Homeowners' Defense Act of 2007

Another approach to solving the crisis in property insurance market after Hurricane Katrina currently making its way through Congress is the *Homeowners' Defense Act of 2007*, 2007 H.R. 3355, a bill to ensure the availability and affordability of homeowners' insurance coverage for catastrophic events sponsored by Representatives Ronald Klein (D-FL) and Timothy Mahoney (D-FL). The purpose of the *Homeowners' Defense Act of 2007* is to establish a program to provide federal support for state-sponsored insurance programs. The legislation would create the "National Catastrophe Consortium," a body into which states' reinsurance funds, risk pools or primary insurance corporation could pool their catastrophe exposures and reduce their risk by purchasing reinsurance or selling catastrophe bonds. The Act also provides for the establishment of the National Homeowners' Insurance Stabilization Program, which would permit the U.S. Treasury to make liquidity and catastrophic loans to state and regional reinsurance programs to ensure the solvency of such programs, improve the availability of homeowners' insurance, and spread the risk of financial loss from a national disaster.

The Act passed the House by a vote of 255 to 155 on November 9, 2007 and was referred to the Senate Committee on Banking, Housing, and Urban Affairs. 2007 Bill Tracking H.R. 3355. On November 6, 2007, Senators Hillary Rodham Clinton (D-NY) and Bill Nelson (D-FL) introduced companion legislation in the Senate, 2007 S. 2310. Insurers, while supportive of the idea of spreading risk from national disasters, are leery of the idea of state insurers increasing their role in the private insurance market.

Insurance Industry Competition Act of 2007

Although there have been other attempts to repeal the exemption from the federal antitrust laws that was granted to the insurance industry by the *McCarran-Ferguson Act of 1945*, 15 USCS § 1011 et seq., over the years, concerns over the mishandling of insurance claims from Hurricane Katrina has caused the 110th Congress to introduce bills in the House and Senate to repeal the exemption. The *Insurance Industry Competition Act of 2007*, 2007 H.R. 1081, 2007 S. 618, was introduced in the House by Representative Peter DeFazio (D-OR) and in the Senate by Senator Patrick Leahy (D-VT), and would give the Federal Trade Commission and Department of Justice the power to enforce federal antitrust laws against the insurance industry. The *McCarran-Ferguson Act* currently provides an exemption to the federal antitrust laws for the "business of insurance" to the extent that it is regulated by the states. 15 USCS § 1012(b). Under the *Insurance Industry Competition Act of 2007*, the states would continue to regulate insurance companies but the FTC would have the authority to review unfair methods of competition.

Insurers maintain that while the *Insurance Industry Competition Act of 2007* was "couched in the language of the current natural catastrophe insurance debate," it is wholly unrelated. *Natural Disaster Insurance: Hearing Before the Subcomm. on Housing and Community Opportunity of the H. Comm. on Financial Services*, 110th Cong. (2007) (statement of Marc Racicot, President of the American Insurance Association). They claim that the repeal of the exemption will do nothing to improve the availability or affordability of property insurance in coastal areas.

Mr. Rossmiller appears to agree, bluntly stating that:

Talk of repealing McCarran-Ferguson is just pure bunk fed to the public to make politicians look like they care or have a clue. In reality, large insurers couldn't care less if McCarran-Ferguson is repealed. All that it really allows insurers to do is share actuarial data without being accused of an anti-trust violation. Large nationwide insurers have enough actuarial data of their own to price their products according to the risk. Small insurers don't, and they would tend to err on the side of increasing price to protect against insolvency, with the result that their products would be less competitive and consumers would suffer. Anti-competitive acts like price fixing and other forms of anti-market collusion are already illegal under the Sherman Act. McCarran-Ferguson is only a limited exemption.

Commission on Catastrophic Disaster Risk and Insurance Act of 2007

On January 12th, Senator Bill Nelson (D-FL) introduced the *Commission on Catastrophic Disaster Risk and Insurance Act of 2007*. 2007 S. 292. The purpose of the bill is to establish a nonpartisan commission on insurance reform prompted by the phenomenal property losses caused by the 2005 hurricane season. The Commission would assess the condition of the property and casualty insurance and reinsurance markets as well as the ongoing exposure of the United States to natural disasters and would make recommendations on legislative and regulatory changes that would improve the health of such markets. The Commission would issue a report 90 days after its members have been appointed. The bill was referred to the Senate Committee on Banking Housing and Urban Affairs, 2007 *Bill Tracking* S. 292, and it appears it was put on the calendar by Senator Dodd on November 1, 2007, 2007 *Bill Tracking* S. 2286. Companion legislation was introduced in the House of Representatives, 2007 *H.R.* 537.

It is important for any practitioner to be aware of and to keep current with the progress of these bills as the passage of any one of them could have far-reaching effects on the insurance industry and the practice of insurance law.

LEGAL ISSUE 3: TRENDS IN STATE REGULATIONS

After Hurricane Katrina, the hardest hit states have created rules to try to ensure a quick and fair resolution to property insurance coverage disputes and to try to keep policyholders informed and protected in the event of future disasters.

Mediation

In an attempt to resolve property claims quickly and painlessly, Mississippi, CMSR 28-000-087, Louisiana, 33 LR 795, and Alabama, Ala. Admin. Code r. 482-1-135-.01 through Ala. Admin. Code r. 482-1-135-.11, set up non-binding mediation programs for residential personal lines claims. Such mediation programs are becoming more the norm in disaster prone areas as they can lead to a quick resolution of a coverage dispute without the expense of drawn-out litigation. An interesting development in Mississippi to the mediation programs, which are generally available to policyholders who are not parties to coverage litigation, is CMSR 28-000-089. Because of overcrowded court dockets and the need for policyholders to have their residential insurance claims resolved quickly, Mississippi recently expanded its mediation program to allow parties involved in coverage dispute litigation to participate in the mediation program if a court order has been issued. Other states may follow Mississippi's lead after a natural disaster in order to provide residents with a swift resolution to their claims and to ease the burden on the court system.

Policyholders Coverage Explained

As Mississippi is the early battleground for the wind vs. water debate, it has created two regulations aimed at ensuring policyholders completely understand what is and is not covered under their property insurance policies. Other states, particularly in areas hardest hit by natural disasters, could follow Mississippi's lead in adopting rules that require insurers to explicitly inform policyholders of their rights and the limits of their policies.

After Hurricane Katrina, Mississippi now requires insurers to provide policyholders with written notice of any flood or earthquake exclusion in the insurance policy when it is issued and each time the policy is renewed. CMSR 28-000-088. The new rule was created to try to prevent the ongoing disputes over coverage that have arisen in the wake of Hurricane Katrina. The rule requires mandatory language that coverage is excluded for flooding from storm surge from a hurricane, surface water, flash floods, waves, tidal water, tidal waves, wind-driven rain or water or any other water from such events. The required language must also inform policyholders that they can purchase flood insurance from the National Flood Insurance Program.

Mississippi has also created the Mississippi Insurance Policyholder Bill Of Rights. The Mississippi Department of Insurance adopted Regulation 2007-1, effective September 1, 2007, after the events of Hurricane Katrina to try to foster a better understanding among residential insurance property policyholders of their rights under Mississippi law. 115 MSGR 79. Under the regulation, property and casualty insurers must provide policyholders with an outline of coverage and a standard checklist of policy contents. The Policyholder Bill of Rights is also intended to serve as standards for the Mississippi Insurance Department to follow in exercising its powers and duties. While the initial cost of the additional paperwork in complying with these regulations might cause insurers to balk, the explicitness required in ensuring that a policyholder understands the limits of the coverage could save unnecessary litigation down the road as well as encourage policyholders to obtain the coverage they need to be fully protected from a natural disaster. However, when asked whether the regulations will have such an effect, Mr. Rossmiller states that:

I think that such attempts, although well meaning, are foolish and doomed to failure because they fail to acknowledge that policy language is written as it is for specific reasons. Insurance coverage law is almost all common law, and insurers adapt policy language in response to court decisions. They also fail to understand that making policy language simpler usually means it becomes more, not less ambiguous. Besides that, what consumer ever reads an insurance policy? Do you? If I wasn't an insurance coverage lawyer, I would never look at an insurance policy. So laws that pretend that policyholders read and understand policies are founded on a notion that is refuted by empirical evidence.

Standardized Requirements after a Natural Disaster

After the 2004 and 2005 hurricane seasons left Florida's residential property insurance market in shambles, Florida adopted standardized requirements applicable to insurers after a hurricane or natural disaster, 69O-142.015, F.A.C. The regulation provides rules with respect to claims reporting requirements, grace periods for premium payments, and the temporary suspension of policy cancellation or nonrenewal after a hurricane or other natural disaster has occurred that prevents policyholders from paying their premiums or otherwise renewing and maintaining their coverage. Looking to find ways to protect their citizens after a natural disaster, other states could follow suit in creating similar rules. However, Mr. Rossmiller observes that "Florida's response to any insurance problem has been to increase regulation, and when that fails, they make another regulation. They are like Wile E. Coyote, with the Acme Rocket Pack. No matter how many times the thing explodes or runs him straight into a cliff, he straps on another rocket pack."

While the ultimate usefulness of such regulations is debatable, other states that might be in the eye of the storm could look to the lessons learned by the Gulf Coast states after Hurricane Katrina in order better prepare themselves and their residents for a natural disaster, it is important to keep an eye on insurance regulation trends coming out of those states to see what ideas take hold.

CONCLUSION

Although it has been more than two years since Hurricane Katrina blew ashore, it is still early to say what the lessons will be for the insurance industry and insurance counsel. Initially, the district court rulings seemed to be sympathetic to the policyholders' plight, overlooking precedent or sound policy language. However, recent appellate decisions have upheld standard policy language and exclusions. Congress has responded to the "crisis" in the insurance industry with a flurry of bills, most of which will likely fade away. If there will be insurance reform and what kind of reform remain open questions, though pressure from an angry public remains for some sort of change as a result of Katrina. States have also attempted to appease their citizens with regulations designed to protect policyholders and expedite the claims process. However, these regulations may only further muddy already cloudy waters. Thus, insurance law is still very much in a state of flux, and counsel must keep an eye out for new developments. Ultimately, Mr. Rossmiller may be right-the most important lesson for insurers and insurance practitioners may be that combining a litigation strategy with a public relations campaign is the way to avoid the negative perceptions and political repercussions that resulted after the storm.

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Business Income Coverage in the Post-9/11 World:

2008 Emerging Issues 2954

Business Income Coverage in the Post-9/11 World: How Insurance Companies Have Changed the Claims Handling Playbook Since 9/11 and Hurricane Katrina

By Marshall Gilinsky and Richard Lewis

December 26, 2007

SUMMARY: The events of 9/11 and Hurricane Katrina set loose a torrent of litigation regarding the scope of coverage of business interruption insurance. The stakes are enormous because those catastrophes gave rise to insurance claims that: are often individually large; are collectively massive; are similar to many other claims, making precedents especially significant; and involve insurance forms of recent vintage with little case authority for guidance.

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ARTICLE: Introduction

The insurance claims that arose from the attacks of September 11, 2001 (9/11) and Hurricane Katrina were a watershed for the way in which insurance companies handle Business Income insurance claims. Those events also set loose a spree of judicial opinions regarding the scope of coverage for Business Income and other time element losses. Indeed, although Business Income coverage has been around for more than a century, about *half* of the time-element cases have been decided since September 11, 2001.

Historically, Business Income and other time element insurance claims were resolved generally by negotiation or appraisal. There are many reasons why such claims increasingly are being litigated, but perhaps the primary reason is the circumstances surrounding 9/11 and, to a lesser extent, Hurricane Katrina. Those catastrophes gave rise to insurance claims that: (1) were often, individually, very large, a condition that by itself led to disputes; (2) were collectively massive, putting at least an initial strain on the industry and its individual players; (3) were quite similar to other policyholders claims, which inclined claims handlers to be conservative, lest policyholders discover favorable claims positions and demand similar treatment; (4) involved forms of recent vintage, with little or no case authority to provide guidance or constrain insurance company claims handlers; (5) involved broad coverage forms, a product of the soft market just beginning to lift in early 2001; and (6) arrived at a time when the financial markets, in which insurance companies are huge investors, were retrenching dramatically. The confluence of these factors, combined with the growing role of outside coverage attorneys in shaping the response to first-party claims, led insurance companies to take newly restrictive coverage positions on policyholders time element claims.

This commentary will provide an overview of the issues that have been the focus of Business Income disputes between policyholders and their insurance companies since 9/11, with special attention paid to the ways in which insurance companies claims handling approach has changed during that period. The article will also suggest how policyholders can avoid the traps recently laid by the insurance industry and its lawyers.

The Non-Existent *Daubert* Exclusion

As a practical matter, Business Income claims are calculated based on projections of what the policyholders revenues would have been in a hypothetical universe where the loss event never occurred. By definition, this analysis represents what is, at best, a rough estimate of what probably would have happened had there been no loss. For most Business Income claims of even modest complexity, this analysis is typically done by separate forensic accountants retained by the policyholder and the insurance company. Although these accountants employ various mathematical and statistical techniques in their analysis, there is no one correct way to estimate any given loss, and no accountants results can ever be said to be 100% accurate, or verifiable with scientific certainty. For exactly this reason, such claims historically have been resolved via give and take discussions between each sides accountants, until they are in substantial agreement on a methodology for estimating the loss which typically yields a claim calculation somewhere in between the result initially obtained by each side.

In many 9/11 Business Income claims, and in some others stemming from the catastrophic hurricanes of 2004 and 2005, insurance companies took a much harder line in discussions over loss calculation methodologies. This forced many policyholders into litigation, where they were required to establish the amount of their damages predominantly through expert testimony by forensic accountants that worked up the Business Income loss projection models. Insurance companies argued that, in order to be admissible, such expert testimony had to meet the standards for reliability established in *Federal Rule of Evidence 702*, as well as *Daubert v. Merrell Dow Pharms.*ⁿ² and its progeny. Thus, once the parties were in court, many insurance companies sought to disqualify the policyholders forensic accountant and thereby effectively undermine the policyholders case by challenging the reliability and accuracy of the accountants Business Income loss calculation under *Dauberts* junk science standard. And in more than one case, insurance companies have succeeded in completely avoiding payment of claims simply by convincing the court that the forensic accountants analysis or the data on which that analysis was based were unreliable under the *Daubert* standard.ⁿ³

Such decisions effectively insert into the insurance policy a requirement that does not otherwise exist a requirement that the accountant or loss adjustor and the data and other evidence relied on in calculating the Business Income loss meet the *Daubert* standard. The reasoning behind such decisions is questionable because the calculation of such losses, by definition, is counterfactual and essentially calls for estimates of revenues in purely hypothetical business environments. Ultimately, results such as these embolden some insurance companies to take a hard line in discussions with their policyholders over Business Income loss calculations, especially in cases where it is difficult to tie the loss-causing event to the policyholders downturn in revenues with a great deal of precision, or where it is difficult to quantify the impact of potential alternate causes of the policyholders decreased revenues on its covered Business Income loss. For example, when a jewelry store damaged in a hurricane suffers a 50% downturn in revenues for the month following the storm, the insurance company is likely to argue that some portion of those losses are attributable to people simply not shopping for luxury products because they were busy dealing with more pressing matters like repairing the roofs on their houses, which alternate cause might not be covered under the jewelry stores policy. So how is the policyholders accountant expected to assess with mathematical reliability the extent to which earring buyers stayed home because they had leaky roofs versus the fact that the broken windows on the jewelers storefront were boarded up?

Although they are problematic for policyholders, decisions such as those noted above are in conflict with a long

line of cases holding that policyholders can prove their Business Income losses through various types of data and expert testimony n4 and do not need to be proved with mathematical precision. n5 When the shoe is on the other foot, insurance companies have lobbied hard for admission of their own forensic accountant evidence as crucial in Business Income cases. n6 Accordingly, there is ample ammunition to defend against improper attempts to inject the *Daubert* standard into the loss adjustment of Business Income claims, and policyholder advocates should be on the lookout for this unsavory insurance industry tactic. Finally, even where expert testimony is rejected under *Daubert*, it still may be possible to present lay testimony from a policyholders accountant to substantiate a Business Income claim. n7

The Undefined Use of Suspension in Business Income Provisions

Most Business Income provisions promise to pay for loss resulting from a suspension of the policyholders operations caused by damage or destruction of property at the premises. Historically, insurance companies have been somewhat successful in arguing to courts that the term suspension means total cessation and, thus, that a policyholder: (1) is entitled to Business Income coverage only during the period of time its operations are at a complete standstill; and (2) is entitled to no coverage if it is able to hobble along and continue operations despite property damage.

The total cessation argument is absurd for a number of reasons. First, the time during which coverage is owed is already measured by the Period of Restoration generally defined as the hypothetical period needed to repair or replace damaged property which clause is rendered moot by the total cessation doctrine. Second, most modern businesses are fully capable of conducting some business by fax, Blackberry, telephone, or laptop despite catastrophic destruction of their premises. Third, most policies contain clauses contemplating partial operations (e.g., giving the insurance company credit for sales of existing stock), and promising Extra Expense coverage for the above-normal costs of engaging in partial operations *during the Period of Restoration*. Fourth, courts adopting the doctrine are not consistent as to whether cessation is a trigger (i.e., the policyholder gets coverage for all losses after an instant of cessation) or whether it relates to the Period of Restoration (i.e., the policyholder gets coverage only for losses during the cessation). Incredibly, some courts come to both conclusions at once. n8 Accordingly, several years ago, the Insurance Services Office (ISO), the insurance industry drafting arm responsible for much of the first-party language in commercial use, included a definition of suspension in its standard-form policy that expressly makes clear that Business Income coverage includes lost profits during slowdowns.

Many modern policies based on broker, manuscript or insurance company forms do not include the ISO definition of suspension. Thus, insurance companies repeatedly raised the total cessation argument in 9/11 Business Income claims, n9 and even obtained judgments in 9/11 claims based on the argument. n10 Insurance companies continue to make this argument and win. n11 Given this potential pitfall, policyholders, at the point of sale, should insist on a definition of suspension akin to that in ISO forms which make clear that partial suspensions of operations are covered.

Location, Location, Location Is Now Being Ignored by Business Income Claims Handlers

Historically, Business Income cases gave policyholders the benefit of location by setting the Period of Restoration the period during which Business Income coverage is owed as the hypothetical time needed to repair or replace damaged property at the original location. If the policyholder relocated during that period, the insurance company got the benefit of any income earned by the substitute operations, but relocation did not end the Period of Restoration. n12

Since 1995, however, ISOs standard form has defined the Period of Restoration as the *lesser* of the time to repair or replace the physical damage at the original location or the time at which operations are resumed at a new permanent location. This modification devalues the policyholders pre-loss location, capping the loss of many policyholders at the point of relocation, despite the fact that their loss will continue at an inferior replacement location. Obviously, if you purchase a policy with ISO language, this argument will be open to the insurance company, although one court has concluded that whether a policyholder has permanently relocated is viewed by the policyholders subjective intent. n13

But what about policies without ISOs restrictive language? In seven 9/11 cases, the insurance companies all argued that the Period of Restoration was not equivalent to the period needed to rebuild the World Trade Center (WTC) where the policyholders had been located, but was the period needed to restart operations *anywhere*. These arguments had varying results:

In three involving firms with offices at the WTC, the courts concluded that the Period of Restoration was equivalent to the time needed to relocate the offices anywhere. n14 In two cases involving stores located in the mall in the concourse of the WTCenter, the courts concluded that the Period of Restoration was not the time needed to rebuild the WTC, but also rejected the insurance companies arguments that the period was equivalent to the time needed to replace anywhere; rather, the court found the policyholders were entitled to coverage for the time needed to find a reasonably equivalent location. n15 Two other courts, however, found that the businesses at issue a janitorial firm servicing the landlord and tenants at the WTC and a company providing temporary office space at the WTC, respectively were entitled to coverage during the hypothetical period needed to rebuild the WTC, essentially because the WTC location was of overwhelming importance given the nature of their operations. n16

Oddly enough, the only case of the above six to contain ISOs constriction of coverage was *International Office Centers*. The absence of such restriction should have been sufficient for the above courts to conclude that the Period of Restoration should be metered by the time necessary to replace at the original location.

Nonetheless, insurance companies will press this point, and policyholders will succeed in avoiding a truncated Period of Restoration only to the degree they can demonstrate that their location was of the essence of their operations. In other words, policyholders must establish that the purpose of Business Income insurance to do for the policyholder what it would have done absent the catastrophe would not be served by basing the Period of Restoration on replacement anywhere, if losses would continue at the inferior replacement location.

Seemingly Illusory Coverage Provided by Civil Authority Clauses

Civil Authority coverage is a Business Income coverage extension that typically covers loss when, in the wake of a catastrophe, civil authorities take actions which affect customer access to a policyholders property. Although the forms vary greatly, typical provisions require access (1) to be prevented or prohibited (2) as a result of property damage. Many policyholders made Civil Authority claims after 9/11, either for loss stemming from Mayor Giuliani's orders prohibiting traffic in lower Manhattan or for loss stemming from decreased customer demand in the wake of the order of the FAA.

The insurance industry, facing a vast number of such claims, strongly resisted them, urging two main defenses: (1) the orders were not as a result of the property damage on 9/11 but were issued to prevent further property damage; n17 and (2) access to premises such as hotels affected by the FAA order was not totally prevented or prohibited. n18

From a policyholders perspective, the first argument is akin to asking: which came first, the chicken or the egg? Take, for instance, the prototypical Civil Authority situation, where the collapse of a building causes city authorities to bar access to adjoining buildings: is such an order because of the existing collapse or because of fear of future collapse? One could make a strong case for either point, but accepting the latter would essentially render Civil Authority coverage illusory.

The second argument was almost universally accepted by courts addressing 9/11 claims, which found that access was not prohibited or prevented even if the policyholders business was dramatically down if it was possible for the customers, or even the policyholder itself, to physically reach the premises, regardless of whether commerce itself was feasible. This argument has also been accepted by one court addressing a Katrina claim. n19 Such holdings not only essentially render Civil Authority coverage illusory, they are often contrary to positions taken by the insurance industry in the press after a catastrophe, to the effect that delays in claims handling were attributable to the inability of claims handlers to reach affected property. The holdings are also contrary to decisions under a similar clause, covering loss caused by prevention of ingress or egress, which have taken a functional and realistic view of the term prevent. n20

As currently construed by the insurance industry, and most courts, Civil Authority coverage is illusory unless the order totally bars access to the policyholder's property by any means. If possible, at the point of sale, policyholders should insist on the terms hindered or impaired in place of prevented or prohibited.

Beware of Arguments as to the Wider Effects of the Loss

A number of insurance companies sought to slash Business Income or Civil Authority recovery on the ground that business in New York was slow after 9/11. In other words, the insurance companies sought to take advantage of the wider effects of the loss, and argue that, because the catastrophe was so big, the recoverable loss for any particular policyholder should be smaller. Note that this issue may be the primary sticking point in Business Income claims stemming from Hurricane Katrina: insurance companies will argue that pre-loss projections of profit must be revised downward because of the decrease in population in New Orleans and along the Gulf Coast.

Historically, issues surrounding the wider effects of a catastrophe in the Business Income context have arisen in cases in which policyholders, whose businesses were destroyed by storm, argued that their lost profits should include the hypothetical increased sales levels they would have enjoyed had the storm at issue spared their business but still flattened neighboring property. Not surprisingly, insurance companies resist such claims on the ground that a policyholder cannot reap a windfall by factoring in the wider effects of the same catastrophe which caused the loss. n21 No doubt insurance companies will take similar positions in Katrina claims where policyholders seek to take advantage of the wider effects of the loss.

Further, ISOs standard form already has two provisions addressing the wider effects of the loss: ISOs Business Income provisions state that favorable business conditions existing in the wake of a catastrophe do not affect the amount of loss, and ISOs Extended Business Income provision excludes loss as a result of unfavorable business conditions caused by the impact of the Covered Cause of Loss in the area where the described premises are located. Accordingly, policyholders facing insurance company efforts to slash Business Income recovery on the basis of the wider effects of the loss can point out that the insurance industry knows how to draft policies, and the absence of any provision granting the insurance company the benefit of the wider effects of the loss means that the insurance company is not entitled to any such benefit.

Beware the Period of Restoration for Unusual Businesses

The Period of Restoration often has a poor fit to businesses with a substantial lag between the time they provide a service or sell a good and the time they get paid. Insurance companies will argue that only losses fully realized during the Period of Restoration may be recovered; under such an interpretation, a law firm out of business a couple of weeks will have no recoverable loss because it will not perform services, bill for them and receive payment during that period. This argument has been accepted by some courts, n22 while other courts have taken a more functional view of when income is earned. n23

Policyholders can attempt to address this problem at the point of sale by purchasing a form which meters the loss in a manner more consistent with the nature of the business (i.e., billable hours lost for a law firm). Most forms, for instance, measure loss for manufacturing concerns in terms of the ultimate value of the product which cannot be manufactured, and not ultimate sales lost during the Period of Restoration. At a minimum, policyholders must resist insurance company efforts to have it both ways. For instance, many insurance companies seek to take advantage of credits for pent-up demand after the Period of Restoration; e.g., sales of eyeglasses to persons who had simply delayed purchase until after the neighborhood eyeglass shop reopens. An insurance company should not be permitted to confine loss to the Period of Restoration, but then seek credits for amounts earned afterward.

Beware of Insurance Company Arguments on Categories of Property Which Will Support a Business Income Loss

Historically, policyholders were entitled to make a Business Income claim when property at the insured premises typically, the building at which the policyholder was located was damaged, regardless of whether the policyholder owned or leased the specific property which was damaged. n24

In 9/11 claims, however, insurance companies took very narrow views on the property which, when damaged, would support a Business Income claim. For instance, in *Zurich Am. Ins. Co. v. ABM Indus Inc.*, n25 which involved a Business Income claim by the firm providing janitorial services to the WTC landlord and tenants, the insurance company variously asserted: (1) the policyholder could not make a Business Income claim from the destruction of property unless it was also entitled to recover for the value of that property (which would have surprised most of the WTCs tenants); and (2) the policyholder could not recover for loss from leased premises unless the policyholders lease required it to rebuild the leased premises if destroyed (ditto!). These positions failed, largely because of statutory law defining an insurable interest as any legitimate business interest in the continued survival of property. n26 Accordingly, an insurable interest in property employed in the operations of the policyholder is, under most forms, sufficient to support a Business Income claim if that property is destroyed.

Relatedly, as noted above, many policyholders in the WTC were surprised to find that their insurance company took the position that their Period of Restoration was the period needed to replace their particular office suite and not the entire WTC. Historically, the term premises has been broadly construed to include the entire building or complex in which a policyholder is located, and not a particular office suite. A number of insurance companies, however, have adopted a practice of listing a particular office suite i.e., WTC 1, Suite 7501 as the insured premises. Such practice may allow the insurance company to avoid paying Business Income losses caused by damage to the building which impacts the policyholders operations if there is no damage in the policyholders office suite. One should pay attention to this tack at the point of sale.

Conclusion

As noted above, Business Income claims which were once negotiated to resolution between independent adjusters (on the insurance company side) and loss adjusters or consultants (on the policyholder side) are now increasingly referred by insurance companies to coverage counsel. Unlike adjusters, coverage counsel are far less likely to be concerned about their relationships with the policyholder, and are far more likely to assume tenuous and highly restrictive coverage positions. Further, as a matter of ethics, attorneys retained by insurance companies owe no duties to policyholders and a duty of zealous advocacy to their client insurance companies; this is why hiring counsel to adjust claims is an act of bad faith. Many of the 9/11 and Katrina Business Income cases were handled by counsel, resulting in the various coverage-restricting positions outlined above. While such positions, if accepted by courts, dramatically restrict the coverage one would expect from a Business Income form, policyholders can expect insurance companies to take these positions in future claims, and should consider them in determining their appetite for Business Income coverage.

Return to Text

n1 . See Daniel T. Torpey & Jeffrey M. Phillips, *World Trade Center Terrorist Business Income Claims Will Challenge Policyholders* (Jan. 2002) (Imagine yourself as an insurance executive with the knowledge that any decision you make on any one loss will impact multiple claims in multiple industries all for one event [the

attack on the World Trade Center (the WTC)]. Accordingly, insurers will be very careful as to how they react to a variety of technical claim issues.).

n2 . 509 U.S. 579 (1993).

n3 . See *Maier v. Continental Casualty Co.*, 76 F.3d 535 (4th Cir. 1996) (applying West Virginia law); *Wyndham Int'l, Inc. v. Ace Am. Ins. Co.*, 186 S.W.3d 682 (Tex. App. 2006); *Lava Trading, Inc. v. Hartford Fire Ins. Co.*, 2005 U.S. Dist. LEXIS 4566 (S.D.N.Y. 2005) (Dolinger, Mag. J.) (report and recommendation), adopted in an unreported order (S.D.N.Y. Apr. 8, 2005) (Castel, J.).

n4 . See *Diamond Shamrock Corp. v. Lumbermens Mut. Casualty Co.*, 466 F.2d 722, 728 (7th Cir. 1972) ([The policyholders] summary exhibits, together with the testimony of [the policyholders] accountant provide a detailed analysis of the method by which the total business loss figures were reached. Those exhibits were sufficient to establish a *prima facie* case of loss in the amount claimed. At that point it became incumbent upon [the insurance company] to prove that the losses claimed were excessive or unreasonable.); *American Medical Imaging Corp. v. St. Paul Fire & Marine Ins. Co.*, 949 F.2d 690, 694 (3d Cir. 1991) (Inherent in the concept of business interruption insurance is the necessity of [policyholders] making claims for lost earnings based in large part on estimates of things that have not happened, i.e., on estimates of what would have happened had there been no fire or other covered cause of loss. Moreover, throughout the world of business, such estimates are invariably based on the results of past performance projected and adjusted on the basis of present business conditions. Unlike the district court, we find no fault with the character of [the policyholders] tendered evidence on lost earnings. Indeed, the fact that [the policyholders] projections were formulated in the regular course of business prior to the alleged loss may commend them to the trier of fact as more reliable than if they had been prepared after the fact for the purposes of litigation. Moreover, we know of no rule requiring that evidence of lost earnings identify the particular customers and hypothetical transactions that would have produced revenues but for the fire or other covered loss.); *Net 2 Press, Inc. v. Employers Fire Ins. Co.*, 2004 U.S. Dist. LEXIS 18929 (D. Me. 2004) (While some evidence of actual loss from interruption of business and extra expense to run the business is required in order to succeed on a claim that this portion of the insurance policy was breached, as well as proof that such evidence was provided to the [insurance company], the law does not require that such evidence be in documentary or any other particular form.); *Gates v. State Auto. Mut. Ins. Co.*, 196 S.W.3d 761 (Tenn. Ct. App. 2005) (while [the policyholders] accounting practices are relevant, we must also consider the nature of the business and the methods employed in its operation. We must conclude that the interpretation advocated by [the insurance company], given the nature of [the policyholders] business and its method of operation, would defeat the essential purpose of business interruption insurance, that is, to place the insured in the position it would have occupied if the interruption had not occurred. The interpretation adopted by the trial court is, under the circumstances of this case, more consonant with the language of the policy as well as the purpose of this type of insurance.).

n5 . See *Springfield Fire & Marine Ins. Co. v. J. T. Wilson Co.*, 67 F.2d 426, 428 (6th Cir. 1933), 67 F.2d 426, 428 (6th Cir. 1933) (it may be said that the amount of liability is not shown with mathematical precision,

but there were sufficient proofs to take the case to the jury and justify the jury, if the evidence was believed, in rendering a verdict in the amount returned); *Vinyl-Tech Corp. v. Cont'l Cas. Co.*, 2000 U.S. Dist. LEXIS 22507 (D. Kan. 2000) (That the amount of lost profits may not be shown precisely will not prevent recovery if the [policyholder] makes the amount of its loss reasonably certain by competent evidence.); *Lite v. Firemen's Ins. Co.*, 119 A.D. 410, 104 N.Y.S. 434, 436 (N.Y. App. Div. 1907) (It is manifest that some loss of profit must have accrued from the inability to use or rent the 10 apartments, and, where there is an evident loss, the insured should not be deprived of indemnity merely because it may be difficult to fix the amount of the loss with absolute precision); *Anchor Toy Corp. v. American Eagle Fire Ins. Co.*, 4 Misc. 2d 364, 365-366 (N.Y. Sup. Ct. 1956) (Such questions as the estimated amount of business during the period and the percentage of profit were not only of great complexity due, among many other factors, to the means of administering the corporate business, but also were at best matters of opinion.); *Holt Atherton Industries, Inc. v. Heine*, 835 S.W.2d 80, 84 (Tex. 1992) (noting that [r]ecovery for lost profits does not require that the loss be susceptible of exact calculation; [t]he amount of the loss must be shown by competent evidence with reasonable certainty; [w]hat constitutes *reasonably* certain evidence of lost profits is a fact intensive determination; and opinions or estimates of lost profits must be based on objective facts, figures, or data from which the amount of lost profits can be ascertained); *State Farm Lloyd's Ins. Co. v. Ashby AAA Auto. Supply Co.*, 1995 Tex. App. LEXIS 3346, at *48-50 (Tex. App. 1995) (Recovery for lost profits does not require the loss to be susceptible of exact calculation. However, the amount of the loss must be shown by competent evidence and with reasonable certainty. What constitutes reasonably certain evidence of lost profits is a fact intensive determination. As a minimum, opinions or estimates of lost profits must be based on objective facts, figures or data from which the amount of loss profits can be ascertained. . A party must show either a history of profitability or the actual existence of future contracts from which lost profits can be calculated with reasonable certainty.) (citations omitted).

n6 . See *Audubon Veterinary Hosp., Inc. v. U.S. Fid. & Guar. Co.*, 2007 U.S. Dist. LEXIS 46301 (E.D. La. 2007).

n7 . See *La. Med. Mgmt. Corp. v. Bankers Ins. Co.*, 2007 U.S. Dist. LEXIS 59956 (E.D. La. 2007) (holding that a policyholder could call its accountant of 20 years to substantiate its Business Income claim as a lay witness because [t]he Third Circuit has held that a companys accountant may offer lost business profits opinion testimony as a lay witness under Rule 701 because of his personal knowledge of the companys finances).

n8 . See *Broad St., LLC v. Gulf Ins. Co.*, 37 A.D.3d 126 (N.Y. App. Div. 2006).

n9 . See, e.g., *Duane Reade, Inc. v. St. Paul Fire & Marine Ins. Co.*, 279 F. Supp. 2d 235, 238-239 (S.D.N.Y. 2003), *affd in part, revd in part*, 411 F.3d 384 (2d Cir. 2005).

n10 . See, e.g., *Royal Indemnity Co. v. Retail Brand Alliance, Inc.*, No. 601164/04 (N.Y. Sup. Ct. Feb. 23, 2006).

n11 . See, e.g., *Madison Maidens, Inc. v. Am. Mfrs. Mut. Ins. Co.*, 2006 U.S. Dist. LEXIS 39633 (S.D.N.Y. 2006).

n12 . See, e.g., *Hawkinson Tread Tire Service Co. v. Indiana Lumbermens Mut. Ins. Co.*, 362 Mo. 823 (Mo. 1951).

n13 . *Shore Pointe Enterprises v. Michigan Millers Mut. Ins. Co.*, 2004 Mich. App. LEXIS 3486 (Mich. Ct. App. 2004).

n14 . *Streamline Capital, L.L.C. v. Hartford Cas. Ins. Co.*, 2003 U.S. Dist. LEXIS 14677 (S.D.N.Y. 2003); *Lava Trading, Inc. v. Hartford Fire Ins. Co.*, 365 F. Supp. 2d 434 (S.D.N.Y. 2005); *Children's Place Retail Stores v. Fed. Ins. Co.*, 37 A.D.3d 343 (N.Y. App. Div. 2007).

n15 . *Duane Reade, Inc. v. St. Paul Fire & Marine Ins. Co.*, 411 F.3d 384 (2d Cir. 2005); *Retail Brand Alliance, Inc. v. Factory Mut. Ins. Co.*, 489 F. Supp. 2d 326, 334 (S.D.N.Y. 2007).

n16 . *Zurich Am. Ins. Co. v. ABM Indus.*, 2006 U.S. Dist. LEXIS 28249 (S.D.N.Y. 2006); *Int'l Office Ctrs. Corp. v. Providence Wash. Ins. Co.*, 2005 U.S. Dist. LEXIS 20494 (D. Conn. 2005).

n17 . See, e.g., *US Airways, Inc. v. Commonwealth Ins. Co.*, 64 Va. Cir. 408 (2004).

n18 . See, e.g., *Southern Hospitality, Inc. v. Zurich Am. Ins. Co.*, 393 F.3d 1137 (10th Cir. 2004).

n19 . *Kean, Miller, Hawthorne, D'Armond McCowan & Jarman, LLP v. Nat'l Fire Ins. Co.*, 2007 U.S. Dist. LEXIS 64208 (M.D. La. 2007).

n20 . See *Fountain Powerboat Indus. v. Reliance Ins. Co.*, 119 F. Supp. 2d 552 (E.D.N.C. 2000).

n21 . See, e.g., *Prudential LMI Commercial Ins. Co. v. Colleton Enterprises*, 1992 U.S. App. LEXIS 25719 (4th Cir. 1992).

n22 . See, e.g., *Pennbarr Corp. v. Insurance Co. of North America*, 976 F.2d 145 (3d Cir. 1992).

n23 . See, e.g., *Vinyl-Tech Corp. v. Cont'l Cas. Co.*, 2000 U.S. Dist. LEXIS 22507 (D. Kan. 2000); *Gates v. State Auto. Mut. Ins. Co.*, 2006 Tenn. LEXIS 502 (Tenn. 2006).

n24 . See, e.g., *Datatab, Inc. v. St. Paul Fire & Marine Ins. Co.*, 347 F. Supp. 36 (D.N.Y. 1972).

n25 . 397 F.3d 158 (2d Cir. 2005).

n26 . *Zurich Am. Ins. Co. v. ABM Indus., Inc.*, 397 F.3d 158, 167-168 (2d Cir. 2005) (New York law embraces the *sui generis* nature of an insurable interest and statutorily defines this term to include any lawful and substantial economic interest in the safety and preservation of property from loss, destruction or pecuniary damage. N.Y. Ins. Law § 3401. [The policyholders] income stream is dependent upon the common areas and leased premises in the WTC complex, and thus [the policyholder] meets New Yorks requirement of having an insurable interest in that property.).

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CGL Insurers Duty to Defend & Indemnify Claims Under the FCRA

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CGL Insurers Duty to Defend and Indemnify Claims rising Under the Fair Credit Reporting Act

By Matthew R. Wildermuth

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SUMMARY: In his analysis of the insurance coverage implications of claims asserted against credit card companies for alleged violations of the Fair Credit Reporting Act ("FCRA"), insurance coverage litigation expert Matthew R. Wildermuth, Esq. explores whether such claims trigger a commercial general liability ("CGL") insurer's duty to defend or indemnify its insured and identifies potential pitfalls for insurers in responding to tenders of such claims.

PDF LINK: Premium Emerging Issues Commentary (\$)

ARTICLE: Introduction

For many Americans, each days mail is likely to turn up at least one unsolicited offer encouraging the recipient to transfer current credit obligations to a new account with another credit card issuer, to create entirely new debt or to consolidate all outstanding unsecured debt with a home equity loan collateralized by the consumers home. With increasing frequency, these offers refer specifically to the consumers personal credit score and suggest that the consumer has been pre-qualified for credit at the terms the issuer has emblazoned on the envelope in bold red ink. To the extent the targeted consumer does not simply chuck these envelopes into the recycle bin or run them through the shredder, he or she may question:

- . Is this daily assault on my mailbox legal? (as discussed below, maybe);
- . Is there anything I can do to shut these things off at the source? (yes, you can n1); and
- . How can I be sure that this credit card company is not using my private credit score information for some improper purpose?

The answers to these questions generally can be found within the provisions of the Fair Credit Reporting Act (hereinafter FCRA) [15 USCS § 1681-1681x], a statute Congress first enacted in 1970 to ensure that consumer reporting agencies exercise their grave responsibilities with a respect for the consumers right to privacy. [15 USCS § 1681(a)(4)]. As with suits seeking to vindicate rights under similar consumer protection statutes, allegations that the putative new creditor violated the FCRA often take the form of class action complaints against the issuer or lender, who in turn may request its general liability insurers assistance to defend against and potentially settle the claims. Focusing on this latter

component of this trend, this article will (a) identify the most prominent coverage issues such claims present under standard commercial general liability (CGL) policy language; (b) explain the courts approach to resolving these coverage issues to date; and (c) offer tactical guidance to parties on both sides of the coverage dispute when framing their respective positions on coverage for alleged FCRA violations.

General Principles As To The Commercial General Liability Insurers Duty

To Defend And Indemnify Claims

The typical CGL primary policyⁿ² includes as a fundamental component of the insurance bargain the insurers obligation to assume and pay for the insureds defense against claims for which there is any potentiality for coverage.ⁿ³ Courts in most states employ the same basic approach to evaluate whether the asserted claims create the potential for coverage:

In determining whether an insurer owes its insured a duty to defend, a court looks to the allegations in the underlying complaint against the insured and compares those allegations to the relevant coverage provisions of the insurance policy ... If the facts alleged in the underlying complaint fall within or potentially fall within the coverage of the policy, the insurer's duty to defend is triggered. [citation omitted] Policies are liberally construed in favor of the insured, and any ambiguities or conflicts are resolved in favor of coverage. [*Canadian Radium & Uranium Corp. v. Indemnity Ins. Co.*, 411 Ill. 325, 332 (Ill. 1952).]

[See, e.g., *Employers Ins. v. Ehlco Liquidating Trust*, 186 Ill. 2d 127, 150 (Ill. 1999) (Illinois law); see also *Res. Bankshares Corp. v. St. Paul Mercury Ins. Co.*, 407 F.3d 631, 636 (4th Cir. 2005) (under Virginia law, an insurers obligation to defend an action depends on comparison of the policy language with the underlying complaint to determine whether the claims alleged in the complaint are covered by the policy).]

In contrast, in order for the insurer to be liable under the policy to indemnify its insured in respect of an underlying claim that has resulted in a judgment or a settlement against it, the insured must prove that the facts developed and claims adjudicated following the filing of the complaint actually come within the scope of coverage under the policy and are not subject to any policy exclusions. [See, e.g., *Crum & Forster Corp. v. Resolution Trust Corp.*, 156 Ill. 2d 384, 397-398 (Ill. 1993) (The duty to indemnify arises only in circumstances of actual coverage; if the insurance policy does not cover what is alleged in the claim, the insurer will not have a duty to indemnify based on that claim.)] This framework requires the court to measure the language of the policy against the outcome of the underlying proceeding, without regard to whether the potential for coverage existed at the time the claimant originally sought relief against the insured. [*Crum & Forster Corp. v. Resolution Trust Corp.*, 156 Ill. 2d 384, 397-398 (Ill. 1993).] In other words, unless the insured is found legally liable for conduct for which the policy actually provides coverage, the insurer has no duty to indemnify the insured even if the potential for coverage required it to defend the claims.

The Operative Policy Language At Issue In FCRA Claims

With these principles in mind, we now turn to the specific policy language courts typically will confront when resolving coverage issues arising out of FCRA claims asserted against the insured. A customary expression of the Insuring Agreement in a primary CGL policy reads as follows:

We will pay those sums that the insured becomes legally obligated to pay as damages because of bodily injury, property damage, personal injury, or advertising injury arising out of an occurrence. We will have the right and duty to defend any suit seeking those damages. We may at our discretion investigate any occurrence and settle any claim or suit that may result.

Property damage is defined as physical injury to tangible property, including all resulting loss of use of that property or loss of use of tangible property that is not physically injured. Advertising injury means injury arising out of one or more of the following offenses:

- a. Oral or written publication of material that slanders or libels a person or organization or disparages a persons or organizations goods, products or services;
- b. Oral or written publication of material that violates a persons right of privacy;

The policy defines an occurrence as an accident, including continuous or repeated exposure to substantially the same general harmful conditions. The first threshold in triggering coverage is that the claim at issue must allege either property damage or advertising injury as defined above arising out of an accident. If the claim meets this initial threshold, then the court will consider the application of any policy exclusions the insurer contends operate to negate or limit the coverage set forth in the insuring agreement. While the standard form CGL policy lists at least 13 specific exclusions, most important for purposes of this commentary are those that preclude coverage for property damage expected or intended from the standpoint of the insured, advertising injury caused by or at the insureds direction with knowledge that the [information] was false and advertising injury arising out of a willful violation of a penal statute committed by or with the consent of the insured. We address the potential applicability of each of these provisions to FCRA claims below.

The Purpose Of The FCRA And Elements Of Recovery

Congress enacted FCRA to ensure that consumer reporting agencies exercise their grave responsibilities with . . . a respect for the consumer's right to privacy. [15 USCS § 1681(a)(4). *See also Safeco Ins. Co. of Am. v. Burr*, 127 S. Ct. 2201, 2205 (U.S. 2007)

(Congress enacted FCRA in 1970 to ensure fair and accurate credit reporting, promote efficiency in the banking system, and protect consumer privacy.); *Perry v. First Nat'l Bank*, 459 F.3d 816, 825 n.2 (7th Cir. 2006) ([T]he FCRA is designed to protect the privacy of consumers' credit histories. . . .); *Stergiopoulos v. First Midwest Bancorp, Inc.*, 427 F.3d 1043, 1045-1046 (7th Cir. 2005) (In an attempt to achieve this balance between consumer privacy and the needs of a modern, credit-driven economy, [FCRA] limit[s] the furnishing of consumer reports to certain statutorily enumerated purposes.).]

Pursuant to the FCRA, a credit or lending institution may obtain or use a consumer report without the consumers written consent only if the issuer or lender obtains the information for certain permissible purposes, such as the extension of credit to the consumer, the review or collection of the consumers account, the underwriting of insurance for the consumer, in connection with a business transaction that the *consumer* initiates, or to make a firm offer of credit to the consumer. [15 USCS § 1681b.] The FCRA defines consumer report to mean any written, oral, or other communication of any information by a consumer reporting agency bearing on a consumers credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living which is used or expected to be used or collected in whole or in part for the purpose of serving as a factor in establishing the consumers eligibility for credit or insurance to be used primarily for personal, family, or household purposes . [15 USCS § 1681a(f).] The requesting entity must certify to the consumer reporting agency that it seeks the information for a permissible purpose under the FCRA. To the extent the requesting party asserts that the permissible purpose is to make a firm offer of credit, the offer must not be a gimmick but must actually have value to the consumer beyond the opportunity to do business with the requesting party. [See *Cole v. U.S. Capital, Inc.*, 389 F.3d 719 (7th Cir. 2004).]

In other words, the entity purporting to make a firm offer of credit cannot impose so many conditions or limitations on the proposed transaction that the offer is stripped of any practical benefit to the consumer:

The statutory scheme of the FCRA makes clear that a "firm offer" must have sufficient value for the consumer to justify the absence of the statutory protection of his privacy. A definition of "firm offer of credit" that does not incorporate the concept of value to the consumer upsets the balance Congress carefully struck between a consumer's interest in privacy and the benefit of a firm offer of credit for all those chosen through the pre-screening process. From the consumer's perspective, an offer of credit without value is the equivalent of an advertisement or solicitation. It is clear that Congress did not intend to allow access to consumer credit information "for catalogs and sales pitches."

[*Cole v. U.S. Capital, Inc.*, 389 F.3d 719, 726-727 (7th Cir. 2004).] The determination whether the specific offer giving rise to an individual or class action complies with the FCRA typically will be a fact-driven inquiry and, as a result, the costs to defend and settle such claims become substantial quickly. This in turn raises the stakes regarding whether some or all of those costs are covered under the defendants CGL policy.

Analysis Of FCRA Coverage Claims To Date

To fully understand the significance of the decisions evaluating coverage under CGL policies for FCRA claims, one must first appreciate the framework that has developed for analyzing coverage under the FCRA's sister statute, the Telephone Consumer Protection Act (hereinafter TCPA) [47 USCS § 227], known colloquially as the junk fax statute. Policyholders and insurers have been clashing over coverage for TCPA claims for several years and, because the TCPA and FCRA share common objectives and other attributes, decisions addressing coverage for TCPA claims ultimately have established at least some of the framework employed to evaluate insurers obligations in respect of FCRA claims.

The TCPA prohibits the use of any telephone facsimile machine, computer, or other device to send an unsolicited advertisement to a telephone facsimile machine." [47 USCS § 227(b)(1), (c).] The TCPA defines "unsolicited advertisement" to mean "any material advertising the commercial availability or quality of any property, goods, or services which is transmitted to any person without that person's prior express invitation or permission." [47 USCS § 227(a)(4).] The typical junk fax claim asserts that the transmission of unwanted faxes harmed the recipient both by wasting his ink and paper and by infringing his right to be free from unwanted intrusions. [See, e.g., *Am. States Ins. Co. v. Capital Assocs. of Jackson County, Inc.*, 392 F.3d 939, 943 (7th Cir. 2004).] Although courts generally regard the unauthorized dissipation of the recipients ink/toner and paper to constitute compensable property damage claim under the standard CGL policy language, insurers have argued successfully in some courts that the transmitting party's act of sending a facsimile to hundreds of recipients without permission rises to the level of intentionally causing damage and, therefore, is not an accident. [See, e.g., *Erie Ins. Exch. v. Kevin T. Watts, Inc.*, 2006 U.S. Dist. LEXIS 91762 (D. Ind. 2006) (intent to cause harm can reasonably be inferred where the insured knew its transmission of the unsolicited fax would, if successful, consume the target consumers ink and paper).]

Because the party transmitting the unsolicited offer to the targeted consumer in an FCRA claim bears all of the cost of presenting the offer, any claim that receipt of the offending offer constitutes property damage is considerably weaker.ⁿ⁴ As a result, the more fruitful area of inquiry for evaluating the extent to which decisions assessing coverage for TCPA claims apply to FCRA claims is the courts respective analysis of the privacy rights at issue. Specifically, the real fight turns on whether the right of privacy the TCPA and the FCRA seek to protect is the same right of privacy to which the CGL policy's provisions afford coverage. [See *Am. States Ins. Co. v. Capital Assocs. of Jackson County, Inc.*, 392 F.3d 939, 940, 943-944 (7th Cir. 2004); see also *Res. Bankshares Corp. v. St. Paul Mercury Ins. Co.*, 407 F.3d 631, 639-643 (4th Cir. 2005) (the word privacy carries different meanings in different contexts).]

The courts that have wrestled with this issue generally fall into one of two camps, with the pivotal distinction being whether the term privacy is construed more narrowly to encompass only an individual's interest in keeping certain information secret or is construed more broadly to extend to the right to not be disturbed or disrupted in the peaceful enjoyment of one's premises or person.ⁿ⁵ [See *Valley Forge Ins. Co. v. Swiderski Elecs., Inc.*, 223 Ill. 2d 352, 376-379 (Ill. 2006).] The courts in the former group reason that the specific torts listed within the definition of advertising injury

(e.g., libel, misappropriation of ideas) contemplate claims arising solely from a violation of the individuals interest in secrecy; because the TCPAs prohibition on unsolicited faxes protects solely against a persons interest in seclusion and is not concerned with the content of the communication (i.e., secret or public information), this is not the type of privacy interest for which coverage attaches. [See, e.g., *Res. Bankshares Corp. v. St. Paul Mercury Ins. Co.*, 407 F.3d 631, 641 (4th Cir. 2005).] In contrast, those courts that find privacy interests to include the amorphous right to be left alone treat the receipt of unsolicited junk faxes as a publication that, by intruding upon the consumers peaceful enjoyment, tramples upon his right to be free from disturbance. [See *Valley Forge Ins. Co. v. Swiderski Elecs., Inc.*, 223 Ill. 2d 352, 364-366 (Ill. 2006).]

Ironically, the insurers concerted efforts to develop this bright line demarcation between seclusion and secrecy privacy interests when challenging coverage for TCPA claims ultimately has proven to be problematic with the advent of FCRA claims. In decisions such as *Resource Bankshares*, the court accepted the insurers argument that the policy provision extending coverage for [o]ral or written publication of material that violates a persons right of privacy was intended to apply only to the victims secrecy privacy interests. [*Res. Bankshares Corp. v. St. Paul Mercury Ins. Co.*, 407 F.3d 631, 640-642 (4th Cir. 2005) (the advertising-injury offense part of the policies is exclusively concerned with those types of privacy which, like secrecy, are implicated by the *content* of the advertisements) (emphasis in original).] Confronted with an FCRA claim, those same insurers cannot credibly contend that a statute designed to protect a consumers interest in limiting access to his private credit history does not implicate the consumers secrecy interest. As a result, insurers have focused their attention on characterizing the lenders transmission of the credit offers directly to the consumer as not constituting a publication. [See *Zurich Am. Ins. Co. v. Fieldstone Mortg. Co.*, 2007 U.S. Dist. LEXIS 81570 (D. Md. 2007).] Although it is still early in the game, to date, insurers efforts along these lines have yielded little success.

In *Fieldstone*, mortgage broker Fieldstone tendered to its insurer for defense and indemnity a lawsuit a claimant filed against it pursuant to the FCRA alleging that Fieldstone accessed his credit report without a permissible purpose. [*Zurich Am. Ins. Co. v. Fieldstone Mortg. Co.*, 2007 U.S. Dist. LEXIS 81570 (D. Md. 2007).] The insurer agreed to defend Fieldstone under a reservation of rights and then promptly sought a declaration that its standard CGL policies did not require it to defend or indemnify Fieldstone in respect of the FCRA claims. [*Zurich Am. Ins. Co. v. Fieldstone Mortg. Co.*, 2007 U.S. Dist. LEXIS 81570 (D. Md. 2007).] On cross motions for summary judgment, the insurer cited *Resource Bankshares* in support of its argument that the FCRA does not establish a right of privacy for which its policies provide coverage. The district court acknowledged that the *Resource Bankshares* court distinguished between two types of potentially affected privacy rights based on the *manner* of the advertisement and the *content* of the advertisement and further noted that courts determination that claims based on the TCPA were concerned with the manner of the advertisement rather than their content. [*Zurich Am. Ins. Co. v. Fieldstone Mortg. Co.*, 2007 U.S. Dist. LEXIS 81570 (D. Md. 2007).] The district court then explained that the FCRA complaint against Fieldstone presented nearly the opposite situation:

It is not solely the manner of the solicitation that forms the crux of Mr. Rhodess complaint; it is the action that undergirds the messages content: the unauthorized accessing of his credit records. Indeed, the Fourth Circuit cites, as a possible category of privacy interests, informational privacy, or control over the processing -- i.e., the acquisition, disclosure and use -- of personal information. [*Res. Bankshares Corp. v. St. Paul Mercury Ins. Co.*, 407 F.3d 631, 640 n.9 (4th Cir. 2005).] As both Zurich and Fieldstone point out, it would be difficult for Mr. Rhodes to prove his case without introducing the content of the letters he received, because in order to prove his FCRA claim, he would have to show that the solicitations did not include a firm offer of credit such that any unpermitted access to his credit records would be forgiven.

[*Zurich Am. Ins. Co. v. Fieldstone Mortg. Co.*, 2007 U.S. Dist. LEXIS 81570, at *11-12 (D. Md. 2007).]

Finding that the FCRA claim alleged against Fieldstone implicated the secrecy interests that clearly implicated the coverage provided, the district court then addressed whether the term publication within the phrase [o]ral or written publication of material that violates a persons right of privacy fell within the policys definition of advertising injury.

The court noted that because the policies did not define the term publication, the court was bound to give the term its customary, ordinary and accepted meaning. [*Zurich Am. Ins. Co. v. Fieldstone Mortg. Co.*, 2007 U.S. Dist. LEXIS 81570, at *11-12 (D. Md. 2007).] Citing to a dictionary definition of publication characterizing its meaning as to produce or release for distribution; specif.: PRINT, the district court concluded that the term could easily be read here to encompass the printing and mailing of written solicitations. [*Zurich Am. Ins. Co. v. Fieldstone Mortg. Co.*, 2007 U.S. Dist. LEXIS 81570, at *11-12 (D. Md. 2007) (citing Merriam-Websters Collegiate Dictionary 1006 (11th ed. 2003)).] As a result, the district court rejected the insurers contention that publication requires proof of distribution to a third party, noting that a majority of the Circuit Courts of Appeals that have addressed the meaning of the term within the advertising injury provision of a CGL policy found the term did not mandate disclosure to a third party. [*Zurich Am. Ins. Co. v. Fieldstone Mortg. Co.*, 2007 U.S. Dist. LEXIS 81570, at *14 (D. Md. 2007) (citing *Park Univ. Enters. v. Am. Cas. Co.*, 442 F.3d 1239, 1248-1249 (10th Cir. 2006).]

Similarly, the United States District Court for the Northern District of Illinois, applying Illinois law, rejected an insurers contention that the insureds transmittal of an offer governed by the FCRA did not constitute a publication that invaded the recipients right of privacy as its standard CGL policy used those terms. [*Pietras v. Sentry Ins. Co.*, 2007 U.S. Dist. LEXIS 16015, at *5 (D. Ill. 2007).] The court first examined the insurers claim that "publication" connotes dissemination to the public at large or certain to become public knowledge and found the insurers proposed definition flatly contradicted by the Illinois Supreme Courts decision in *Valley Forge*, in which a single fax transmission to a single recipient constituted "publication" under an identical policy provision. [*Pietras v. Sentry Ins. Co.*, 2007 U.S. Dist. LEXIS 16015 (D. Ill. 2007).] Finding that the *Valley Forge* decision dispositively resolved how courts applying Illinois law are to construe the term "publication" within the policys "advertising injury" provisions, the district court rejected the insurers attempts to promote a different interpretation of publication based on the common law tort of invasion of privacy. [*Pietras v. Sentry Ins. Co.*, 2007 U.S. Dist. LEXIS 16015 (D. Ill. 2007).] The court therefore found that the FCRA complaint asserted against the insured triggered the insurers duty to defend its insured and that the insurers refusal to assume the insureds defense against the claim constituted a breach of its duty to defend. [*Pietras v. Sentry Ins. Co.*, 2007 U.S. Dist. LEXIS 16015, at *12 (D. Ill. 2007).]

Potential Pitfalls When Assessing Coverage For FCRA Claims

As the *Fieldstone* and *Pietras* decisions confirm, the well-pled allegations of an FCRA complaint present at least the potentiality for coverage and therefore trigger a primary CGL insurers duty to defend. That said, policyholders should prepare to confront other challenges that CGL insurers may mount in connection with FCRA claims. First, notwithstanding favorable developments regarding the interpretation of provisions addressing privacy interests and publication discussed above, these advances will be for naught if the policyholder fails to prove that the claim meets all of the conditions of the insuring agreement.

As noted above, allegations in an FCRA complaint that accuse the policyholder of intentionally or willfully violating the Act expose the policyholder to the defense that the complaint does not allege an accident. With no accident, there is no occurrence and, therefore, no insurable event. A determination whether the policyholders conduct rises to the level of actual or inferred intent to cause harm likely will involve specific factual inquiries regarding the basis for the policyholders actions, and it would be foolhardy for policyholders to presume that insurers will not exploit the opportunity to make such inquiries in the appropriate cases. [*See, e.g., Prime TV, LLC v. Travelers Ins. Co.*, 223 F. Supp. 2d 744 (D.N.C. 2002) (the intent component of the "occurrence" analysis requires a subjective inquiry); *Waste Management of Carolinas, Inc. v. Peerless Ins. Co.*, 315 N.C. 688, 696 (N.C. 1986) ("Whether events are accidental' and constitute an occurrence' depends upon whether they were expected or intended from the point of view of the insured.").] Similarly, insurers may assert that such allegations trigger the exclusion for damages expected or intended from the standpoint of the insured. Although application of the expected intended exclusion requires a slightly different analytical approach from the no accident defense (the latter prevents coverage from attaching in the first instance), discovery regarding its potential application would require the same or a similar inquiry into the policyholders motives.

The standard CGL policy also excludes coverage for personal injury or advertising injury from publication caused by or at the insureds direction with knowledge that the underlying content was false. The typical junk fax complaint alleging violations of the TCPA did not address the facsimiles substantive content (if any), so coverage cases decided in that context provide no meaningful guidance for FCRA claims. Because a court will use an objective test to determine whether a particular solicitation offers sufficient benefits to the consumer to comply with the FCRA, issues regarding the truth or falsity of the information provided in the solicitation are not material in assessing liability under the Act. As a result, it appears that insurers would not get much mileage asserting this exclusion as a bar to coverage.

In contrast, insurers may find that the policy exclusion for damages arising out of the insureds Willful Violation of a Penal Statute has meaningful potential. In order to preserve the claimants right to seek and ultimately recover treble damages, the typical FCRA complaint expressly alleges that the defendant(s) willfully violated the FCRA in accessing the claimants credit history. Insurers may cite to this allegation in the underlying complaint as evidence that the claim falls outside of their coverage based on the policys exclusion for personal injury or advertising injury arising out of a willful violation of a penal statute committed by or with the consent of the insured.

Neither the *Fieldstone* court nor the *Pietras* court evaluated the merits of this defense to an FCRA claim. In *Fieldstone*, the court did not reach the issue of the potential applicability of exclusions because it found that sufficient potentiality for coverage existed to trigger the duty to defend and any decision regarding indemnity would be premature until the underlying case was fully resolved. [*Zurich Am. Ins. Co. v. Fieldstone Mortg. Co.*, 2007 U.S. Dist. LEXIS 81570 (D. Md. 2007).] In *Pietras*, the court precluded the insurer from asserting any coverage defenses as a sanction for breaching its duty to defend its insured against the FCRA claim the insured timely tendered to it. [*Pietras v. Sentry Ins. Co.*, 2007 U.S. Dist. LEXIS 16015, at *12-13 (D. Ill. 2007).]

This issue has, however, arisen in the context of TCPA claims, and the courts confronting it consistently have interpreted that statute to be remedial and not penal. [See, e.g., *Western Rim Inv. Advisors, Inc. v. Gulf Ins. Co.*, 269 F. Supp. 2d 836, 848 (D. Tex. 2003); *Terra Nova Ins. Co. v. Fray-Witzer*, 449 Mass. 406, 419-420 (Mass. 2007).] In a nutshell, courts have placed particular emphasis on the fact that the TCPA directs that the consumer receive his or her actual damages or the statutory amount rather than depositing such funds into an account to be used for the benefit of the general public (the latter being a hallmark of penal remedies). [See, e.g., *Western Rim Inv. Advisors, Inc. v. Gulf Ins. Co.*, 269 F. Supp. 2d 836, 848 (D. Tex. 2003); *Terra Nova Ins. Co. v. Fray-Witzer*, 449 Mass. 406, 419-420 (Mass. 2007).]

The TCPA and the FCRA each are designed to accomplish complementary consumer protection goals through a consistent regulatory scheme that allows the complaining consumer to recover actual or statutory damages for violation. Accordingly, I project that a court presented squarely with the issue whether the FCRA is a remedial or penal statute will find it to be remedial, thereby nullifying the effect of the exclusion for willful violation of a penal statute.

In light of the uncertainties in this developing area of insurance coverage law, a word of caution regarding the potential implications of an insurers breach of its duty to defend its insured against a timely tendered FCRA claim is warranted. Under Illinois law, if a complaint potentially provides coverage, and the insurer believes that a defense to coverage exists, the insurer has two options: it can either seek a declaratory judgment as to its obligations and rights under the policy, or it can defend the insured under a reservation of rights. [*Fidelity & Casualty Co. v. Envirodyne Engineers, Inc.*, 122 Ill. App. 3d 301, 303 (Ill. App. Ct. 1983).] If the insurer fails to exercise either of these options, and it is later determined that the claim was subject to the insurer's duty to defend the insured, the insurer is estopped from raising policy exclusions or non-coverage as a defense in a coverage action. [*Central Mut. Ins. Co. v. Kammerling*, 212 Ill. App. 3d 744, 748 (Ill. App. Ct. 1991).] Moreover, the estoppel doctrine has broad application and operates to bar the insurer from raising policy defenses to coverage, even those defenses that may have been successful had the insurer not breached its duty to defend. [*Employers Ins. v. Ehlco Liquidating Trust*, 186 Ill. 2d 127, 150 (Ill. 1999).]

Similarly, under Arizona law, an insurer that fails or refuses to defend its insured against a claim that subsequently is determined to have triggered coverage faces serious consequences. Once the insurer elects not to defend its insured,

the insured may take all steps necessary to protect itself against the claim, including entering into a settlement with the injured party through which the insured assigns its rights under the policy to the claimant in exchange for the claimants covenant not to execute on the insureds personal assets. [See *Holt v. Utica Mut. Ins. Co.*, 157 Ariz. 477, 483 (Ariz. 1988); *Damron v. Sledge*, 105 Ariz. 151, 153 (Ariz. 1969); *Arizona Property & Casualty Ins. Guar. Fund v. Helme*, 153 Ariz. 129 (Ariz. 1987).] Because Arizona courts treat an insurers refusal to defend to be equivalent to an assertion that the insurer has no interest in the outcome of the underlying action, an insurer that breaches its defense obligation will not be allowed later to intervene in the underlying action to challenge the evidence submitted at the damages hearing in the underlying action. [See *Damron v. Sledge*, 105 Ariz. 151, 155 (Ariz. 1969) (finding an insurers breach of the duty to defend so substantial and so antithetical to the essential purpose of the insurance contract as to forfeit its right to intervene).] Thus, under Arizona law, an insurer that refuses to defend at all has thereby accepted the risk that an unduly large verdict may result from the lack of cross-examination and rebuttal on damages issues that otherwise might have occurred if the insurer had actively participated in the underlying action. [*Damron v. Sledge*, 105 Ariz. 151, 155 (Ariz. 1969).]

Although the consequences for an insurers breach of its duty to defend its insured in other states are less severe than in Illinois and Arizona, n6 an insurer that refuses to defend its insured faces some degree of risk, even if that risk is only that the insurer will not be permitted to actively participate in the defense and settlement of the claim. To the extent coverage issues later may turn on the evidence introduced and theories tried to the fact finder in the underlying action, the non-defending insurer may forfeit its right to be informed of and involved in the development of the underlying case. In sum, then, the insurer may find it worthwhile to defend its insured under a reservation of rights until sufficient facts are known about the underlying FCRA claim to allow the insurer to seek a determination that may terminate its duty to defend.

Conclusion

The FCRA's remedial provisions encourage consumers to protect their privacy interest in the confidentiality of their personal credit scores by pursuing recovery against prospective creditors who have accessed their credit history without a permissible purpose. As these suits proliferate, defendant policyholders will in turn pursue insurance coverage from their CGL insurers for defense and settlement of the claims. Although it appears that policyholders have an initial advantage based on courts willingness to find that FCRA claims trigger the potential for coverage under policy provisions extending protection for damages arising out of publications that violate the recipients right of privacy, serious substantive coverage issues remain. In light of the uncertainties regarding coverage for such claims and the potential penalties for breaching the duty to defend, insurers may find it in their interest to err on the side of caution and defend their insureds against FCRA claims until the legal framework for evaluating such claims is better developed.

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n1 . See FCRA § 604(e), 15 USCS § 1681b (Election of consumer to be excluded from pre-screened offer lists).

n2 . By typical CGL policy, I refer to the occurrence-based policy form introduced by the Insurance Services Office in 1986, and subsequently amended, to replace the prior policy form denominated as the comprehensive general liability policy form (also abbreviated at the time as CGL coverage). As pertinent here, the more recent ISO CGL form includes broad coverage for bodily injury and property damage liability

(Coverage A) and personal injury and advertising injury liability (Coverage B) subject to reductions in scope by endorsement. See Rupp's Insurance & Risk Management Glossary, <http://insurance.cch.com/RUPPS/commercial-general-liability-policy.htm>.

n3 . I confine my analysis in this article to the operative provisions of typical primary CGL policy forms, as excess CGL policies ordinarily do not require the excess insurer to defend the insured at the outset of a claim.

n4 . It is conceivable that a consumer targeted by unsolicited offers of credit could make out a claim for property damage to the extent that he or she has to pay extra amounts for waste disposal, recycling fees or shredder maintenance. However, any such claim seems attenuated at best in light of the FCRA's focus on the more ethereal secrecy concerns discussed below.

n5 . In contrast to the junk faxes prohibited under the TCPA, a firm offer of credit or other solicitation subject to the FCRA may be communicated by regular mail, facsimile, telephone or electronic mail. See 15 USCS § 1681h.

n6 . See, e.g., *SCSC Corp. v. Allied Mut. Ins. Co.*, 536 N.W.2d 305, 319 (Minn. 1995) (an insurer that elects not to defend its insured against a claim that triggers its coverage may be found liable for its fair share of the defense costs it refused to pay; as well as the reasonable fees and costs the insured (or another insurer) was required to expend to force the non-defending insurer to contribute to the insured's defense).

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The Greening of the Insurance Industry

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The Greening of the Insurance Industry

By Kathleen B. Havener

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SUMMARY: Insurers are realizing the many benefits of "green buildings"--structures that are built or renovated to be energy-efficient and disaster-resistant as well as protective of indoor-air quality and the environment. This commentary introduces and analyzes the benefits of building green.

PDF LINK: Premium Emerging Issues Commentary (\$)

ARTICLE: Environmental and Economic Costs

If our society fails to take the appropriate steps to meet the unequivocal challenges of global climate change, who will pay the price? We all will and a steep one at that. We will have to face not only the impact of global climate change in wildfires, flooding, droughts, rising sea levels, coastal erosion, mudslides, ever-more-powerful hurricanes, regions deforested and lives lost--but the economic cost--the money that will be necessary to rebuild infrastructure, replace lost homes and businesses, and even whole regions.

In a speech to the World Affairs Council, the Honorable Lord Peter Levene, Chairman of Lloyds of London, noted:

- . Between the 1960s and the 1990s, the number of natural catastrophes doubled.
- . Insured losses increased nearly seven-fold during the same period, most of which were weather-related.
- . 2005 was the worst year ever for the insurance industry, with global insurance claims exceeding \$83 billion, more than 80 percent resulting from the hurricanes in the United States.
- . Insurers need to be able to look policyholders in the eye and assure them that there will be funds available to cover their losses when disaster strikes--and the insurers can only stay around to pay if they price insurance realistically in relation to the underlying risk.

According to the Association of British Insurers, the costs of natural catastrophes fall on different parts of society depending on the arrangements.

. Where private insurance covers weather risks, the costs of climate change will be shared among the insured portions of society. With risk-based pricing, those at greatest risk pay most for this risk-sharing, while those who avoid risk pay least.

. Where government carries the risk directly or as insurer of last resort, the costs of natural catastrophes are borne by the taxpayer, contributing according to the tax regime of the country. There is no reward for avoiding risks, and no personal penalty for accepting them.

. Where there is no insurance or state-backed compensation for weather risks, the costs of natural catastrophes fall on the individual. In many cases, these costs could be a substantial portion of an individual's wealth, leading to devastating personal and business liabilities. The individual can only prevent potentially bankrupting costs by avoiding or carefully managing risks.

[Association of British Insurers: Summary Report, Financial Risks of Climate Change, § 4.1 (June 2005).] The questions about policy change with respect to global warming far outnumber any available answers. How much can we and our global economy survive?

The conventional wisdom that elevating the discourse about climate change will harm the economy is changing even more quickly than the climate. Companies and consumers are increasingly conscious that failure to take action to reduce the severity of climate change is the most significant risk to our future economy. Moreover, insurance regulators have begun to urge the industry to take affirmative steps to address climate change. The insurance industry--likely to suffer profound losses related to climate change even if the entire global community starts mending its ways immediately--is taking note of this sea change and responding.

Loss Prevention

One response is to encourage consumers to invest in loss prevention. There are many strategies, for example, for improving the disaster-readiness of insured structures. It only makes sense that such practices are cost-effective, sometimes extremely so. FM Global, a commercial property insurer with an engineering orientation, issued hurricane loss-prevention recommendations that nearly 500 of its insureds' facilities implemented prior to Hurricane Katrina. Those facilities located in the region impacted by the horrific storm suffered one-eighth the losses of those which had not done so. Thus, total customer investments of only \$2.5 million in loss-prevention strategies allowed these facilities to avoid approximately \$500 million in losses during Hurricane Katrina. n2 Less dramatic structural improvements encouraged by insurers are, for example, installing storm shutters and other upgrades to make homes less vulnerable to wind damage. Both MetLife and Allstate reportedly provide incentives to their customers for such wind-proofing steps. Other insurers, including State Farm and Allstate, lobby for more realistic building codes and their strict enforcement.

Rebuilding Right

Another response is a movement called Rebuilding Right that came into being after the catastrophic losses of Hurricane Katrina. According to Dr. Evan Mills:

Rebuilding Right . . . could involve everything from wetlands restoration to energy-efficient and disaster-resistant housing to renewably-based distributed energy supplies that are less vulnerable to disruption from future extreme weather events.

[See The CERES Report at 17.] In the category of rebuilding right, Dr. Mills includes innovative commercial insurance products that encourage building and rebuilding structures such that they meet current green construction standards. Examples of these are the Firemans Fund Green Upgrade product and Lexingtons Upgrade to Green coverage, discussed below. Insurers are making vigorous efforts to ensure that replacement buildings after losses meet all the appropriate code requirements to render them less susceptible to disaster.

The insurance industry is in an ideal position to assess emerging risks and to develop and market more creative and forward-looking insurance products in the coming years that will help business owners and individuals to lessen their own contributions to global warming and will save insurers losses as well.

Energy-Savings Insurance

Any effort to lower global greenhouse gas emissions to any significant degree must include--in large measure--reductions derived from improved energy efficiency and conservation of resources. Aware of this need, project developers are making efforts to lessen their environmental footprint. A very few insurers have developed policies that protect the installer or owner of an energy-efficiency project against losses resulting from the failure of the improvements to actually achieve the anticipated energy savings. Thus, energy savings insurance (ESI) is essentially the formal insurance of predicted energy savings. Others are providing performance bonds in states or countries that require a contractor to obtain a bond guaranteeing the predicted savings to be achieved by the energy efficiency measures taken. n3

There are multiple benefits to energy savings insurance. Among them are:

- . ESI transfers performance risk from the balance sheet of the entity implementing the energy savings project, thereby freeing up capital that would otherwise be needed to self-insure the projected savings.

- . ESI reduces barriers to market entry of smaller energy services firms who do not have strong enough balance sheets to self-insure the savings.

- . ESI encourages those implementing energy savings projects to go beyond standard measures and achieve more significant levels of energy savings by innovation.

- . ESI providers stand to be proponents of improved savings measurement and verification techniques, as well as maintenance, thus contributing to national energy savings objectives and possibly elevating the quality of information available for project evaluation. n4

Renewable Energy Project Insurance

Insurance is a critical factor in encouraging investment in renewable energy projects. It provides financial protection against losses resulting from delay or damage during the fabrication, transportation, assembly, and operational phases of the project--whether for technical reasons or caused by human error or natural event.

Insurers are developing new products to insure renewable energy projects. Munich Re, for example, piloted exploration risk insurance for geothermal energy companies. AXA has designed a comprehensive offering for wind farms, which generated \$14 billion in revenues for the insurer in 2006. n5 The AXA package can include construction insurance, physical damage and third-party liability insurance and coverage for delays in the building of a wind farm, loss of earnings and business interruption insurance once the operation is up and running. AXAs wind turbine coverage even compensates the policyholder for production losses if the wind farms annual wind levels fall below forecast. n6

Aon has created an agri-fuels group to provide risk management assistance to the rapidly growing biofuels industry. n7

Green Building Insurance

Clean and healthy buildings can reduce legal claims and liabilities. The cover story of the June 5, 2000 issue of *Business Week* reported the enormous surge in the number of cases of sick building syndrome. n8 There have been many toxic mold cases. Green buildings are healthier for tenants and the environment, and they are less risky, with air quality relatively free of indoor pollutants. They have benefited from the use of non-toxic paint products. Apparently in the developing consciousness of the insurance industry--they are better-constructed and less subject to losses.

The residential green building industry alone is expected to be a market of \$40 to \$50 billion by 2010. n9 Insurers are therefore racing to design new insurance products to accommodate this growing trend. Green buildings certainly lessen some risks. Green buildings tend to have better indoor air quality and lower energy costs. Commercial green buildings experience reduced absenteeism, and increased productivity. Firemans Fund product director Steve Bushnell has said, We perceive there is less risk in a building that is constructed with products and systems so state-of-the-art that they lower operating costs, increase resale values, create a healthier work environment, and provide an opportunity for greater workplace productivity.

In 2006, Firemans Fund was the first insurer to offer a line of non-residential Green Gard(SM) coverages. David Cohen of Firemans Fund explained that the development of the Green Gard began about four years ago at the urging of its parent company, Allianz, and Allianz commitment to finding solutions to global climate change. Market research demonstrated that green building was not a trend, said Cohen. It was quickly becoming mainstream. But our traditional coverages did not accommodate all the requirements for insuring green buildings. In response, Product Director Steve Bushnell, working closely with the United States Green Building Council and Dr. Evan Mills, came up with the concept, conducted the necessary research, and designed the new coverages. Realizing that the concept that the commissioning of green buildings goes to the very heart of the most common losses in commercial buildings, i.e., fires due to electrical problems, leakage from plumbing and roof problems, and losses due to the improper installation or operation of HVAC systems, the company concluded that a commissioned building--in which the electrical, plumbing, roofing, and HVAC systems are all integrated and approved by a trained and certified engineer--would suffer fewer losses than traditional buildings. Accordingly, the customer should pay lower premiums.

According to the Firemans Fund, [w]hether youve built green from the ground up, have made green renovations to existing buildings, or would like to rebuild as green in the event of a loss, we provide solutions to protect both your financial and environmental investments. n10 The insurer offers discounted Green Gard Certified Green Building Coverage for properties that meet the Leadership in Energy and Environmental Design (LEED) requirements n11 issued by the United States Green Building Council. n12 In the event of a loss, the insurer even covers the cost of engaging a LEED-accredited professional to oversee the repairs to the property. On May 1, 2007, The Tower Companies became the first enterprise in the Washington, DC metropolitan area to receive a 5% discount on property insurance from Firemans Fund for their green facility.

Firemans Fund also offers Green Gard commissioning coverage to both green-certified and traditionally designed buildings. This product ensures that, after a loss, the necessary repairs are environmentally friendly, they perform as intended, and they are integrated into other systems in the existing building. The insurer covers the cost of engaging a commissioning engineer to ensure that the building systems in the repaired or rebuilt structure (electrical, plumbing, heating and air conditioning) align with one another and provide top-notch performance. n13

Some examples of the innovative coverages? Green buildings often have vegetative roofs. Obviously, the typical sublimits on trees, shrubs, and other plants would not come close to funding the replacement of a vegetative roof after a loss. So Firemans Fund allows a green building owner with a vegetative roof a far higher sublimit for vegetation. Many green structures have photovoltaic or other environmentally friendly water-generating systems that require storage located at some distance from the primary structure. Though traditional insurance would not allow for coverage for

anything located more than 100 feet from the main structure, green building insurance does away with that limit for water storage facilities. If a solar-powered green building is selling power back to the grid, but then suffers a loss, Firemans Fund makes insurance coverage available to make up for the loss of that revenue stream.

Firemans Funds Green Gard coverages have been a success in the marketplace and have lent credibility to the importance of building green in the commercial construction and real estate arenas. They are now approved in all 50 states. The Green Upgrade form has been the most popular product. ⁿ¹⁴ It gives commercial property owners who *want* to go green the means to rebuild and replace with green alternatives after a loss. According to The CERES Report, Green Gard has helped elevate the discourse surrounding the emerging field of green financial services. ⁿ¹⁵

From a business standpoint, because green buildings *are* subject to fewer losses, it only makes sense to allow owners of traditional buildings to insure that--in the event they suffer a loss--they will have the means to rebuild with a green equivalent to their prior structure. If after suffering a total loss of a traditional building, the owner--through its coverage--ends up with an upgraded LEED certified green building, its future losses are likely to decline, its insurance costs should go down, and both the customer and the insurance company have lowered their risk, and the environment is the beneficiary. It is socially responsible business at its best.

Firemans Fund is presently expanding its coverages to include builders risk, to cover the additional time and costs necessary to maintain LEED certification after a loss. New green buildings under construction and existing buildings in the process of green renovations have unique exposures regarding loss of income and extra expenses that are not covered under traditional builders risk policies.

It may be more expensive and take longer to bring buildings back to peak efficiency and use following a loss when the building is to be green certified, explains Mike Halvey, vice president, commercial real estate, Firemans Fund. The green amendments to the builders risk policy will offer real estate owners protection of their green assets and pay for losses to green streams of income. These amendments protect against specific exposures--not ordinarily covered by traditional policies--for new green buildings under construction and existing buildings undergoing green renovations, including:

- . *Loss of earnings*: broadened to include coverage for the loss of income arising from the inability to feed surplus power and receive credits, reimbursement or rebates from the utility due to a covered loss to alternative power generating equipment.

- . *Soft costs*: broadened to cover additional reasonable commissioning expense, flush out expense, recycling expense and re-registration or recertification expense.

- . *Rental value*: broadened to include the additional time needed to comply with the extra procedures and process necessary to meet the level of green certification incorporated into the building design prior to the loss.

In addition to the builders risk policy, the new green amendments will also be available for historic buildings under course of certified historic rehabilitation, covering specific exposures related to rehabilitation projects and the preservation of unique features for historic properties. Additional commercial products that currently include green coverage options include senior living facilities and durable goods.

Firemans Fund is also striving to develop a personal line to provide homeowners insurance to those who have built green. Even more remarkable, Firemans Fund has responded to the recent California wildfires with an unprecedented offer--an innovative green upgrade for impacted policyholders. Firemans Fund will rebuild its Prestige Premier policyholders homes that were damaged or destroyed in the devastating Southern California wildfires green if policyholders desire. ⁿ¹⁶

Lexington Insurance (a member of AIG) also offers Upgrade to Green(SM) endorsements to policies of both homeowners and owners of commercial buildings. The Upgrade to Green product for residential properties, in the event

of a partial loss, could be expected to cover products and materials with an Energy Star rating or its equivalent. Coverage would be provided for repairs or replacement of damage to (or total loss of) appliances, heating and cooling equipment, lighting, windows, insulation, and home electronics (including office equipment). Claims could include reimbursement for green upgrade--renewable interior wood products (such as bamboo or cork flooring, for example), flooring or floor covering made from recycled materials, environmentally friendly paints, and more. When a total loss occurs, the new policies would allow the homeowner to rebuild to the applicable Energy Star option the policyholder has chosen.

Lexingtons Upgrade to Green commercial products would allow a policyholder that is not currently LEED certified to rebuild using LEED Silver criteria. If the policyholders property had been previously LEED-certified, the policy would be able to rebuild to a higher LEED certification (to the extent that is available). Coverage is available for the recycling of materials rather than the disposing of recyclables in landfills. Coverage is also available for the engagement of an architect or engineer with LEED certification to guide the design and/or rebuilding of the damaged part of the building. If the building is already LEED certified, the policy will cover the registration and certification fees for recertifying the building with the U.S. Green Building Council.

Why Should Coverage Lawyers Care?

Because green building insurance is such a new product, there is little if any legal analysis addressing how the new products will affect insurance coverage lawyers. To the extent that we are involved in advising clients about insuring their green buildings, we surely need to be aware of the new products. We need to recognize--and be able to communicate to our clients--that there are enormous differences between a green construction project and a traditional one, and between green facilities and their standard counterparts. Parties cant rely on standard contracts to address the risks involved. As coverage lawyers, the most important advice we can give to our clients is that they confirm that there is adequate insurance coverage (including professional liability insurance for design and building professionals) that account for the green nature of the work and that is the product that best suits the project on which they are embarking.

Green building designers and other professionals have been on the cutting edge of the culture for some time. Their passionate advocacy for green principles has caught the attention of the insurance industry, the second largest industry in the world (as measured by assets). Insurance and risk management professionals are lending their voices to the chorus encouraging the development of green practices. Insurance coverage lawyers should be carefully listening.

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n1 . The Intergovernmental Panel on Climate Change described as unequivocal its position that climate change is underway.

n2 . Evan Mills, Ph.D., From Risk to Opportunity: 2007: Insurer Responses to Climate Change, at 15 (internal citations omitted) (October 18, 2007) (the CERES Report, commissioned by CERES, a national coalition of investors, environmental groups, and other public interest organizations working with companies to address sustainability challenges such as climate change).

n3 . [See, e.g., D.C. Code § 2-303.22(a)(3).] See also Bryan Seifert, The Emerging Arena of Sustainable Building and The Contract Surety, *Surety Claims Institute Newsletter*, Vol. 18, No.2, p. 4 (2006).

n4 . Risk Transfer via Energy Savings Insurance: A Potential Asset for the ENERGY STAR Buildings Program, prepared by Evan Mills for the Environmental Protection Agency, Oct. 1, 2001. A sample ESI policy, attached to the cited report, is reproduced along with this article.

n5 . See The CERES Report at p. 24.

n6 . Carbon Disclosure Project 2005, citing 2004 Activity & Sustainable Development.

n7 . See AON News Release, Aon Establishes New Agri-Fuels Group to Manage Renewable Fuels Industry Risks, January 31, 2007, cited in The CERES Report at p. 24.

n8 . IS YOUR OFFICE KILLING YOU? Business Week, June 5, 2000.

n9 . The CERES Report at p. 24.

n10 . Obtained from <http://www.firemansfund.com/servlet/dcms?c=business&rkey=437> on November 28, 2007.

n11 . For more information about the LEED rating system, visit <http://www.usgbc.org/LEED>.

n12 . See Firemans Fund Green Building Upgrade Policy.

n13 . See Firemans Fund Green Commissioning Sample Policy.

n14 . See Firemans Fund Green Upgrade Sample Policy.

n15 . The CERES Report at p. 25.

n16 . See Firemans Fund press release dated November 5, 2007.

ABOUT THE AUTHOR(S):

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FL new statute & implementing regulation prohibiting discriminatory underwriting

2008 Emerging Issues 1646

Jim Poolman on Floridas new statute and implementing regulation prohibiting discriminatory underwri

By Jim Poolman

December 19, 2007

SUMMARY: The denial of an insurance policy of a Florida Congresswoman has shined the spotlight on the use of an applicants future travel plan when insurers underwrite life insurance policies. Policymakers as well as regulators are debating the issue across the country. Former North Dakota Insurance Commissioner Jim Poolman examines this politically sensitive issue and the new Florida regulations that govern how an applicants plans of future travel can be used, and the requirements placed on insurers to be able to use the information.

PDF LINK: [Click Here for Enhanced PDF of Commentary](#)

ARTICLE: The use of lawful foreign travel in issuing life insurance policies has been the subject of debate by regulators and lawmakers for well over a year. The politically and emotionally sensitive issue was brought to light after Congresswoman Debbie Wasserman-Schultz (D-FL) applied for a life insurance policy through an AIG company, and was turned down for coverage based on questions asked of her for underwriting purposes. This raised a firestorm that has rippled through Congress and some state legislatures, and has caused some state insurance commissioners to pursue regulation in their states.

As the Congresswoman tells it, the story is an interesting one. According to Wasserman-Schultz, the agent who was taking the application for her life insurance policy asked her about her past foreign travel, and then went on to ask her if she had any future travel plans, to which she replied no. Then the questions became more nebulous. The Congresswoman was asked about *possible* future travel to any foreign country. Wasserman-Schultz responded that if she were to travel, she would very much like to go to Israel. According to the company, the policy was denied based on future foreign travel plans, in this case because of the instability in Israel.

The Congresswoman saw the denial of her life insurance policy as one of veiled discrimination. As a Jewish-American, Wasserman-Schultz sees Americans traveling to Israel on a constant basis, and saw the denial of her policy as discrimination against those of Jewish descent who want to travel to Israel. With the backing of the Anti-Defamation League and other human rights organizations, the Congresswoman took her case to the Congress and to state regulators across the country.

Congresswoman Wasserman-Schultz found a sympathetic ear in her home-state Insurance Commissioner Kevin McCarty who also saw this practice by life insurance companies as unfair discrimination. McCarty became a leading

voice on the issue with national regulators and his home state legislators. He pursued enabling legislation by amending the Unfair Trade Practices Act in the Florida legislature (see Fla. Stat. § 626.9541(1)(dd)) and has now implemented new regulation 69O-125.003, F.A.C., that now governs the underwriting of life insurance policies for Florida citizens. These additional requirements on insurers were designed to protect those Floridians who travel lawfully, but will be considered by insurers doing business in Florida as unnecessary burdens.

The new regulation prohibits insurers from refusing to write coverage, limit the amount of coverage to an applicant, or determine the rates, based on the intent of the applicant to engage in *future lawful foreign travel or based upon past lawful foreign travel, unless the insurer can demonstrate the insureds who have traveled or intend to travel are a separate actuarially supportable class whose risk of loss is different from those insureds who have not traveled and do not intend to travel*. In addition, insurers are prohibited from using past lawful foreign travel as a sole determinant in underwriting a life insurance policy.

It is important to pay specific attention to the separate actuarially supportable class language of the regulation, because the new requirements in the regulation require an insurance company to do a filing with the Florida Department of Financial Services (Department) demonstrating this new class. Before any underwriting decisions can be made by an insurer using this travel information, an insurer must first get the approval of the Department. This is to make sure that analysis is detailed and meets the requirements of the law. There are several requirements the actuarial analysis has to meet before the Department will consider approval such as: details of the specific impact of the proposed risk; demonstration that risk exposures will be similarly treated; use of statistically credible data specific and relevant to the risk, and the disclosure of underwriting and rating options with supporting documentation, just to summarize a few.

Insurers have many more requirements in the regulation, and a few are important to note. Companies are required to collect and maintain data related to the underwriting of their policies. Those insurers are to report to the Department information related to all policy denials, non-renewals, cancellations or limitations on coverage. Insurers are required to track the reason for each case and prepare a brief summary and report that information to the Florida Department each calendar year.

The Department lays out penalties for insurers who violate the new rule. The Department can levy administrative penalties because of unfair discrimination laid out in Fla. Stat. § 626.9541(1)(g) and (dd), but can also order restitution to the policyholder, issue coverage that was previously denied, and pay any valid claim incurred subsequent to the initial application date, if the underwriting model that uses lawful foreign travel is not filed with the regulator.

The new Florida regulations will continue the debate between those who see regulating underwriting practices of insurers as unnecessary and those who see the use of lawful travel to foreign countries, especially those with religious distinctions as discriminatory practices by insurers. The fundamental questions that must be asked of insurers: Does travel to foreign countries pose a significant risk to mortality that can be quantified? Are certain countries riskier than others? Obviously countries at war or countries where significant military action is taking place may have more risk, but is the risk only to those actively engaged in the military, and not to civilians who are visiting less dangerous parts of the country?

Some would argue that visiting certain areas in our large cities could pose a larger mortality risk than visiting the quiet ranching areas of Israel. Thus the debate about the quantification of mortality in the underwriting practices. Floridas new regulations that require the collection of data about the policy denials, cancellations, or limitations of coverage could provide data that will either subdue the debate about whether this is a significant issue, or give regulators and civil rights groups the necessary ammunition to clamp down further on the underwriting practices of life insurance companies. As stated earlier, some companies will consider the new regulations burdensome, so much so that some may even stop using the underwriting practice entirely. This could be an unintended consequence that some will consider a victory in itself.

ABOUT THE AUTHOR(S):

Jim Poolman was elected North Dakota Insurance Commissioner in 2000, and overwhelmingly reelected in 2004. While Insurance Commissioner, he was an outspoken leader at the National Association of Insurance Commissioners, serving as their Vice-President, Chairman of the Midwestern Zone, Chairman of the Life Insurance and Annuities Committee, Executive Committee on Principles Based Reserving, Chairman of the Producer Licensing Working Group; amongst a host of other leadership posts. In North Dakota he was instrumental in preserving a competitive marketplace while passing very important consumer protections ranging in areas from privacy of consumers medical and financial information, suitability in annuity sales, restrictions on the use of claims information, insurance fraud and life settlements, amongst others. Mr. Poolman has been a sought after speaker on numerous insurance topics around the country. In August of 2007, Mr. Poolman resigned his post in North Dakota to start an independent regulatory consulting practice based in Bismarck, North Dakota. Mr. Poolman received his bachelors of Business Administration degree from the University of North Dakota in 1992. Mr. Poolman also served four terms in the North Dakota House of Representatives before being elected Insurance Commissioner.



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Godes on the State of NY Ins. Department Liquidation Bureau v. Generali Ins.

2008 Emerging Issues 1647

Scott N. Godes on the State of New York Insurance Department Liquidation Bureau v. Generali Insurance

By Scott N. Godes

December 19, 2007

SUMMARY: A recent New York Appellate Division decision is a breath of fresh air for policyholders. In *State of New York Insurance Department Liquidation Bureau v. Generali Insurance Co.*, the Appellate Division, First Department, found that insurance companies had to cover all shares of defense and settlement costs related to lead paint claims, and could not pro-rate the costs to the policyholder, even when there were significant periods of time in which the policyholder had no insurance.

PDF LINK: [Click Here for Enhanced PDF of Commentary](#)

ARTICLE: A recent New York Appellate Division decision is a breath of fresh air for policyholders. In *State of New York Insurance Department Liquidation Bureau v. Generali Insurance Co.*, 844 N.Y.S.2d 13; 2007 N.Y. App. Div. LEXIS 10659 (N.Y. App. Div. 2007) the Appellate Division, First Department, found that insurance companies had to cover all shares of defense and settlement costs related to lead paint claims, and could not pro-rate the costs to the policyholder, even when there were significant periods of time in which the policyholder had no insurance. This decision is critical, because it refuses to make policyholders cover shares of defense and settlement costs for periods where there is no insurance, and ensures that claims are paid in full when policyholders are defunct and therefore unavailable to pay claims.

The Underlying Lead Paint Claims. The underlying lead paint claims at issue alleged exposure to lead paint from 1982 through 1993. (Certain facts are based on the trial courts opinion, which contains additional details about the underlying facts. See *State of N.Y. Ins. Dept Liquidation Bureau v. Generali Ins. Co.*, No. 401446/2003, slip op. (N.Y. Sup. Ct. Apr. 4, 2006).) The policyholder owned the premises on which the alleged exposure occurred from 1988 through 1992. The policyholder was dissolved in 1994, but its insurance remained in place to resolve claims.

The Lack of Available Insurance. The policyholder bought insurance from the insurers who were party to this case Transtate Insurance Company (in liquidation, and represented by the New York State Liquidation Bureau) and Generali Insurance Co. Transtate had sold only 10.2 months of coverage for the property; Generali had sold only 5.5 months of coverage. There were 35 months that were uninsured.

The Insurers Could Not Discount Their Payments to Reflect Periods of When the Policyholder Had No Insurance. The Appellate Division rejected Generalis argument that, for purposes of paying defense and indemnity

costs, it should be obligated to pay based on a strict time-on-the-risk formula.

Generali proposed that the court create a fraction to determine the amount of loss it would cover. To create the fraction, Generali would take the entire period for which the policyholder was potentially responsible (*e.g.*, the period of the policyholders property ownership), and use that as the denominator in the fraction used to calculate payment. Here, Generali argued that there were 50.7 months of risk; using its proposed approach, Generalis share would be $x/50.7$. The numerator (x) would be the number of months that Generali had issued coverage. So, the full fraction would be $5.5/50.7$, meaning Generali would be responsible for approximately 10.8% of all defense and indemnity costs.

The court disagreed. First, the court found that the full amount of defense costs, without any discount for policy periods when the policyholder had no insurance, should be shared equally by the insurers. Just as significant, the dissenting opinion agreed with that formula for splitting defense costs equally. Accordingly, Generali was responsible for paying 50% of defense costs, rather than the 10.8% that it proposed.

Negotiation tip for coverage-in-place and claims handling agreements. Note that this is a great victory for policyholders, because the court refused to require policyholders to pay any defense costs, even in light of periods not covered by insurance. Therefore, when policyholders negotiate coverage-in-place or claims handling agreements, they should cite this case as supporting a refusal to be assigned shares of defense costs, without regard to uncovered periods.

Second, the court rejected Generalis proposed fraction for indemnity costs. It upheld the fraction employed by the trial court. Rather than using the entire period of time that the policyholder was on the risk as the denominator ($x/50.7$), the court used the number of months of available coverage ($x/15.7$). Thus, Generali was responsible for $5.5/15.7$, or 35% of all indemnity costs, rather than the 10.8% that it proposed. Transtate was responsible for the remaining $10.2/15.7$, or 65%, meaning the entire settlement was covered by the insurers, rather than assigning a portion to the policyholder (or, in effect, reducing the amount of the settlement money that the claimant could collect).

The court also found the formulas to be consistent with *Consolidated Edison Co. v. Allstate Insurance Co.*, 98 NY2d 208, 774 N.E.2d 687, 746 N.Y.S.2d 622 (2002) and *Serio v. Public Service Mutual Insurance Co.*, 304 AD2d 167, 168, 759 N.Y.S.2d 110 (2003), notwithstanding their holdings that costs should be allocated on a *pro rata* basis. The court distinguished those cases by explaining that, among other reasons, they did not involve settlements pertaining to risks extending over uninsured periods. The court noted that the *Consolidated Edison* decision explained that the use of time-on-the-risk proration in that case did not foreclose *pro rata* allocation among insurers by other methods and that this is not the last word on proration.

Import of the Decision. The decision should have great impact on policyholders who are negotiating with their insurers regarding any sort of payments defense or indemnity. Insurers, particularly when the applicable state law calls for *pro rata* allocation, take the position that the policyholder must pay portions of defense costs based on the fraction of time where the policyholder had not bought insurance. But this case establishes law in New York that the policyholder is not responsible for paying any defense or indemnity costs, without regard to the unavailability of coverage in certain years. Rather, the insurers must divide defense costs by equal shares, and indemnity costs by a fraction that looks to the number of months they were on the risk and that of existing insurance coverage in total.

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Scott N. Godes is an attorney in the Washington, DC office of Dickstein Shapiro LLP. Mr. Godes represents corporate policyholders in insurance coverage disputes. He is an experienced trial lawyer who has litigated complex insurance coverage disputes, including class actions, in state, federal, bankruptcy, and appellate courts, as well as in commercial arbitrations. Mr. Godes has a wide-ranging coverage practice, pursuing insurance in disputes relating to directors and officers claims for alleged securities violations; allegations of damaged computer data, hardware, and software; mass tort liabilities, including asbestos; environmental property damage; flood claims; allegations of improper

alcohol advertising; and class actions. Recently, Mr. Godes was lead counsel in *Continental Casualty Co. v. Employers Insurance Co. of Wausau*, a landmark case decided by the New York Supreme Court that ruled there are millions of dollars of coverage for thousands of asbestos claims, even after the insurers claimed to have paid their full aggregate limits of coverage. Mr. Godes received his B.A., cum laude, from Middlebury College, and his J.D., with honors, from the George Washington University Law School.



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Scott N. Godes on Bombar v. West American Insurance Company

2008 Emerging Issues 1648

Scott N. Godes on Bombar v. West American Insurance Company

By Scott N. Godes

December 19, 2007

SUMMARY: A recent Pennsylvania appellate decision is good news for policyholders. *Bombar v. West American Insurance Company* is a significant decision because it found that negligence and failure to warn claims do not fall within the completed operations hazard (or exclusion), even if the claims are against a company whose physical installation operations are complete. Not only is this decision favorable to companies facing bodily injury claims, but it is a terrific result specifically for former contractors facing asbestos claims the decision confirms that coverage without aggregate limits applies to their claims.

PDF LINK: [Click Here for Enhanced PDF of Commentary](#)

ARTICLE: A recent Pennsylvania appellate decision is good news for policyholders. *Bombar v. West American Insurance Company*, 932 A.2d 78, 2007 Pa. Super. LEXIS 2171 (Pa. Super. Ct. 2007) is a decision from Pennsylvania's Superior Court, on appeal from the Court of Common Pleas, which interpreted the products/completed operations hazard in a general liability policy. The court found that the insurance company could not rely on its products/completed operations hazard exclusion to deny coverage for a tort claim that resulted from the policyholders failure to install properly a backup alarm for a forklift, even though the bodily injury took place after the policyholder had finished physically installing the alarm and had sold and delivered it to the claimants employer.

This decision is critical for two reasons. First, it means that there is coverage under general liability policies for negligence and strict liability claims, even if the policies exclude coverage for claims falling within the products/completed operations hazard. Second, it means that for policyholders who face asbestos claims due to their former contracting operations, claims alleging negligence and strict liability are not subject to the aggregate limits for the completed operations hazard; they are subject only to per occurrence limits (without aggregates), found in premises/operations coverage.

The Tort Claim. The claimant in the underlying tort claim had her leg amputated after she was struck by a forklift that was driven in reverse without a backup warning alarm. The policyholder was the forklifts distributor. The policyholder had installed an aftermarket alarm to signal when the forklift was reversing, but the alarms wiring was installed in way that left wires hanging, and the wires were either disconnected by employees or were caught and ripped out while the forklift was moving. The claimant brought an action for strict liability and negligence, alleging that the faulty installation of the aftermarket alarm caused her injuries.

No Coverage for Claims Meeting the Products/Completed Operations Hazards Requirements. The policyholder had purchased a commercial general liability (CGL) policy that excluded coverage for claims meeting the products/completed operations hazard. The policyholder tendered the claim to its CGL insurer, but the insurer denied coverage, asserting that the products/completed operations hazard exclusion applied.

The policy defined the products/completed operations hazard as:

Products-completed operations hazard:

a. includes all bodily injury and property damage occurring away from premises you own or rent and arising out of your product or your work except

1. Products that are still in your physical possession; or

2. Work that has not yet been completed or abandoned. However, your work will be deemed completed at the earliest of the following times:

(a) When all of the work called for in your contract has been completed.

(b) When all of the work to be done at the job site has been completed if your contract calls for work at more than one job site.

(c) When that part of the work done at a job site has been put to its intended use by any person or organization other than another contractor or subcontractor working on the same project.

Work that may need service, maintenance, correction, repair or replacement but, which is otherwise complete, will be treated as completed.

Bombar, 932 A.2d at 87-88.

The Parties Contentions. The insurance company asserted that the claim met the requirements of the products/completed operations hazard, because the claimants bodily injury arose from the policyholders work, which was not in the policyholders physical possession, and had been completed at the time of the injury.

The claimant, standing in the shoes of the policyholder, asserted that the injury arose from the policyholders negligent failure to warn or provide instructions as to the backup alarm. She asserted that such claims are not within the products/completed operations hazard, and, therefore, not excluded from coverage.

The Courts Holding. The court explained that the thrust of the underlying claim rested upon negligence, including negligent failure to warn of defects in the alarm, and negligent installation, service, and maintenance of the alarm, among other counts. The court noted that at first glance, coverage may not exist, but, on further analysis, coverage was not excluded by the products/completed operations hazard.

The installation of the backup alarm by [the policyholder] was a service, but *it was not completed at the time the accident occurred because the installation was both faulty and negligent*, which the jury concluded gave rise to the complained of injury. 932 A.2d at 89 (emphasis added). Moreover, although the products/completed operations hazard purports to exclude claims alleging failure to warn after the installation was complete, *the warnings were not complete at the time the product was put to use*, because of the negligent failure to warn, and, therefore, the operation was not complete at the time of the accident or bodily injury. *Id.* Because the operation could not be complete, due to the failure to give proper warnings, the completed operations hazard could not apply.

Import of the Decision

Non-latent injury claims. The *Bombar* decision is critical in the context of straightforward strict liability tort claims for cases in which the policyholder had not purchased products/completed operations hazard coverage. Policyholder counsel should be aware of, and rely on, this case to refute insurers denials of coverage for product liability and negligence claims against policyholders who did not purchase, or already had exhausted their products/completed operations hazard coverage. Because the policyholders operations could not have been complete until the policyholder gave proper warnings regarding its product, the products/completed operations hazard cannot apply; policy exclusions for such coverage are irrelevant under *Bombar*.

Non-latent injury claims, including asbestos. The *Bombar* decision is even more critical in the context of asbestos claims against policyholders who face potential liability because they formerly installed, repaired, and/or removed asbestos products.

Under pre-1986 CGL policies, there were per occurrence or per accident limits of coverage, which applied to each asbestos claim, and there was no overall or general aggregate limit of liability, meaning the policy limit applied separately for each new accident or occurrence. *See, e.g., ACandS, Inc. v. Travelers Cas. & Sur. Co.*, 435 F.3d 252, 255--56 (3d Cir. 2006) (Alito, J.); *Natl Cas. Co. v. First State Ins. Group*, 430 F.3d 492, 494--95 (1st Cir. 2005). There were aggregate limits for the products and completed operations hazards, meaning a policyholder would exhaust this coverage after the aggregate limit had been paid, without regard to how many accidents or occurrences there were under the policy. *See, e.g., ACandS, Inc.*, 435 F.3d 252, 255--56. Not surprisingly, insurance companies historically assigned asbestos claims to the products hazard, so that the claims would be subject to an aggregate limit, and exhaust the policy.

But more recent case law confirms that asbestos claims, which are based on exposure to insulation contracting operations, do not fall within the products hazards of CGL policies; rather, they are covered by premises/operations coverage, which has no aggregate limit. *See, e.g., Contl Cas. Co. v. Employers Ins. Co.*, 839 N.Y.S.2d 403 (N.Y. Super. 2007). Insurance companies, desperate to find a way to make claims subject to an aggregate limit after their products hazard interpretation was rejected, began arguing that certain claims were subject to the completed operations hazard (which is subject to an aggregate limit). Many insurers have argued that even if the asbestos claims are based on exposure to contracting operations (which should be covered by premises/operations insurance), these claims later transform into completed operations claims, after the policyholder no longer is engaged in contracting operations. *See In re Wallace & Gale*, 385 F.3d 820 (4th Cir. 2004) (finding that claims due to exposure to ongoing contracting operations were not subject to the products or completed operations hazard, but became subject to the completed operations hazard during policy periods after the physical contracting operations had ended).

The *Bombar* decision rejects this recent insurance company position. Most, if not all, asbestos claims alleging exposure to asbestos released by insulation contractors assert the tort claims of negligence and failure to warn. *See, e.g., Commercial Union Ins. Co. v. Porter Hayden Co.*, 698 A.2d 1167, 1208 (Md. Ct. Spec. App. 1997). Under *Bombar*, such claims would not be subject to the completed operations hazard, because installation of [asbestos] was not completed at the time of the installation of the [asbestos] because of the negligent failure to warn, and, therefore, the operation was not completed. 932 A.2d at 89; *see also St. Paul Fire & Marine Ins. Co. v. A.P.I., Inc.*, No. C9-02-8084, slip op. at 19-20 (Minn. D. Ct. Sept. 27, 2005) (all asbestos claims . . . alleg[ing] . . . failure to warn or failure to instruct are not subject to the product hazard or the completed operations hazard). Because such claims are not subject to the products or completed operations hazard, they are subject to premises/operations coverage, which does not have an aggregate limit.

The difference between the types of coverage is critical. Because many policyholders face asbestos-related claims, billions of dollars in insurance coverage are at stake in how those claims are classified if the claims are premises/operations claims, not subject to aggregate limits, [t]he greater the number of occurrences, the larger [the insurers] liability to its insureds. *Travelers Cas. & Sur. Co. v. ACandS, Inc.*, No. 103059/03, slip op. at 2 (N.Y. Sup. Ct. July 18, 2003); *Natl Cas. Co. v. First State Ins. Group*, No. 04-10167-MLW, slip op. at 5 (D. Mass. Apr. 28, 2005), *affd*, 430 F.3d 492, (1st Cir. Dec. 2, 2005).

Practice tip for counsel representing policyholders facing asbestos claims. Make sure that the insurer is classifying claims properly. Under *Bombar* (and other cases, like *Continental Casualty*), asbestos claims due to alleged exposure to insulation contracting operations, such as installing pipe covering, or repairing insulation, or removing gaskets, are not subject to the products or completed operations hazards, whether coverage for those hazards was excluded or not.

If the insurers are either denying coverage (because the products/completed operations hazards were excluded from the policy, or have been exhausted), or simply eroding the aggregate limits for the products and completed operations hazards, cite *Bombar* to refute the insurers position. Keep in mind that a coverage action may be necessary. The proper coverage premises/operations for such claims likely is worth many times what it is worth for the products/completed operations hazards.

ABOUT THE AUTHOR(S):

Scott N. Godes is an attorney in the Washington, DC office of Dickstein Shapiro LLP. Mr. Godes represents corporate policyholders in insurance coverage disputes. He is an experienced trial lawyer who has litigated complex insurance coverage disputes, including class actions, in state, federal, bankruptcy, and appellate courts, as well as in commercial arbitrations. Mr. Godes has a wide-ranging coverage practice, pursuing insurance in disputes relating to directors and officers claims for alleged securities violations; allegations of damaged computer data, hardware, and software; mass tort liabilities, including asbestos; environmental property damage; flood claims; allegations of improper alcohol advertising; and class actions. Recently, Mr. Godes was lead counsel in *Continental Casualty Co. v. Employers Insurance Co. of Wausau*, a landmark case decided by the New York Supreme Court that ruled there are millions of dollars of coverage for thousands of asbestos claims, even after the insurers claimed to have paid their full aggregate limits of coverage. Mr. Godes received his B.A., cum laude, from Middlebury College, and his J.D., with honors, from the George Washington University Law School.



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Scott N. Godes on Continental Casualty Co. v. Employers Insurance Co. of Wausau

2008 Emerging Issues 1649

Scott N. Godes on Continental Casualty Co. v. Employers Insurance Co. of Wausau

By Scott N. Godes

December 19, 2007

SUMMARY: A recent New York Supreme Court case is a landmark decision in favor of policyholders facing asbestos and other latent injury claims. In *Continental Casualty Co. v. Employers Insurance Co. of Wausau*, Justice Richard Braun held that claims due to exposure to asbestos dust released during contracting operations are due premises/operations coverage (so-called non-products claims), and are not subject to the products hazard in comprehensive general liability insurance policies. This is significant because premises/operations coverage has no aggregate limit, unlike products/completed operations hazards under pre-1986 general liability policies, thus making multiple limits of coverage available for the asbestos claims at issue. Even though the insurance companies claimed that they had paid their full aggregate limits (more than \$100,000,000), Justice Braun held that there was coverage available for claims arising from exposure to dust released during contracting operations, and that coverage is not subject to aggregate limits. This commentary, written by Scott N. Godes, who was co-lead counsel in phase I of the *Continental Casualty Co.* case and represents policyholders in insurance coverage disputes, discusses the implications of this important decision.

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ARTICLE: A recent New York Supreme Court case is a landmark decision in favor of policyholders facing asbestos or other latent injury claims. In *Continental Casualty Co. v. Employers Insurance Co. of Wausau*, 839 N.Y.S.2d 403 (N.Y. Sup. Ct. 2007) (*Keasbey*), Justice Richard Braun held that claims due to exposure to asbestos dust released during contracting operations are due premises/operations coverage (so-called non-products claims), and are not subject to the products hazard in comprehensive general liability insurance policies. This is significant because premises/operations coverage has no aggregate limit, unlike products/completed operations hazards under pre-1986 general liability policies, making multiple limits of coverage available for the asbestos claims at issue. Even though the insurance companies claimed that they had paid their full aggregate limits (over \$100,000,000), Justice Braun held that there was coverage available for claims arising from exposure to dust released during contracting operations, and that coverage is not subject to aggregate limits. *Keasbey* confirms that significantly more insurance coverage is available for asbestos claims against insulation contractors that insurance companies have been willing to admit to their policyholders.

The Robert A. Keasbey Company. The Robert A. Keasbey Company (*Keasbey*) is a defunct insulation contractor that had installed, repaired, removed, and abated asbestos-containing insulation materials in the New York area, starting in the late 1800s and continuing for nearly a century. *Keasbey* also engaged in some straight sales of asbestos products

and mixed and relabeled asbestos cement products. Keasbey was dissolved by New Yorks Secretary of State in 2001.

Claims Against Keasbey. Over the past 20 years, Keasbey was sued in thousands of tort claims by claimants asserting that Keasbey caused their asbestos-related bodily injuries. Most claims settled, but some went to verdict. Even after it went out of business and was dissolved, claimants continued to sue Keasbey, and there were approximately 20,000 bodily injury claims pending against Keasbey at the time the *Keasbey* coverage case was litigated. Describing the types of tort claims against Keasbey, the court explained that claimants who have contracted asbestos-related diseases have sued defendant Keasbey seeking compensation due to alleged exposure to asbestos released [w]hen defendant Keasbey cut, sawed, mixed, and removed asbestos-containing materials as part of its insulation operations at various job sites. *Continental Casualty Co. v. Employers Insurance Co. of Wausau*, 839 N.Y.S.2d at 410. (N.Y. Sup. Ct. 2007).

CNAs Lawsuits Against Keasbey and a Defendant Class of Asbestos Claimants. Two of Keasbeys primary insurers (collectively, CNA) had continued to defend Keasbey against these tort claims, but in 2001, CNA filed a declaratory judgment action in New York state court against Keasbey and more than 100 individuals with claims pending against Keasbey, seeking a declaration that it owed no duty to defend or indemnify Keasbey for asbestos-related claims. CNA withdrew and refiled the action in 2003, as a defendant class action.

CNA alleged in its complaint that all of the pending asbestos-related claims fell within the products hazard, and, therefore, were subject to the aggregate policy limits, which, conveniently for CNA, were exhausted. CNA asserted that the argument that asbestos claims against an insulation contractor do not fall within the products hazard was a newly minted and meritless theory. Indeed, CNA and Wausau had treated all past claims against Keasbey as products hazard claims.

CNA also sued Employers Insurance Co. of Wausau (Wausau), which had sold Keasbey two primary policies, and One Beacon, which had sold a wrap up policy where Keasbey performed contracting operations.

The Parties Positions at Trial. The case was tried over a four-month period. The biggest issue at trial was whether all of the claims were subject to the products hazard. CNA, Wausau, and One Beacon asserted that all of the claims were subject to the products hazard. This was not surprising, because an aggregate limit of coverage applied to the products hazard, such that a single limit (here, \$10,700,000) applied to all claims, no matter how many claims were pending against Keasbey. The Defendant Class argued the opposite that every claim arising from exposure to insulation contracting operations was due premises/operations coverage, subject to a separate per occurrence limit (here, \$10,700,000 multiplied by the number of claims), and no aggregate limit applied. Under CNAs theory, because it and Wausau already had paid \$10,700,000 under their primary policies, there was no further coverage; under the Defendant Class theory, \$10,700,000 was available to cover each claim arising from exposure to contracting operations.

The Courts Holdings. Among other requests from CNA that the court rejected, Justice Braun denied CNAs request to apply the products hazard to all pending asbestos claims against Keasbey. Following the New York Court of Appeals holding in *Frontier Insulation Contractors, Inc. v. Merchants Mutual Insurance Co.*, 91 N.Y.2d 169 (1997), the court held that the products hazard applies to only certain asbestos claims those due to exposure to asbestos away from the policyholders premises, involving the policyholders product, and after the policyholder relinquished possession of

the product. *See Continental Casualty Co. v. Employers Insurance Co. of Wausau*, 839 N.Y.S.2d 403, 410--11 (N.Y. Sup. Ct. 2007).

Overall, the court held that the products hazard does not apply to asbestos claims arising from exposure to Keasbeys insulation contract operations, because Keasbey had not relinquished possession of the products at the time of the exposure. *See Continental Casualty Co. v. Employers Insurance Co. of Wausau*, 839 N.Y.S.2d 403, 411 (N.Y. Sup. Ct. 2007). Specifically, the court held:

Here, the claims by all of the claimants in the underlying actions were that they were injured away from the premises of defendant Keasbey. Plaintiffs [CNA] have not demonstrated that the injuries occurred after relinquishment of the asbestos products or after the operations were completed To the contrary, the evidence has shown that the injuries happened while the installation operations of defendant Keasbey were ongoing, which were covered under the operations coverage provisions of the subject insurance policies.

See Continental Casualty Co. v. Employers Insurance Co. of Wausau, 839 N.Y.S.2d 403, 411 (N.Y. Sup. Ct. 2007).

The court rejected all of the insurers arguments relating to the products hazard. As stated above, the court found that premises/operations coverage, not the products hazard, applies to claims based on exposure to dust released during contracting operations, rejecting the insurers arguments that all claims involving a product are subject to the products hazard. *See Continental Casualty Co. v. Employers Insurance Co. of Wausau*, 839 N.Y.S.2d 403, 411 (N.Y. Sup. Ct. 2007). . The court also rejected the argument that products were relinquished, for purposes of the products hazard, when products had been drop shipped to Keasbeys job sites. *See Continental Casualty Co. v. Employers Insurance Co. of Wausau*, 839 N.Y.S.2d 403, 411 (N.Y. Sup. Ct. 2007).

The Import of the Decision. The decision should have great impact on policyholders who face asbestos claim liability due to their insulation contracting operations. The courts refusal to apply the products or completed operations hazard, and the related aggregate limit, to claims based on exposure to contracting operations, means that numerous limits of coverage are available for such claims, rather than a single aggregate limit.

This holding is critical to policyholders facing asbestos, or other latent injury, liability due to alleged exposure to asbestos released during contracting operations or on the policyholders premises. Rather than just a single policy limit being available for such claims, numerous limits are available, restricted only by the number of accidents/occurrences at issue. Indeed, the court explained in *Keasbey*:

It is estimated by plaintiffs that approximately \$100,000,000 to \$250,000,000 is at issue in this action (or possibly even more).

See Continental Casualty Co. v. Employers Insurance Co. of Wausau, 839 N.Y.S.2d 403, 408 (N.Y. Sup. Ct. 2007).

Keasbey demonstrates that insurers cannot make blanket determinations that all asbestos claims are subject to the products hazard without regard to the policyholders past operations. Because many insurance companies have refused, and continue to refuse, to provide premises/operations coverage for asbestos claims against insulation contractors, *Keasbey* is a powerful decision to use to refute such determinations.

Policyholders facing such liability should ensure that their coverage is not being eroded wrongly because claims are assigned to the products/completed operations hazards. *Keasbey* makes clear that it is improper to assign claims due to exposure to contracting operations to products/completed operations hazard coverage, without regard to how the insurer treated the claims in the past.

ABOUT THE AUTHOR(S):

Scott N. Godes is an attorney in the Washington, DC office of Dickstein Shapiro LLP. Mr. Godes represents corporate policyholders in insurance coverage disputes. He is an experienced trial lawyer who has litigated complex insurance coverage disputes, including class actions, in state, federal, bankruptcy, and appellate courts, as well as in commercial arbitrations. Mr. Godes has a wide-ranging coverage practice, pursuing insurance in disputes relating to directors and officers claims for alleged securities violations; allegations of damaged computer data, hardware, and software; mass tort liabilities, including asbestos; environmental property damage; flood claims; allegations of improper alcohol advertising; and class actions. Recently, Mr. Godes was lead counsel in *Continental Casualty Co. v. Employers Insurance Co. of Wausau*, a landmark case decided by the New York Supreme Court that ruled there are millions of dollars of coverage for thousands of asbestos claims, even after the insurers claimed to have paid their full aggregate limits of coverage. Mr. Godes received his B.A., cum laude, from Middlebury College, and his J.D., with honors, from the George Washington University Law School.



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Kohane: Duty to Cooperate Under a Liability Insurance Policy A 3-Step Approach

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Kohane: Duty to Cooperate Under a Liability Insurance Policy A 3-Step Approach

By Dan D. Kohane

December 19, 2007

SUMMARY: Every policy of liability insurance establishes a duty on the part of the insured to cooperate with its insurer. Cooperation is essential to aid in the insurer's desire to provide a proper defense. What happen if the insured fails to assist in the defense on the case or otherwise materially and adversely impacts on the insurer's attempts to defend? What are the standards for establishing a breach of the duty to cooperate under a liability policy? Who has the burden of proof and how heavy is it? In *State Farm Mutual Automobile Insurance Company v. Campbell*, the Appellate Division of the State Supreme Court, Third Department, reminded carriers and counsel alike of the standards under which a liability insurance company can declare an insured in breach of an insurance policy's condition of cooperation. Dan Kohane discusses the cooperation obligation and the recent Appellate Division decision reviewing the protocols for establishing a breach.

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ARTICLE: What is the Duty to Cooperate. In *State Farm Mutual Automobile Insurance Company v. Campbell* ___ AD3d ___. 2007 NY Slip Op 8238; 845 N.Y.S.2d 88; 2007 N.Y. App. Div. LEXIS 11117 (3rd Dept. 10/30/07), the Appellate Division of the State Supreme Court, Third Department, reminded carriers and counsel alike of the standards under which a liability insurance company can declare an insured in breach of an insurance policys condition of cooperation. New York State law allots the burden the proof to the insurer in establishing a breach of the cooperation clause, and it is a heavy burden indeed.

An insured under a liability policy has an obligation to cooperate with its insurer, whether that insured be named, additional or otherwise. Every commercial general liability, auto, homeowners, directors & officers and errors & omissions policy, and all others as well, establish contractual conditions requiring insureds to assist the carrier in the defense of litigation. Attorneys representing insureds under liability policies, whether appointed by the insurer or retained directly by the insured, need to understand the duty, as well as its breadth and scope. Likewise, it is critical to understand the burden placed upon carriers to establish a breach of that duty

An Overview of the Duty to Cooperate. Failure, on the part of an insured, to cooperate may have dire consequences on the continued availability of liability coverage, and can leave an otherwise covered claim uninsured. Insurance companies count on the continued involvement of their insureds in many aspects of the claim and litigation process. Insureds are charged with providing notice of accidents, occurrences, claims and lawsuits, and correspondingly

responsible for assisting the insurer in investigation, gathering and preserving evidence, participating in depositions and in appearing and testifying at trial.

As early as 1928, Judge Cardozo, in *Coleman v. New Amsterdam Cas. Co.* (247 NY 271, 274-276 [1928]), outlined the importance of the duty imposed on an insured to cooperate:

Co-operation does not mean that the assured is to combine with the insurer to present a sham defense. Co-operation does mean that there shall be a fair and frank disclosure of information reasonably demanded by the insurer to enable it to determine whether there is a genuine defense. The attitude of this assured was one of willful and avowed obstruction. It did not deny that it was in a position to give information, material and instructive, in aid of an investigation of the grounds of liability

The default of the assured was more than sluggishness or indifference, phases of thought and conduct that might be the subject of varying inferences when considered by a jury. It was so avowed and purposed that but one inference is possible. If this was cooperation, one is at a loss to imagine when co-operation could be lacking.

Under New York State Insurance Law § 3420(c), if an insurer alleges in defense of a claim against it for coverage that that the insured failed or refused to cooperate with the insurer in violation of any provision in the policy or contract requiring such cooperation, the burden shall be upon the insurer to prove such alleged failure or refusal to cooperate.

The cooperation clause is a multi-purpose provision. It has as its goal the assurance that the carrier is able to properly defend the lawsuit. Moreover, it is the mechanism by which a carrier is able to secure testimonial and documentary evidence from its insured in order to be able to put on a solid defense. It is also the clause that requires the insured to attend depositions, search records, produce documents and attend trials. In addition, it is designed to prevent collusion between plaintiffs counsel and the insured to make certain that the insured is not conspiring with others to have an unwitting insurer make payments that it need not or should not make.

The practitioner should understand that the cooperation clause attempts to make as certain as possible that insurer has a good handle on the facts and circumstances of the loss. In addition, the clause charges the insured with a duty not to misrepresent facts, or to change his, her or its story, so as to make the defense of the case more troublesome. It is also the tool insurance carriers rely upon to secure the assistance of their insureds in the prosecution of the subrogation effort, in third party practice or cross claims, in order to make certain that rights of contribution and indemnity can be enforced.

The clause also reminds that the insured should not make voluntary payments that can prejudice the rights of the insurer. An insured is obligated, as part of its cooperation responsibilities, to contribute its time to the defense of the lawsuit. The insured may be entitled to be reimbursed for out-of-pocket expenses, but not for the loss of earnings incurred by cooperation.

How is the Duty Breached? In the *State Farm Mutual Insurance Company v. Campbell* opinion, the court reminds us that while it is the insured who is charged with breaching a duty of cooperation, it is often the conduct of the insurer, in seeking that cooperation, that becomes the focus of the courts attention. An insured may not respond to letters and telephone calls sent by the insurer or defense counsel for any number of reasons. Perhaps the insured is no longer receiving mail or calls at the locations previously identified. The insured may not understand the communications received. He or she may be too infirmed or disabled to respond. It may be that the insured does not understand the importance of the contacts or the identity of the correspondent.

Accordingly, the courts focus on the attempts by the insurer to secure the insureds cooperation; and the counseling point is that the focus on the practitioners investigation should be the same. The standards set forth in the decision emanate from Judge Cardozos decision in *Coleman, supra* and from the 1967 decision from the Court of Appeals in *Thrasher v. United States Liability Ins. Co.*, 19 N.Y.2d 159, 168-169 and relying upon *Matter of Eagle Ins. Co. v Sanchez*, 23 AD3d 655; *Matter of Continental Ins. Co. v Bautz*, 29 AD3d 989, 990; *City of New York v Continental Cas.*

Co., 27 AD3d 28 and *State Farm Fire & Cas. Co. v Imeri*, 182 AD2d 683).

First of all, the insurer needs to demonstrate that the insured has by action or inaction materially hampered the insurers ability to properly defend the case. If so, there is then a three point test to evaluate the insurers conduct:

1. Did the insurer act diligently to bring about the insured's co-operation,
2. Were the efforts employed by the insurer were reasonably calculated to obtain the insured's co-operation and
3. Was the attitude of the insured, after his co-operation was sought, one of "willful and avowed obstruction."

In the *State Farm* case, the carrier failed to failed to establish that it was sufficiently diligent or that its efforts were reasonably calculated to bring about its insured's cooperation. In support of its conclusion, the court cited to *Rucaj v Progressive Ins. Co.*, (19 AD3d 270 [1st Dept. 2005]).

The *Rucaj* case provides an excellent backdrop to analyze the quality of the efforts made by the insurer to secure cooperation. In *Rujac*, the claims specialist employed by the liability insurer submitted an affidavit indicating that he contacted the insured by cell phone and asked him to send him information about proof of residence (which was never received). The claim representative then conducted a skip trace, and learned that the insured lived in both New York and Virginia. Eight months went by and the insurer did nothing to contact the insured until it learned that a default judgment had been entered. Only then did the insurer try to re-contact the insured by telephone. No attempt was made to send an investigator to the insureds Virginia residence on his mothers home in the Bronx, and no attempts were made to contact him at his place of employment.

The court, in *Racaj* found the undertaking by the carrier insufficient. It follows that the court found no proof that the insured willfully failed to thwart the insurer's attempt to investigate. The fact that the insured was aware of the lawsuit and did nothing was insufficient to establish a failure on the part of the insured to cooperate.

The message from these cases is clear: non-action by an insured is insufficient to establish willful and avowed obstruction." Without proof that the carrier met the three point *Thrasher* test, a lack of cooperation cannot be established to demonstrate a lack of coverage under the policy.

ABOUT THE AUTHOR(S):

Dan D. Kohane is a senior partner in the Buffalo, New York law firm of Hurwitz & Fine, P.C. and an adjunct Professor of Insurance Law at the Buffalo Law School. Mr. Kohane provides insurance coverage counsel and practices through the State of New York. He received his B.A., *magna cum laude*, from State University of New York at New Paltz in 1975 and his J.D. from the Buffalo Law School in 1979. He lectures widely on insurance coverage issues through the United States, Canada and Europe and has often been retained as an expert witness on matters relating to insurance coverage. Immediate Past President and currently Board Chair of the highly-selective Federation of Defense & Corporate Counsel, Mr. Kohane also serves on the Board of Directors of the DRI and the Lawyers for Civil Justice. He is admitted to practice in the State of New York, the Second Circuit Court of Appeals and the United States District Courts of the Southern, Western, Eastern and Northern Districts of New York. Mr. Kohane is the editor and publisher of *Coverage Pointers*, a bi-weekly electronic insurance newsletter and has recently completed a co-authoring a chapter which will be published in *Applemans New Insurance Law Practice Guide*.



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Cope on Ryan v. Gifford

2008 Emerging Issues 1585

Cope on Ryan v. Gifford

By Carrie Cope

December 17, 2007

SUMMARY: Until now, the only substantive stock options backdating decisions have addressed motions to dismiss based on demand futility. This left open a key question: how would courts react to discovery disputes in the backdating context? In the first decision to tackle these questions, the influential Chancellor Chandler of the Delaware Court of Chancery has ruled that a company's internal investigation is discoverable because the special committee conducting the investigation waived the attorney-client privilege.

PDF LINK: [Click Here for Enhanced PDF of Commentary](#)

ARTICLE:

Over the last year, the insurance industry has been coping with the fallout of the stock options backdating scandal. As is now well known, it appears that for many years directors and officers of corporations from across the business spectrum engaged in the backdating of executive stock option grants. Essentially, these individuals retrospectively chose grant dates of their stock options, picking dates at which the stock price was lower than the date of the grant. This resulted in an instant paper profit to the recipients of the grant. After the scandal broke, derivative lawsuits were filed against scores of companies directors and officers alleging breaches of fiduciary duty, fraud, and related counts. Although backdating is not in itself illegal so long as the backdated grants are properly expensed, the defendants in backdating cases allegedly backdated options for their own benefit without following the proper accounting procedures.

In many cases, in order to proceed with a valid derivative claim, a plaintiff must plead that making a pre-suit demand on the board would have been futile because the board was interested in the subject matter and thus incapable of exercising its independent business judgment. In the last year, numerous courts have issued substantive opinions addressing the issue of demand futility in the context of backdating cases. One of the most important early decisions was *Ryan v. Gifford*, 918 A.2d 341 (Del. Ch. February 6, 2007) (the *Maxim* decision), where the influential Chancellor Chandler permitted a complaint to survive dismissal based largely on the plaintiffs allegations that statistically calculated returns on purportedly secretly backdated grants made to executives far outstripped the return to the company's investors, thus suggesting backdating. As such backdating is considered fraudulent, the Chancellor found that it was an act of bad faith on Maxims shareholders and thus a violation of the defendants fiduciary duties. In the wake of the *Maxim* decision, many California federal court decisions used it as a benchmark in dismissing several derivative cases, ostensibly because the cases at bar were distinguishable from the *Maxim* decision, most frequently because they

did not contain a statistical analysis of the returns on the allegedly backdated grants. More recently, however, plaintiffs attorneys appear to have synthesized the lessons from *Maxim* and the California federal court decisions and have amended their complaints accordingly. This frequently entails vastly expanded statistical analysis of the sort seen in the *Maxim* case but not included in many of the complaints initially filed. As a result, it now appears likely that many backdating cases will survive motions to dismiss based on demand futility and will enter the discovery phase of litigation.

Last month, Chancellor Chandler issued an opinion addressing various discovery disputes in the *Maxim* case. This is the first decision from the Delaware Court of Chancery on this issue, and like the original *Ryan v. Gifford* decision, will likely have widespread influence over courts addressing discovery conflicts in the backdating context.

In *Ryan v. Gifford*, Case No. 2213-CC (Del. Ch. November 30, 2007), the plaintiffs filed numerous motions to compel after the defendants failed to produce various documents. Interestingly, one of the successful motions asked that the defendants be required to produce computer records in their original file format, with metadata intact. As the Chancellor noted, the metadata is particularly important where the integrity of dates entered on documents was in dispute. The most important of these motions, however, concerned a production request by the plaintiffs asking for all communications that occurred between the special committee (appointed by Maxims board to investigate its historical options granting process) and the special committees attorneys, as well as communications between Maxim and the special committees attorneys. Specifically, the plaintiffs sought discovery concerning the communications between the attorneys and the special committee throughout the special committees investigation and the attorneys presentation of their final report to the special committee and Maxims board.

In addition to the traditional attorney-client privilege between the special committee and its attorneys, Maxim opposed the request to produce communications between the company and the special committees attorneys. According to Maxim, because the special committee was formed at its direction in direct response to the litigation challenging its grants, the special committee and Maxim shared a joint privilege. The Chancellor was unconvinced, holding that the joint defense privilege did not apply because the plaintiffs showing of good cause vitiated it. The Chancellor emphasized that the information sought by the plaintiffs was unavailable from any other source. The Chancellor found that even if a joint privilege existed, it was rendered irrelevant by his critical conclusion that the special committee had waived the attorney-client privilege it enjoyed with its attorneys. Over a two-day period, the special committee presented its final oral report to Maxims board. In addition to the special committee and its attorneys, the members of the board and attorneys from another law firm were present. The Chancellor ruled that the presentation of the report constituted a waiver of the attorney-client privilege because the client, the special committee, disclosed its communications concerning the investigation and final report to third parties the individual director defendants and the second law firm whose interests were not common with the client. This precluded the application of the common interest exception to protect disclosed communications. Indeed, because the special committee was formed to investigate wrongdoing and in response to litigation in which certain directors were named as defendants, the Chancellor noted that the relationship between the special committee and the individual director defendants was more akin to an adversarial relationship. Significantly, although the plaintiffs demonstrated waiver only with respect to the reports presentation, the Chancellor held that this partial waiver operated as a complete waiver for *all* communications regarding the subject matter of the report.

The potential impact of the Chancellors decision is difficult to underestimate. The standard procedure for many companies implicated in the stock options backdating scandal has been to create a special committee to investigate the companys historical options granting process. These special committees retain their own, independent attorneys to assist with the investigation. At the conclusion of the investigation, the special committee reports to the board regarding its findings. While the special committees general findings are often made public, the specific evidence they rely upon to reach those findings remains confidential and has not been accessible by derivative plaintiffs. Although much of the underlying evidence would likely be discoverable from other sources, the plaintiffs will now be able to examine how the special committees and their attorneys scrutinized and interpreted the evidence. In addition, there is always the possibility that the special committees may have uncovered evidence that would not have otherwise been revealed

during discovery.

The Chancellors decision will be particularly distressing for companies who have directors, named as defendants, still sitting on their boards, who were present when the special committee presented its finding to the board. This could potentially have the impact of providing plaintiffs with full access to all materials gathered by special committees and their attorneys during discovery. n2 With this decision, derivative plaintiffs have won an alarming and unanticipated victory, one whose implications are likely to impact many similar backdating cases in the future.

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n1 The Chancellors rulings on the plaintiffs other motions were not insignificant. In addition, the defendants were required to create a privilege log for all documents relating to the termination of two of Maxims executives that had not been produced on grounds of privilege; the Chancellor is to review the log and the documents and will compel production of any documents he finds are not privileged. The defendants were also ordered to produce a CD or DVD of their production previously made to the SEC.

n2 The Chancellor did reaffirm that any notes made by attorneys during witness interviews could be work product, but he also ordered the special committees attorneys to provide him with copies of all such notes, and he stated that he would disclose them if he found that they did not include counsels thoughts, impressions, opinions, or conclusions or redacted versions if possible.

ABOUT THE AUTHOR(S):

Carrie Cope is a partner in the Chicago office of Tressler, Soderstrom, Maloney & Priess, LLP where she specializes in insurance law and has two synchronized practice areas of insurance regulation and specialty lines claim handling. In her regulatory practice, she represents insurers, agents, brokers, reinsurers, reinsurance intermediaries, alternative risk insurance groups and third party administrators on a wide variety of regulatory and compliance issues. She also has over fifteen years of experience in providing specialty lines claim handling and coverage consulting services to the insurance industry. Her coverage practice is primarily concentrated in the areas of directors and officers liability, professional liability, miscellaneous errors and omissions insurance and employment practices liability. She is a member of the Professional Liability Underwriting Society and she recently authored a chapter which will be published in *New Appleman Insurance Law Practice Guide*.



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Cope on Requiring D&O Insurers to have the Duty of Defense under their Policies

2008 Emerging Issues 1586

Cope on Requiring D&O Insurers to have the Duty of Defense under their Policies

By Carrie Cope

December 17, 2007

SUMMARY: Will the New York Insurance Department require D&O insurers to have the duty of defense under insurance policies issued to public companies? The New York Insurance Department is currently taking that position based on the New York legislatures failure earlier this year to pass legislation that would have explicitly exempted D&O policies from that requirement. This startling position conflicts with New York case law as well as the D&O insurance industrys longstanding practice. The decision effectively limits the rights of sophisticated insureds to defend themselves and would have an overall chilling effect on the D&O industry given that it applies to both admitted companies and insurers doing business in New Yorks Free Trade Zone.

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ARTICLE: For many years the New York Insurance Department has permitted directors and officers liability insurers to issue insurance policies in which the insured has the duty of defense even though it required insurers issuing other types of liability insurance policies, such as automobile liability insurers, to defend their insureds. Earlier this year, the New York legislature failed to pass legislation that would have explicitly addressed the defense obligation under directors and officers liability policies by exempting them from the requirement that the insurer have the duty to defend the insureds. The proposed legislation amended N.Y. Ins. Law § 3420 by including language permitting the Department, via regulations promulgated by the superintendent, to authorize coverage on an indemnification basis with respect to directors and officers liability insurance policies or liability insurance policies insuring large commercial risks. Although the legislation did not pass, a position by the Department that the insurer must have the duty of defense under directors and officers liability policies would contravene New York law and not meet the needs of the archetypal insured purchasing directors and officers liability insurance. This is a significant issue as the requirement applies not only to insurers issuing policies in New York on admitted paper, but those writing insurance in the Free Trade Zone as well.

It is true that the proposed regulation would have *explicitly* excluded D&O policies from the requirement mandating that the insurer have the defense obligation. More significantly, however, the legislation would have statutorily required that all liability policies contain a duty to defend. As no such requirement is currently mandated by statute, it is counterintuitive to conclude that the requirement should be enforced, while the exception is no longer allowed.

In addition, a decision by the Department mandating that insurers have the duty of defense under D&O policies would conflict with New York case law, which explicitly acknowledges that an insured may have the duty to defend under a D&O Policy. In *National Union Fire Ins. Co. of Pittsburgh v. Ambassador Group Inc.*, 157 A.D.2d 293, 299 (1990), the court examined a D&O policy stating, the policy herein, as is the case with most directors and officers liability policies [emphasis added], does not impose an obligation to provide a defense, but only reimburse expenses incurred in the defense. See also *Amrep Corp. v. American Home Assurance Co.*, 81 A.D.2d 325, 440 N.Y.S.2d 244 (1981); *Gon v. First State Insurance*, 871 F.2d 863 (1989); *Federal Ins. Co. v. Kozlowski*, 18 A.D.3d 33, 35 (2005).

Moreover, other materials issued by the New York Insurance Department continue to support the Departments historical position permitting insureds to have the duty of defense under D&O insurance policies. For example, General Counsel Opinion 12-14-99 (#2), which interprets, in relevant part, N.Y. Ins. Law § 3420, acknowledges that the Department has approved D&O policy filings in which the insurer does not have the duty of defense.

Finally, a decision by the Department requiring D&O insurers to provide a duty of defense under their policies would not address the needs of the typical insured purchasing a D&O policy. D&O insurance policies are commonly purchased by corporations to address the risks inherent in their business activities. They may also be purchased by directors who sit on corporate boards. It is not unusual for the scope of coverage to be heavily negotiated and corporations often employ risk managers who are experienced in such negotiations. Given the sophistication of the typical insured, it is not surprising that they want to control the defense of any claims and thus, do not want the insurer to have the duty of defense under the policy. In high stakes litigation, the insureds invariably want to use counsel familiar with their business and with whom they are comfortable. They also want to control the defense strategy which is typically the right of the party having the duty of defense under the policy. This is such a pivotal issue that a decision by the Department that takes away the insureds right to defend themselves may encourage insureds to seek the desired coverage outside the State of New York, thus, potentially having a chilling effect upon the D&O insurance industry in New York.

Conclusion: A decision by the New York Insurance Department requiring D&O insurers to have the duty of defense under their policies is inconsistent with New York law and would unilaterally impose constraints on an established marketplace which has successfully met the needs of insureds for several decades.

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SEC Investigations: An Increasing Risk Leading to Unanticipated Coverage?

2008 Emerging Issues 1587

Cope on SEC Investigations: An Increasing Risk Leading to Unanticipated Coverage?

By Carrie Cope

December 17, 2007

SUMMARY: What happens when D&O policies do not expressly afford coverage for investigations by the Securities and Exchange Commission and other types of actions such as letters of inquiry? This is currently a pivotal issue given that SEC investigations have dramatically increased in recent years. However, only a few courts have addressed the issue directly.

PDF LINK: [Click Here for Enhanced PDF of Commentary](#)

ARTICLE: Over the last few years, investigations by the Securities and Exchange Commission (SEC) into the activities of corporations and their directors and officers has continued to increase, from 2,926 pending investigations in 2003 to 4,146 pending investigations in 2006. While SEC investigations often result in formal judicial proceedings, they also involve other actions such as letters of inquiry, subpoenas and orders of investigation that do not progress much past the information-gathering stage. As the number of investigations continues to rise and the need to respond to SEC inquiries generate, in many cases, substantial defense or investigation costs, it is not surprising that corporations and their directors and officers are increasingly turning to their D&O insurance policies seeking coverage for those costs. In the wake of the rising tide of SEC investigations, one issue that is becoming of vital interest to insureds is whether some types of activities by the SEC constitute covered claims under their D&O policies. While lawsuits historically have constituted claims under D&O policies, other types of actions, such as a letters of inquiry, generally have not fallen within the claim definition. Although some of the newer policy forms on the market specifically define the term claim to include specific SEC actions, many existing policies were drafted when such coverage was not contemplated by insurers in drafting their policies, nor sought by insureds in purchasing their policies. The result is that insureds and their insurers sometimes end up battling over whether the policy's definition of claim was intended to encompass the costs incurred in defending some types of SEC activities.

Very few courts have addressed this issue directly. Among them, *Pepsico, Inc. v. Continental Casualty Co.*, 640 F.Supp. 656 (S.D.N.Y. 1986), involved several class actions filed against the insureds alleging fraud taken on the market for falsifying financial statements. The court does not provide much detail in its opinion analyzing coverage for costs incurred in the SEC investigations, but briefly states, because the litigation and the investigations were each directed at the same allegedly fraudulent activity, and directed against both PepsiCo and its directors and officers, it would seem that these defense costs are covered loss within the policy. The court's opinion on this issue is of limited value because it does not specifically evaluate the policy language potentially encompassing coverage for SEC investigations, but

addresses the issue only in very broad terms.

However, other courts have evaluated whether coverage is available for SEC investigations and other actions by considering whether specific actions taken by the SEC constitute a proceeding under the applicable policy and/or whether such proceeding subjects the insured to a binding adjudication of liability, or more generally, whether relief is sought from the insured. The policy in *Foster v. Summit Medical Systems, Inc.*, 610 N.W.2d 350 (Minn.App. 2000), defined Securities Action Claim as any judicial or administrative proceeding initiated against any of the directors and officers or the company in which they may be subjected to a binding adjudication or other relief... The SEC issued a subpoena duces tecum to the insured. The parties agreed that the subpoena was an administrative proceeding under the policy but disputed whether it was a proceeding in which the respondent may be subjected to a binding adjudication for relief. The court specifically defined relief as equitable redress or specific performance, and concluded that the SEC's ability to compel production of documents did not fit any reasonable reading of the term relief. Consequently, the SEC investigation was not a Securities Action Claim under the policy.

Two unpublished opinions out of California and Illinois also addressed the issue. While neither opinion holds precedential value, they provide some guidance as to how courts may address coverage for some types of SEC actions. In *JB Oxford Holdings, Inc. v. Certain Underwriters at Lloyds, London*, 2001 Cal.App.Unpub. LEXIS 111, the policy in question defined securities action claim to be any loss resulting from any judicial or administrative proceeding... in which they may be subjected to a binding adjudication of liability or other relief. The court noted that the SEC distinguishes between adjudicative proceedings and investigations because parties to adjudicative proceedings are given certain rights, while parties to investigations are not given the same rights. The court held that since the issuance of an SEC subpoena could not itself result in a potentially covered binding adjudication of liability or other relief, there was no possibility of coverage for costs incurred in connection with the subpoena.

In *Minuteman International v. Great American Insurance Co.*, 03-C-6067 (N.D. Ill. 2004), the policy's definition of Claim included a civil, criminal, administrative or arbitration proceeding made against any Insured seeking monetary or non-monetary relief and Securities Claim included any Claim (including a civil lawsuit or criminal proceeding brought by the Securities and Exchange Commission) The SEC issued an Order Directing Private Investigation and Designating Officers to Take Testimony, a subpoena, and a cease-and-desist order. In analyzing coverage for costs incurred during the SEC proceeding, the court focused on whether an SEC subpoena could be construed as a proceeding in which relief was sought, noting that under the policy, the definition of Claim applied to Securities Claim. The parties agreed that the SEC's activities were a proceeding. The court concluded that a demand for relief was broad enough to include a demand for something due, including a demand for document production or testimony. The court reasoned that if the insured did not comply with the subpoena, such relief would be sought through the courts, and concluded that the insured's cost of complying with the SEC subpoena demand was covered under the policy.

A New York court, in *Home Ins. Co. of Illinois v. Spectrum Info.*, 930 F. Supp. 825, 837 (E.D.N.Y. 1996), specifically addressed the scope of the SEC's definition of proceeding in the insurance policy context in a case where an insured did not disclose an SEC investigation on its application for coverage. The insurer argued that the term proceeding encompassed informal investigations based on definitions in Black's Law Dictionary and Webster's Dictionary. The court found that the meaning of the term with which an applicant is most likely familiar is the definition that should be used, that the insured had good reason to believe the inquiry in question was not a proceeding and that the word proceeding suggests something more than an informal inquiry.

Conclusion: In considering whether an insurance policy provides coverage for SEC investigations policy language, of course, is pivotal. However, many policies do not contain language specifically addressing coverage for SEC investigations or other types of actions. Given the increasing risk of incurring costs in conjunction with SEC investigations, the best strategy for insurers and their insureds is to address the issue up front, in the negotiation of the policy or upon renewal. Insureds may want to ensure that their policy's definition of claim specifically encompasses a full array of SEC actions, recognizing that their insurers will have a right to charge a premium for the additional coverage.

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n1 <http://www.sec.gov/about/secstats2007.pdf>; <http://www.sec.gov/about/secpar/secpar04stats.pdf>.

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Cope on Shielding Insurers From Bad Faith in Settlement Negotiations

2008 Emerging Issues 1588

Cope on Shielding Insurers From Bad Faith in Settlement Negotiations

By Carrie Cope

December 17, 2007

SUMMARY: Is a White Waiver necessary for settlement discussions taking place prior to the mediation of California claims? A White Waiver protects an insurer against allegations from insured that a settlement offer was made in bad faith. California legislation enacted subsequent to the court opinion, out of which the White Waiver arose, appears to obviate the need to for a White Waiver for settlement negotiations during mediation but courts have not yet addressed how far that protection extends.

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ARTICLE: An insurers obligation to handle claims in good faith is of paramount importance. n1 Given that the stakes can be high in an action for bad faith, even the most well-intentioned insurer must consider taking steps to insulate itself from potential liability in the often-multifaceted context of settlement negotiations. As California courts have held that an insurers good faith obligation does not end even after the commencement of litigation against it, n2 the insurer must fulfill its obligation to its insured while at the same time asserting its right to protect itself. An agreement called a White Waiver can protect an insurer from liability arising from allegations that it failed to fulfill its duty of good faith and fair dealing in settlement negotiations.

The term White Waiver originated after *White v. Western Title Insurance Co.*, the seminal California Supreme Court case addressing an insurers liability for failure to negotiate a settlement in good faith. In *White*, the court found the admission of settlement negotiations between the insured and its insurer was not barred from evidence when introduced to show the insurers bad faith in a subsequent action. Since the *White* ruling, it is increasingly common for insureds to assert that an insurers actions during litigation constitute bad faith conduct. To protect against admission of such evidence, counsel for insurers now commonly draft White Waivers prior to settlement negotiations involving claims subject to California law. Essentially, parties entering settlement negotiations agree, in writing, that all communications related to settlement discussions shall be considered confidential and not admissible as evidence in any proceeding for any purpose.

Subsequent to the *White* case, the California legislature enacted legislation that, in relevant part, addressed the confidentiality of settlement negotiations during mediation. n3 California Evidence Code § 1119 provides that:

(a) No evidence of anything said or any admission made for the purpose of, in the course of, or pursuant to, a

mediation is admissible or subject to discovery, and disclosure of the evidence shall not be compelled, in any proceeding in which, pursuant to law, testimony can be compelled to be given.

(b) No writing prepared for the purpose of, in the course of, or pursuant to, a mediation is admissible or subject to discovery, and disclosure of the writing shall not be compelled, in any proceeding in which, pursuant to law, testimony can be compelled to be given.

(c) All communications, negotiations, or settlement discussions by and between participants in the course of mediation or a mediation consultation shall remain confidential.

Given the plain language of California Evidence Code § 1119, and the legislative intent encouraging the promotion of candid communications between parties without fear that information disclosed in mediation will be used against them, n4 the scope of the Statutes would seem to obviate the need for a White Waiver with respect to settlement negotiations occurring during the mediation process. In fact, there is virtually an absolute bar n5 to admissibility of mediation discussions, reports, testimony or findings by any participant in the mediation in a subsequent proceeding. n6 Even communications that have taken place outside the confines of the mediation itself, such as emails sent prior to the mediation, have also been protected under the *Evidence Code* § 1119. n7 Consequently, it is not surprising that no California case has specifically addressed the need for a White Waiver in the mediation context.

Notwithstanding the language of California Evidence Code §§ 1115--1128 and the legislative intent behind it, one case came close to testing the limits of the Code in a manner that might have addressed the use of a White Waiver in a mediation setting, but the case was voluntarily dismissed before the issue was decided. *Epstein v. Superior Court*, 2d Civ. No. B 169884. n8

Practice Tip. Although the broad scope of California Evidence Code §§ 1115--1128 seems to foreclose the need for a White Waiver during mediation, prudent insurers should consider requesting that insureds execute a White Waiver for any settlement communications arguably outside the mediation context or the purview of the above referenced Code sections.

Practice Tip. The White Waiver addresses issues arising under California state law and does not apply in Federal Court. In Federal Court, under *Federal Rule of Evidence 408*, evidence of settlement negotiations may not be used to prove bad faith. n9 When drafting a White Waiver, the practitioner should consider including language confirming that the agreement is consistent with the California and Federal Evidence Codes.

Conclusion. The White Waiver can be an effective tool for protecting insurers against allegations of bad faith arising from settlement negotiations in situations where other protections, such as state and federal evidentiary laws, may not apply.

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n1 . *Fletcher v. Western National Life Ins. Co.*, 10 Cal.App.3d 376, 401 (1970), citing *Crisci v. Security Ins. Co.*, 66 Cal.2d 425, 429 (1967).

n2

[2]. *White v. Western Title Insurance Co.*, 40 Cal.3d 870, 885 (1985).

n3

[3]. California Evidence Code, §§ 1115--1128.

n4

[4]. California *Code Civ. Proc.*, § 1775, subd. (c)., *Foxgate Homeowners' Association v. Bramalea*, 26 Cal.4th 1, 14 (2001).

n5

[5]. The limited exceptions to mediation confidentiality include 1) written agreement of the parties allowing for admissibility; 2) where inadmissibility would interfere with the constitutional right of a criminal defendant; and 3) where inadmissibility would interfere with the right to rebut a settlement agreement resulting from mediation that is legally unenforceable, See Douglas K. deVries, Special Considerations for Settling and Mediating the Insurance Bad Faith Case, www.califinsurancelaw.com (April 2007).

n6

[6]. *Foxgate*, 26 Cal.4th at 4. See also, *Paul v. Friedman*, 95 Cal.App.4th 853, 869 (2002); *Rojas v. Superior Court*, 102 Cal.App.4th 1062 (2002); *Eisendrath v. Superior Ct. of Los Angeles*, 109 Cal.App.4th 351 (2003); *Fair v. Bakhtiari*, 121 Cal.App.4th 1286 (2004); *Fair v. Bakhtiari*, 122 Cal.App.4th 1457 (2004); *Travelers Casualty & Surety v. Superior Court*, 126 Cal.App.4th 1131 (2005); *Fair v. Bakhtiari*, 40 Cal.4th 189 (2006); *Wimsatt v. Superior Court*, 152 Cal.App.4th 137 (2007).

n7

[7]. *Wimsatt*, 152 Cal.App.4th at 159.

n8

[8]. Jeff Kichaven, Insurance Bad Faith and Mediation Confidentiality: Critical Policies on a Collision Course, www.IRMI.com (March 2004).

n9

[9]. *Clemco Industries v. Commercial Union Ins. Co.*, 665 F. Supp.816, 829 (N.D. Cal. 1987).

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Gerber & Delaney: August Entertainment, Inc. v. Philadelphia Indemn. Ins. Co.

2008 Emerging Issues 1589

Gerber & Delaney: August Entertainment, Inc. v. Philadelphia Indemn. Ins. Co.

By Daniel W. Gerber and Sarah J. Delaney

December 17, 2007

SUMMARY: Most corporations, via their directors and officers, conduct the majority of their business through contracts and contractual relationships. Corporations should be aware: courts have held the contractual liability exclusion in directors and officers policies broadly, limiting coverage for a large portion of the directors and officers responsibilities.

PDF LINK: [Click Here for Enhanced PDF of Commentary](#)

ARTICLE: There are no standard industry-wide directors and officers coverage forms, nonetheless the contractual liability exclusion is a common exclusion in directors and officers coverage. Recently, courts have broadly construed the exclusion, and applied it to any claim remotely relating to a contract. This presents a problem for the insured because most of the transactions taking by directors and officers involve a contractual responsibility of some sort. Thus, in practical terms, the exclusion could swallow the coverage, and the insured and practitioner should be aware of the potential implications.

August Entertainment, Inc. v. Philadelphia Indemn. Ins. Co., 146 Cal.App.4th 565 (Cal. Ct. App. January 7, 2007), provides a tidy discussion of the exclusion and its application to both officers and corporations. It involves a contract relating to distribution rights for certain films owned by August Entertainment. The insured, InternetStudios, had entered the contract via one of its officers, a Robert Maclean. Following the execution of the contract, InternetStudios attempted to escape the deal because it became clear that InternetStudios was unable to actually acquire all of August's distribution rights, as originally believed when the agreement was entered into. It asserted that there was no agreement. Naturally, August took the opposite tact, and insisted that a binding agreement existed.

August and InternetStudios later agreed that Mr. Maclean was acting as an officer of InternetStudios, and on behalf of InternetStudios, but retained separate liability because he failed to advise August he was signing in that capacity, and the letterhead he used did not indicate that InternetStudios was a corporation. It was then agreed that judgment would be entered against Maclean, and his rights under the D&O policy would be assigned to August.

InternetStudios maintained a Directors and Officers policy with Philadelphia Indemnity Insurance Company. As with nearly all D&O policies, the Philadelphia policy provided coverage for the individual directors and officers liability, as well as for the company itself. With regard to coverage for Maclean's liability, August asserted that Maclean

was liable as an individual because, by signing the agreement on behalf of InternetStudios without the proper formalities, he became individually, but not personally, liable.

Although there is no contractual liability exclusion in Side A coverage (applying to the directors and officers personal liability), there is apparently still no coverage for breach of contract claims under that coverage according to *August*. The court held that there was no coverage for Maclean because: (1) an officer acting in an official capacity cannot be liable for a breach of corporate contract; and (2) an officer who is liable is excluded from coverage because he or she was not acting as an official. Thus, an officer could never breach a contract within the meaning of D&O coverage.

With regard to coverage for the company itself, the court held that a contract loss was not a loss created by a wrongful act; rather to allow such coverage would make the insurer an unwitting investor in the deal, noting that some courts hold that breaches of contract are not covered, even in the absence of an exclusion. Just because the contract may have been entered into negligently, it did not create coverage for obligations that were not actual losses. But the court did not go so far as to hold that breaches of contract were uninsurable *per se*. Rather, We do not suggest that officers who make seemingly minor scrivener errors must face financial ruin. Broader coverage may be available.

In the short time since *August Entertainment* was decided a number of other courts have addressed the issue. In *S.J. Amoroso Construction Co., Inc. v. Executive Risk Indemnity, Inc.*, (N.D.Ca October 30, 2007) (unpublished), the president of the insured, Amoroso, made representations regarding an assignment of liability relating to a construction contract. Amoroso was not actually a party to the contract in question. Amoroso eventually denied that the president was authorized to make the representations in question.

Ultimately, a lawsuit was brought alleging defects in the construction, and the insured sought coverage under their D&O policy. The D&O carrier disclaimed, and the insured sued asserting that the breach of contract exclusion only applies if the insured is a party to the contract. As an initial note the court, citing *August, supra*, found that there was no coverage for the named insured because it had disavowed the acts of its officer. In other words, because the insured disclaimed responsibility for the actionable statements, the statements were not made by an insured, and therefore no coverage was available to the insured. The insured apparently disavowed its way out of coverage in that regard.

With regard to the contract exclusion, the insureds negligence could not be independent from the contract because, even though the insured was not a signatory to the contract, it would have not had the opportunity to be negligent in its absence, citing *Spartas Company v. Federal Ins. Co.*, 481 F.Supp.2d 993 (E.D.Mo. March 7, 2007). The court also cited the public policy concern that allowing coverage for breach of contract claims would encourage insureds to breach contracts with impunity. In *Spartas* the claims against the insured and its officers were for conversion and unjust enrichment, clearly not contractual duties. The relationship to the party making those claims was contractual, however, and therefore it did not matter that the causes of action would exist unless the insured had entered into a contract.

In *Verticalnet, Inc. v. U.S. Specialty Ins. Co.*, 492 F.Supp.2d 452 (E.D.Pa. May 21, 2007), the insured corporation agreed to merge with another. Following the merger, the corporation was to issue new share certificates, and change the file registration statement with the state. It failed to do either, and a lawsuit resulted. The court held that although the failures were part of standard corporate duties, they arose due to the merger documents, and therefore were contractual. Although the policy did not contain a contractual exclusion, and therefore were not excluded, if such exclusion had existed, the court would have found it to apply. Thus, the formation and reconstitution of a corporation is contractual, and any missteps along the way do not result in loss *per se*, even if there is a palpable devaluation of the corporation. The existence and broad application of the contractual exclusion is tricky from both the perspective of the insured and the perspective of the insurer. Most corporations do most of their business through contracts. See *GE HFS Holdings, Inc. v. National Union Fire Ins. Co. of Pittsburgh, PA*, ____ F.Supp.2d ____, 2007 U.S. Dist. LEXIS 78769 (D. Mass. September 5, 2007).

As demonstrated by the above cases, contractual relations come in many forms, and result in many variant claims.

Therefore, the contractual liability exclusion, applied broadly, could eliminate coverage in many, if not all instances, which lends itself to the argument that directors and officers coverage is illusory for companies that deal mostly with contracts. But that is apparently not the case: the *GE HFS, supra*, court held that arising out of was to be read expansively, and that if a policy still provided coverage for some acts, an exclusion was not void simply because of a potentially wide exclusion.

Directors and Officers Coverage is most often procured to protect both directors and officers, as well as the corporation, from the missteps and potentially wrongful actions of the officers. The lesson to be learned from these cases is that coverage is often more restricted than anticipated, and coverage for many of a corporations activities is excluded. Yet, despite the apparent breadth of the exclusion, amount of resulting litigations is relatively small.

In-house counsel and insureds should be aware of the potential limitations of the exclusions, and the emerging number of instances where the insurer seeks to apply it. Indeed, as there are no standard D&O policy forms, it would be ideal if a corporation could negotiate a policy without the exclusion. In practical terms, arguably the insurer would still not be liable for the amounts directly related to a standard breach of contract because it would not be strictly a loss. *See August, supra*.

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Daniel W. Gerber is a partner of Goldberg Segalla LLP in New York. He maintains an international practice in commercial litigation with a focus on complex insurance coverage disputes and analysis, including reinsurance and excess insurance, as well as mediation and arbitration. He chairs his firms Life, Health, Disability and ERISA practice group and manages its Insurance Coverage practice group. He is an author for the renowned Insurance Treatise, New Appleman's Insurance Law Practice Guide, as well as Mealeys Emerging Insurance Disputes. Mr. Gerber is admitted to the United States Supreme Court, as well as all federal and state courts in New York and Pennsylvania. He argues regularly before the New York Court of Appeals and the U.S. Second Circuit Court of Appeals arguing the seminal case in New York on late notice in insurance law. He has received the Chairperson of the Year Award for his work as Chair of the Insurance Coverage Committee for the New York State Bar Associations Torts, Insurance and Compensation Law Section, and will chair the almost 3,500 member Torts, Insurance and Compensation Law Section in 2008. Mr. Gerber is also an active member of the Association of Life Insurance Counsel, the International Claims Association and the International Association of Defense Counsel, as well as the American Bar Associations Life, Health and Disability Committees. Mr. Gerber possesses an AV rating from Martindale Hubbell, a Super Lawyer designation from Law & Politics Magazine, and has been named consecutively by his peers to Business First's Who's Who in Law.

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Gerber and Bryan Richmond on Whether All Additional Insured Coverage is Primary

2008 Emerging Issues 1591

Gerber and Bryan Richmond on Whether All Additional Insured Coverage is Primary

By Daniel W. Gerber and Bryan D. Richmond

December 17, 2007

SUMMARY: Since the New York Court of Appeals decision in *Pecker Iron Works* and the First Departments decision in *BP Air-Conditioning*, arguments have been made from co-insurers in New York that an insureds coverage as an additional insured is always primary to any coverage as a named insured. However, due to the Court of Appeals recent decision in *BP Air-Conditioning*, practitioners and insurers should be weary of extending such an argument since any determination regarding priority of coverage requires a careful comparison of the policies other insurance clauses. Put simply, the policies other insurance clauses matter.

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ARTICLE: A current debate in New York has been whether other insurance clauses in contracts of insurance have any effect when a party is named as additional insured. In other words, is all additional insurance primary? Since the Court of Appeals decision in *Pecker Ironworks of New York, Inc. v. Travelers Insurance Company*, 99 N.Y.2d 391 (2003) and, more recently, the First Departments decision in *BP Air-Conditioning Corp. v. One Beacon Insurance Group*, 33 A.D.3d 116 (1st Dept. 2006), arguments have been made from co-insurers in New York that an insureds coverage as an additional insured is always primary to any coverage as a named insured, regardless of whether the other insurance clause purports to provide excess coverage only. The Court of Appeals recent decision in *BP Air-Conditioning Corp. v. One Beacon Insurance Group* should put an end to this debate.

Pecker Iron Works of New York, Inc. v. Travelers Ins. Co. In 2003, New Yorks highest court rendered a decision in *Pecker Iron Works of New York, Inc. v. Travelers Ins. Co.* that has had a significant impact on the insurance and indemnification obligations a subcontractor and/or its insurer have in New York litigation. 99 N.Y.2d 391 (2003). In that case, the Court of Appeals determined that implicit in an obligors contractual obligation to procure liability coverage naming the obligee as an additional insured was the premise that the coverage for the additional insured under the obligors liability policy would be primary and noncontributory, even where the contract between the parties did not expressly state that such coverage would be or should be primary.

However, the Court of Appeals in *Pecker Iron Works* did not address the issue of priority of coverage between insurers. The *Pecker Iron Works* court simply examined whether *Pecker Iron Works* was entitled to primary or excess coverage from *Travelers* based upon the specific additional insured endorsement at issue. Once the court found that *Pecker Iron Works* was entitled to primary coverage from *Travelers*, it was not asked to consider the relationship

between Travelers and the other insurers policies. In other words, the court did not consider whether Travelers policy was the sole primary coverage or co-primary with the other insurer.

BP Air Conditioning Corp. First Departments Decision. The First Departments holding in *BP Air Conditioning Corp. v One Beacon Insurance Group*, 33 A.D.3d 116 (1st Dept. 2006) contains similar facts and appeared to base its holding on *Pecker Iron Works*. The lower court had granted BPs motion for summary judgment to the extent that One Beacon is obligated to provide a defense in the underlying action. It refused to declare that One Beacon was primarily responsible for BPs defense costs since no other policies were submitted on the motion and it could not ascertain whether some other carrier should be treated as co-insurer or excess insurer to One Beacon without comparison of the policy language.

In modifying the lower courts decision, the First Department Appellate Division in *BP Air Conditioning*, extended *Pecker Iron Works* by finding that between an insureds coverage as an additional insured, and its coverage as a named insured, the additional insured coverage is always sole primary, without comparison of the language used in the policies. To support its conclusion that the insurer affording additional insured coverage was the sole primary coverage, the *BP Air Conditioning* court relied exclusively on the following quote from the Court of Appeals decision in *Pecker Iron Works*:

When Pecker engaged Upfront as a subcontractor and in writing provided that Upfront would name Pecker as an additional insured, Pecker signified, and Upfront agreed, that Upfronts carrier--not Peckers would provide Pecker with primary coverage on the risk.

In its decision, however, the First Department apparently extended *Pecker Iron Works* beyond its intended reach by ignoring the circumstances of that case and setting aside the long-held and well-recognized tenet that insurance agreements, and not underlying subcontracts, govern priority disputes among insurers.

BP Air Conditioning Corp. Court of Appeals Decision. In the Court of Appeals recent decision, New Yorks highest court addressed this issue and clarified its holding in *Pecker Iron Works*. In its decision, the Court of Appeals first addresses whether an insurers duty to defend an additional insured is triggered by the allegations in the underlying Complaint or must await some judicial determination as to whether the loss occurred as a result of the work. Relying on a number of its previous holdings, the Court held that an insurers duty to defend is exceedingly broad and an insurer will be called upon to provide a defense whenever the allegations of the complaint suggest a reasonable possibility of coverage. Holding that One Beacon was obligated to provide coverage, the Court noted

A duty to defend is triggered by the allegations contained in the underlying complaint. The inquiry is whether the allegations fall within the risk of loss undertaken by the insured and it is immaterial that the complaint against the insured asserts additional claims which fall outside the policys general coverage or within its exclusionary provisions. The merits of the complaint are irrelevant and, an insureds right to be accorded legal representation is a contractual right and consideration upon which a persons premium is in part predicated, and this right exists even if debatable theories are alleged in the pleading against the insured. An insureds right to representation and the insurers correlative duty to defend suits, however groundless, false or fraudulent, are in a sense litigation insurance expressly provided by the insurance contract.

Turning to the issue of priority, the Court stated in the first paragraph of its decision that it was unable to answer a second question regarding priority of coverage since the relevant parties and policies at issue are not before us. In addressing the issue later in the decision, however, the Court nonetheless held that the First Department erred in finding that One Beacons additional insured coverage is primary and BPs coverage under its own policy is excess. Modifying the Appellate Divisions order by reinstating the Supreme Courts decision, the Court of Appeals held

In order to determine the priority of coverage among different policies, a court must review and consider all of the relevant policies at issue. Here, Supreme Court correctly concluded that because none of the other insurance carriers are

parties to this declaratory judgment action and no other relevant policies have been submitted, the priority of coverage cannot be determined.

Other Insurance Clauses Matter. Practitioners and insurers should learn from this case that additional insured coverage can not be deemed sole primary without a comparison of the other insurance clauses contained in the policies. Practically stated, other insurance clauses matter. The Court of Appeals decision in *BP Air Conditioning* should eliminate arguments stemming from the First Departments conclusion that *Pecker Iron Works* stood for the proposition that additional insured coverage is always sole primary without regard to the language utilized in the policies at issue. By concluding that the issue of priority cannot be judicially determined without a comparison of the policies, the Court of Appeals implicitly held that additional insured coverage is not always sole primary. Although the Court of Appeals did not expressly state that additional insured coverage is not always sole primary in its decision, practitioners and insurers should be weary of extending an argument based upon the *Pecker Iron Works* decision that coverage to an additional insured is primary without a careful comparison and analysis of the policies other insurance clauses.

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Gerber on New York Insurance Dept. Liquidation Bureau v. Generali Insurance Co.

2008 Emerging Issues 1592

Gerber on New York Insurance Dept. Liquidation Bureau v. Generali Insurance Co.

By Daniel W. Gerber and Kimberly E. Whistler

December 17, 2007

SUMMARY: One of the fundamental principles recognized in New York regarding insurance coverage is that the duty to defend is greater than the duty to indemnify. The First Department recently expanded this already broad rule by holding insurers, who may have only provided coverage for a small percentage of time, will ultimately be found to cover years the insured did not otherwise have insurance. Moreover, the insured may avoid contributing to defense costs for years it was uninsured.

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ARTICLE: Any litigation that involves multiple occurrences over a span of many years, such as cases of lead paint or asbestos exposure, potentially triggering multiple insurance policies, will undoubtedly run into issues relating to costs to be borne by the insurers. Not only will issues arise with respect to priority of coverage, but the appropriate pro-ration of costs and, if the insured did not have insurance for a period of time, what costs the insured should incur. To only further murky the waters, costs associated with the defense versus indemnification will likely have to be examined separately.

Until recently, the state courts of New York have avoided constructing a steadfast rule to follow in determining the sharing of defense costs when the insured was either self-insured or underinsured for periods that would have triggered other policies of insurance. The First Department in *State of New York Liquidation Bureau v. Generali Insurance Company*, 44 A.D.3d 469, 844 N.Y.S.2d 13 (1st Dept. 2007) (*Generali*), however, recently issued a decision that could shape sharing of costs in these cases, which often are often costly in both time and money.

The State of New York Insurance Department, Liquidation Bureau (Liquidation Bureau), in place of the defunct Transtate, sought contribution for defense and settlement costs incurred in an underlying personal injury action, stemmed from alleged exposure to lead. Generali Insurance Company (Generali) moved for summary judgment and the Liquidation Bureau cross-moved. The lower courts decision was affirmed by the First Department in finding the Liquidation Bureau was entitled to half of the defense costs from Generali and that the two insurers should bear the entire amount of the settlement, including years the insured was uninsured.

The owner of the property at issue was Rosan Realty Corporation. Rosan was insured by Generali for approximately five and a half months and Transtate Insurance for a little over ten months during which time the plaintiff was exposed. Rosan was uninsured for approximately thirty-five months. Generali had initially disclaimed any

obligation to defend and indemnify Rosan. The Liquidation Bureau in turn defended the action and negotiated a settlement for \$600,000. The Liquidation Bureau then sought contribution from Generali for defense costs and the settlement.

In determining the amount of contribution, the lower court applied the Liquidation Bureau's formula of the ratio of the time on the risk to the entire time the property was insured. This analysis required Generali to contribute over \$200,000 to the settlement. The lower court rejected Generali's argument that the ratio of the time on the risk should be equated to the total time Rosan owned the property (including uninsured periods), which would have required Generali to only contribute \$65,000. Generali appealed this decision.

On appeal, Generali sought reversal of the lower court's decision on both defense costs and allocation of the settlement. In support of its contention that the court erred in its allocation of indemnity, Generali cited *Consolidated Edison Co. of New York v. Allstate*, 98 NY2d 208 (2002) and *Serio v. Public Serv. Mut. Ins. Co.*, 304 AD2d 167 (2003). Generali asserted it should only be responsible for its actual time on the risk. Generali argued that these cases limited its exposure to the time it actually insured Rosan and that it should only contribute based upon the entire time Rosan owned the property.

With respect to attorney's fees, Generali argued that the fees were easily apportioned and, therefore, should be allocated according to the time on the risk. Generali noted that the insured corporation was in existence for fourteen months after the initiation of the suit and argued that Transtate had ample opportunity to seek contribution from the insured. Generali further contended that the insured chose to forego obtaining insurance and should endure any resulting consequences. See *U.S. Fidelity & Guar. Co. v. Treadwell*, 58 F.Supp.2d 77 (S.D.N.Y. 1999).

The Liquidation Bureau distinguished the case law relied upon by Generali by noting that *Serio* dealt with a continuous exposure scenario, whereas the instant issue was how to deal with periods of no insurance coverage. Because the court in *Serio* did not address the issue of pro-rata for uninsured years, to a defunct company nonetheless, the Liquidation Bureau argues it is inapplicable. Moreover, it characterizes the actions of Generali as a gamble and stated that Generali was trying to limit its exposure having lost its bet. Considerable reference was made to Generali's failure to defend the insured and participate in the lawsuit, and it was implied that requiring Generali to contribute a significant share was equitable.

With respect to legal fees, the Liquidation Bureau referenced the long-standing principle of an insurer's overarching duty to defend its insured. The Liquidation Bureau rejected the argument that it could look to the insured for contribution to legal fees. Initially, the insured was not a party to the action, and therefore, the court had no authority to require anything of the insured. The brief noted that there was no case law discussing pro-rata to the insured affecting the right of contribution of one insurer against another, where one failed to pay any defense or settlement costs in similar circumstances. The Liquidation Bureau argued that in the absence of contrary case law, the court should look to the established principle that where a complaint pleads a covered occurrence within the scope of the policy, then the duty to defend against the entire complaint is triggered.

In a 3-2 decision, the First Department initially addressed allocation of the defense costs between Generali and Transtate/Liquidation Bureau. The court rejected Generali's contention that defense costs should be allocated according to its "time on the risk." Instead, the court upheld the lower court's determination that defense costs should be divided equally. Having affirmed this portion of the lower court's decision, the First Department turned its attention to the allocation of the settlement costs.

As stated, Generali argued its indemnification obligations should be determined based on its true time on the risk. See *Consolidated Edison*, *supra*, and see *Serio*, *supra*. The court rejected the applicability of these cases stating that the cases did not involve settlements pertaining to risks extending over uninsured periods. The First Department noted that the Court of Appeals decision in *Consolidated Edison* left open pro rata allocations by "other methods" and stated,

Under the particular circumstances presented, in which the plaintiff, in the face of Generali's unjustified refusal to honor its obligation, bore nearly the entire costs of defending and settling the underlying claim against the defunct insured, covering lengthy periods for which there was no applicable coverage, the proration formula employed by the motion court was manifestly fair and should stand. *See State of New York Liquidation Bureau, supra*.

In the end, the First Department's majority completely rejected the arguments made by Generali. Although not explicitly stated, it is arguable that the decision weighed so heavily in favor of the Liquidation Bureau, in part, because of Generali's refusal to defend the insured and/or otherwise participate in the action. The court seemed to suggest, that Generali gambled and lost and, therefore, could not seek to limit its exposure after the underlying case was resolved.

The dissent by two judges rejected Generali's argument as inequitable. Again, the court relied heavily on the fact that Generali had initially disclaimed coverage allowing the Liquidation Bureau to absorb all of the costs. Contrarily, the dissenters agreed with Generali's reliance on *Consolidated Edison* and *Serio, supra*. Recognizing those cases did not involve settlements including uninsured years and that this was a case of first impression in state courts, the dissent focused on the federal court decisions in *Stonewall Ins. Co. v. Asbestos Claims Mgmt*, 73 F3d 1178 (2d Cir. 1995) and *US Fidelity & Guaranty Co. v. Treadwell Crop, supra*.

The dissent found Generali's argument that the determination to be uninsured was a conscious one and should therefore provide that its own liability is limited to its actual time on the risk persuasive. Moreover, the judges rejected the Liquidation Bureau's argument that contribution can no longer be obtained from the insured because it was no longer a viable entity based on the fact the insured was viable for fourteen months after the declaratory judgment was commenced. As such, the Liquidation Bureau had an opportunity to seek contribution.

Practice Tip. While this case will likely be heard by the New York Court of Appeals, there are several potential trouble points raised in this case that a practitioner must consider. First and foremost, a practitioner must assess whether its case should be commenced in federal court or if, for defense counsel, whether it should be removed to federal court. If coverage litigation was pursued in federal court, the decision in *Stonewall, supra*, may be far more favorable to a client in Generali's position, than if in state court.

Further, the judiciary appeared to be in agreement that Generali should bear a greater apportionment of defense costs as a result of initial disclaimer of coverage. If nothing else, this decision reemphasizes that a practitioner or an insurer should proceed with caution before denying coverage. The court was obviously less sympathetic to Generali's position in light of the fact it failed to initially provide coverage, minimally for its insured defense costs. It is uncertain whether this case could have been decided differently if Generali initially provided coverage.

It should further be considered what implications this case has to an insurer when issuing a policy? Should an insurer have to look at the overall history of the insured's coverage and reconsider if there is a span of years where the insured was self-insured or uninsured? From this decision, this must be answered in the affirmative. The court seemed to ignore the fact that the insured may have made a conscious decision to forego coverage and made the insured's gamble a successful one.

If the dissent's position is taken, an insurer seeking contribution from other insurers or the insured should do so immediately. Manufacturers who face repeated litigation may be forced to consider bankruptcy, liquidation or dissolving their company. If the incidents happened during years there was no insurance coverage, the remaining insurers will likely be the parties who absorb the remaining costs. Otherwise, claimants may be left with no remedy. The dissent considered the fact the insured was a viable company at the time of the settlement. The Liquidation Bureau was, therefore, penalized for not seeking contribution from the insured prior to it becoming a defunct corporation.

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Shidlofsky on Subrogation & the Made Whole Doctrine: Fortis Benefits v. Cantu

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Shidlofsky on Subrogation & the Made Whole Doctrine: Fortis Benefits v. Cantu

By Lee H. Shidlofsky

December 17, 2007

SUMMARY: Across the nation, in many jurisdictions, insureds have relied upon what is known as the made whole doctrine, wherein an insurer is not entitled to subrogation from its insured unless the insured has been fully compensated for its losses. Recently, however, the Supreme Court of Texas, in *Fortis Benefits v. Cantu*, 234 S.W.3d 642 (Tex. 2007), upended the traditional balance finding that an insurers contractual right to subrogation prevailed over the equitable made whole doctrine.

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ARTICLE: A Medical Insurance Policy Opens the Door for Texas to Address the Made Whole Doctrine

Vanessa Cantu (Cantu) was seriously injured in an automobile accident in which she was not at fault. Fortis Benefits (Fortis), as her insurer, provided Cantu with benefits under her personal medical insurance policy. Later, Cantu filed a lawsuit against the driver of the car in which she was riding at the time of the accident, the drivers employer, the seller of the vehicle, and Ford Motor Company--the manufacturer of the vehicle. Fortis intervened and asserted it was entitled to equitable subrogation and reimbursement from any tort recovery in the amount of medical benefits paid under its policy. During a pre-trial conference, Fortis agreed with all the parties that it would be excused from the proceedings and would look only to Cantu during the post-verdict phase in order to resolve its claims.

Prior to trial, Cantu settled with the defendants for \$1.445 million. Thereafter, Cantu and Fortis disagreed as to the amount of the settlement, if any, that should be paid to Fortis. Thus, Cantu moved for summary judgment claiming that she had not been made whole by the settlement. Cantu contended that her past and future medical expenses (not to mention amounts for pain and suffering and the like) exceeded the settlement amount plus the amount paid to her by Fortis. Thus, Cantu argued, the made whole doctrine precluded Fortiss contractual claims of subrogation and reimbursement. The trial court granted Cantus motion for summary judgment and a divided court of appeals affirmed. [See *Fortis Benefits v. Cantu*, 170 S.W.3d 755 (Tex. App.--Waco 2006, pet. granted).] The Supreme Court, however, reversed and remanded the case to the trial court for further proceedings.

The History of the Made Whole Doctrine from Texas Point of View. The Supreme Court of Texas first

recognized the made whole doctrine in *Ortiz v. Great Southern Fire & Casualty Insurance Co.*, 597 S.W.2d 342 (Tex. 1980). The Court, in *Ortiz*, reversed a lower courts decision and held that [a]n insurer is not entitled to subrogation if the insureds loss is in excess of the amounts recovered from the insurer and the third party causing the loss. The *Fortis* Court explained that in deciding *Ortiz* it recognized that equity cuts both ways depending on the facts of a situation. Thus, just as equity requires prevention of an insured from obtaining a double recovery--first from the insurer and then from the tortfeasor--equity also means that if either the insured or insurer must recover less than its losses, then the insurer must take the loss as the insured paid the insurer to assume that risk. In other words, the insured must be made whole before the insurer. Many jurisdictions agree with this principle. [See, e.g., *Wasko v. Manella*, 849 A.2d 777 (Conn. 2004); *Ruckel v. Gassner*, 646 N.W.2d 11 (Wis. 2002); *Kral v. Am. Hardware Mut. Ins. Co.*, 784 P.2d 759 (Colo. 1989).]

The Supreme Court of Texas made clear that had *Fortis* sought equitable subrogation, then *Ortiz* would have been controlling case law. Because *Fortis* sought contractual rights of subrogation and reimbursement, however, the made whole doctrine did not apply. The Court discussed a Fifth Circuit opinion, as well as an El Paso Court of Appeals decision upon which the Fifth Circuit had relied. [See *Oss v. United Servs. Automobile Assn*, 807 F.2d 457 (5th Cir. 1987); *Means v. United Fid. Life Ins. Co.*, 550 S.W.2d 302 (Tex. Civ. App.--El Paso 1977, writ refd n.r.e.).] In *Oss*, the Fifth Circuit held that, in Texas, the same principles govern both equitable and contractual subrogation, and thus the made whole doctrine applied. Nevertheless, in *Fortis*, the Supreme Court rejected those decisions because *Oss* relied on *Means*, which was issued against a legal landscape that did not yet include the made whole doctrine.

Turning to the differences between legal (or equitable) and conventional (or contractual) subrogation, the Court noted that the first depends on principles of equity while the second is governed by contract and the rules of contract interpretation. The Court discussed the Austin Court of Appeals findings that the right of subrogation has been given unusually hospitable treatment in Texas, and that express subrogation agreements are given considerable weight. [See *Lexington Ins. Co. v. Gray*, 775 S.W.2d 679, 683 (Tex. App.--Austin 1989, writ denied).] The Court also discussed the Austin Court of Appeals opinion in *Esparza v. Scott & White Health Plan*, 909 S.W.2d 548 (Tex. App.--Austin 1995, writ denied), in which it backed down from its *Lexington* opinion. In *Esparza*, the appellate court held that a contractual subrogation provision does not answer the question of when and how much an insurer should be entitled to through subrogation. That court concluded that contracts confirm, but [do] not expand, the equitable subrogation rights of insurers, and the equities must still be balanced to achieve justice.

The Supreme Court of Texas then said in *Fortis Benefits*:

We do not disagree that equitable and contractual subrogation rest upon common principles, but contract rights generally arise from contract language; they do not derive their validity from principles of equity but directly from the parties agreement. The policy declares the parties rights and obligations, which are not generally supplanted by court-fashioned equitable rules that might apply, as a default gap-filler, in the absence of a valid contract. If subrogation arises independent of any contract, then an express subrogation agreement would be superfluous and serve only to acknowledge this preexisting right, a position we reject.

The Court found that its refusal to extend the made whole doctrine to contractual rights of subrogation and reimbursement was not a novel concept. It discussed precedent from the U.S. Supreme Court and the Fifth Circuit, dealing with ERISA subrogation cases. [See *Sereboff v. Mid Atlantic Medical Servs., Inc.*, 547 U.S. 356, 126 S.Ct. 1869, 164 L.Ed.2d 612 (2006); *Walker v. Wal-Mart Stores, Inc.*, 159 F.3d 938 (5th Cir. 1998) (per curiam). See also *N. Buckeye Educational Counsel Group Health Benefits Plan v. Lawson*, 814 N.E.2d 1210 (Ohio 2004); *Ex Parte State Farm Fire & Cas. Co. v. Hannig*, 764 So.2d 543 (Ala. 2000); *Medica, Inc. v. Atlantic Mut. Ins. Co.*, 566 N.W.2d 74 (Minn. 1997).] In *Sereboff*, the U.S. Supreme Court held that an ERISA health plan that included a written subrogation

right could not be altered by equitable defenses that were beside the point. And, in *Walker*, the Fifth Circuit held that language in an ERISA health plan providing for recovery against any and all third-party settlements meant the insurer was entitled to reimbursement for all medical benefits paid under the plan.

Finally, the Court reiterated that equity follows the law, and so equitable doctrines must conform to contractual and statutory mandates, not the other way around. Therefore, unless a contract violates positive law or public policy, equity must yield. Finding that subrogation and reimbursement claims clearly do not violate Texas public policy, the Court refused to allow equity to stand in the way of the parties contract. Similarly, the Court was loathe to rewrite the terms of the parties contract, noting that the Department of Insurance or the Legislature were better suited for that job. We agree with those courts holding that contract-based subrogation rights should be governed by the parties express agreement and not invalidated by equitable considerations that might control by default in the absence of an agreement.

Applying the New Law, Cantu is Made Less Than Whole. Having found that the made whole doctrine must yield to the parties contractual agreement, the Court addressed the terms of the insurance policy at issue. The provision entitled Subrogation Right entitled Fortis the right of subrogation to all rights of recovery Cantu may have against *any* person or organization, including the proceeds of *any* settlement, but limited to the amount of benefits *actually paid* by Fortis. The Court said: Nowhere does this provision suggest that Cantu must first be made whole for Fortis to recover. As a result, the specific language in the partys contract controlled and the equities embedded in the made whole doctrine were pushed aside. Thus, the Court held that Fortis was entitled to recover the total amount of benefits it paid to Cantu from the \$1.445 settlement.

For nearly three decades, Texas insureds have been entitled to the benefit of equity through the made whole doctrine. Similarly, in other jurisdictions across the country, the same has been true. Scorecards are always difficult to achieve when interpreting majority vs. minority views. In fact, amicus curiae briefs filed in *Fortis Benefits* took diametrically opposing views as to what the majority view was with respect to whether a contractual subrogation provision overrides the made whole doctrine. Either way, the *Fortis Benefits* decision has changed the insurance law landscape in Texas and may be persuasive for other jurisdictions grappling with the issue.

While logical on its surface, the Courts opinion deals a blow to insureds by prioritizing contract language over equity. Even so, as the Court noted, bargained-for contractual rights should take a back seat to positive law and public policy. The effects of the *Fortis Benefits* decision may not be clear quite yet. One can assume, though, that the reasoning of the decision will extend beyond health insurance to all forms of policies that contain specific subrogation language like that in *Fortis Benefits*. As such, after *Fortis Benefits*, insureds are faced with the reality that they actually are entitled to less of their settlements with third parties than ever before.

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Jim Poolman On The State of Minnesota vs. Allianz Life Insurance Company

2008 Emerging Issues 1488

Jim Poolman On The State of Minnesota vs. Allianz Life Insurance Company

By Jim Poolman

December 13, 2007

SUMMARY: Former North Dakota Insurance Commissioner Jim Poolman discusses the lawsuit that Minnesota Attorney General Lori Swanson filed in Jan. 2007 against Allianz Life Insurance Company for violating Minnesotas suitability law in the sale of deferred annuities to senior citizens, analyzes the governing statute, outlines the terms of the parties settlement and suggests some lessons that insurers may take away from the settlement in terms of making suitability determinations and complying with suitability laws.

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ARTICLE: On Jan. 9, 2007 Minnesota Attorney General Lori Swanson filed suit against Allianz Life Insurance Company of North America alleging that "Allianz and agents working on behalf of Allianz sold deferred annuities to Minnesota senior citizens that were not suitable for seniors' particular circumstances and/or misrepresented the terms and conditions of Allianz's deferred annuity products." The complaint cites that since 2000, Allianz sold 4,900 deferred annuities to Minnesota seniors over the age of 70 with a value totaling \$259,392,040. The suit was settled on Oct. 8, 2007 with a consent judgment agreed to by General Swanson, Allianz, and Hennepin County District Court Judge Kevin S. Burke.

Suitability Definition And Governing Statute. Attorney General Swanson alleges that Allianz violated Minn. Stat. Ann. Minn. Stat. § 72A.20, subdivision 34, which states that "In recommending or issuing life, endowment, individual accident and sickness, long-term care, annuity, life-endowment, or Medicare supplement insurance to a customer, an insurer, either directly or through its agent, must have reasonable grounds for believing that the recommendation is suitable for the customer."

Attorney General Swanson alleged that producers representing the Minnesota-based insurance company lured seniors into purchasing the products by using different estate planning and wealth management seminars. She said that these seminars led to the sales of deferred annuity products with lengthy surrender charges and product stipulations that force

the policyholders to annuitize at the maturity date rather than simply taking a lump sum distribution of the annuity. Swanson purported that these products were unsuitable because some of the seniors were on fixed incomes. If their financial status changed, the annuity would only allow them to withdraw a small portion of the annuity without penalty.

The issue of trying to accurately or properly define the "suitability" of a product has been frustrating to regulators and insurers alike. In addition to defining what is "suitable" it can be a difficult task for either an insurer or producer to determine what "reasonable grounds" are to determine this nebulous definition of "suitable." What may be appropriate for a customer at the time the product was purchased may not be appropriate months or years later as the insured's circumstances may change.

Producers are supposed to be charged with representing their clients' best interests, and so the question is often asked what the insurer's role should be in determining what is suitable. If one is to assume that the former is true, then the insurer should be able to solely rely on the producers' recommendation. Recent laws passed in several states based on the model drafted by the National Association of Insurance Commissioners focuses on the process of determining suitability rather than defining "suitability". The Minnesota statute does not define what processes should be used in determining suitability nor does it specifically provide a definition of what is suitable. In the absence of direction in the statute the agreement between the Minnesota Attorney General and Allianz lays out ground rules for processes that Allianz shall follow in determining whether their products are appropriate for the prospective customer.

Stipulated Relief: Enhanced Processes For Allianz In Determining Suitability. What are reasonable grounds for determining whether or not a product is suitable for a customer? As previously mentioned, the Minnesota statute does not define a process to be used in determining reasonable grounds. The agreement between the Attorney General's office and Allianz specifically addresses what processes will be used to reasonable determine suitability for a prospective insured. The detailed requirements impact those Allianz annuity purchasers in Minnesota age 65 or over on the date of the annuity application.

The processes described in the settlement agreement are similar to what is prescribed in legislation crafted by the National Association of Insurance Commissioners, but prescribed in much more detail. Ms. Swanson mandates that Allianz obtain from annuity applicants all reasonable information necessary to make sure the annuity products sold to consumers are suitable.

The consent agreement entered into with Allianz requires the insurance company to enhance their internal suitability system to have controlling threshold tests before an annuity contract could be issued. These tests apply specifically for those annuity applicants 65 and older. If one of the threshold tests is triggered, the annuity application must be subject to an "elevated review". If the product is subject to further scrutiny under the review process, Allianz must specifically document in the applicant's file "specific, objective evidence that clearly establishes that the sale is suitable to the applicant in light of his or her stated financial condition, needs and objectives."

The threshold tests include a number of very specific minimum income and asset requirements, as well as testing the premium paid for the annuity compared to the net worth of the prospective insured. One question the settlement begs is: "What magic is behind the very specific numbers included in the settlement?" For example, one of the threshold tests that would trigger heightened review for suitability is that the applicant's annual income is less than or equal to \$20,000. The specific dollar amounts are indexed up by 3% starting in January 1, 2009. Some will argue that these specific dollar amounts and percentages in the settlement document are arbitrary and will increase compliance costs for an unnecessary elevated review.

Many companies selling annuity products have created suitability forms to comply with the requirements of state laws. Many states are moving toward requiring insurers and their producers to gather an applicant's personal financial information including their tax status and savings objectives. These particular requirements are found in the National

Association of Insurance Commissioners (NAIC) model act being considered in state legislatures across the country. The Allianz settlement requires the company to use specific language in their forms to capture the asset, income, expense and net worth information that is far more detailed than prescribed by the NAIC model.

Restitution For Aggrieved Policyholders: Next Steps For Allianz. Under the terms of the settlement agreement, Allianz and the Minnesota Attorney General's Office will be setting up a claims review process for policyholders who felt they were aggrieved in the sale of their annuity. The claims process will have representatives of both the AG's office and the insurance company to review the purchase of the annuity and make a determination of whether or not the product was suitable at the time of sale. The parties will have the ability to determine if the contract should be rescinded, and, if the parties can't agree, an independent third party will make a decision. If the contract is rescinded, the policyholder will receive the full premium paid plus a mandated 4.15 percent interest compounded annually from the date the premium was paid to the date the contract was rescinded. Any amount paid previously to the policyholder under the terms of the annuity would be subtracted out of the payment of the rescinded contract.

The settlement agreement groups policyholders into three groups for making potential restitution. The first is any Allianz policyholder who has made complaint to the Attorney General's office in which the insurance company did not rescind the annuity contract. The second group of policyholders is those who have made complaint to Allianz directly and the contract was not rescinded. The third group consists of policyholders who were 65 or older when the annuity contract was issued.

Conclusion: Are There Lessons To Be Learned? Regulators' desire to hold insurance companies accountable for their sales practices and the practices of those producers contracted to sell for them is becoming more and more popular. Even though Minnesota law is vague when it comes to defining suitability, or what specific "reasonable grounds" are required for a company or producer to believe the annuity product being sold is suitable for the consumer, this settlement agreement sets out guidelines for what may be expected when selling these products, not only in Minnesota but elsewhere. Obviously the complaint against Allianz was not tested in the courts. We do not know what the company's defense would have been, or what processes were previously in place at the company to determine whether or not a product was suitable for the consumer. One has to think that juries will tend to fall on the side of the consumer against the insurance company. That is just the optics. As one who has been involved in the regulatory and legislative processes, sometimes laws and regulations are often drafted vaguely. Right or wrong, this is done so that the powers of regulators are expanded over the regulated, so that overarching settlements like the Allianz agreement can be achieved.

One important lesson to be taken from this settlement is that regardless of what the internal processes are in place for insurance companies to determine suitability, there should be constant review of these policies and procedures. Gathering more information from applicants rather than less can be a strong defense against a mandate to retroactively determine whether or not a product was suitable, as is prescribed in the Allianz settlement.

As one of the most aggressive marketers of annuity products based in Minnesota, I am sure the company was eager to settle a suit brought on by their home state law enforcement officials. The question yet to be answered is whether or not this makes Allianz less competitive in Minnesota with other carriers licensed to sell annuity products there. Right or wrong, if an independent producer has the opportunity to sell an annuity product, they may choose to sell for the company without the additional regulatory requirements brought on them by the settlement agreement. I vigorously disagree with that conduct, but it may be a reality to deal with in the future.

The company has just recently hired Patrick Nelson, the former Deputy in the Minnesota Department of Commerce as their new Suitability Officer. With Allianz Life Insurance Company of North America, and their recent settlement, it seems that suitability has become much more than just a regulatory buzzword.

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Jim Poolman was elected Insurance Commissioner in 2000, and overwhelmingly reelected in 2004. While Insurance Commissioner, he was an outspoken leader at the National Association of Insurance Commissioners, serving as their Vice-President, Chairman of the Midwestern Zone, Chairman of the Life Insurance and Annuities Committee, Executive Committee on Principles Based Reserving, Chairman of the Producer Licensing Working Group; amongst a host of other leadership posts. In North Dakota he was instrumental in preserving a competitive marketplace while passing very important consumer protections ranging in areas from privacy of consumers medical and financial information, suitability in annuity sales, restrictions on the use of claims information, insurance fraud and life settlements, amongst others. Mr. Poolman has been a sought after speaker on numerous insurance topics around the country. In August of 2007, Mr. Poolman resigned his post in North Dakota to start an independent regulatory consulting practice based in Bismarck, North Dakota. Mr. Poolman received his bachelors of Business Administration degree from the University of North Dakota in 1992. Mr. Poolman also served four terms in the North Dakota House of Representatives before being elected Insurance Commissioner.

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Poolman on the NAIC Suitability in Annuity Transactions Model Act

2008 Emerging Issues 1490

Poolman on the NAIC Suitability in Annuity Transactions Model Act

By Jim Poolman

December 13, 2007

SUMMARY: Former North Dakota Insurance Commissioner Jim Poolman draws upon his experience as Chairman of the National Association of Insurance Commissioners Life Insurance and Annuities Committee to provide a unique perspective on the NAICs Suitability in Annuity Transactions Model Act. Former Commissioner Poolman discusses the difficulties regulators have experienced in reaching a consensus on issues relating to suitability, the accountability of both insurers and producers in the sales process, mitigation and enforcement by insurance regulators, and the difficult balancing act that regulators must perform in trying to avoid conflicting provisions imposed by other regulatory authorities.

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ARTICLE: In recent years complaints made to departments of insurance about the sales of annuity products have increased across the country. Regulators, whether they be state insurance commissioners, state securities regulators, or FINRA (Financial Industry Regulatory Authority) are taking a much more aggressive aim at the sale of annuities to determine whether or not the sale of the product is "suitable" for the consumer. State insurance commissioners have drafted a model act that is being considered in state legislatures across the country to hold both the insurer and the insurance producer accountable in unsuitable sales of all annuity products whether they are variable or fixed in nature.

History--No Easy Consensus! Years ago, insurance regulators started discussions in order to draft laws to protect consumers against harmful annuity sales. With the understanding that annuity products can be good for many consumers, there are some consumers that sold annuity products that are not suitable for their personal needs. Complaints of high surrender charges lasting for many years and producers who never explained the potential downsides were becoming more frequent.

What was the definition of suitability? There is an old saying about pornography; nobody can seem to define it, but you know it when you see it. The same seemed to apply to unsuitable annuity sales. Regulators could not agree on a definition of suitability because it would be overly broad, ambiguous, and would not live up to the consumer protection standards for which regulators were striving. Early attempts at defining "suitability" for insertion into states' Unfair Trade Practices Acts clearly were becoming futile. Thus, regulators started to focus on the sales process being used to

distribute annuity products, and put consumer protections in place regarding the sales process, rather than attempt to define suitability.

The Model Act originally was voted by the membership of the NAIC in September of 2003. At that time, the legislation was only applicable to transactions of annuity products if the consumer was age 65 or over at the time of application. The specific age restriction was removed from the Model Act in June of 2006, and reaffirmed by the NAIC membership. Most states that have passed the Model Act have done so without the age restriction, so the legislation is applicable to annuity transactions with all consumers regardless of age.

Who Is Accountable In The Sales Process? Insurers And Their Producers. There is considerable debate about who is responsible for an unsuitable sale to a consumer. In many cases the insurer would like to say that the producer has sole responsibility in determining that the product being recommended to their customer is suitable for their needs. In regulators' minds, the producer does have significant responsibility in making a suitable recommendation for their customer, because even though they contract with individual insurance companies by appointment, they have a fiduciary responsibility to represent their customers' best interests. That being said, the insurer also has the responsibility to make sure that their appointed producers are acting ethically and within the bounds of the law. Thus, the National Association of Insurance Commissioners focused on defining the responsibility of both the producer and the insurer in the sales process in their Suitability In Annuity Transactions Model Act.

The Model Act specifically applies to transactions where a producer or an insurer is making a specific recommendation to a consumer. It does not apply to direct response solicitations, or transactions where there are employee-sponsored pension plans or welfare plans used to fund annuity products. These transactions were exempted because there typically is no producer making a recommendation to an individual consumer.

The NAIC's Model Act specifically lays out the responsibilities of producers to make sure they have the necessary information to make an appropriate and suitable recommendation in an annuity sale. In states where the Model Act has passed, producers now have to make a reasonable effort to obtain several pieces of financial information from the consumer. Examples of this information include: The consumer's financial status; the consumer's tax status; the consumer's investment objectives, and any other information considered to be reasonable in making recommendations to the consumer. Some consumers may refuse to supply this information to their insurance producer, and that does not bar the sale from taking place. But, under the Model Act, producers must have the applicant sign a refusal to give the necessary information or incomplete information.

With the clear responsibilities of insurance producers in the legislation comes the need to clarify where the responsibility of the insurer comes into play. The Model Act requires insurers to set up a system of compliance to make certain that insurers are also holding their producers accountable. This system is required to supervise the producer to make sure they have made the attempts to retrieve the necessary information to make a suitable recommendation of an annuity product. Insurers are required to have specific written procedures for compliance, and must conduct "*periodic reviews of its records that are reasonably designed to assist in detecting or preventing violations of this regulation.*" This system set up by the insurer must be adopted by any general agent and independent agency to supervise their producers.

Under the Model Act there is the ability to contract out the compliance system to a third party. This was added to accommodate companies that may not have significant compliance departments, thus giving them the opportunity to delegate the authority to better equipped third parties. If the insurer chooses to contract out to a third party, the insurer still maintains the obligation to review the third party to make sure that integrity of the compliance processes are being met.

Mitigation And Enforcement By The Commissioner. The Model Act provides very clear guidance for insurers

and producers who are not playing by the rules. The mitigation section of the law is broadly drafted to give the commissioner in the respective jurisdiction the ability to take corrective action with both the insurer and the producer to make sure the consumer's interests are protected, restitution is provided, and administrative penalties allowed by that state are imposed.

Trying To Avoid Conflicting Laws With Other Regulators--Necessary, But Sometimes A Difficult Balancing Act. Insurers and their producers who sell annuity products are subject to a number of different state and national regulators. When drafting the Model Act, the NAIC was very conscious of the number of regulatory authorities who have their hand in protecting consumers. The goal was not to create unnecessary and duplicative regulation, but to create a system where the chief insurance regulator could also hold an insurance company or producer licensed in their state accountable for misconduct in the sale of annuity products. The NAIC drafted a section in the Model Act that specifically provides for a safe harbor for insurers or their producers when the National Association of Securities Dealers (NASD, now FINRA) has reviewed a transaction and found that it complies with their conduct rules pertaining to suitability. This is obviously especially important for those producers and insurers who sell variable annuities.

The conduct rules for transactions involving variable annuities have seen change and significant debate among the players in the marketplace. FINRA Rule 2821 was approved by the Securities and Exchange Commission on September 7, 2007. The rule will actually take effect 180 days after FINRA issues their regulatory notice to all of their members. The rule heightens the suitability obligations which will include expanded review and approval requirements and increased training and supervision for variable annuity producers. The rule also specifically focuses on the replacements or exchanges in consumers' accounts. This comes from concern that consumers' products are being churned, where customers are sold new products in large part to bring about a new commission payment to the producer.

As FINRA's rules continue to change related to variable annuities, the safe harbor provided for in the NAIC Model Act will allow for both insurers and producers to avoid unnecessary regulations that drastically differ, but still allow for adequate consumer protection, all while giving the insurance regulator the power to hold both insurers' and producers' feet to the fire in monitoring annuity transactions for suitability.

Conclusion: Both Policymakers And Regulators Believe In Suitability Legislation. The National Association of Insurance Commissioners Model Act has gotten serious traction. With endorsements from the National Conference of Insurance Legislators, industry trade groups, and an annuity working group comprised of a cross section of regulators, the legislation should continue to have a successful path in state legislatures across the country. Companies should start preparing now for compliance in states that don't have suitability requirements because they are likely to come soon. They can use the NAIC Model Act as the template for the minimum standards to create systems of gathering necessary customer information, monitoring producers, and ensuring that their products are suitable for the customer. Better to prepare now than pay later!

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Jim Poolman was elected Insurance Commissioner in 2000, and overwhelmingly reelected in 2004. While Insurance Commissioner, he was an outspoken leader at the National Association of Insurance Commissioners, serving

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Jennifer K. Mailander on Chinas Circular 91

2008 Emerging Issues 1491

Jennifer K. Mailander on Chinas Circular 91

By Jennifer K. Mailander

December 13, 2007

SUMMARY: Jennifer K. Mailander, an attorney with extensive experience in corporate and commercial law, insurance and risk management discusses the China Insurance Regulatory Commissions released Circular No. 91, entitled Circular of China Insurance Regulatory Commission concerning Printing and Distributing the Guidelines for the Compliance Management of Insurance Companies. Mailander outlines the basic compliance framework of the Guidelines, and also discusses extensive reporting, reviews and evaluations that must be performed under the Guidelines throughout all levels of an insurance company.

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ARTICLE: In November, 2001, China was approved as a full member of the World Trade Organization (WTO). As part of its acceptance into the WTO, China agreed to adopt measures to better define and regulate practices within the insurance industry. To fulfill these requirements, China has revised and adopted several insurance-related laws, regulations, and guidelines. The most recent of these was issued on September 7, 2007 when the China Insurance Regulatory Commission (CIRC) released Circular No. 91, entitled *Circular of China Insurance Regulatory Commission concerning Printing and Distributing the Guidelines for the Compliance Management of Insurance Companies* (hereafter, *Guidelines*.) n1

China's acceptance into the WTO offered it a significant growth opportunity to expand its insurance market to include foreign investors. To accommodate this potential growth China also needed to significantly revamp and modernize its insurance and legal infrastructure. It's important to recognize that modern Chinese insurance law is relatively young and was introduced with the passage of the Insurance Law of the Peoples Republic of China in 1995. n2 The most interesting aspects of the *Guidelines* involve the compliance framework that is proposed and the incredibly detailed reporting requirements.

The Basic Compliance Framework. The *Guidelines* provide the overall framework for the compliance program of an insurance company doing business in China. The *Guidelines* consist of six chapters and 36 articles. The topics

covered include: General Rules, Compliance Duties for the Board of Directors, Board of Supervisors, General Manager, and Compliance Chief, Compliance Management, and External Supervision. The *Guidelines* are written in a very direct albeit somewhat simplistic manner. This is most likely because the document had to be translated into English and the sophistication may have gotten lost in translation.

Common compliance concepts and terms that are often assumed to be understood in much of the world are clearly detailed in the *Guidelines* because the concept of compliance is a relatively new one for China. For example, the *Guidelines'* identified purpose is to "regulate the governance structure of insurance companies and strengthen the compliance management of insurance companies" n3 Definitions for key terms such as "compliance", "compliance risk", and "Compliance management" are included. "Compliance" means that insurance companies and their employees "shall carry out insurance operation and management behaviors subject to the related laws and regulations, provisions of insurance regulatory organs, self-discipline rules of the industry, their internal management system and the ethic code of honesty and good faith." In more established legal systems terms like these are generally understood and do not require a definition.

The definition provided for "Compliance management" explains that an insurance company "shall prevent, identify, evaluate, report and handle compliance risks" by setting up a compliance department or positions, by setting up and implementing compliance policies, and by conducting actual compliance monitoring and training. n4 The *Guidelines* also provide directions on how to set up a compliance department. n5

While the *Guidelines* state that "Everybody is responsible for compliance," the concept of Compliance being enforced and supported from top level of management down is a theme that is repeated throughout the *Guidelines*. n6 First mentioned in Chapter I, Article 4, "The values board of directors and the senior managers of an insurance company shall advocate ethics and values of honesty and good faith, advocate such philosophies as voluntary compliance and compliance bringing about values, etc., and make internal compliance management and external supervision better interacted with each other." This concept of board and senior management support is most likely guidance received from more experienced members of the WTO. It has long been recognized that for a compliance program to be successful, a program needs buy in and continued support from all levels of senior management and a company's board of directors.

The largest portion of the *Guidelines* is focused on the responsibilities of the Compliance Chief and Compliance Department, detailed in Chapter III. While ultimate liability for compliance management lies with an insurance company's board of directors n7, the Compliance Chief and Department have overall day-to-day responsibility for compliance within the company and its branches. This responsibility ranges from "setting down and revising" compliance policies to training, to "monitoring, identifying, evaluating and reporting compliance risks." n8 This type of activity can obviously not be done in a vacuum and would necessitate a great deal of interaction with and knowledge of other departments and groups within a company. To address this issue, The *Guidelines* require the insurance companies to establish certain "rights" so that the Compliance Chief and Compliance Department can do their jobs. The *Guidelines* require the insurance company to ensure that Compliance gets invited to meetings, that there are "smooth" reporting channels, that Compliance have the ability to independently investigate violations, and any other rights as determined by the Board.

Reporting, Reviews & Evaluations. The *Guidelines* require extensive reporting, reviews and evaluations to be performed throughout all levels of an insurance company. There are at least 14 separate discussions on reporting, reviews and evaluations to be performed. It's easy to see how this could quickly become a bureaucratic nightmare with so many requirements, but very few explanatory details as to the ultimate goal of the reporting, review, or evaluation.

At the highest level of reporting, CIRC requires that each insurance company file an annual compliance report. The annual reports are to be presented to CIRC before April 30th of each year, for the prior year's activity. Prior to this, the annual report has to go through several internal reviews, first from the General Manager, then to the Auditing Committee and finally to the full board of directors for approval prior to presentation to CIRC. In addition, the Auditing Committee is required to conduct a review of the "semi-annual compliance report."

The General Manager is required to review and evaluate policies and compliance risks and verify the compliance risk management plan for the upcoming year. The Audit department (which cannot have direct management responsibility for the Compliance Department) is responsible for auditing and reporting on the Compliance Department annually. And at the individual level, insurance companies "shall prescribe compliance risk reporting routes" so that individuals know what to do in the event of a risk event or compliance violation. n9 The insurance companies are also required to set up an "effective compliance evaluation and accountability system" to assess the performance of senior managers. It is unclear as to who is responsible for setting up this accountability system.

Conclusion. The compliance framework and reporting requirements described in the *Guidelines* are quite detailed and seem to establish fairly thorough processes. However, process can only take a company or country so far. It is one thing to write detailed instructions on a compliance structure and reporting requirements. It is quite another to actually implement, integrate, and actually live the concept of compliance. A culture of compliance needs to be developed at the company level, the industry level, and the country level and this will take time.

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n1 . *Guidelines for the Compliance Management of Insurance Companies*, [cited 13 December, 2007]; available from http://www.fdi.gov.cn/pub/FDI_EN/Laws/law_en_info.jsp?docid=86161; INTERNET.

n2

[2]. *Necessary Reform of Insurance Law in China After its WTO Accession*, 31 Syracuse J. Int'l L. & Com. 25.

n3

[3]. *Guidelines*, Chapter I, Article 1.

n4

[4]. *Guidelines*, Chapter I, Article 3.

n5

[5]. *Guidelines*, Chapter III, Chapter IV.

n6

[6]. *Guidelines*, Chapter I, Article 4.

n7

[7]. *Guidelines*, Chapter II, Article 6.

n8

[8]. *Guidelines*, Chapter III, Article 11.

n9

[9]. *Guidelines*, Chapter IV, Article 23.

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Poolman on ND newly enacted statute on suitability of annuity transactions

2008 Emerging Issues 1489

Poolman on North Dakotas newly enacted statute on suitability of annuity transactions

By Jim Poolman

December 13, 2007

SUMMARY: Annuities are becoming more and more popular as financial planning tools for consumers of all ages. With the products becoming more complex, regulators across the country are giving these products increased scrutiny. More responsibility will be placed on both the insurer and the insurance producer to gather the necessary information to determine whether the product is suitable for the purchasers' personal circumstances.

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ARTICLE: As baby boomers are retiring and aging, more and more assets are being transferred out of retirement plans and into other savings and investment options. Aggressive marketing of annuity products that compete against mutual funds, stocks and other insurance products are becoming more common. After receiving an increased number of inquiries from consumers and seeing potential regulatory pitfalls, state Insurance Commissioners are forcefully pursuing legislation to protect consumers from sales that may not be suitable for their personal situations.

The North Dakota Legislature recently passed Senate Bill 2155, sponsored by Senator Nicholas Hacker (R-Grand Forks) and signed by Governor John Hoeven (R). The statute became effective on August 1, 2007. N.D. Cent. Code, § 26.1-34.2-02 defines the responsibilities of both insurance producers and companies in the sales of annuities, and defines the powers of the Insurance Commissioner in enforcing this new law. The North Dakota statute follows the model act drafted and passed by the National Association of Insurance Commissioners.

The legislation received support from the American Council of Life Insurers, the North Dakota Insurance Commissioner, the North Dakota Association of Insurance and Financial Advisors, and the North Dakota AARP. This support has been consistent nationally as the model act moved through the drafting process at the National Association of Insurance Commissioners.

Duties of Producers And Insurers. Prior to the new enactment of these statutes there was no real clear definition of whose role it was to make sure an annuity transaction was suitable for the customer, nor what powers a regulator had in holding the parties involved in the transaction accountable for a sale of an inappropriate annuity product that clearly did not meet the expectations of the consumer, nor was suitable for their personal needs. N.D. Cent. Code, §

26.1-34.2-03 now makes it clear that an insurance producer or an insurer, if there is no producer involved in the transaction must gather information to make sure a sale is suitable. Much of this information is rather simple to gather: consumers' financial status, consumers' tax status and the consumers' investment objectives.

As is sometimes the case, consumers may not want to give personal financial information to determine whether or not a sale is suitable. They may just want to buy the product. A consumer may still purchase the annuity product after refusing to give the necessary information to the producer or the insurer. In this instance the consumer will have to attest to not giving the information. Under this provision there is no obligation to the insurer or the producer to make a suitability recommendation on the purchase. This protects both the insurer and the producer if the consumer files a complaint to an insurance department or other legal authority about the sale being unsuitable.

Under the new law insurers will be required to set up compliance programs to monitor their producers selling annuity products. Insurers are not required to review every solicited transaction, but must create a system to maintain written procedures to ensure suitable sales and conduct periodic reviews of their producing community to make sure they are complying with the new laws, and compliance programs of the insurer.

Insurers under the chapter are allowed to contract these monitoring and compliance functions out to a third party. This is designed to provide flexibility to companies that may not have large in-house compliance departments.

Many insurers have built "input" oriented compliance systems to flag sales that may not meet suitability tests. For example, some insurers will not proceed with a transaction unless all information that is required by statute is gathered, or require it to immediately have further review before an annuity contract is issued. Some insurers have set up "suitability" departments that will specifically review transactions of questionable suitability for the customer to make sure they err on the side of compliance. This is advisable, as annuity products are becoming more complex with various benefits or riders, and benefits and potential product risks that are becoming more difficult for consumers to understand.

Penalties. The new statute lays out new penalties that may be issued to enforce the new responsibilities of insurers and the producers in the marketplace. N.D. Cent. Code, § 26.1-34.2-04 allows the Commissioner of the North Dakota Department to order corrective action by the insurer or a producer for action that has harmed a consumer in an unsuitable sale. This corrective action may also be extended to a general agency or independent agency that employs or contracts with an agent to solicit or sell annuity products. The Commissioner may order monetary penalties against the insurer, producer or general or independent agency for violating the new chapter. These penalties may be reduced if the respective party responsible for the unsuitable sale takes corrective action quickly.

Oversight--Compliance Is Key. North Dakota like most state Departments of Insurance across the country has consumer service employees who process complaints lodged by consumers. This is most likely how initial information on unsuitable annuity sales is obtained. In some of these cases, the customer has already had initial contact with the producer or the company to air their grievance and has not received satisfaction. It is imperative that companies engaging in annuity business have strong internal complaint departments with specific written guidelines on how these complaints are being processed.

These complaints with Departments of Insurance can be the lead indicator of the need to pursue a market conduct examination of an insurer. Some market conduct examinations may be broad in scope, and others may be targeted toward a specific activity of the insurer, such as the compliance programs built into the suitability law just enacted in North Dakota.

Conclusion-Be Proactive. The North Dakota suitability statutes will resemble what many other states will be doing. In an era when annuity products that are becoming more popular yet more complex, companies will want to err on the side of caution when complying with the new laws. Compliance programs with more thorough "testing" of

transactions for suitability will prove more reliable and friendlier to regulators as they examine companies. Those companies and producers without clear written guidelines on how to test for suitability, that have poor recordkeeping and documentation and poor or undocumented procedures on how to handle grievances with their customers, will certainly be subject to the regulators' scrutiny.

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Robinson on Workers Compensation and Suicide: Moore v. Western Forge Corp.

2008 Emerging Issues 1402

Robinson on Workers Compensation and Suicide: Moore v. Western Forge Corp.

By Thomas A. Robinson

December 8, 2007

SUMMARY: Within the workers compensation context, suicide cases usually present the basic legal question: Was the act of suicide an intervening cause breaking the chain of causation between the initial injury and the death? This Emerging Issues Analysis by Thomas A. Robinson analyzes *Moore v. Western Forge Corp.*, and discusses relevant issues related to suicide within the workers compensation context.

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ARTICLE: Within the workers compensation context, suicide--that sad moment in which the primary actor and victim are the same--usually presents the following pattern of facts: a severe, or extremely painful, or hopelessly incurable injury, followed by a deranged mental state ranging from depression to violent lunacy, followed in turn by suicide. The basic legal question seems to be agreed upon by almost all authorities: *Was the act of suicide an intervening cause breaking the chain of causation between the initial injury and the death?*

In a recent case of first impression from Colorado, a state appellate court was faced with a highly unusual situation: a suicide that flowed not from the original injury, but from the denial of the injured employees workers compensation claim. This expert commentary analyzes the case, discusses relevant issues related to suicide within the workers compensation context, and observes that in spite of the unusual fact pattern involved, the Colorado court utilized traditional legal tests to determine that the surviving spouses tort claim against the employer and claims administrator could not be successfully maintained. The author points out that in spite of the strong general policy of ignoring worker fault within the workers compensation, suicide claims continue to be strongly disfavored, even when, as was the case with the recent claim from Colorado, there is a relatively powerful but for connection between the work-related injury and the conditions that lead the worker to take his or her own life.

Colorado Claimants Suicide After Reading Form Denying His Claim Held Not Compensable. In a case of first impression in Colorado, that states Court of Appeals, in *Moore v. Western Forge Corp.*, 2007 Colo. App. LEXIS 2199 (November 15, 2007), recently held that a widow (Moore), whose husband committed suicide shortly after he received a Notice of Contest from his employers workers compensation claims administrator stating that his claim was being contested pending completion of an investigation, could not recover in tort against the employer and the claims administrator for breach of defendants duty of good faith and fair dealing; her husbands suicide was an independent intervening act not proximately caused by the denial of the claim. Affirming the entry of summary judgment in favor of

the employer and claims administrator, the state appellate court concluded, in relevant part, that the defendants were not liable for the suicide, even if the trial court accepted as true Moores proof of a chain of actual causation in her husbands death.

Facts of the Case. Moores husband filed a workers compensation claim against his long-term employer. The employer was self-insured and used the defendant company to administer its claims. The claims administrator mailed decedent, who was at home awaiting surgery for his injury, a Notice of Contest stating that the claim was being contested pending completion of an investigation. Shortly after reading the notice, decedent killed himself.

According to Moores legal theory, because the employer and claims administrator owed her husband a duty of good faith and fair dealing, the breach of which would permit recovery of damages for decedents emotional distress, the defendants liability also extended to decedents suicide upon a showing of causation connecting the bad faith handling of the claim, the resulting emotional distress, and decedents uncontrollable impulse to kill himself.

The defendants countered in relevant part that because decedents suicide was an independent intervening act, even if one assumed the defendants had breached their duty of fair dealing and that such breach had resulted in emotional distress and further, that such emotional distress was a factor in decedents suicide, Moore nevertheless was still required to prove the requisite level of proximate cause and she had failed to do so.

Actual (But For) Causation Versus Legal (Proximate) Causation. The court agreed with the defendants. It acknowledged that there was a dispute of material fact as to whether or not defendants conduct had been the actual cause of decedents suicide and that if this was the sole question, the matter should have gone to trial and not have been disposed of with summary judgment. It added, however, that once actual causation was established, decedents widow still was required to show legal causation, that is to say, that the suicide was the proximate result of the denial of the claim and, according to the court, Moore had made no such showing. Quoting the Restatement (Second) of Torts § 455 (1965), the court recognized that

[i]f the actors negligent conduct so brings about the delirium or insanity of another as to make the actor liable for it, the actor is also liable for harm done by the other to himself while delirious or insane, if his delirium or insanity (a) prevents him from realizing the nature of his act and the certainty or risk of harm involved therein, or (b) makes it impossible for him to resist an impulse caused by his insanity which deprives him of his capacity to govern his conduct in accordance with reason.

The court observed in relevant part that the record failed to show that decedents suicide resulted from delirium or insanity that made it impossible for him to resist an impulse caused by his insanity. While Moores expert opined that the denial of the claim resulted in decedents uncontrollable impulse to commit suicide, there was no showing of the required intervening link--that this impulse was the result of delirium or insanity.

Dissenting Opinion. Judge Vogt dissented in relevant part, noting that the majoritys reasoning, while appropriate for cases in which the issue was the defendants alleged *negligent* infliction of emotional distress, was inapposite in the instant case, that while Moore had not alleged an intentional tort in so many words, her allegations of bad faith were significantly stronger than allegations of mere negligence, that she should have been allowed to proceed to a jury on her claim that the suicide resulted from her husbands emotional distress, and that the defendants should not benefit from the fact that the emotional distress caused by their breach of duty was so severe that it resulted in suicide and not lesser harm.

Typical Factual Pattern Within Workers Compensation Context. Within the workers compensation context, suicide most typically presents the fact finder with a severe, or extremely painful, or hopelessly incurable injury, followed by a deranged mental state ranging from depression to violent lunacy, followed in turn by suicide. For example, in another Colorado case (a workers compensation claim, not a tort claim, cited by dissenting Judge Vogt, but not by the majority), *Jakco Painting Contractors v. Industrial Commission*, 702 P.2d 755, 757 (Colo. App. 1985),

decedent suffered severe facial burns when he was splattered with paint remover. He underwent a series of surgical treatments, but his face remained badly scarred. He became self-conscious, depressed, and prone to fits of rage, during which he sometimes beat his wife. After one such incident, she fled with her children to a shelter for battered women. He threatened suicide if she did not contact him by a certain deadline, which she failed to do. He then carried out his threat. Both his psychiatrist and his plastic surgeon testified that the decedent had undergone significant personality changes after the accident and suffered from post-traumatic stress disorder. Following the Larson Chain of Causation Test (see *Larsons Workers Compensation Law* § 38.03), the court awarded death benefits. The suicide was not an independent intervening act; the decedents depression and delirium flowed from the original work-related injury and they supplied the necessary causal connection with the suicide.

Moore Represents Unusual Factual Twist. *Moore* represents an unusual factual twist in that the suicide was not so much connected to the original injury, but rather to the administrators denial of the decedents claim. The basic legal question--rather than being whether the act of suicide was an intervening cause breaking the chain of causation between the work-related injury and the death--became instead, whether the suicide broke the chain of causation between the *denial of the claim* and the death?

It is somewhat surprising that Moores tort claim could not survive a summary judgment motion given the fact that she had an expert who opined that her husbands suicide was causally connected to the denial of the claim. The appellate court drew a fine line between the denial of the claim and the suicide and indicated that along this fine line, an intervening condition--insanity or delirium--must be shown. According to the majority of the court, it was insufficient to show that the administrators denial caused the suicide; Moore had to show that the denial produced some sort of insanity or delirium and that the insanity or delirium, in turn, produced the suicide. That this question was resolved against Moore via summary judgment means, of course, that she cannot now go back and ask her expert a follow-up or rephrased question: Did the denial of the claim produce a form of insanity or delirium in the decedent and did that insanity or delirium cause the suicide?

Inadequacy of But For Relationship. The courts determination is not as unfair as it may seem at first blush, however. Moore had certainly established that but for the administrators denial, her husband would not have died. But the court was also concerned about a second but for relationship. But for the decision of the decedent to kill himself, he would not have died. We are back to the issue of independent intervening act. If decedent did not suffer from insanity or delirium, the court reasoned, his decision to kill himself could not be ignored. For the majority of the court, the decedent died not so much because the denial of his claim upset him; rather, he died because he decided to kill himself.

Tort Action Versus Claim for Death Benefits Under Workers Compensation. As noted above, there is an important jurisdictional difference between the instant case and *Jakco Painting Contractors* cited above. *Jakco* was not a tort claim, but rather a claim for death benefits under the Colorado Workers Compensation Act. For public policy reasons, one would expect a close case like *Jakco* to be resolved in favor of the worker or the workers dependents within the workers compensation setting. After all, within that setting the fault of the worker is generally not an issue. One should note, however, that in spite of *Jakco* and the closeness of the causation issues related to her husbands death, this was Moores second attempt to recover for her husbands death. She had already been unsuccessful in her attempt to gain workers compensation death benefits (in an unpublished decision, *2005 Colo. App. LEXIS 989* (June 23, 2005), a division of the court of appeals affirmed a decision of a panel of the Industrial Claim Appeals Office that upheld a denial of death benefits). The bottom line is that whether the case is in the tort arena or before an administrative agency administering the workers compensation law, successful resolution of the issue of independent intervening cause is crucial to recovery.

For further discussion related to the workers' compensation issues related to suicide within the workers compensation context, see generally *Larson's Workers' Compensation Law* § 38.01 et seq.

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Workers' Compensation & Telecommuting: Wait v. Travelers Indemnity Co.

2008 Emerging Issues 1363

Robinson on Workers' Compensation and Telecommuting: Wait v. Travelers Indemnity Co.

By Thomas A. Robinson

December 5, 2007

SUMMARY: Large numbers of employees now commute not from their residence to the companys home office, but from a designated work zone within the home. This Emerging Issues Analysis by Thomas A. Robinson analyzes a recent case of first impression, in which a home-based employee who was attacked and severely beaten by an intruder was denied compensation. on the basis that her injuries did not arise out of her employment.

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ARTICLE: In 2006, approximately 34 million American workers telecommuted to some degree (Telecommuting: A Reasonable Accommodation Under the Americans With Disabilities Act As Technology Advances, *19 Regent U. L. Rev.* 537, 544 (2006-2007)). In a recent Wall Street Journal article (Sue Shellenbarger, Good News for Professionals Who Want to Work at Home, *Wall Street Journal*, 11/15/2007, Page D1), it was reported that at Safeco, a Seattle-based insurer, some 1,500 of its 7,000 employees now work away from corporate offices. Large numbers of employees at IBM, UnitedHealth Group and other corporations now commute not from their residence to the companys home office, but from the kitchen to an office or specially designated work zone within the home. Issues arise as to the compensability of injuries sustained by employees in these home-based offices. Is the employer--who, after all, has little control over conditions within an employees residence--nevertheless responsible for workers compensation benefits along the same basis as if the employee were injured on the companys premises? The answer is mixed.

In a recent case of first impression from Tennessee, a home-based employee attacked and severely beaten by an intruder was denied compensation on the basis that her injuries did not arise out of her employment. This expert commentary analyzes the case, discusses relevant issues related to workers compensation and the telecommuter, and observes that the Tennessee decision should not be negatively viewed by the claimants bar. According to the author, the state courts reasoning actually shows a judicial temperament toward treating home-based and company premises-based employees on equal footing. The author also cautions the practitioner to differentiate between true telecommuter situations and those that merely fall within the category of hearthside activities.

Tennessee Telecommuters Assault in Home-based Office Held Not Compensable. In a case of first impression in Tennessee, the Supreme Court of Tennessee, in *Wait v. Travelers Indemnity Co.*, 2007 Tenn. LEXIS 1033 (November 16, 2007), recently held that severe injuries sustained by a telecommuting employee as a result of an assault at her home during working hours was not compensable; her injuries occurred in the course of her employment, but did not arise

from such employment. Acknowledging that there was some relationship between the employees home-based employment activities and her injuries, the court nevertheless held the connection was not sufficiently strong so as to support an award of benefits.

Wait worked as a senior director for the American Cancer Society. Because of the Societys lack of office space in Nashville, it allowed Wait to work from her Nashville home, furnishing Wait with all the necessary office equipment, as well as a dedicated telephone line, and a budget for the purchase of office supplies. Not only did Wait perform virtually all her work from her home office, her supervisor and coworkers often attended meetings at Waits house.

One work day, while she fixed herself lunch, Wait was attacked and severely beaten by a neighbor whom Wait had allowed into the house. Wait did not know it at the time, but the assailant apparently had been stalking her for some weeks or even months. Wait subsequently sought workers compensation benefits, contending the assault arose out of and occurred in the course of her employment with the Society. The chancery court disagreed, granted summary judgment in favor of the workers compensation carrier, and Wait appealed.

The Tennessee Supreme Court affirmed, although it did not utilize the rationale of the trial court. Treating the arising out of/in the course of the employment issue in a bifurcated fashion, the Court held that Waits injuries had, indeed, occurred in the course of her employment since, at the time of the assault, Wait was where the employer reasonably expected her to be and was performing actions which were either related to her work or were incidental to that employment. That Wait was fixing lunch was unimportant, indicated the Court, since such activity was not the sort that would ordinarily remove Wait from the work environment. Treating Waits residence as an extension of the employers premises, the Court pointed to ample case law supporting the rule that an on-premises lunch break was generally within the course of the employment.

According to the Court, Waits injuries did not, however, arise from her employment. Citing Tennessee case law that assaults originating from inherently private disputes or which were imported into the work place were generally not compensable within the workers compensation scheme for providing disability benefits, the Court indicated the evidence established that the assault had no inherent connection with the employment.

Furthermore, the Court refused to extend the so-called street risk doctrine to the facts of the case. Under that doctrine, if the employment exposes the employee to the hazards of the street, the necessary causal connection between the employment and the injury can be supplied by a showing that the employee was injured by a danger associated with that so-called street risk. The Court observed that over time, the street risk doctrine had been expanded to cover incidents well beyond streets and highways. For example, in *Jesse v. Savings Prods.*, 772 S.W.2d 425 (Tenn. 1989), a convenience store employee recovered benefits when she was raped and assaulted by an assailant. The court reasoned that the street risk doctrine applied when an employees indiscriminate exposure to the general public was one of the conditions under which the work was required to be performed. Likewise, in *Braden v. Sears, Roebuck & Co.*, 833 S.W.2d 496 (Tenn. 1992), the Tennessee Supreme Court held that the street risk doctrine satisfied the causal connection requirement where the employee was assaulted by unknown assailants as he removed paperwork from his employer's van while it was parked at his residence.

The *Wait* Court reasoned that nothing in Waits employment required any exposure to the public while she worked in her home. According to the Court, unlike the cases noted in the previous paragraph, nothing in the facts of the case indicated the assailant had attacked Wait because she was identifiable as an American Cancer Society employee, or because she was performing a job duty, or because she was safeguarding the societys property at the time. Her attack was totally unrelated to her status as an employee. Her injuries, therefore, did not arise from her employment and were not compensable.

Wait Case Is Not a Significant Defeat for the Telecommuter. In spite of the fact that the trial courts summary denial of Waits claim was affirmed by the Supreme Court of Tennessee, telecommuters should not view the decision as a stinging defeat.

. The Court utilized a standard arising out of and in the course of the employment rules in affirming the denial of Waits claim. In other words, the Court refused to say that all assaults of home-based employees are barred; it carefully examined the circumstances surrounding Waits injuries *in the same manner* as it would have had the injuries occurred at the employers primary premises. The Court certainly leaves the impression that if a similar assault had occurred on the employers primary work site, the claim similarly would have been denied because there was no causal connection between the employment and the assault. That the home-based employee be treated the same as if he or she was employer premises-based is all that can be expected.

. The Courts decision in *Wait* was not based on the employers inability to control the conditions of the home office. Employers have sometimes argued that it is unfair to saddle them with legal responsibility for injuries sustained at a work site, such as a personal residence, where they cannot and do not exercise any control. According to this argument, the financial cost of work-related injuries is an incentive to enforce safety guidelines and maintain a safe work environment. The notion is that since the employer cannot enforce a safe work environment at an employees residence, it should not bear the risk of injury. While this point was not central to the employers argument in *Wait*, there is little in the *Wait* decision that indicates the Tennessee court would rule favorably on those grounds in other telecommuting cases.

. *Wait* certainly appears to support the notion that injuries sustained while performing personal comfort activities--getting fresh air, using the toilet, or taking a short walk--are just as compensable when they are suffered by the home-based telecommuter as when they are sustained by employer premises-based employees. Here the Court clearly refused to sustain the employers argument that Waits claim was not compensable because her injuries occurred while she fixed lunch--an activity unrelated to her actual duties. The Court observed that latitude for on-premises lunches was given to those working at the employers office. The same sort of latitude should be given the telecommuter.

. *Wait* may help carve out an additional exception to the going and coming rule. At several points in its opinion, the Tennessee high court acknowledged that for the true telecommuter, ones home office should be considered part of the employers premises. Since the general rule in most jurisdictions is that an injury sustained during work-related travel between one part of the employers premises and another is compensable, an injury sustained in traveling from the office-in-the-home to the employers primary premises would appear to fall outside the ordinary going and coming rule. More specifically, if a worker like Wait sustained injuries in an accident as she traveled to the employers premises to attend a meeting, her claim would be compensable under this line of reasoning. It should, of course, be observed that the going and coming rule was not at issue in *Wait*.

Practice Point True Telecommuting Must Be Distinguished From Hearthside Activities. In *Wait*, the employee was engaged in rather formalized telecommuting. She was allowed to work out of her home because her employer lacked adequate office space within its own facility. Wait met with subordinates and supervisors in her home. She was provided with necessary office equipment and was given a special telephone line and an expense account for necessary office supplies. For all intents and purposes, her home office served as an extension of the Cancer Societys main Nashville premises. As noted above, this fact was an important consideration in the Courts reasoning. It should be remembered, however, that just because some work is conducted from the home does not mean a true telecommuting arrangement has been created, such that injuries sustained in and around the home or while traveling from the home to the employers facility are compensable.

Under the Larson rule, for a true telecommuting arrangement to be established, the home must be transformed into a work situs generally. Normally there must be some evidence that both the employer and the employee receive some important benefit from the arrangement and that the arrangement is part of the overall bargain of employment, less teachers who prepare lessons or correct papers at home, lawyers who take home briefs, salespeople who work on accounts at home, and newspaper columnists who polish up a bit of writing at home might be tempted to assert compensation coverage of all their movements to, from or around the house by virtue of some morsel of work carried around in their pockets (*Larsons Workers Compensation Law* § 16.10[1]). As at least one court has indicated, [the]

contemporary professional frequently takes work home. There, the draftsman designs on a napkin, the businessman [or woman] plans at breakfast, the lawyer labors in the evening. But this hearthside activity--while commendable--does not create a white collar exception to the going and coming rule (*Santa Rosa Junior College v. Workers Comp. Appeals Board*, 40 Cal. 3d 345, 220 Cal. Rptr. 94, 101, 708 P.2d 673, 680 (1985).) Nor does it mean that an employee injured at home while pursuing some of this hearthside activity has a compensable claim under the workers compensation system for providing disability and medical benefits.

For further discussion related to the workers' compensation issues related to work place assaults, see generally *Larson's Workers' Compensation Law*, § 8.01 et seq. For further discussion related to telecommuters, see generally *Larson's Workers' Compensation Law*, § 16.10 et seq.

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Clifford on Insurance Coverage Issues Raised by Massachusetts v EPA.

2008 Emerging Issues 1302

Clifford on Insurance Coverage Issues Raised by Massachusetts v EPA.

By Robert C. Clifford

December 4, 2007

SUMMARY: In *Massachusetts v. EPA*, the U.S. Supreme Court held that the Clean Air Act authorized the Environmental Protection Agency (EPA) to regulate greenhouse gas emissions from new motor vehicles despite the EPA's contrary claim and that MA had standing to challenge the EPA's denial of a rulemaking petition to promulgate such regulations.

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ARTICLE: *Introduction.* In *Massachusetts v. EPA*, 127 S. Ct. 1438 (U.S. 2007), the U.S. Supreme Court held that the Clean Air Act authorized the Environmental Protection Agency (EPA) to regulate greenhouse gas emissions from new motor vehicles -- despite the EPA's contrary claim -- and that Massachusetts had standing to challenge the EPA's denial of a rulemaking petition to promulgate such regulations. Many commentators believe that this decision, and the increased public awareness of the threat of environmental damage caused by the emission of greenhouse gases will result in a substantial increase in litigation. See, e.g., James M. Davis & Noel C. Paul, *Managing the Risks of Global Warming: Avoiding the Mass Tort Template and Insurance Coverage Implications*, 17 Coverage 1 (LexisNexis).

The increase in environmental claims raises the question for potential emitters as to the availability of insurance coverage to provide indemnity and the payment of anticipated large defense expenses. In the business world, comprehensive general liability (CGL) policies ordinarily provide primary insurance coverage. The policies generally provide broad coverage, but such coverage is subject to various exclusions. Here, the pollution exclusion may be the primary roadblock for policy holders. However, on the flipside, the concept of an insured's reasonable expectation may be the key to obtaining coverage for liability arising from the emission of greenhouse gases.

The lesson to be learned here is that litigation concerning climate change and claims against entities who are involved in the emission of greenhouse gases will undoubtedly increase as a result of the Court's decision in *Massachusetts v. EPA*. The practical implications of the holding will be that class actions against polluters will escalate and both the plaintiff and defense bar, as well as in-house counsel, should be aware of the scope of the decision, the

prospective increase in litigation, and the potential insurance coverage issues that may result.

This commentary discusses the issues that affect the availability of coverage for damage caused by greenhouse gases. Policy holders will contend that the damage caused by greenhouse gases is within the terms of a comprehensive general liability policy and that the pollution exclusion contained in the policy is not effective to preclude coverage. In addition, policy holders will probably rely upon the doctrine of reasonable expectations for coverage. See James M. Davis & Noel C. Paul, *Managing the Risks of Global Warming: Avoiding the Mass Tort Template and Insurance Coverage Implications*, 17 Coverage 1 (LexisNexis).

Insurers, on the other hand, will most likely contend that the damage resulting from the emission of greenhouse gases is neither an occurrence nor an accident within the terms of a comprehensive general liability policy. See Seth A. Ribner & Deborah L. Stein, *The Costs of Climate Change: Why Industry Should Not Look to Liability Insurance to Bear Them*, 17 Coverage 1 (LexisNexis September/October 2007). In addition, insurers will likely contend that the doctrine of reasonable expectations is inapplicable as that doctrine is implicated only to assist in resolving ambiguities. Insurers may also contend that the injury did not occur during the policy period because the emission of greenhouse gases does not immediately cause damage, and a CGL policy is not implicated until damage is sustained.

General Principles of Interpretation of Insurance Policies. The interpretation of an insurance policy is a question of law and follows the general rules of contract interpretation. *Crane v. State Farm Fire & Casualty Co.*, 5 Cal. 3d 112 (Cal. 1971). The fundamental rules of contract interpretation are based on the premise that the interpretation of a contract must give effect to the mutual intention of the parties. *Vyn v. Northwest Casualty Co.*, 47 Cal. 2d 89 (Cal. 1956), *Nationwide Mut. Ins. Co. v. Devlin*, 11 Cal. App. 4th 81 (Cal. Ct. App. 1992). Under statutory rules of contract interpretation, the mutual intention of the parties at the time the contract is formed governs interpretation. See, e.g., Cal Civ Code § 1636. Such intent is to be inferred, if possible, solely from the written provisions of the contract. The clear and explicit meaning of these provisions, is interpreted in their ordinary and popular sense, unless used by the parties in a technical sense or a special meaning is given to them by usage. A policy provision will be considered ambiguous when it is capable of two or more constructions, both of which are reasonable. But language in a contract must be interpreted as a whole and in the circumstances of the case and cannot be found to be ambiguous in the abstract. See *Otter v. General Ins. Co.*, 34 Cal. App. 3d 940, 948 (Cal. Ct. App. 1973) and cases cited therein.

Insurance coverage is interpreted broadly so as to afford the greatest possible protection to the insured, whereas exclusionary clauses are interpreted narrowly against the insurer. See *Otter v. General Ins. Co.*, 34 Cal. App. 3d 940, 948 (Cal. Ct. App. 1973) and *MacKinnon v. Truck Ins. Exchange*, 31 Cal. 4th 635 (Cal. 2003). An insurer cannot escape its basic duty to insure by means of an exclusionary clause that is unclear. It is well established that an exception to the performance of the basic underlying obligation must be so stated as clearly to apprise the insured of its effect. Thus, the burden rests upon the insurer to phrase exceptions and exclusions in clear and unmistakable language. The exclusionary clause 'must be conspicuous, plain and clear'. This rule applies with particular force when the coverage portion of the insurance policy would lead an insured to reasonably expect coverage for the claim purportedly excluded. *Bank of the W. v. Superior Court*, 2 Cal. 4th 1254 (Cal. 1992). The burden is on the insured to establish that the claim is within the basic scope of coverage and the burden is on the insurer to establish that the claim is specifically excluded.

Extent of Potential Litigation. Significantly, the *Massachusetts v. EPA* majority held that greenhouse gases constitute air pollution under the Clean Air Act, and that the Act authorizes the EPA to regulate such gases. *Massachusetts v. EPA*, 127 S. Ct. 1438, 1460 (U.S. 2007). In light of this holding, counsel for an injured person or entity should consider the liability of all potential contaminators. Given the numerous contributors of greenhouse gases, establishing the responsible entities will require sophisticated expertise to prove the degree to which damage is caused by the emission of greenhouse gases. Identifying the polluters and the issue of causation may prove to be a formidable task and the resolution of these issues will affect the issue of insurance coverage.

Because the Supreme Court recognized global warming as a redressable wrong, commentators have compared the possible increase in environmental litigation caused by global warming to the surge of asbestos claims and tobacco litigation which also involved multiple defendants and claimants. See James M. Davis & Noel C. Paul, *Managing the Risks of Global Warming: Avoiding the Mass Tort Template and Insurance Coverage Implications*, 17 Coverage 1 (LexisNexis). With an increase in greenhouse gas damage claims, the concomitant issue of whether insurance coverage is available to cover the claims comes into play.

Potential Insurance Coverage Problems. Numerous difficulties are present in attempting to determine whether insurance coverage exists in situations where continuous tortious conduct occurs that causes extended and cumulative damage to myriad claimants. An innumerable number of insurance policies with various insuring agreements, exclusions, definitions, policy periods and terms may be implicated. The potential defendants cover an extensive range of industries and businesses. Identifying the emitter will be a formidable task for the plaintiff, potential defendants and insurers.

Establishing causation may also be difficult when numerous potential polluters exist. Establishing the fault and responsibility for the damage incurred when there exist many possible causes for the damages incurred would prove difficult. Proof that the emissions causing the plaintiff's damage occurred within a particular policy period could be difficult not only for the plaintiff, but also for the emitter and the emitter's insurance carriers.

Insurance Coverage Analysis. The first task of counsel is to examine closely the liability insurance policies that may be implicated including the insuring agreement, the pertinent policy exclusions, terms, definitions, and policy dates. Beyond reviewing the policy, counsel should review any correspondence with the insurer or the producing broker. The insurance policy of an emitter most likely to be implicated is the comprehensive general liability (CGL) policy. Such a policy typically obligates the insurer to pay all sums for which the insured becomes legally obligated to pay as damages caused by bodily injury, property damage or personal injury.

A CGL policy generally provides coverage for bodily injury and property damage that occur during the policy period. However, the time of the emission of greenhouse gases is largely immaterial in establishing coverage. For example, the court in *Stonelight Tile, Inc. v. California Ins. Guarantee Assn.*, 150 Cal. App. 4th 19, 36 (Cal. Ct. App. 2007) stated,

[t]he timing of the accident, event, or conditions causing the bodily injury or property damage, e.g., an insured's negligent act, is largely immaterial to establishing coverage; it can occur before or during the policy period. Neither is the date of discovery of the damage or injury controlling; it might or might not be contemporaneous with the causal event. It is only the effect -- the occurrence of bodily injury or property damage during the policy period, resulting from a sudden accidental event or the 'continuous or repeated exposure to conditions' -- that triggers potential liability coverage.

Pollution Exclusion. The pollution exclusion in CGL policies is likely to be asserted by insurers to avoid coverage for greenhouse gas claims. A common pollution exclusion provision provides that the insurer does not cover bodily injury or property damage resulting from the actual, alleged, or threatened discharge, dispersal, release or escape of pollutants at or from the insured location. The terms, "pollution or pollutants" are commonly defined, in the definitions section of the policy, as "meaning any solid, liquid, gaseous or thermal irritant or contaminant, including smoke, vapor, soot, fumes, acids, alkalis, chemicals and waste materials. Waste materials include materials which are intended to be or have been recycled, reconditioned or reclaimed." See *MacKinnon v. Truck Ins. Exchange*, 31 Cal. 4th 635 (Cal. 2003).

The California Supreme Court in *MacKinnon v. Truck Ins. Exchange*, 31 Cal. 4th 635 (Cal. 2003) considered the applicability of the pollution exclusion and reviewed those jurisdictions that had taken a definitive position on whether the exclusion applied. The court noted that the narrower interpretation of the pollution exclusion appeared to be in the majority. However, there are a number of jurisdictions which have held that the pollution exclusion does preclude coverage under a comprehensive general liability policy. Courts have denied coverage on the grounds that the exclusion

is plain and unambiguous. See, e.g., *Reliance Ins. Co. v. Moessner*, 121 F.3d 895 (3d Cir. 1997); *Bernhardt v. Hartford Fire Ins. Co.*, 102 Md. App. 45 (Md. Ct. Spec. App. 1994); *League of Minnesota Cities Ins. Trust v. Coon Rapids*, 446 N.W.2d 419 (Minn. Ct. App. 1989).

In light of the lack of consensus as to the effect of the pollution exclusion, counsel contemplating litigation on the issue of whether coverage exists, such as a declaratory relief action, should carefully consider the question of venue. Despite the abundance of opinions construing the exclusion, courts have not reached a clear consensus as to its proper interpretation. For example, in *Gainsco Ins. Co. v. Amoco Prod. Co.*, 53 P.3d 1051, 1065 (Wyo. 2002), the Supreme Court of Wyoming commented on the conflict in authorities as to the intent and scope of the total pollution exclusion. The *Gainsco* court opined that it did not know if it was taking the majority position, but joined with those courts that have held that the total pollution exclusion is limited to the concept of environmental pollution. See also *American States Ins. Co. v. Koloms*, 177 Ill. 2d 473 (Ill. 1997) (comprehensive review of differing approaches taken by various jurisdictions).

Courts which have restricted the pollution exclusion's otherwise potentially limitless application hold that the exclusion applies only to hazards associated with environmental pollution. For example, *Doerr v. Mobil Oil Corp.*, 774 So. 2d 119 (La. 2000) held that the general purpose of pollution exclusions has remained constant: to exclude coverage for environmental pollution, and under such interpretation, the clause will not be applied to all contact with substances that may be classified as pollutants. In *Sullins v. Allstate Ins. Co.*, 667 A.2d 617, 622 (Md. 1995), the Court of Appeals of Maryland stated that the insurance industry apparently intended the pollution exclusion to apply only to environmental pollution. In *American States Ins. Co. v. Koloms*, 177 Ill. 2d 473 (Ill. 1997), the Supreme Court of Illinois also agreed with those courts which have restricted the exclusion's otherwise potentially limitless application to only those hazards traditionally associated with environmental pollution.

Jurisdictions which hold that the pollution exclusion applies to environmental pollution present a possible obstacle for an insured attempting to obtain coverage -- if the emission of greenhouse gases constitutes environmental pollution, the pollution exclusion will apply and bar coverage. Jurisdictions following this view appear to have found support in *Massachusetts v. EPA's* holding that greenhouse gases constitute air pollution under the *Clean Air Act*. *Massachusetts v. EPA*, 127 S. Ct. 1438, 1460 (U.S. 2007). Consequently, to ensure the best possible chances for triggering or obtaining insurance coverage for greenhouse gas damage claims, counsel should carefully craft pleadings that do not describe or otherwise characterize the emission of greenhouse gases as environmental pollution.

Background of the Pollution Exclusion. Because the issue of whether insurance coverage for environmental damage exists may hinge largely upon the applicability of the pollution exclusion, a review of the exclusion's background is helpful. In *MacKinnon v. Truck Ins. Exchange*, 31 Cal. 4th 635, 643 (Cal. 2003), the California Supreme Court undertook such a review. Quoting extensively from the Illinois Supreme Court's comprehensive review in *American States Ins. Co. v. Koloms*, 177 Ill. 2d 473 (Ill. 1997), the *MacKinnon* court noted that insurance companies began adding the exclusion to their CGL policies in 1970, in the form of an endorsement. The endorsement provided in pertinent part "[the] policy shall not apply to bodily injury or property damage arising out of the discharge, dispersal, release or escape of smoke, vapors, soot, fumes, acids, alkalis, toxic chemicals, liquids or gases, waste materials or other irritants, contaminants or pollutants into or upon land, the atmosphere or any watercourse or body of water; but this exclusion does not apply if such discharge, dispersal, release or escape is 'sudden and accidental.'" *MacKinnon v. Truck Ins. Exchange*, 31 Cal. 4th 635, 643 (Cal. 2003). At about the same time, Congress substantially amended the Clean Air Act, creating more stringent air quality standards. During the next 13 years, a significant amount of coverage litigation centered on the issue of ". . . whether the word 'sudden' was intended to be given a strictly temporal meaning such that, in order for the exception to apply, the discharge of pollution had to have been 'abrupt.'" *MacKinnon v. Truck Ins. Exchange*, 31 Cal. 4th 635, 643 (Cal. 2003). The insurers responded by drafting a new version of the exclusion, now commonly referred to as the "absolute pollution exclusion." The exclusion's two most notable features included ". . . (i) the lack of any exception for the 'sudden and accidental' release of pollution, and (ii) the elimination of the requirement that the pollution be discharged into or upon land, the atmosphere or any watercourse or body of water." *MacKinnon v. Truck Ins. Exchange*, 31 Cal. 4th 635, 644 (Cal. 2003). Such language appears to support the contention that the

exclusion would apply to the discharge of greenhouse gases into the atmosphere, provided that the gases were considered to be "pollution," within the meaning of the exclusion.

After thoroughly reviewing the history of the pollution exclusion and related policy concerns, the *MacKinnon* court embraced a narrow interpretation and concluded that the exclusion did not bar CGL coverage for a wrongful death action that arose from the landlord's application of pesticides at an apartment complex. *MacKinnon v. Truck Ins. Exchange*, 31 Cal. 4th 635, 650 (Cal. 2003). The Court explained that it was rejecting the insurer's broad interpretation of the exclusion because it would lead to the absurd result of classifying virtually any substance as an excluded pollutant. *MacKinnon v. Truck Ins. Exchange*, 31 Cal. 4th 635, 650 (Cal. 2003). Consequently, the *MacKinnon* holding would appear to support the contention that greenhouse gases, similar to pesticides, while harmful, do not constitute excluded pollutants. This argument finds further support in the California Supreme Court's rejection of the term, "absolute pollution exclusion" due to its overly broad connotations. *MacKinnon v. Truck Ins. Exchange*, 31 Cal. 4th 635, 644 (Cal. 2003).

Insured's Reasonable Expectations. A contention by an insurer that the pollution exclusion bars coverage for damages caused by greenhouse gases may also be contrary to an insured's reasonable expectations. The California Supreme Court has repeatedly held that the purpose of the comprehensive general liability policy is to provide the insured with the broadest spectrum of protection against liability for unintentional and unexpected personal injury or property damage arising out of the conduct of the insured's business. *MacKinnon v. Truck Ins. Exchange*, 31 Cal. 4th 635, 648 (Cal. 2003). The court noted that the coverage provision in the commonly used comprehensive general liability policy provides that the policy insures "all sums for which the insured becomes legally obligated to pay as damages caused by bodily injury, property damage or personal injury" demonstrates the insurer's intent to provide protection for ordinary acts of negligence and other fault-based conduct by insureds. *MacKinnon v. Truck Ins. Exchange*, 31 Cal. 4th 635, 649 (Cal. 2003).

Normally a policy holder who takes a "comprehensive" insurance policy with express coverage would expect his or her ordinary transactions to be covered. If the insurer creates an exception to the general import of the principal coverage clauses, the burden rests upon it to phrase that exception in clear and unmistakable language. *MacKinnon v. Truck Ins. Exchange*, 31 Cal. 4th 635, 648 (Cal. 2003). If this is not done, any ambiguity or uncertainty is resolved in favor of the policyholder. Indeed, an exception must be couched in terms which are clear to the ordinary mind, or any doubts as to meaning will be resolved against the insurer. *Ritchie v. Anchor Casualty Co.*, 135 Cal. App. 2d 245 (Cal. Ct. App. 1955).

In situations where insureds have been sued for damages resulting from the discharge of greenhouse gases, insurers will likely contend that the pollution exclusion bars coverage. However, an insured has a reasonable expectation of coverage for liability arising from normal business operations. Arguably, if an insured's normal operations involves the emission of greenhouse gases, a claim for damages should be covered despite the presence of the pollution exclusion.

Although a policy holder may contend that it had a reasonable expectation that the CGL policy would provide coverage for damage caused by the emission of greenhouse gases, the doctrine is employed only to assist in the interpretation of an ambiguous policy provision. The plain meaning of a policy governs, and insured's reasonable expectations are not considered except when the policy provisions are ambiguous. *Prudential Ins. Co. of Am. v. Superior Court*, 98 Cal. App. 4th 585, 598 (Cal. Ct. App. 2002), citing *Foster-Gardner, Inc. v. Nat'l Union Fire Ins. Co.*, 18 Cal. 4th 857, 868 (Cal. 1998). See also *Boghos v. Certain Underwriters at Lloyd's of London*, 36 Cal. 4th 495, 501 (Cal. 2005) ("If contractual language is clear and explicit, it governs. If the terms are ambiguous, the court

interprets them to protect the objectively reasonable expectations of the insured.")

An insurer cannot escape its basic duty to insure by means of an exclusionary clause that is unclear. The *MacKinnon v. Truck* court commented that it has repeatedly held that an exception to the performance of the basic underlying obligation must be so stated to apprise the insured of its effect. Thus, the burden rests upon the insurer to phrase exceptions and exclusions in clear and unmistakable language. The exclusionary clause must be conspicuous, plain and clear. This rule applies with particular force when the coverage portion of the insurance policy would lead an insured to reasonably expect coverage for the claim purportedly excluded. The burden is on the insured to establish that the claim is within the basic scope of coverage and on the insurer to establish that the claim is specifically excluded. *MacKinnon v. Truck Ins. Exchange*, 31 Cal. 4th 635, 648 (Cal. 2003).

The court in *Pipefitters Welfare Educ. Fund v. Westchester Fire Ins. Co.*, 976 F.2d 1037, 1044 (7th Cir. 1992) held that the pollution exclusion does not apply to injuries resulting from everyday activities gone slightly, but not surprisingly, awry. The court commented that there is nothing that is unusual about paint peeling off of a wall, asbestos particles escaping during the installation or removal of insulation, or paint drifting off the mark during a spray painting job. A reasonable policyholder would not characterize such routine incidents as pollution.

In *Saltarelli v. Bob Baker Group Medical Trust*, 35 F.3d 382 (9th Cir. 1994), the U.S. Ninth Circuit Court of Appeals applied the reasonable expectations doctrine to a health insurance policy's preexisting condition exclusion clause and held that it was unenforceable because it lacked a clear, plain and conspicuous statement of the exclusion. This doctrine, which grew out of the law of adhesion contracts and construction of ambiguities in insurance policies, has been formulated as follows: "In general, courts will protect the reasonable expectations of applicants, insureds, and intended beneficiaries regarding the coverage afforded by insurance carriers even though a careful examination of the policy provisions indicates that such expectations are contrary to the expressed intention of the insurer." *Saltarelli v. Bob Baker Group Medical Trust*, 35 F.3d 382, 384 (9th Cir. 1994).

The doctrine of protecting the reasonable expectations of the insured is closely related to the doctrine of contracts of adhesion. Where there is unequal bargaining power between the parties so that one party controls all of the terms and offers the contract on a take-it-or-leave-it basis, the contract will be strictly construed against the party who drafted it. *Garcia v. Truck Ins. Exch.*, 36 Cal. 3d 426, 438 (Cal. 1984); *Gray v. Zurich Ins. Co.*, 65 Cal. 2d 263 (Cal. 1966). Most courts recognize the great disparity in bargaining power between insurance companies and those who seek insurance. Further, they recognize that, in the majority of cases, a lay person lacks the necessary skills to read and understand insurance policies, which are typically long, set out in very small type and written from a legalistic or insurance expert's perspective. Finally, courts recognize that people purchase insurance relying on others, the agent or company, to provide a policy that meets their needs.

The result of the lack of insurance expertise on the part of insureds and the recognized marketing techniques of insurance companies is that "the objectively reasonable expectations of applicants and intended beneficiaries regarding the terms of insurance contracts will be honored even though painstaking study of the policy provisions would have negated those expectations." *Atwater Creamery Co. v. Western Nat'l Mut. Ins. Co.*, 366 N.W.2d 271, 277 (Minn. 1985).

The traditional approach to construction of insurance contracts is to require some kind of ambiguity in the policy before applying the doctrine of reasonable expectations. Some courts, however, have adopted the view that ambiguity ought not be a condition precedent to the application of the reasonable-expectations doctrine. *See, e.g., Hallmark Ins. Co. v. Superior Court*, 201 Cal. App. 3d 1014 (Cal. Ct. App. 1988), *Wint v. Fidelity & Casualty Co.*, 9 Cal. 3d 257 (Cal. 1973).

The reasonable-expectations doctrine gives courts a standard by which to construe insurance contracts without having to rely on arbitrary rules which do not reflect real-life situations and without having to bend and stretch those rules to do justice in individual cases. Ambiguity in the language of the contract is not irrelevant under this standard, but becomes a factor in determining the reasonable expectations of the insured, along with such factors as whether the

insured was told of important, but obscure, conditions or exclusions and whether the particular contract provision is an item known by the public generally. The doctrine does not automatically absolve an insured of the responsibility to read the policy. It does, however, recognize that in certain instances, such as where major exclusions are hidden in the definitions section, the insured should be held only to reasonable knowledge of the literal terms and conditions. The insured may show what actual expectations he or she had, but the fact-finder should determine whether those expectations were reasonable under the circumstances. *Atwater Creamery Co. v. Western Nat'l Mut. Ins. Co.*, 366 N.W.2d 271, 277 (Minn. 1985).

Exception to Reasonable Expectations Doctrine. The doctrine of reasonable expectations based upon the disparity of bargaining power and the fact that in the majority of cases an insured may lack the necessary skills to read and understand insurance policies may not apply to the policy holders in pollution cases where the defendant emitter is often a large corporation with a sophisticated and knowledgeable insurance department whose personnel are capable of understanding policy terms and are able to negotiate alternative policy provisions. *See, e.g., AIU Ins. Co. v. Superior Court*, 51 Cal. 3d 807, 823 (Cal. 1990).

Directors' and Officers' Insurance. Although the Comprehensive General Liability policy is the most likely principal source of insurance for an emitter of greenhouse gases, counsel should not overlook the possibility of implicating the company's directors and officers insurance policies. The directors' and officers' liability coverage might be implicated if there has been a failure on the part of the company's officers to recognize and disclose possible risks caused by a corporate emitter of greenhouse gases. Corporate officers may have a duty of care to remedy the problem of the emission of greenhouse gases and the resulting claims. Failure to anticipate claims relating to global warming and the emission of greenhouse gases may subject a director to liability and implicate his or her director's policy.

Conclusion. The U.S. Supreme Court's decision in *Massachusetts v. EPA*, 127 S. Ct. 1438 (U.S. 2007), coupled with increased public awareness of the threat of global warming, will most likely result in a substantial increase in litigation over damages allegedly caused by the emission of greenhouse gases. The increase in environmental claims raises the question for potential emitters as to the availability of insurance coverage to pay for defense costs and provide indemnity in the event of an adverse judgment or settlement agreement. As noted, commentators are split on whether coverage exists. *See, e.g., James M. Davis & Noel C. Paul, Managing the Risks of Global Warming: Avoiding the Mass Tort Template and Insurance Coverage Implications*, 17 Coverage 1 (LexisNexis May/June 2007) (arguing that coverage exists and the pollution exclusion does not apply); and Seth A. Ribner & Deborah L. Stein, *The Costs of Climate Change: Why Industry Should Not Look to Liability Insurance to Bear Them*, 17 Coverage 1 (LexisNexis September/October 2007) (arguing that greenhouse gas emissions are an ordinary industrial activity and are therefore not an "occurrence" within the meaning of a CGL policy). In any event, sufficient case law appears to exist on both sides of the argument, which means that the nation's courts will have to sort the matter out over a series of decisions in the years to come.

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Kohane on Liberty Mutual Insurance Company v. Insurance Company of Pennsylvania

2008 Emerging Issues 1309

Kohane on Liberty Mutual Insurance Company v. Insurance Company of Pennsylvania

By Dan D. Kohane

December 4, 2007

SUMMARY: What will be the order of insurance coverage in a construction accident lawsuit where there are primary, co-primary and excess policies? For the practitioner, understanding the order of coverage among primary and excess policies is critically important.

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ARTICLE: The Appellate Division of the New York State Supreme Court unraveled the relationships grappled with the interrelationship between and among primary and excess policies in *Liberty Mut. Ins. Co. v. Insurance Co. of the State of Pa.*, 2007 NY Slip Op 6576 (N.Y. App. Div. 2007). The court held that two primary policies had to contribute equally to the resolution of a lawsuit before an excess policy, providing coverage over one of the two policies, had an obligation to contribute. Following that layer of coverage would be the excess carrier's policy which referenced the coverage limits on what would have otherwise been an employer's liability policy with unlimited coverage. Practitioners need to understand the order of liability coverage and the corresponding obligations of primary and excess carriers.

The Underlying Dispute. The underlying claim presented a typical New York construction lawsuit. A construction project was ongoing in New York City. In New York, where an injury occurs on a construction site, various provisions of the New York State Labor Law, including Section 200, 240(1) and 241(6) apply to permit an injured construction worker to bring an action against the owner, general contractor and agents, other than the worker's own employer, to recover for sustained injuries.

New York Exclusivity Rules. Under the exclusivity provisions of the Workers' Compensation Law, an employee may not sue his or her own employer. However, New York permits a party who is sued to implead the plaintiff's employer, even if the employer has provided Workers' Compensation benefits, in two instances. An employer can be sued for contractual indemnity, if it is a party to an enforceable contractual indemnity agreement with a party to the lawsuit. An employer can also be sued for common law negligence, for contribution, even without the presence of an indemnity agreement if the plaintiff has sustained a "grave injury" as defined by Section 11 of the Workers' Compensation Law. n1 In this case, both claims were being pursued. That led to a battle between the carriers over the obligation to defend and indemnify.

Surely, this dispute is important both to the insured as well as the claimant. The insured needs to know which carrier will provide it with primary defense.

In the underlying case, the injured construction worker-plaintiff was employed by General Industrial Service Corporation (General). Unable to sue his employer, he commenced an action against the project owner and construction manager seeking to recover for personal injuries under the provisions of the New York State Labor Law. Those defendants then commenced a third party action against General seeking both common law and contractual indemnity.

Policies Implicated. Three carriers insured General.

General had purchased a Commercial General Liability (CGL) policy through Diamond with liability limits of \$1,000,000 per person, per accident. Under that policy, Diamond had an obligation to defend General in any lawsuit that contained contractual liability claims. While the decision does not speak to it, it is likely the policy contained typical employer's liability exclusions. Those exclusions would redact coverage for claims made against the employer-insured for common law contribution in a lawsuit commenced by an employee, even if the claims against the employer were made by third-parties. Accordingly, Diamond would be on the risk for any contractual liability claims brought against General arising out of an "insured contract," but would have no obligation to indemnify the insured for common law contribution claims.

In addition to the CGL policy, General purchased a Workers' Compensation / Employer's Liability policy through The Insurance Company of the State of Pennsylvania and AIG (collectively referred to as AIG). That policy provided unlimited coverage under "Coverage B" for common law contribution claims made against General for employee injuries. See: New York State Insurance Department Circular Letter 1987-17 Supplement 1 [http://www.ins.state.ny.us/acrobat/CL17_87_1.PDF]. General also acquired an excess policy with Liberty Mutual Insurance Company (Liberty) that provided liability limits in excess of underlying policies.

AIG refused to participate in the defense of the third party action commenced against its insured, and would not contribute towards the settlement. The employee's personal injury claim was ultimately settled for \$2.5 million. Diamond contributed its policy limits of \$1 million, and Liberty contributed the \$1.5 million from its excess limits, reserving its right to seek reimbursement of those proceeds from the Workers' Compensation/Employer's Liability carrier (AIG).

After the settlement, Liberty instituted this declaratory judgment action seeking reimbursement of its \$1.5 million payment from AIG. The questions before the appellate court focused on the allocation of indemnity payments. As Diamond, the carrier that provided the defense was not a party to the declaratory judgment action, the recovery of an allocable share of defense costs was not before the court.

Allocation of Coverage. Providing counsel to practitioners, the court had to unwind the policies to determine the order of coverage.

The Appellate Division concluded that AIG was a primary insurer whose obligation to provide indemnity "took precedence over that of Liberty." AIG argued, unsuccessfully, that the claim by the project owner against General was an impermissible violation of the rule which prohibits insureds under the same policy from bringing claims covered by the same policy, the so-called, *anti-subrogation* rule. (see *Jefferson Ins. Co. of N.Y. v Travelers Indem. Co.*, 92 NY2d 363, 375 [1998]).

However, the court refused to grant judgment in favor of Liberty because it was not clear whether or not, in the underlying action, the owner and construction manager would have to secure a judgment in contribution, against the employer, General. Why?

Had the underlying case gone to verdict (remember, it was settled), the owner and construction manager could not have secured a judgment for contribution that would have triggered the employer's liability policy unless they would have established that the plaintiff suffered a "grave injury." Since the case did not go to verdict, and the record was not clear on the subject, the court remanded the matter back for a hearing on that specific question.

If a "grave injury" were not established, there could only be a contractual liability determination against the employer, and thus no trigger of the Employer's Liability Policy.

If a "grave injury" were established, the Appellate Division went on to determine the allocation of coverage for the settlement. On the first level would be the two primary policies, the Diamond \$1,000,000 CGL limit and the AIG Employers Liability limit.

The message from the court was clear; the primary carriers each had an obligation to defend and indemnify, so each would need to participate.

How does a policy with limited coverage share with a policy with unlimited coverage?

Liberty argued that since, in New York, under Coverage "B" of Employer's Liability policies there is an unlimited coverage, the Liberty policy should never be triggered. The court disagreed because the Liberty policy provided that coverage thereunder was "implicated by liability in excess of the insured's "Retained Limit," defined, in pertinent part, as "the total amounts stated as the applicable limits of the underlying policies listed in the Schedule of Underlying Insurance and the applicable limits of any other insurance providing coverage." In other words, the policy indicated an expectation it would be in excess of specific limits. As the Schedule of Underlying Insurance specifically listed the AIG policy and "attributes to it a \$1 million per-accident limit of insurance," the Liberty policy would provide coverage thereafter (*see State Ins. Fund v International Ins. Co.*, LexisNexis 1998 N.Y. App. Div. LEXIS 6541, *lv denied* LexisNexis 1998 N.Y. LEXIS 4924; *cf. Commissioners of State Ins. Fund v Aetna Cas. & Sur. Co.* LexisNexis 2001 N.Y. App. Div. LEXIS 6271).

AIG's final argument was that its coverage was limited to \$500,000, as there should be apportionment between the primary policies. The court rejected that argument since the Diamond policy was exhausted, thereby eliminating the apportionment issue. The excess policy would not be implicated until all the primary coverage was spent. Accordingly, Diamond's \$1,000,000 primary limits would be joined by the \$1 million AIG limits referenced in the Liberty policy and followed by \$500,000 paid by Liberty.

The counseling point is that allocation of coverage between and among carriers requires a close reading of policy language, particularly "other insurance" clauses. New York courts continue to insist, as a general rule, that all primary policies covering a risk be exhausted before implicating excess policies. By refusing to participate in the defense, AIG lost its opportunity to complain amount of the settlement.

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n1 . Under Section 11 of the Workers' Compensation law, a "grave injury" is defined as "death, permanent and total loss of use or amputation of an arm, leg, hand or foot, loss of multiple fingers, loss of multiple toes, paraplegia or quadriplegia, total and permanent blindness, total and permanent deafness, loss of nose, loss of ear, permanent and severe facial disfigurement, loss of an index finger or an acquired injury to the brain caused by an external physical force resulting in permanent total disability." The burden of establishing a "grave injury" rests not on the plaintiff, but, by statute, on the third-party plaintiff(s), the parties that have commenced the

action against the employer.

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Kohane on Guishard v. General Security Insurance Company

2008 Emerging Issues 1310

Kohane on Guishard v. General Security Insurance Company

By Dan D. Kohane

December 4, 2007

SUMMARY: When is an accident involving an automobile not an "automobile accident" for the purposes of liability insurance coverage? Often, the practitioner needs to know whether the automobile liability carrier or a general liability insurer has the obligation to defend and indemnify a motor vehicle owner.

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ARTICLE: What is "maintenance" of an automobile for purposes of determining the breadth of an "auto" exclusion in a CGL policy? The Court of Appeals provided some insight in *Guishard v. General Sec. Ins. Co.*, 2007 NY Slip Op 6581 (N.Y. 2007), __ NY3rd __ (9/11/07), when it held that an activity that transforms the auto's function is not "maintenance" and thus not excluded under a Commercial General Liability policy.

This case reminds us that it is critically important to identify the proper carrier entitled to notice following an accident. Not all accidents involving cars or trucks are "motor vehicle" accidents where coverage is provided by an auto carrier. The location of the accident provides guidance, but not necessarily the answer to the question: "who insures this risk?"

The Challenge to Identify the Proper Coverage. Surely, for the practitioner, whether it be claimant or insured's counsel, to promptly notify the appropriate insurer after an accident or loss or when litigation is commenced. All policies contain "prompt notice" provisions requiring the insured to notify an insurer of a loss or suit. New York Insurance Law § 3420(a)(3) empowers and obligates an injured party to notify the putative defendant's carrier as well. Best practices dictate that counsel act quickly to provide notice as a failure to comply with contractual provisions can result in a loss of liability coverage.

In the traditional automobile accident case, or the *slip and fall* or work-related accident, the practitioner has little difficulty in identify the type of insurer likely to be involved and entitled to notice. However, there are some closer questions and the practitioner is cautioned to consider carefully the nature and extent of the claim in order to pinpoint the right insurer.

The CGL Policy and its Relationship to Auto Accidents. As a general rule, commercial general liability (CGL) policies and homeowners policies are designed to exclude claims relating to automobile accidents. On a primary basis, motor vehicle accidents are ordinarily covered by personal and business auto policies.

The most common CGL form used in the industry is the Commercial General Liability form developed by the Insurance Services Office. In its grant of coverage, the typical CGL policy provides liability insurance protection to an insured for bodily injury or property damage caused by an occurrence which takes place during the policy period (for "occurrence" form policies). By way of an exclusion, the policy then removes from coverage for bodily injury or property damage claims which arise from "auto" accidents. n1

g. Aircraft, Auto Or Watercraft

"Bodily injury" or "property damage" arising out of the ownership, maintenance, use or entrustment to others of any aircraft, "auto" or watercraft owned or operated by or rented or loaned to any insured. Use includes operation and "loading or unloading".

Insurance Services Office, Form CG 00 01 10 01

Clearly, by its terms, the exclusion of coverage is broader than the traditional car accident.

For example, over a number of years, following the Court of Appeals decision in *Lalomia v Bankers & Shippers Ins. Co* (35 AD2d 114 [2nd Dept. 1970] *affd* 31 NY2d 830 [1972]) many CGL and homeowners policies provided coverage for claims of negligent *entrustment of a motor vehicle* was separate and distinct from a claim for *use and operation of a motor vehicle*. Thus, a claim of negligent entrustment was not excluded from a CGL policy. The industry reacted by adding the term "entrustment" to the "arising out of the ownership, maintenance, or use of * * * a motor vehicle" to the exclusion to eliminate those claims from coverage.

That being said, not every accident arising within, or upon, a vehicle would fall within the ambit of a liability automobile coverage. When faced with the question of determining which carrier is entitled to notice and likely to defend, counsel needs to focus on the cause of the accident, not just its location. If the accident arose out of the *use and operation or maintenance* of a vehicle, the motor vehicle insurer is more generally the one providing coverage.. The claim must be connected with the use of a vehicle, as a vehicle, or as the courts have described it: *automobile qua automobile*. (see, e.g., *Olin v Moore*, LexisNexis 1991 N.Y. App. Div. LEXIS 16383, 178 A.D.2d 517, [2nd Dept. 1991] [stabbing in car not covered]; *United Servs. Auto. Ass'n v Aetna Cas. & Sur. Co.*, 75 A.D.2d 1022 [4th Dept. 1980] [injury by spitball in car not covered]; *Empire Ins. Co. v Schliessman*, LexisNexis 2003 N.Y. App. Div. LEXIS 7669, 306 A.D.2d 512 [2nd Dept. 2003] [child falling off of non-moving truck not covered]).

The Importance of Rules of Contract Construction. When reviewing contract terms, the New York courts have set out some clear rules on policy construction and understanding those rules provides guidance to the practitioner "When interpreting [contract terms] in an insurance policy, we must construe the word[s] as would the ordinary [person] on the street or ordinary person when he [or she] purchases and pays for insurance. [I]n a case such as this one involving a policy issued to a business, by examining the "reasonable expectation and purpose of the ordinary business [person] when making an ordinary business contract .. The term "is not given a narrow, technical definition by the law. It is construed, rather, in accordance with its understanding by the average [person] .. who, of course, relates it to the factual context in which it is used" (*Miller v Continental Ins. Co.*, 40 NY2d 675, 676 [1976]). " (*Michaels v City of Buffalo*, 85 N.Y.2d 754, 757 [1995] citing, in part, *Johnson Corp. v Indemnity Ins. Co.*, 7 NY2d 222, 227 [1959]).

With respect to exclusionary language relied on by a carrier to deny coverage, the courts insist that "an insurer must establish that the exclusion is stated in clear and unmistakable language, is subject to no other reasonable interpretation,

and applies in the particular case" (*Continental Cas. Co. v Rapid-American Corp.*, 80 N.Y.2d 640, 593 N.Y.S.2d 966, 609 N.E.2d 506 [1993]). It follows that policy exclusions are given a strict and narrow construction, with any ambiguity resolved against the insurer (*Thomas J. Lipton, Inc. v Liberty Mut. Ins. Co.*, 34 N.Y.2d 356, 361, 357 N.Y.S.2d 705, 314 N.E.2d 37 [1974]). See *Belt Painting Corp. v. TIG Ins. Co.*, 100 N.Y.2d 377, 383 [2003]). It is with these rules in mind, that the Court review policy terms and exclusions.

"Maintenance" Examined. There have been few cases appellate cases that have interpreted the term *maintenance* in the exclusionary language which removes claims under the CGL policy if they arise from the *ownership, maintenance, use or entrustment* of an "auto". How broad is that term?

The New York State Court of Appeals took the opportunity to accept for review, and provide its insight on this question in the *Guishard* case. The question before the high Court was whether there was an obligation under a CGL policy with an "auto" exclusion, for the carrier to defend a lawsuit involving an eye injury that occurred when a van was being converted into a Mr. Softee ice cream truck. The CGL carrier argued that the work being performed on the truck fell within the auto exclusion, and thus outside of coverage. In support of this position, the insurer maintained that since the policy excluded claims for bodily injury "arising out of the ownership, maintenance, use or entrustment to others of any . . . 'auto' . . . owned or operated by or rented or loaned to any insured" a claim for injuries by an individual who was working on the truck conversion would be excluded under the policy's language.

The Appellate Division held that since the carrier had not submitted the policy schedule defining the term "auto," it had not demonstrated that the van fell within the relied-upon policy exclusion. The Court of Appeals accepted the case for review, and then resolved the case based on a different approach by considering the exclusionary language.

The Court of Appeals held that the CGL carrier was required to defend. The work being performed by the injured person did not constitute "maintenance" of an auto. "Maintenance," as that term is used in an insurance policy, means performance of work on "*an intrinsic part of the mechanism of the car and its overall function.*" The Court referenced cases where "maintenance" was established as those involving replacing or repairing a tire.

The Court opined that transforming a van in furtherance of its conversion to an ice cream truck aids in transforming the auto's function, an activity distinct from "maintenance." Accordingly, the conversion was not maintenance, and the exclusion did not apply. In turn, the CGL carrier was required to defend.

Surely, had the matter been submitted to the insured's automobile liability insurer, that carrier would have argued, likely successfully, that its policy, which provided coverage for "use, operation, maintenance, loading and unloading of a motor vehicle", did not apply to provide coverage for this accident.

The approach for the practitioner is clear. Look at terms in a policy as the ordinary policyholder purchasing that kind of a policy would understand those terms. For exclusionary language, consider whether the term is in clear and unmistakable language, and subject to no other *reasonable* interpretation. Following those guideposts, policy language become much easier to understand. For a more thorough discussion of the Auto Exclusion in the CGL policy, see Appleman on Insurance Law And Practice (2nd Ed.), Volume VI, Liability Insurance, Chapter 132 "coverage A" Exclusions In The Commercial General Liability (CGL) Insurance Policy, 21-132 Appleman on Insurance § 132.1.

Remember also, the importance of prompt notification to the right carrier, lest there be a loss of coverage. Counsel, unsure of who may provide risk protection may consider sending out notice to all carriers that may have some connection with the risk, and sorting out coverage denials at a later date. Rather one invest in an extra postage stamp and notify a larger number of carrier than risk the loss of coverage because of a failure to satisfy policy requirements.

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n1 . "Auto" is a defined term and "means a land motor vehicle, trailer or semitrailer designed for travel on public roads, including any attached machinery or equipment.." Mobile equipment does not fall within the definition.

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***Where Liability Ins. Meets Indemnity Agreements*Harleysville Ins. Co. v. Traveler**

2008 Emerging Issues 1311

Kohane on Where Liability Insurance Meets Indemnity Agreements--Harleysville Ins. Company v. Traveler

By Dan D. Kohane

December 4, 2007

SUMMARY: A common, complicated question that is present in most construction accident cases revolves around the relationship of liability insurance coverage to indemnity agreements contained in contracts between owners, contractors, and subcontractors. For many practitioners, trying to weave through insurance policies that may require a defense and indemnity and contractual indemnity agreements that might have different obligations can be daunting.

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ARTICLE: Even the most experienced insurance practitioner can be perplexed by questions involving the interrelationship of indemnity obligations arising out of insurance policies, and parallel promises made in a contractual indemnity provisions that may be part of construction contracts or leases. The Court of Appeals recently denied leave to appeal to Harleysville Insurance Company (Harleysville) from an Appellate Division, Fourth Department order in *Harleysville Ins. Company V. Travelers Ins. Co. LexisNexis 2007 N.Y. App. Div. LEXIS 3450* , 38 AD3d 1364 (4th Dept. 2007), motion for leave den. by App. Div., *LexisNexis 2007 N.Y. App. Div. LEXIS 7271* , 41 AD3d 1323 (2007), motion for leave den. by Ct. App. 10/18/07).

The *Harleysville* case helps frame a procedure for the practitioner to follow when confronted with additional insurance questions that are presented along with indemnity obligations under leases or construction contracts. The case reminds us that the universes of tort and coverage are parallel ones, and that each needs be examined separately in order to ascertain primacy of obligations.

In *Pecker Iron Works of N.Y., Inc. v. Travelers Ins. Co.*, 99 N.Y.2d 391, 394 (2003), the Court of Appeals made it clear that insurance provided to an entity under a policy that adds that entity as an "additional insured" is a grant of coverage to the additional insured which is equal to that provided to the named insured.

Pecker's claim against Travelers arises from its status as an "additional insured" under the policy, so we begin with that document. It is undisputed that Travelers provided Upfront with primary coverage and that Upfront agreed to make Pecker an additional insured. "Additional insured" is a recognized term in insurance contracts, with an understanding crucial to our conclusion in this case. As cases have recognized, the "well-understood meaning" of the term is "an 'entity

enjoying the same protection as the named insured" (*Del Bello v General Acc. Ins. Co.*, 185 A.D.2d 691, 692, 585 N.Y.S.2d 918 [1992], quoting Rubin, Dictionary of Insurance Terms 7 [Barron's 1987]; see also *Jefferson Ins. Co. v Travelers Indemnity Co.*, 92 N.Y.2d 363, 372, 681 N.Y.S.2d 208, 703 N.E.2d 1221 [1998]; *Wong v New York Times Co.*, 297 A.D.2d 544, 547, 747 N.Y.S.2d 213 [2002]).

When Pecker engaged Upfront as a subcontractor and in writing provided that Upfront would name Pecker as an additional insured, Pecker signified, and Upfront agreed, that Upfront's carrier--not Pecker's--would provide Pecker with primary coverage on the risk. Pursuant to the policy provision at issue, Travelers agreed to provide primary insurance to any party with whom Upfront had contracted in writing for insurance to apply on a primary basis. When Upfront agreed to it, the policy provision was satisfied.

(*Pecker Iron Works of N.Y., Inc. v Traveler's Ins. Co.*, 99 N.Y.2d 391, 394 [NY 2003].)

The practitioner learns from *Pecker* that "additional insured" status provided to a general contractor by a subcontractor's policy should be considered primary coverage. The *Harleysville* decision takes this discussion to the next step, and considers the primacy questions when another policy also provides the general contractor with protection.

Harleysville provided primary coverage to a subcontractor, W.C. Roberson Plumbing & Construction Corp. (Roberson), and that policy also added the general contractor, Savarino Construction Company, Inc. (Savarino), as an additional insured. That additional insured status was provided pursuant to a contract between plaintiff's named insured, Savarino, and Roberson, whereby Roberson promised to provide Savarino insurance as an addition insured.

The Harleysville policy did just that. Of note, however, Savarino had its own commercial general liability policy issued by Travelers. Also, above the Harleysville primary policy was a Harleysville excess policy that insured the subcontractor but did not provide additional insurance protection to the general contractor, Savarino.

Harleysville recognized it had to provide additional insured status to Savarino, and when the lawsuit was commenced by the injured worker, Harleysville assumed the defense of the general contractor. Eventually, it settled the case with the injured worker. Harleysville then sought to recover contribution from Travelers by arguing that Travelers provided co-primary coverage for Savarino.

In the underlying lawsuit, it had already been determined that the indemnity agreement between the general contractor and the subcontractor was valid and enforceable. As a result, it was determined that Roberson was required to indemnify Savarino for any losses arising out of the work.

The Appellate Division, Fourth Department concluded that the proper approach to determine the primary obligation is to compare the *other insurance* clauses of the two first layer policies. It concluded that based on those clauses, the Harleysville first layer policy was primary and Travelers' policy was next in line.

Best practices dictate that no coverage decision can be made without examining the full policies and in this case, a careful examination of the *other insurance clauses*. Here, the court recognized that the *other insurance clauses* were not identical:

The dispute is whether, pursuant to the terms of the policies, Travelers' coverage of Savarino is primary along with plaintiff's primary coverage of Savarino as an additional insured. or whether Travelers' coverage of Savarino is excess to plaintiff's coverage. We have therefore examined "the purpose each policy was intended to serve as evidenced by both its stated coverage and the premium paid for it . . . , as well as . . . the wording of its provision concerning excess insurance" (citation omitted).

Although we note that both policies provide coverage for sums that the insured is legally obligated to pay as

damages for bodily injury and that the premium Savarino paid Travelers was for primary coverage. we disagree with plaintiff that the "other insurance" clauses in the policies are identical and that they therefore both provide primary coverage. Pursuant to the "other insurance" clauses in both policies, the policies provide primary coverage except that the coverage is excess where any other primary insurance is available to the insured for which the insured has been added as an additional insured by attachment of an endorsement. Savarino is added as an additional insured on plaintiff's primary policy, and thus the excess clause is triggered in the Travelers policy but not in plaintiff's policy.

We therefore conclude that the excess coverage clauses are not "deemed to cancel each other out" and thus do not result in coinsurance. Rather, pursuant to the terms of the policies, Travelers' coverage is excess to plaintiffs coverage, and we therefore 'conclude' that coverage under plaintiffs primary policy must be exhausted before Travelers is required to contribute under its policy (*see generally Cheektowaga Cent. School Dist. v Burlington Ins. Co.*, 32 AD3d 1265, 1268).

Accordingly, the court concluded that the first layer of primary coverage for Savarino would come from Harleysville. The Travelers policy then provided the next layer of coverage for the general contractor. There was no other coverage for the general contractor other than the Harleysville and Travelers policies.

However, that was only the first step of the analysis. The court was now faced with the enforceable indemnity agreement in the construction contract that called for Harleysville's insured, Roberson, to indemnify Savarino:

We note that, in the underlying third-party action, Savarino was granted summary judgment against Roberson on its cause of action for contractual indemnification. Travelers would therefore have a right of subrogation against Roberson in that third-party action. and, as a practical matter, would be entitled to reimbursement from Roberson for the amount that Travelers is obligated to pay plaintiff as excess coverage for Savarino's liability to Roberson's employee (*see generally United States Fid & Guar. Co. v CNA Ins. Cos.*, LexisNexis 1994 N.Y. App. Div. LEXIS 10528, 208 AD2d 1163, 1165).

Accordingly, the court determined that since Savarino was entitled to indemnity from Roberson, any money paid out by Travelers, could pass through that indemnity agreement to Roberson, and thus Harleysville. Travelers, therefore, would be fully protected by Harleysville, and Harleysville's excess policy provided the source of that reimbursement. Harleysville's excess policy, at the end of the day, had to pick up the settlement payments NOT because its policy proceeds came before the Travelers policy (a position expressly rejected by the court), but instead because the excess carrier's indemnity obligations to the subcontractor.

The practitioner must be cautioned that there may be times when reimbursement can not be obtained. This would occur if a claim between parties will violate the anti-subrogation prohibition; that is, if the parties were insured for the same loss under the same policy. *It has often been said that an insurer may not be subrogated to a claim against its own insured, at least when the claim arises from an incident for which the insurer's policy covers that insured (Pennsylvania General Ins. Co. v. Austin Powder Co.*, 68 N.Y.2d 465, 471 [1986]).

In light of the court's holding, the practitioner is presented with a checklist of documents to obtain, and an analysis to conduct, in order to determine which carrier will defend and eventually indemnify:

- a. Secure and examine the *other insurance clauses of all policies*;
- b. Determine the priority, if any, of all policies issued to the parties as primary policies, and assign defense and provide first layers of coverage based on the interrelationship of the *other insurance clauses*;
- c. Examine the excess or umbrella policies and, using the same analysis, determine who is insured under each, and the respective priority of coverage;
- d. Once the alignment is determined, consider the enforceability, scope and indemnity agreement in place between

and among the parties;

e. Remember anti-subrogation prohibitions.

The lesson to be learned is clear. When considering the interrelationship of insurance policies and indemnity agreements, all relevant documentation must be secured and dissected with the greatest of care. Questions relating to primacy of defense obligations, order of coverage and ultimate applicability of indemnity agreements are very important and must be answered with the utmost attention to the individual facts of each case.

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The Wall Street Reform Act's Effect on the Insurance Industry

2010 Emerging Issues 5204

Reed Smith LLP on the Dodd-Frank Wall Street Reform and Consumer Protection Act's Effect on the Insurance Industry

By Paul Walker-Bright

July 18, 2010

SUMMARY: This commentary reviews the provisions of the Dodd-Frank Wall Street Reform and Consumer Protection Act that are pertinent to the insurance industry and opines on what those provisions portend for the regulation of the insurance industry in the future.

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ARTICLE: On July 21, 2010, President Obama signed into law the "Dodd-Frank Wall Street Reform and Consumer Protection Act" (the "Dodd-Frank Act"), the most comprehensive legislative reform of the financial services industry since the Great Depression. n1 The Dodd-Frank Act will now be sent to President Obama, who likely will sign the bill into law soon. The Act has several provisions that directly or indirectly affect the insurance industry, and may indicate the beginning of greater federal regulation of insurance after decades of nearly exclusive regulation by the states.

Establishment of the Federal Insurance Office. Title V of the Dodd-Frank Act, the "Federal Insurance Office Act of 2010," establishes the Federal Insurance Office ("FIO") within the Department of the Treasury. n2 The FIO has the authority:

(A) to monitor all aspects of the insurance industry, including identifying issues or gaps in the regulation of insurers that could contribute to a systemic crisis in the insurance industry or the United States financial system;

(B) to monitor the extent to which traditionally underserved communities and consumers, minorities . . . and low- and moderate-income persons have access to affordable insurance products regarding all lines of insurance, except health insurance;

(C) to recommend to the Financial Stability Oversight Council that it designate an insurer, including the affiliates of such insurer, as an entity subject to regulation as a nonbank financial company supervised by the Board of Governors pursuant to title I of the Dodd-Frank Wall Street Reform and Consumer Protection Act;

(D) to assist the Secretary in administering the Terrorism Insurance Program established in the Department of the Treasury . . .;

(E) to coordinate Federal efforts and develop Federal policy on prudential aspects of international insurance matters, including representing the United States, as appropriate, in the International Association of Insurance Supervisors (or a successor entity) and assisting the Secretary in negotiating covered agreements . . .;

(F) to determine, in accordance with subsection (f), whether State insurance measures are preempted by covered agreements;

(G) to consult with the States (including State insurance regulators) regarding insurance matters of national importance and prudential insurance matters of international importance; and

(H) to perform such other related duties and authorities as may be assigned to the Office by the Secretary. n3

The FIO also will advise the Secretary of the Treasury on major domestic and prudential international insurance policy issues, and the Director of the FIO will serve in an advisory capacity on the Financial Stability Oversight Council. n4

The FIO has no regulatory authority, and primarily will monitor insurance issues of national importance and give reports to the Treasury Secretary and Congress on such issues. Regulation of insurance in the first instance remains in the hands of the states. n5 However, as discussed in more detail below, the authority to recommend that an insurer be designated as an entity subject to regulation as a nonbank financial company could have the effect of restricting the states' ability to regulate insurance companies so designated. Such insurers would be supervised by the Board of Governors of the Federal Reserve System, which would potentially entail meeting financial stability requirements different from those required under state regulations.

In addition, the Federal Insurance Office Act directs the FIO to conduct a study and submit a report to Congress on "how to modernize and improve the system of insurance regulations in the United States." n6 The FIO's report will be based on and guided by several considerations and factors, and was clearly intended to be detailed and comprehensive. n7 The FIO will make recommendations for legislative, administrative and regulatory changes that are necessary to carry out or effectuate the findings in the report. n8

It is interesting to note that in March 2008 the Treasury Department issued a report of its study of the financial services industry, including insurance, entitled "Blueprint for a Modernized Financial Regulatory Structure." n9 With respect to the insurance industry, the Treasury Department concluded that the state-based regulatory system was not the most efficient or effective way to regulate an industry that has become global in its scope. n10 The Treasury Department recommended establishing an optional federal charter that would provide a system of federal chartering, licensing, regulation and supervision of insurers, reinsurers and insurance producers. n11 The Treasury Department also recommended creating an Office of National Insurance and an Office of Insurance Oversight. n12 The Office of National Insurance would create and oversee the necessary regulatory, supervisory, enforcement and rehabilitative powers of the optional federal charter. n13 The Office of Insurance Oversight would promote international insurance regulatory policy for the United States and serve as an advisor to the Secretary of the Treasury on major domestic and international insurance policy issues. n14

In the March 2008 Treasury Department Blueprint, the Treasury Department has already come out in favor of a comprehensive scheme of federal regulation that would replace much, if not all, of the existing state-based regulatory regime. It appears that the Federal Insurance Office Act adopted the Treasury Department's recommendation to create an Office of Insurance Oversight, in the form of the FIO, but not the recommendation to create a federal agency with regulatory and enforcement powers over insurance. If the Treasury Department Blueprint can be considered foreshadowing of the FIO's report to be issued 18 months from now, further federal involvement in the regulation of insurance may be in the offing.

Section 314 of the Federal Insurance Office Act gives the Secretary of the Treasury and the United States Trade Representative the authority to negotiate and enter into "covered agreements" on behalf of the United States. n15 A "covered agreement" is an agreement entered into between the United States and one or more foreign governments, authorities or regulatory agencies, that relates to prudential measures in the business of insurance or reinsurance that achieve a level of protection for consumers substantially equivalent to the level of protection achieved under State insurance or reinsurance regulation. n16 If a State insurance measure results in less favorable treatment of a non-United States insurer in a jurisdiction that is subject to a covered agreement than a United States insurer, and is inconsistent with a covered agreement, it will be preempted by the covered agreement. n17

State-Based Insurance Reform. The Dodd-Frank Act contains various insurance reforms in the "Nonadmitted and Reinsurance Reform Act of 2010." n18 Part I of the Nonadmitted and Reinsurance Reform Act is intended to encourage States to "adopt nationwide uniform requirements, forms, and procedures, such as an interstate compact, that provide for the reporting, payment, collection, and allocation of premium taxes for nonadmitted insurance. . . ." n19

To accomplish this goal, the Act prohibits any State other than the home State of an insured from requiring any premium tax payment for nonadmitted insurance, but allows the States to enter into a compact or establish procedures to allocate premium taxes paid to an insured's home State among the States. n20

The placement of nonadmitted insurance will be subject to the regulatory requirements solely of the insured's home State, and no State other than an insured's home State may require a surplus lines broker to be licensed in order to sell, solicit or negotiate nonadmitted insurance to that insured. n21 After two years from the date of enactment, a State may not collect any fees relating to the licensing of a surplus lines broker unless the State has in effect laws or regulations that provide for participation in the national insurance producer database, maintained by the National Association of Insurance Commissioners ("NAIC"), for the licensure of surplus lines brokers. n22 The Nonadmitted and Reinsurance Reform Act imposes uniform standards for surplus lines eligibility and a procedure that makes it easier for commercial purchasers of insurance to obtain nonadmitted insurance. n23 The Comptroller General of the United States is directed to conduct a study of the nonadmitted insurance market to determine the effect of the Nonadmitted and Reinsurance Reform Act on the size and market share of the nonadmitted insurance market for providing coverage typically provided by the admitted insurance market. n24

Part II of the Nonadmitted and Reinsurance Reform Act attempts to create a more uniform regulatory environment for reinsurance. If the State of domicile of a ceding insurer is accredited by the NAIC, and recognizes credit for reinsurance for the insurer's ceded risk, no other State can deny such credit for reinsurance. n25 All laws, regulations, provisions or other actions of a State that is not the domiciliary State of the ceding insurer (except with respect to taxes and assessments on insurers or insurance income) are preempted to the extent that they (1) restrict or eliminate the rights of the ceding insurer or the assuming insurer to arbitrate disputes pursuant to a contractual arbitration provision, (2) require that a certain State's law shall govern the reinsurance contract, (3) attempt to enforce a reinsurance contract on terms different from those in the contract, or (4) otherwise apply the laws of the State to reinsurance agreements of ceding insurers not domiciled in that State. n26 The State of domicile of a reinsurer will be solely responsible for regulating the financial solvency of the reinsurer, as long as the State is accredited by the NAIC or has financial solvency requirements substantially similar to the NAIC's. n27

Potential Effect on Insurance Companies of the "Financial Stability Act of 2010." The Financial Stability Act of 2010 gives authority to the Board of Governors of the Federal Reserve System to supervise any "nonbank financial company" if "material financial distress" at the company or the "nature, scope, size, scale, concentration, interconnectedness, or mix of the activities" of the company "could pose a threat to the financial stability of the United States." n28 "Nonbank financial company" is broadly defined as a company, other than a bank holding company, that is "predominantly engaged in financial activities." n29 Although only "financial activities" of the company will be subject to supervision or the prudential standards, n30 what constitutes "financial activities" is based on Section 4(k) of the Bank Holding Company Act (Pub. L. No. 511, 70 Stat. 133 (1956), codified at 12 U.S.C. § 1841 *et seq.*). The Bank Holding Company Act expressly includes "insuring . . . in any State" as a "financial activity." n31 Thus, the broad

definition of "financial activities" encompasses insurance companies and holding companies whose subsidiaries include insurance companies (*e.g.*, the former AIG, Inc.). As discussed above, the FIO will have the authority to recommend that an insurance company be designated as a nonbank financial company subject to the Board of Governor's supervision. n32 The ultimate authority to designate a nonbank financial company as subject to the Board of Governor's supervision rests with the newly created Financial Stability Oversight Council ("FSOC"). n33

A nonbank financial company subject to the Board of Governor's supervision will be required to meet certain "prudential standards" concerning its operation. n34 These prudential standards will be established based on recommendations from the FSOC. n35 The prudential standards will be particularized to the various types of nonbank financial companies being supervised, and will be "more stringent than those applicable to other nonbank financial companies . . . that do not present similar risks" to the nation's financial stability. n36 The Board of Governors is directed to establish prudential standards for nonbank financial companies under its supervision with total consolidated assets equal to or greater than \$50 billion. n37

Among the specific recommendations the FSOC may make are requiring the nonbank financial company to maintain a minimum amount of contingent capital that is convertible to equity in times of financial distress, and to require the company to have a plan for rapid and orderly resolution in the event of material financial distress or failure. n38 The FSOC also may make recommendations to limit the risks that failure of any individual company could pose to nonbank financial companies, to require enhanced public disclosures by the nonbank financial company, and to require short-term debt limits to mitigate the risks associated with over-accumulation of such debt. n39

The FSOC also may recommend more stringent regulation of a financial activity to the primary financial regulatory agencies for that activity. n40 The primary financial regulatory agencies must then implement the recommended standards or, within 90 days after the recommendations are issued, explain in writing to the FSOC why they are not following the recommendations. n41

If the Board of Governors determines that a nonbank financial company under its supervision poses a "grave threat to the financial stability of the United States," the Board of Governors will limit the ability of the company to merge with, acquire, consolidate with, or become affiliated with another company, restrict the ability of the company to offer financial products, require the company to terminate one or more activities, impose conditions on the manner in which the company operates, or, if all else fails, require the company to sell off or transfer assets to unaffiliated entities. n42 The Board of Governors will establish regulations for the early remediation of financial distress of a nonbank financial company. n43

Finally, Title II of the Dodd-Frank Act sets forth procedures for the orderly liquidation of a financial company for which the Federal Deposit Insurance Corporation ("FDIC") and the Board of Governors have determined a receiver should be appointed. n44 For cases involving insurance companies, or a financial company which has an insurance company as its largest United States subsidiary, the FIO and the Board of Governors must make the determination whether to appoint a receiver. n45 The liquidation or rehabilitation of an insurance company will be conducted under the applicable State law. n46 However, if the appropriate State insurance department does not file the necessary judicial action to place the company into liquidation within 60 days of the determination by the FIO and the Board of Governors, the FDIC will have the authority to stand in the place of the State insurance department and file the appropriate judicial action to place the company into liquidation. n47

Conclusion. The Dodd-Frank Act has opened the door to federal regulation of the insurance industry, a door that has remained firmly shut since 1945. If, 18 months from now, the FIO comes to the same conclusion as the March 2008 Treasury Department Blueprint regarding the need for more comprehensive, nationwide regulation of insurance, the stage could be set for expanding the federal government's role in that direction. The federal government's expanded role almost certainly would come at the expense of state insurance departments and the NAIC. The FIO already is set to supplant the state regulators in negotiating "covered agreements" that deal with insurance issues on an international scale. State regulators must initiate liquidation proceedings with respect to insurers designated for receivership by the

FIO and the Board of Governors or risk having that function taken over by the FDIC. Some insurance companies, or holding companies with insurers among their major subsidiaries, are at risk of being placed under supervision by the Board of Governors after being declared, in the vernacular, "too big to fail." Such companies will have to comply with "prudential standards" concerning their operations in addition to, or instead of, state insurance regulations. The prudential standards may limit the ability of subject insurance companies to operate with the same level of freedom they now enjoy under the state-based regulatory regime. Overall, the states' ability to regulate insurance companies under the Board of Governor's supervision may be more limited as a result of the Dodd-Frank Act.

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n3 H.R. 4173, 111th Cong., § 502 (to be codified at *31 U.S.C. § 313(c)(1)*).

n4 H.R. 4173, 111th Cong., § 502 (to be codified at *31 U.S.C. § 313(c)(2)-(3)*).

n5 *See* H.R. 4173, 111th Cong., § 502 (to be codified at *31 U.S.C. § 313(k)*): "Retention of Existing State Regulatory Authority - Nothing in this section or section 314 shall be construed to establish or provide the Office or the Department of the Treasury with general supervisory or regulatory authority over the business of insurance."

n6 H.R. 4173, 111th Cong., § 502 (to be codified at *31 U.S.C. § 313(p)(1)*).

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n30 H.R. 4173, 111th Cong., § 113(6).

n31 Pub. L. No. 511 § 4(k)(4)(B), 70 Stat. 133.

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n44 H.R. 4173, 111th Cong., §§ 202-203.

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Insurance Coverage for Damages Arising from the Gulf Oil Spill

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McCarter and English LLP on Insurance Coverage for Damages Arising from the Gulf Oil Spill

By Brian J. Osias and David C. Kane

June 12, 2010

SUMMARY: This commentary focuses on insurance considerations affected by the Gulf oil spill. Many types of damage that could result from the oil spill may be covered losses, under first-party, business interruption, directors and officers, and/or certain liability insurance policies, particularly Environmental Impairment insurance policies.

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ARTICLE: I. INTRODUCTION

The recent oil spill in the Gulf of Mexico has become arguably the worst in United States history. n1 The federal government has estimated that between 12,000 and 19,000 barrels a day have leaked into the Gulf. n2 A subsequent estimate placed the leak as high as 30,000 barrels per day. n3 By early June, the spill was at least twice the size of the Exxon Valdez disaster of 1989. n4 Though initially downplaying the extent of damage, British Petroleum's ("BP") CEO finally acknowledged the spill is an "environmental catastrophe" a month after it occurred. n5 Third parties will invariably suffer damage from the oil onslaught and will seek reimbursement from their insurance carriers.

As the oil spill spreads, coastal property will be affected to a greater and greater extent. Hundreds of millions, perhaps billions, of dollars will be necessary for cleanup. Whole industries will suffer serious economic consequences. For many businesses, financial harm will last well beyond the eventual completion of cleanup. Thus, the damage levied by the spill will have far-reaching and long-lasting effects.

This article focuses on the more mundane, but nevertheless important, insurance considerations affected by the spill. Many types of damage that could result from the oil spill may be covered losses. Businesses must review their entire portfolio of policies for potential coverage. When potentially applicable policies are identified, a close examination of provisions becomes necessary to determine their application to specific claims.

II. The Gulf Oil Spill

The spill originated with the explosion of the Deepwater Horizon rig on April 20, 2010. BP, the largest investor in

the rig, leased the rig from its owner, Transocean Ltd. n6 The rig was located forty miles off the Louisiana coast. n7 Just before the spill, workers attempted to place cement seals at the bottom of the oil well, which led to a chemical reaction that created a methane gas bubble. n8[8] The methane gas, commonly found around oil reservoirs, escaped from the well into the drill column. n9 Around 9:47 P.M., workers on the rig heard the sudden release of methane gas. n10 The gas rapidly expanded through protective seals and barriers in the drill column and exploded. n11

An intense fire broke out on the rig with soaring temperatures and massive plumes of smoke. n12 Though many workers survived by diving overboard to escape the intense heat, eleven crewmembers died and dozens of others suffered injury as a result of the catastrophe. n13 After burning for two days, the rig sank into 5,000 feet of water. n14 For weeks afterward, oil gushed forth from the damaged well, spreading across the surface and throughout the subsurface of the water.

Original estimates suggested the amount of oil spilling from the leak was low. It has since become clear that incredible amounts of oil have spilled out of the well. BP has undertaken a number of attempts to stop the leak and prevent expansion of the spill, including drilling a relief well, n15 using chemical dispersants to break up the oil, n16 the failed "top kill method" of inserting drilling mud into the well, n17 and the "top hat" device. n18 Oil continues to flow from the well and has already reached the Gulf coast. Many scientists believe currents could carry it up the eastern seaboard. n19 Even if the leaked is stopped, the escaped oil will remain in the Gulf and continue to push to the coastline.

The spill has already had a significant ecological impact. Both oil and the dispersants used in the cleanup effort cause harm to wildlife. n20 Underwater life forms will be the first impacted. The effects on marine life, however, will not be limited to the Gulf because marine life from across the Atlantic use the Gulf as breeding grounds. n21 As oil reaches land, coastal life will suffer as well. Along the Louisiana shoreline, birds, turtles, insects, and other wildlife have been found covered in oil and, unfortunately, often dead as a result. n22 Harm to any species will affect many other life forms across the food chain.

III. Insurance Coverage Issues

Insureds have already begun to look to their carriers for reimbursement of costs associated with the oil spill. Policyholders may find that their policies provide coverage for their losses. This article analyzes the potential for recovery under property, business interruption, directors and officers, and liability policies for third parties who suffer oil damage.

A. First-Party Property Coverage

As the oil reaches land, beachfront real estate will suffer direct damage. Buildings, structures, and equipment belonging to coastal businesses may also be harmed. The cost of cleaning up and repairing any damage to property caused by oil can be extraordinarily expensive. For example, many resorts along the Gulf Coast have shoreline property. As tides carry the oil ashore, it will not only cover but penetrate the ground and any plant life within reach. Few vacationers are willing to visit oil contaminated resorts. These establishments clearly must remove the oil from their property to maintain business. First-party property policies may provide insurance recoveries to insureds for these costs.

First-party property policies, as opposed to third-party policies, provide coverage for an insured's own property. n23 Broadly speaking, these policies cover direct physical loss to covered property. n24 Two types of first-party property policies exist. The breadth of coverage depends on the type of property policy purchased. All risk property policies cover all property the insured owns unless specifically excluded. n25 All risk, of course, is a misnomer as the policies almost always exclude specified perils. The broad grant of coverage creates a higher likelihood of recovery for oil damage claims. An insured need only show it suffered property damage during the policy period. The burden is on the carrier to prove that an exclusion applies to preclude coverage. n26 Owners of all risk policies should carefully review the policy's exclusions for provisions that may bar oil related damages.

The other type of first-party property policy has a much more limited grant of coverage. Named peril policies cover only losses specifically named in the policy. n27 The insured has the burden to prove the loss falls within the grant of coverage. n28 In contrast with owners of all risk policies, insureds with named peril policies must review the entire policy for provisions that may provide coverage for the oil cleanup.

Coverage under a property policy depends on the cause of damage. In *Lititz Mutual Insurance Co. v. Boatner*, for instance, the insurer issued a windstorm policy. n29 A hurricane destroyed the insureds' home. n30 The insurer denied coverage based on an exclusion for loss caused by "flood, surface water, waves, tidal water, or tidal wave, overflow of streams or other bodies of water, or spray from any of the foregoing, all whether driven by wind or not," arguing a tidal wave destroyed the home. n31 The Court disagreed, finding the house had been destroyed by strong winds before the tidal wave came ashore. n32 Thus, the exclusion did not apply because wind, a covered cause of loss, was the actual cause of the damage.

First-party property policies usually contain contamination exclusions. Courts have applied these provisions to bar coverage to property damage caused by environmental harms. In *Hartory v. State Automobile Mutual Insurance Co.*, the policyholders incurred moving and living expenses when authorities forced them to evacuate their home after a methane gas contamination. n33 The insurer denied coverage based on an exclusion for "contamination." n34 The Court found contaminate meant "to render unfit for use by the introduction of unwholesome or undesirable elements." n35 As an "an unwholesome and undesirable element," the Court held methane gas constituted contamination and applied the exclusion to bar coverage. n36

Contamination exclusions, however, may not necessarily bar coverage for cleanup of oil from the Gulf spill. The standard exclusion often extends coverage for cleanup of pollutants from land or water caused by a covered loss. n37 The burden of proof depends on the type of policy, but if the oil damage constitutes a covered loss a policy with such a provision may provide coverage.

Debris removal provisions, which are standard in property policies, could be a source of coverage for removal of oil. In fact, courts have applied these provisions to cleanup of oil spills. In *Lexington Insurance Co. v. Ryder System, Inc.*, oil leaked from underground storage tanks at the insured's business. n38 The all risk policy covered all personal property including oil in pipelines. n39 The policyholder also sought coverage for cleanup of oil on the ground, citing the debris removal provision. The provision covered the "cost of demolition and removal of debris formerly an insured part of the property and no longer suitable for the purpose for which it was intended." n40 The insurer argued no coverage existed because the oil was not debris and was not subject to "demolition." n41 The Court found that the insured need only show a need for removal of debris and not demolition and held the oil constituted debris for which coverage existed. n42 Unfortunately for policyholders, many modern debris removal provisions explicitly exclude removal of pollutants. n43 This type of exclusion would in all likelihood bar recovery for cleanup of oil spill damage. Policyholders should take a close look at these provisions to determine the extent of any possible coverage.

Finally, sue and labor provisions may cover additional costs related to the cleanup of oil. These provisions provide for reimbursement of reasonable costs expended to mitigate losses. n44 The purpose of these provisions is to confer a benefit on the insurer by reducing the amount of damage the insurer might otherwise be forced to pay. n45 Sue and labor coverage can be valuable to numerous industries affected by the Gulf oil spill. For instance, fishing businesses may have to remove boats from water to land to protect them from damage. This will result in both moving and storage costs. Insureds should take advantage of their entitlement to costs incurred in preventing damage to their property from the oil spill.

B. Business Interruption

The Gulf oil spill will damage businesses in ways other than direct property damage. The property damage itself will limit or foreclose the ability of many businesses to operate, resulting in loss of income. For instance, oil damage to docks and boats may prevent fishermen from accessing the Gulf to fish. Similarly, coastline businesses that depend on

the shipping industry to receive goods will lose income if ports are damaged. The tourism industry has already faced a sharp decline. Coastline resorts inundated by oil may have to shut down during the time it takes to cleanup.

Business interruption insurance covers lost income resulting from direct physical loss to the policyholder's property. n46 The purpose of business income coverage is to compensate the insured for income it would have earned had there been no interruption. n47 In other words, business income coverage preserves "the continuity of the insured's earnings." n48 Considered a time element loss policy, it essentially picks up where a property policy leaves off by covering the effects of damaged property rather than the property itself. n49

Application of business income insurance to the oil spill is straight forward. An insured need demonstrate it suffered property damage that resulted in lost income. Recovery is limited to the amount of income the business would have earned during the cleanup period. n50 Courts make that determination by reviewing the business' income levels and trends prior to the interruption. n51 The policyholder, of course, must show an actual monetary loss compared with prior earnings. n52 If the company's past indicates it would not have earned income, the policyholder will be unlikely to recover.

Depending on policy language, some courts have held coverage exists only when a complete cessation of business results from the property damage. Some courts have actually held that a decrease in business may not trigger coverage if the business remains open. This has particular consequence in the tourism industry. In *Forestview v. All Nation*, for example, the insured resort suffered storm damage and closed four of its cabins. n53 The resort kept its remaining cabins open and continued to operate the resort. n54 The business interruption coverage provided the insurer would "pay for the actual loss of Business Income you sustain due to necessary suspension of your 'operations' during the 'period of restoration.'" n55 Interpreting the term "suspension," the court held that coverage did not apply to a partial termination of operations where the resort remained open. n56 Many policyholders may find themselves in a similar situation as oil damage will affect shoreline real estate but may not require a complete cessation of business.

"Extra expense" coverage, commonly found in business income policies, can also be a valuable source of recovery. The Court of Civil Appeals of Texas explained the purpose of "extra expense" insurance as:

...not for the cost of rebuilding or restoring the physical structure on the premises, but primarily for securing extra facilities and for "necessary emergency expenses" of a concrete or practical nature to compensate for extra expenses incurred in getting the business back in normal operation at the earliest practicable time. n57

In essence, insureds may recover extra expenses incurred to resume operations. To obtain recovery, the extra expenses claimed must have been necessarily incurred. n58 Like sue and labor provisions in property policies, extra expense coverage creates entitlement to reimbursement for indirect damages from the oil spill. The fishing industry, for instance, may need to replace damaged boats or equipment and these provisions may provide coverage in that regard.

C. Directors & Officers Liability Insurance

Corporate officers and directors have a duty to exercise reasonable care in the conduct of the business. This broad requirement subjects them to potential shareholder suits alleging, among other possibilities, negligent preparation for the oncoming oil spill. n59 In other words, shareholders may assert that officers and directors knew the oil would reach corporate property but failed to adequately prevent damage from occurring. These suits will implicate directors and officers coverage.

Most directors and officers policies contain an exclusion for environmental liability. As with all policies, these provisions vary. Some exclude coverage only for violations of environmental laws or suits brought to enforce environmental regulations. n60 This type of exclusion might not bar coverage for a suit alleging negligent preparation of property in advance of the pending oil spill. Other policies, on the other hand, contain much broader exclusions.

At least one court, however, has held a broad pollution exclusion does not apply to all pollution related claims. In

Sealed Air Corp. v. Royal Indemnity Co., corporate shareholders alleged securities violations against corporate directors and officers, claiming they misrepresented a predecessor company's liability for pollution and caused a decline in the stock price. n61 The insurer denied coverage on the ground that the exclusion for "financial loss to [the Company's] security holders . . . based on, arising out of, or in any way involving . . . the . . . discharge, release, escape, seepage, migration or disposal of pollution into the atmosphere" was broad enough to include the shareholder suit. n62 The New Jersey Appellate Division disagreed, finding the connection between the pollution exclusion and alleged securities violations too attenuated. n63 Policyholders seeking to avoid a pollution exclusion for suits alleging breach of corporate duties arising out of the Gulf oil spill may be able to make a similar argument.

Additionally, recovery is barred under directors and officers coverage for intentional breaches of corporate duties. n64 In light of the widespread media coverage of the expanding oil spill, insurers may argue that directors' and officers' breaches were intentional because they were fully apprised of the impending oil spill. The insurer has the burden to prove a breach was intentional. n65 Reassuringly for policyholders, coverage usually exists for wrongs that exceed simple oversight. n66

D. Liability Coverage

Third-parties will not face liability for the oil spill or its cleanup. However, third-parties could face liability for bodily injury caused by oil on their property or from others alleging property owners permitted oil to seep onto their property. Certain types of liability policies may cover liabilities faced by third-parties arising from the oil spill.

1. Commercial General Liability Policies

Commercial general liability ("CGL") policies, written on a per occurrence basis, provide coverage for liabilities arising from bodily injury or third-party property damage. n67 They were initially designed to cover all risks not specifically excluded by the carrier. n68 Until the early 1970s, CGL policies provided coverage for all liabilities arising from pollution related damages. n69

Most CGL policies have included some form of pollution exclusion since the early 1970s. n70 Initially, policies contained the "sudden and accidental" pollution exclusion, which still left policyholders with some coverage for pollution. n71 However, modern CGL policies usually contain a "total" or "absolute" pollution exclusion, which creates a complete bar for liability for environmental injuries. n72 Insureds holding policies with such exclusions will find their CGL policies do not provide coverage.

Not all liability policies, however, contain absolute pollution exclusions. For instance, Certain Underwriters at Lloyd's, London ("London") filed suit against BP in the Southern District of Texas on May 21, 2010. In the complaint, London alleges BP constitutes an additional insured under excess policies sold to Transocean only for "above land/water surface pollution from substances in Transocean's possession." n73 Thus, the complaint alleges BP does not have additional insured status because the oil emanates from a well below the water's surface. n74 London's pleading makes clear that some level of pollution coverage exists under its policies.

2. Environmental Impairment Liability Policies

Environmental impairment liability ("EIL") policies, on the other hand, provide coverage specifically for liabilities arising from environmental contamination. In fact, carriers purportedly developed EIL insurance to fill the hole in coverage created by inclusion of the standard pollution exclusion in commercial general liability policies. n75 These policies provide coverage for pollution related bodily injury and property damage liability as well as the costs of off-site cleanup. n76

Of course, EIL coverage will be of greater importance to BP and similar entities liable for remediation as opposed to those damaged by the spill. As mentioned, however, third-parties may find themselves facing liabilities arising from oil. Unfortunately, most small businesses without a serious pollution risk do not purchase EIL coverage, nor would they

likely be able to rely upon such coverage for the losses at issue. EIL policies, unlike CGL coverage, are drafted on a claims-made, rather than occurrence, basis. n77 Most policies contain an extended sixty day reporting period and permit the insured to purchase additional time to report claims. n78 However, where policies have no extended period, an insured may lose coverage if a subsequently purchased policy does not cover environmental accidents that occurred before inception. As claims made policies, an insurer need not show prejudice to escape coverage for late notice. n79 As a result, it is absolutely necessary to submit a claim for coverage as soon as possible.

To obtain EIL coverage, a business must submit an environmental assessment report prepared by an independent environmental consulting firm. n80 Based on the report and its own investigation, an insurer will usually issue an EIL policy that excludes any potential pollution risks. n81 This can be a major problem for companies seeking to obtain complete pollution coverage. However, it should have little consequence to policyholders along the coast affected by the oil, unless their EIL carrier considered oil a considerable enough risk to exclude at the time of policy issuance.

IV. Conclusion

Policyholders have a variety of potential coverages from which to seek reimbursement for damages arising from the Gulf oil spill. Close examination of policy provisions is necessary to determine whether the grant of coverage includes the damages claimed. In particular, policyholders must closely review exclusions for contamination, pollution, and oil to determine their application to oil claims. Most importantly, policyholders should collect and review all policies immediately to assess what costs and expenditures will have coverage.

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n48 *United Air Lines v. Ins. Co. of Pa.*, 439 F.3d 128 (2d Cir. 2006) (citing N.Y. Jur. Insurance § 539 (2005)).

n49 *Altru Health v. Am. Protection Ins. Co.*, 238 F.3d 961 (8th Cir. 2000).

n50 *Rogers v. Am. Ins. Co.*, 338 F.2d 240 (8th Cir. 1964).

n51 See, e.g., *W. S. Shamban & Co. v. Commerce & Ind. Ins. Co.*, 475 F.2d 34 (9th Cir. 1973).

n52 *Berkeley Inn, Inc. v. Centennial Ins. Co.*, 422 A.2d 1078 (Pa. Super. Ct. 1980).

n53 704 N.W.2d 773, 774 (Minn. Ct. App. 2005).

n54 *Id.*

n55 *Id.* at 775.

n56 *Id.*

n57 *Travelers Indem. Co. v. Pollard Friendly Ford Co.*, 512 S.W.2d 375 (Tex. Civ. App. 1974).

n58 *Tower Auto. v. Am. Protection Ins.*, 266 F. Supp. 2d 664 (W.D. Mich. 2003).

n59 Officers and directors have been found liable for environmental related damages in the past. *See, e.g., Kelley ex rel. Michigan Natural Resources Co. v. Arco Indus. Corp.*, 723 F. Supp. 1214 (W.D. Mich. 1989).

n60 Lathrop, *supra*, at 5-24.

n61 961 A.2d 1195, 1201 (N.J. Super. Ct. App. Div.), *certif. denied*, 960 A.2d 396 (N.J. 2008).

n62 *Id.*

n63 *Id.* at 1205-06.

n64 *See Raychem Corp. v. Federal Ins. Co.*, 853 F. Supp. 1170, 1180 (N.D. Cal. 1994).

n65 *Id.*

n66 Jeffrey W. Stempel, *Stempel on Insurance Contracts* § 19.03 (Aspen Publishers 2010).

n67 Amy Timmer, *The Insurance Industry's Ambiguous Pollution Exclusion: Why the Insurer, and not the Innocent Insured, Should Pay for Pollution Caused by Prior Landowners*, 46 *Baylor L. Rev.* 355, 357 n.1 (1994).

n68 Jim L. Julian, *Insurance Coverage for Environmental Clean-Up Costs Under Comprehensive General Liability Policies*, 19 *U. Ark. Little Rock L.J.* 57, 57-58 (1996).

n69 Julian, *supra*, at 58.

n70 Kathy D. Bailey, *Using Environmental Insurance to Reduce Environmental Liability*, 11 *Nat. Resources & Env't.* 26, 26 (1996-1997).

n71 *Id.*

n72 *Id.*

n73 Complaint at 5, *Certain Underwriters at Lloyd's, London v. BP plc*, Case 4:10-CV-01823 (S.D. Tex. May 21, 2010).

n74 *Id.*

n75 Lathrop, *supra*, at 5-3.

n76 *Id.* at 5-5.

n77 Committee on Business Management Liability Insurance, *Liability Insurance Against Environmental Damage: A Status Report*, 38 *Bus. Law.* 217 (1982-1983).

n78 Ralph A. DeMeo, *Insuring Against Environmental Unknowns*, 23 *J. Land Use & Envtl. L.* 61, 76 (2007-2008).

n79 *Matador Petroleum Corp. v. St. Paul Surplus Lines Ins. Co.*, 174 *F.3d* 653, 659 (5th Cir. 1999).

n80 *See, e.g., Olin Corp. v. Ins. Co. of N. Am., 743 F. Supp. 1044, 1052-53 (S.D.N.Y. 1990).*

n81 *Id.*

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McCarter and English LLP on Key Coverage Issues Associated with Chinese Drywall

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McCarter and English LLP on Key Insurance Coverage Issues Associated with Chinese Drywall

By Brian J. Osias, Nicholas M. Insua and Jason M. Alexander

December 30, 2009

SUMMARY: Lawsuits are occurring alleging property damage and bodily injury arising from contaminated Chinese Drywall in residential construction. Insurance coverage disputes have followed, some resulting in declaratory judgment actions. Insurers' defenses include applying the pollution exclusion. Courts analyzing Chinese Drywall coverage disputes will likely look to analogous authority as to other underlying toxic torts, including mold and asbestos.

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ARTICLE: INTRODUCTION

The use of contaminated Chinese Drywall in residential construction has been linked to serious health problems and extensive property damage. Homeowners, homebuilders, developers and contractors, among others, have therefore turned to their insurers looking for coverage. Insurers, however, have resisted claims related to contaminated Chinese Drywall invoking various policy provisions. Indeed, commercial insurers have filed declaratory judgment actions seeking declarations that they owe their insureds no coverage for claims arising from contaminated Chinese Drywall. After providing an overview of Chinese Drywall and associated claims, this article will focus on a few of the key arguments commercial insurers are asserting in liability coverage disputes with their policyholders over coverage for contaminated Chinese Drywall. Namely, the article discusses the pollution exclusion, whether Chinese Drywall claims constitute an "occurrence," and potential recoupment of defense costs.

BACKGROUND

Allegedly contaminated Chinese Drywall was imported into the United States mainly between 2004 and 2007. Prior to 2005, Chinese Drywall imports into the United States were miniscule. Since 2006, however, the United States imported an estimated 550 million pounds of contaminated Chinese Drywall. Tim Padgett, *Is Drywall the Next Chinese Import Scandal?*, Time, Mar. 23, 2009, <http://www.time.com/time/printout/0,8816,1887059,00.html> (last visited Dec. 10, 2009). The demand for foreign drywall was driven largely by the rebuilding efforts in the Southeastern United States after Hurricane Katrina, and other hurricanes, as well as by the mid-decade housing boom. *Id.* Although it is difficult to know how extensive the problem is, some have estimated that upwards of 100,000 homes may contain

allegedly contaminated Chinese Drywall. Duane Marsteller, *Extent of Chinese Drywall Problem Questioned*, Dec. 4, 2009, Miami Herald, <http://www.miamiherald.com/news/breaking-news/v-fullstory/story/1359617.html>.

The Consumer Products Safety Commission ("CPSC"), is heading a group of federal agencies, including HUD, the CDC and EPA, in investigating alleged problems associated with contaminated Chinese Drywall. CPSC, *Imported Drywall Fact Sheet*, September 2009 (can be found at www.billnelson.senate.gov/news/090923cpscfactsheet.pdf). Human exposure to the toxins released from the contaminated Chinese Drywall (mainly sulfurous gases) allegedly cause health problems including "irritated and itchy eyes and skin, difficulty in breathing, persistent cough, bloody noses, runny noses, recurrent headaches, sinus infection, and asthma attacks." *CPSC Drywall Information Center*, <http://www.cpsc.gov/info/drywall/investigation.html> (last visited Dec. 30, 2009). Contaminated Chinese Drywall has also been linked to the blackening and corrosion of metal surfaces like air conditioning coils, copper pipes and electrical wiring. *Id.* Such corrosion has led to the breakdown and malfunctioning of central air conditioning units, appliances, and electronics. *Id.*

The first complaints related to contaminated Chinese Drywall were received by the CPSC in late December 2008. Consumers complained of a "rotten-egg" odor and the corrosion of metal in their homes. The CPSC reports that as of November 2009, it has received over 2,700 complaints. Although those complaints have come from 36 states, Washington D.C., and Puerto Rico, they have been concentrated heavily in states with warm, humid climates. Approximately 95% of the complaints are from Florida, Louisiana, Mississippi, Alabama and Virginia. *CPSC Drywall Information Center*, <http://www.cpsc.gov/info/drywall/where.html> (last visited Dec. 30, 2009). Heat and humidity allegedly accelerate the release of toxins in the drywall. Jason Hannan, *Florida: Drywall has material that can emit corrosive gas*, *CNN.com*, Mar. 24, 2009, <http://www.cnn.com/2009/US/03/24/chinese.drywall/> (last visited Dec. 30, 2009).

INSURANCE COVERAGE LAWSUITS

Aside from lawsuits, including class actions, filed by homeowners against their homeowners insurers, at least two lawsuits have been filed by commercial insurers seeking to escape their coverage obligations in connection with claims arising from contaminated Chinese Drywall. See *Complaints in Builders Mutual Ins. Co. v. Dragas Mgmt. Corp., et al.* No. 2:09-CV-185 (E.D. Va. filed April 23, 2009), and *Am. Home Assur. Co. V. Peninsula II Developers, Inc.*, No. 09-CV-23691 (S.D. Fla., filed Dec. 11, 2009). Both complaints allege, inter alia, that the pollution exclusion serves to bar insurance coverage for claims arising from Chinese Drywall.

THE APPLICABILITY OF THE POLLUTION EXCLUSION TO CHINESE DRYWALL CLAIMS

As noted, Chinese Drywall claims have lead to denials of coverage based on the so-called pollution exclusion - just as with previous cases involving asbestos-containing building materials and mold. See Complaint in *Am. Home Assurance Co., supra*, at 26 (alleging that "Total Pollution Exclusion" barred coverage "for bodily injury and property damage ... associated with defective [Chinese] drywall, arising from the actual, allege [sic] or threatened discharge, dispersal, seepage, migration, release or escape of 'pollutants,' as that term is defined in the policy"). But a growing jurisprudence has recognized that the pollution exclusion should not apply to such claims, which are confined to the indoors and do not cause traditional, industrial pollution of the environment, of the type intended to be targeted by such exclusions.

For example, in *Nav-Its, Inc. v. Selective Ins. Co. of Am.*, 869 A.2d 929 (N.J. 2005), the New Jersey Supreme Court considered whether a pollution exclusion in a CGL policy precluded coverage for bodily injury claims resulting from alleged exposure to fumes from painting, coating and floor sealing work. The work was performed in a shopping center, and the claims were brought against the contractor by a tenant in the center. The pollution exclusion in *Nav-Its* provided that the insurer was not required to defend or indemnify a suit alleging injury arising out of a pollution hazard. The *Nav-Its* exclusion also defined "pollutant" to include "any solid, liquid, gaseous, or thermal irritant or contaminant," and defined "pollution hazard" to mean "an actual exposure or threat of exposure to the corrosive, toxic or other harmful

properties of any 'pollutants' arising out of the discharge, dispersal, seepage, migration, release or escape of such 'pollutants.'" *Id.* at 932. The carrier refused to defend or indemnify its insured, and the insured sought a declaration of the carrier's obligations. The New Jersey Supreme Court determined that the pollution exclusion did not bar coverage:

"We have reviewed the development of the pollution exclusion to assist our interpretation of the pollution exclusion in the Selective policy. Based on that review, we are confident that the history of the pollution-exclusion clause in its various forms demonstrates that its purpose was to have a broad exclusion for *traditional environmentally related damages*.

"Notably, we have not been presented with any compelling evidence that the pollution exclusion clause in the present case, when approved by the Department of Insurance, was intended to be read as broadly as Selective urges."

Id. at 936-37 (citations omitted) (emphasis added). The court concluded that "the scope of the pollution exclusion should be limited to injury or property damage arising from activity commonly thought of as traditional environmental pollution" and observed that this conclusion was consistent with the policy terms "discharge, dispersal, release or escape." *Id.* at 937. The court noted that the foregoing terms reflect "the exclusion's historical objective-avoidance of liability for environmental catastrophe related to intentional industrial pollution." *Id.* (citation omitted).

Similarly, the District of New Jersey, in *Baughman v. U.S. Liab. Ins. Co.*, No. 08-2901, 2009 U.S. Dist. LEXIS 106400 (D.N.J. Nov. 12, 2009), recently followed *Nav-Its* and refused to apply the pollution exclusion to claims for bodily injury resulting from exposure to mercury inside a daycare center. The court rejected the insurer's claim that the underlying case involved traditional environmental pollution, stating that "traditional environmental pollution does not include exposure to toxic materials released indoors." *Id.* at *28.

In another recent decision, *In re Idleaire Tech. Corp.*, 2009 Bankr. LEXIS 343 (Bankr. D. Del. Feb. 18, 2009), the insurers argued that the pollution exclusions in their policies precluded coverage for bodily injury claims brought against their insured, a manufacturer of truck HVAC systems, by truckers who were injured when the HVAC system allowed carbon monoxide to enter the sleeper cab of a tractor-trailer, resulting in serious bodily injury. The pollution exclusion in question precluded coverage for the "'contamination' of any 'environment' by 'pollutants' that are produced at any time, anywhere, in any way." *Id.* at *5. "Environment" was defined to include "any person, *any man-made object or feature*, animals, crops or vegetation, land, bodies of water, underground water or water table supplies, air and any other feature of the earth or its atmosphere, whether or not altered, developed or cultivated, including, but not limited to any of the above, owned, controlled or occupied by the insured." *Id.* at *6 (emphasis added). The United States Bankruptcy Court for the District of Delaware determined that the clause was latently ambiguous: "Because the terms 'irritant' and 'contaminant,' when viewed in isolation, are virtually boundless in their inclusion, for there is virtually no substance or chemical in existence that would not irritate or damage some person or property, the Total Pollution Exclusion is latently ambiguous" *Id.* at 30-31 (citation omitted). The court also determined that enforcing the exclusion as drafted would defeat the policyholders' reasonable expectations, and was thus contrary to applicable law. *Id.* at 27-28.

Not all courts agree, however, that pollution exclusions should not apply to "indoor" losses not associated with traditional, environmental pollution. In *CBL & Assoc. Mgmt. Inc. v. Lumbermens Mut. Cas. Co.*, No. 05-cv-210, 2006 U.S. Dist. LEXIS 51240 (E.D. Tenn. July 25, 2006), the owner of a shopping center sought coverage from two of its carriers for the claims filed against one of its tenants by a subtenant. The subtenant filed suit against the tenant, alleging, inter alia, negligent infliction of emotional distress resulting from a plumbing problem that "caused sewage, debris, waste and water to shoot out of the sink drains and flood [the space] during rainfalls." *Id.* at *6. Both insurance policies provided coverage, albeit for different periods of time, for bodily injury, and both contained a pollution exclusion precluding coverage for bodily injury "arising out of the actual, alleged or threatened discharge, dispersal, seepage, migration, release or escape of pollutants . . . [a]t or from any premises, site or location which is or was at any time owned or occupied by or rented or loaned to . . . any insured." *Id.* at *8 (emphasis added). The carriers denied coverage, and the owner filed suit, contending that pollution exclusions only apply to traditional environmental pollutants and not sewage and waste.

Noting that Tennessee courts had not yet determined the meaning of the pollution exclusion, the district court pointed to the policies' definition of pollutants: "any solid, liquid, gaseous or thermal irritant or contaminant, including smoke, vapor, soot, fumes, acids, alkalis, chemicals and waste." *Id.* at *19-20. Relying on a standard dictionary definition of waste, the court concluded that "the pollution exclusion is unambiguous and excludes from coverage the damages claimed by [tenant]. While the materials presented in [the space] do not fall under the definition of 'irritant,' it is clear that they do fall under the definitions of both 'contaminant' and 'waste.'" *Id.* at *21. In reaching its conclusion, the court noted:

"The Court is aware that there are two distinct lines of cases interpreting the pollution exclusion - one line supporting Plaintiff's argument and one line supporting Defendants' argument. In the first line of cases, the pollution exclusion clause is found, based on the original purposes behind the inclusion of such clause in insurance policies and the use of terms of art from environmental law, to be applicable only to traditional environmental pollutants. In the second line of cases, the pollution exclusion is found to be applicable to all types of pollution that fall under the letter of the clause, not just traditional environmental pollutants.

"The Court concludes, however, that Tennessee courts, if faced with this issue, would adopt the reasoning of the second line of cases and would conclude that the pollution exclusion applies to all types of pollution, including sewage, and not just to traditional environmental pollutants."

Id. at *22-24 (citations omitted). While the CBL court did not address that the pollution clauses specifically addressed pollution at a *premise*, it based its broad reading on Tennessee's "well-established principles," which "require the Court to determine the 'plain, ordinary and popular meaning' of the language at issue." *Id.* at *25-26.

ARE ALLEGED "CONSTRUCTION DEFECT" CLAIMS COVERED BY CGL POLICIES?

Many Chinese Drywall claims also will allege that the bodily injury or property damage arose from a construction defect. Insurance companies frequently deny such "construction defect" claims for a variety of reasons, including that construction defect claims allegedly do not arise from an "occurrence," they do not cause "property damage," or a series of exclusions - commonly, collectively referred to as the "business risk" exclusions - apply. This is an additional hurdle policyholders will have to clear when seeking coverage for Chinese Drywall claims. Further, as with the pollution exclusion, decisions are mixed about whether such claims should be covered.

For example, In *Times Fiber Communications, Inc. v. Travelers Indem. Co. of Ill.*, No. CVX05CV030196619S, 2005 Conn. Super. LEXIS 335 (Conn. Super. Ct. Feb. 2, 2005), the court held there was no occurrence where plaintiffs (policyholders) supplied their customer (Southwestern Bell Video Services) with millions of feet of telephone/coaxial cable used in residential dwellings that Southwestern Bell ultimately had to remove and replace because the cable did not meet National Electric Code requirements and was not UL approved and listed. The cable was installed inside of walls, so the removal and replacement of the cable required those walls to be torn open and repaired. The policyholders wrongly assured Southwestern Bell the cable was suitable for indoor residential use. Southwestern Bell sued the policyholders (in two actions) for its damages resulting from the need to remove and replace the cable. The policyholders sought a defense for Southwestern Bell's suits.

The policies at issue defined "Property Damage" as including both (1) physical injury to tangible property including the resulting loss of use of said property and (2) loss of use of tangible property that is not injured. The court first held that property damage does not include damage due to the cable's removal. "In this case there is no allegation that the [policyholders'] cable harmed anything. Instead, the claims are solely for replacement and repair costs resulting from the removal of the defective cable. It is clear that there would be no coverage if the cable could have been removed without causing damage to the surrounding walls and based on the analysis in *Weedo* the court finds that the allegations in this case are for contractual liability due to faulty workmanship instead of tort liability for physical damages." *Id.* at

*22.

Second, the court held that although the removal of the cable resulted in loss of use of tangible property (i.e., the residential dwellings), such loss of use was not caused by an occurrence and, thus there was no coverage. The policies defined "occurrence" to mean "accident, including continuous or repeated exposure to substantially the same general harmful conditions." "Accident" was undefined in the policy but has been interpreted by the Connecticut Supreme Court to mean an unintended or unexpected happening. According to the court, the allegations in Southwestern Bell's complaints did not constitute accidents:

"Our Supreme Court has stated that 'the "accident" is "the event" causing the injury, not the cause of that event.' In this case the alleged 'accident' would have to be the removal of the cable because this was and will be the event causing the injury to the [residential dwellings]. The alleged loss of use of property is therefore based entirely on harm which resulted from repair activities necessary to replace the nonconforming cable. The accident was therefore not the installation of the non-conforming cable as claimed by plaintiff. It is also clear that the decision to remove the cable and make repairs was not an accident and therefore not an occurrence. The repairs were not something that happened 'unexpectedly without design.' Accordingly, there are no allegations of property damage caused by an occurrence in the underlying complaints and the defendants had no duty to defend the plaintiffs in the California or Texas actions."

Id. at *29.

Similarly, the Pennsylvania Supreme Court has held that "faulty workmanship" does not constitute an occurrence for purposes of CGL coverage for "accidents." See *Kvaerner Metals Div. of Kvaerner U.S., Inc. v. Commercial Union Ins. Co.*, 908 A.2d 888, 899 (Pa. 2006) (stating that providing CGL coverage for faulty workmanship would improperly "convert a policy for insurance into a performance bond"). The *Kvaerner Metals* case involved construction of a coke oven battery for Bethlehem Steel Corporation. *Id.* at 891. The ovens were defectively constructed, and Bethlehem sued for breach of contract and breach of warranty. *Id.* The trial court found there was no "accident" triggering coverage. *Id.* at 894. On appeal, the Superior Court reversed, and the Supreme Court reversed again. The Supreme Court held that faulty workmanship does not constitute an "occurrence," defined as "an accident, including continuous or repeated exposure to substantially the same general or harmful conditions." *Id.* at 897-98. Whereas the *Kvaerner* court discusses several cases from Pennsylvania and other jurisdictions which hold that faulty workmanship might be covered if it causes damage to other property, *see id.* at 898-99 (citing, *inter alia*, *Snyder Heating v. Pa. Mfrs. Ass'n Ins. Co.*, 715 A.2d 483 (Pa. Super. Ct. 1998) (addressing third-party property damage caused by malfunction of an insured's product)), the Court's actual holding makes no mention of that nuance, and simply declares that faulty workmanship is not an occurrence.

In contrast, in Conn. Super. LEXIS 2268 (Conn. Super. Ct. July 27, 2006), the court held there was an occurrence where the insured was sued by the Bellagio Hotel for alleged defects in the design and construction of showers in over 2,500 Bellagio hotel rooms. The Bellagio alleged the defective design and construction resulted in water and mold exposure to the walls, floors, drywall, and so forth, surrounding the showers. The complaint, however, did not allege a date upon which the water and mold exposure began.

Travelers refused to defend the insured, claiming its policies expired prior to the date the alleged property damage occurred (Travelers policies expired on February 1, 1998 and the water leakage was discovered around March 1998). The court held that damage from water or mold may "occur over a period of time" and such damage can constitute an occurrence. The date on which the exposure began was vital to the court's resolution of the insurer's defense obligation:

"Therefore, the date at which this repeated exposure to water and mold began is paramount to the court's resolution of the plaintiff's motion. Travelers is correct in asserting that the underlying complaint does not allege a specific date when the property damage occurred that is within the policy period. However, in viewing the record in a light most favorable to the plaintiff, it is conceivable that the property damage began at some point during the policy period. If the alleged property damage began sometime between the installation of Laticrete's shower pans in September of 1996 and the

expiration of the policy period on February 1, 1998, then Travelers would have a duty to defend Laticrete."

Id. at *9. The event that triggers coverage, however, is not the installation of the product, but rather the water leaking through the product and causing damage to the property. The court inferred from the known facts that the triggering event (i.e., water damage) possibly occurred during the coverage period, therefore, Travelers could not escape its defense obligations. Id. at *10-11.

INSURERS TREATMENT OF MIXED CLAIMS

Underlying lawsuits arising out of Chinese Drywall, like other construction defect lawsuits, are likely to involve both covered and non-covered allegations. For instance, insurers generally agree that under a CGL policy allegations of negligence are covered, but may dispute coverage for counts alleging breach of contract or intentional conduct. In these sort of "mixed actions" insurers will often argue that they need only pay for costs associated with the covered counts (an approach which the law generally disfavors), or, alternatively, that they can seek to recoup costs expended in connection with uncovered allegations at the conclusion of the underlying lawsuit. Whether the insurer is entitled to do so is often a function of state law. Depending on the jurisdiction, the insurers' right to reimbursement may hang over the policyholder's head throughout the litigation concerning Chinese Drywall liabilities.

A seminal case on this topic is *Buss v. Transamerica Insurance Company*, 939 P.2d 766 (Cal. 1997), which held that an insurer may seek to recoup from a policyholder a share of defense costs. In the case, the insurer defended the policyholder based upon a single cause of action. After the case settled, the insurer sought reimbursement for the non-covered counts and the policyholder disputed the insurer's right to do so. The California Supreme Court held that the insurer may seek reimbursement in connection with claims that are not even potentially covered and that can be allocated solely to those claims. Id. at 772-74. More recently, the California Supreme Court issued a decision largely parroting the reasoning in *Buss*. See *Scottsdale Ins. Co. v. MV Transportation*, 115 P.3d 460 (Cal. 2005). Under *Buss*, however, the insurer must specifically identify its "right" to recoupment in a reservation of rights letter. See *Buss*, 939 P.2d at 784 n.27. Absent such a reservation, there would be no right to recoupment.

New Jersey is similar to California in terms of the law with respect to mixed actions, but demonstrates that the effect of the apportionment cases is muted by practical realities. Indeed, in cases involving a mix of covered and uncovered claims, the New Jersey Appellate Division has held:

"[The insurer's] duty to defend is limited to the allegations covered under the policy, provided that the defense costs can be apportioned between covered and non-covered claims. When the defense costs cannot be apportioned, the insurer must assume the cost of the defense for both covered and non-covered claims."

See *Hebala v. Healthcare Ins. Co.*, 370 N.J. Super. 260, 275 (N.J. App. Div. 2004), quoting *SL Indus., Inc. v. Am. Motorists Ins. Co.*, 128 N.J. 188, 214-15 (1992) (emphasis added), also citing *Cont'l Cas. Co. v. Bd. of Educ., Charles County*, 489 A.2d 536, 545 (Md. 1985) ("So long as an item of service or expense is reasonably related to defense of a covered claim, it may be apportioned wholly to the covered claim.").

Although *Hebala* states that the court may estimate an apportionment, the opinion makes clear that any such estimate must be based upon a careful and thorough review of the attorney bills. The court cites the following example:

"[I]f the insured's counsel deposed a witness as to issues relevant to [an uncovered claim] and [a covered claim], and simply recorded the time spent at the deposition without explanation - i.e., "attend deposition of Smith for 7 hours" - the court must endeavor to estimate how much of that time was (a) solely of interest to the [covered claim], (b) solely of interest to the [uncovered claim], and (c) otherwise indistinguishable. In that example, [the insurer] would be obligated to reimburse [the insured] for time falling within the second category but not the first; [the insurer] would also be obligated for the time falling within the third category to the extent it is reasonably related to the defense of the [covered claim]."

See 370 N.J. Super. at 278. *Hebala* also instructs that the amount of overlap between covered and non-covered claims must be determined -- with the overlap to the benefit of the insured. *Id.* at 266-67 ("the trial judge should not reduce [the amount recoverable] because the same services were rendered, or benefited, [the insured's covered claims].") Additionally, the insurer has the burden of persuasion, by a preponderance of the evidence, as to whether and how fees should be allocated. *Id.* at 280. These factors are likely to be important in Chinese Drywall cases because many of the defense costs will be coincidental. The defense lawyer will have to show up for the deposition, for example, in connection with the covered and non-covered counts and it often will be difficult to segregate time. Therefore, apportionment between covered and non-covered time may be difficult, if not impossible. This favors the policyholder.

Other jurisdictions go a step further and reject recoupment entirely. New York, for example, rejects the right of recoupment except where the policy specifically includes that right. CGL policies typically do not. *Federal Ins. Co. v. Kozlowski*, 792 N.Y.S.2d 397, 404 (N.Y. App. Div. 1st Dept. 2005), for example, recognized the concept of recoupment, but only in very limited circumstances. It noted "[t]his Court has recognized that *under a directors and officers liability policy calling for the reimbursement of defense expenses*" ... "insurers are required to make contemporaneous interim advances of expenses where coverage is disputed, subject to recoupment in the event it is ultimately determined no coverage was afforded." *Id.* (emphasis added). In *Allstate Ins. Co. v. Oles*, 838 F. Supp. 46, 55 (E.D.N.Y. 1993), on the other hand, the Court declined to order the insured to repay defense costs under homeowner's and umbrella policies that did not contain an express reimbursement provision:

"In addressing the recovery of attorney's fees, the Court notes that ... the main case relied upon by Allstate, does not address the issue of recovery of reasonable attorney's fees after counsel is permitted to withdraw as a result of a finding that the insurance coverage is excluded due to the intentional conduct of the insured. Additionally, none of the parties address this issue in any of the papers. In an independent review of the law, the Court was unable to locate binding precedent requiring the awarding of reasonable attorney's fees to Allstate in this type of situation. *Accordingly, the Court declines to award the reasonable value of the services rendered by Allstate's attorneys.*"

(Emphasis added). Similarly, courts have held that the concept of reimbursement is fundamentally inconsistent with an insurers' defense obligation. The United States District Court in Minnesota, for example, rejected outright an insurer's right to reimbursement:

"The question as to whether there is a duty to defend an insured is a difficult one, but because that is the business of an insurance carrier, it is the insurance carrier's duty to make that decision To allow the insurer to force the insured into choosing between seeking a defense under the policy, and run the potential risk of having to pay for this defense if it is subsequently determined that no duty to defend exists, places the insured in the position of a making a Hobson's choice. *Furthermore, endorsing such conduct is tantamount to allowing an insurer to extract a unilateral amendment to the insurance contract.*

"When an insurer tenders a defense or pays defense costs pursuant to a reservation of rights, the insurer is protecting itself as much as it is protecting its insured. Thus, we cannot say that an insured is unjustly enriched when its insurer tenders a defense in order to protect its own interests.... *Certainly, if an insurer wishes retain its right to seek reimbursement of defense costs ... the insurer is free to include such a term in its insurance contract.*"

See *Westchester Fire Ins. Co. v. Wallerich*, 527 F. Supp. 2d 896, 905-06 (D. Minn. 2007) (emphasis added), *aff'd in relevant part*, *Westchester Fire Ins. Co. v. Wallerich*, 563 F.3d 707, 715 (8th Cir. 2009) (stating that most recent decisions "have refused to recognize claims by insurers for reimbursement of defense costs expended under a unilateral reservation of rights, absent a provision for such reimbursement in the insurance policy.").

CONCLUSION

In short, Chinese Drywall has generated and will likely continue to generate extensive litigation. Although to date

the number of coverage suits related to Chinese Drywall have been relatively few in number, such lawsuits may increase over time. The battle lines between insurers and their insureds have likely already been drawn in connection with other, similar liabilities such as mold, asbestos and construction defect. Courts will be called upon to consider *inter alia* whether Chinese Drywall contamination is a "Pollutant," and whether defects associated with Chinese Drywall constitute an "occurrence," as well the treatment of defense costs for "mixed claims." These are three of the potential issues, but there will undoubtedly be a myriad of others. Although Chinese Drywall is not likely to tread entirely new ground in terms of coverage issues, nuances will without doubt present themselves as the coverage case law develops.

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Sonnenschein on Insurance Subrogation and the Made-Whole Rule Under ERISA

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Sonnenschein Nath & Rosenthal on Insurance Subrogation and the Made-Whole Rule: When Does and Should It Apply Under ERISA

By William T. Barker and Frank P. VanderPloeg

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SUMMARY: First-party insurers are usually entitled under state insurance law to subrogation or reimbursement, typically subject to a requirement that the insured first be made whole for his injuries. Under ERISA, there is a multi-way split among the circuits as to whether and when a Plan's rights of subrogation or reimbursement will be conditioned on the beneficiary being made whole. This commentary examines the cases and analyzes the proper rules.

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ARTICLE: Insurance policies and employee benefit plans commonly provide that, when benefits are paid for losses like damage to property or medical expenses, then the insurer is subrogated to the insured's rights to recover from any responsible tortfeasor and/or is entitled to be reimbursed out of any recovery the insured might make from any tortfeasor. Even without express provisions in the policy, state common law often would grant similar rights, but typically qualified by a requirement that the insured must be made whole before the insurer is entitled to any recovery.

This issue involves a significant difference between state insurance law (which almost uniformly applies some variation of the made-whole requirement) and federal common law of employee benefits under the Employee Retirement Income Security Act ("ERISA") (where there is a multi-way circuit split). This commentary examines and evaluates the various rules applied under ERISA, after providing background on state law. n1

I. BACKGROUND: INSURANCE SUBROGATION AND THE MADE-WHOLE REQUIREMENT

A. The Made-Whole Requirement, the Principle of Indemnity, and the Collateral Source Rule

One of the doctrines of insurance law is the "principle of indemnity," "[t]he concept that insurance contracts shall confer a benefit no greater in value than the loss suffered by an insured." n2 As a leading treatise explains:

"[I]t is now a generally accepted fundamental tenet of insurance law that opportunities for net gain to an insured through the receipt of insurance proceeds exceeding a loss should be regarded as inimical to the public interest. In other

words, insurance arrangements are structured to provide funds to offset a loss, either wholly or partly, and the payments made by an insurer generally are limited to an amount that does not exceed what is required to restore the insured to a condition relatively equivalent to that which existed before the loss occurred." n3

The principle of indemnity coexists with the collateral source rule, whereby a tortfeasor is liable for all damages suffered by the injured party, whether or not those damages have been compensated by insurance or some other collateral source. n4 Allowing subrogation or reimbursement reconciles those two rules, by compensating the injured party's loss, but allowing the collateral source to recover any payments made that would exceed the net loss after the tort recovery. n5 Thus, the primary burden of compensating tortious injuries is placed on the tortfeasor, with collateral sources playing a secondary role, only to the extent necessary.

The principle of indemnity serves two purposes of current significance. First, by eliminating any profit from suffering an insured loss, it avoids creating any incentive to cause such losses (as by arson) and it minimizes the incentives to take less care to avoid such losses. Second, by limiting the net amount the insurer must pay and allowing the insurer to set premiums appropriate for that net payment level, it avoids the need to charge higher premiums that would create double-recovery windfalls for some insureds at the expense of those who have no opportunity for such a double recovery. Such double recoveries are regarded as a form of unjust enrichment: while the insured has paid a premium for compensation of losses, premiums should take account of the principle of indemnity and should not include the costs of providing a net recovery in excess of the loss. n6 Paying higher premiums for a chance at a double recovery would have some elements of a lottery; rational insureds would not want to participate in such a lottery, because charges for the insurer's expenses and profits would make any expected recovery less than the cost. n7

In an ERISA case, the Seventh Circuit has summarized the argument for allowing subrogation or reimbursement rights to insurers (whether or not subject to a requirement that the insured be made whole):

"In the usual case the insured incurs a medical expense for which he is promptly reimbursed by the insurance company (or equivalent), which then exercises its right of subrogation and goes off on what sometimes proves to be a wild goose chase after a possible tortfeasor to whom the expense can be shifted. The insured is out of the picture - well, not entirely, because he is entitled to any excess recovery by the insurance company. Subject to this qualification, of which more later, the risk of an uncertain recovery is shifted from the individual to a specialist in bearing risk and enforcing claims - the insurance company. The price of the insurance is thereby reduced (or, equivalently, the insured can buy more insurance for the same price) because the insurance company acquires a contingent claim by virtue of the subrogation clause. Without subrogation, a part of the risk is shifted back to the insured. He pays more for the insurance because he retains, rather than (in effect) sells, a right to obtain through litigation a recovery that may actually exceed the actual loss that (after receiving the insurance proceeds) he suffered. This is because, by virtue of the collateral benefits rule, a tort plaintiff need not deduct from the judgment he receives in his tort suit compensation for the same loss which he may have obtained from another source, such as an insurance policy."

A legal right, for example a tort victim's right to sue his tortfeasor for damages, is like a lottery ticket. Its payoff is highly uncertain. Subrogation, consistent with the objective of insurance, transfers the lottery ticket from the individual policyholder to the collectivity of policyholders. The risk is spread, and by being spread eliminated or at least greatly reduced. Subrogation also eliminates the incentive to careless behavior created by the collateral benefits rule, which by enabling the insured victim of a tort to recover for the same loss from both the insurance company and the tortfeasor may (depending on the adequacy of tort damages) make the tort victim better off than he would have been had there been no accident. n8

A common-law rule providing insurers a right to subrogation or reimbursement, absent specific provision in the policy on that subject, both implements the public policy expressed in the principle of indemnity and fills a contractual gap by effectively implying contractual terms that probably correspond with what most buyers of insurance would want, if they were fully informed and asked to make a choice. n9 Such a rule is widely followed. n10

B. Implications of Tort Law Rules

A right to subrogation normally operates as a partial assignment by operation of law, entitling the subrogee to step into the shoes of the subrogor and sue the tortfeasor based on the subrogor's rights. Of course, the tortfeasor is entitled not to have the claim split between two lawsuits, but that problem can be avoided by having the insured and the insurer join in a single suit, each seeking recovery of its own portion of the claim. n11 More fundamentally, tort claims for personal injury are commonly held not assignable, a limit that would also preclude true subrogation. n12 One may question the rule against assignment, as applied to claims for medical expenses, n13 but even assuming that assignment is impermissible, the insurer should at least have a common-law right (absent a contrary policy provision) to reimbursement out of any recovery the insured may make, subject to the requirement that the insured be made whole, and equivalent contractual rights should be enforceable. n14 Contractual rights to reimbursement are usually enforced. n15

C. The Made-Whole Requirement in Insurance Law

Courts have taken a variety of approaches to the ability of contractual terms to override the made-whole rule. Many jurisdictions hold that the requirement that the insured be made whole before the insurer is entitled to recover cannot be overridden by any contrary contractual provision. n16

Other jurisdictions hold that contractual language can override the made-whole rule, though they differ on the standard to be applied in determining whether particular language does that. A few say that even general subrogation language, if unambiguous, will override equitable principles n17 Most jurisdictions that allow a contract to override the made-whole rule impose a heightened requirement of clarity and explicitness for contractual language to have that effect n18

Courts requiring clear and explicit contractual language typically do not consider sufficient provisions stating only that the insurer will be subrogated (without addressing priority), n19 that the insurer shall be entitled to reimbursement of "duplicate" payments (when any tort recovery is insufficient to fully compensate the insured and is not allocated to particular damages), n20 that the insurer shall be entitled to reimbursement "to the extent of [its] payment" n21 Language that has been held sufficient specifically addresses the issue of priority. n22 A particularly good, succinct example is:

"" Health Plan ... shall be entitled to the payment, reimbursement, and subrogation as provided in section C(1) regardless of whether the total amount of the recovery of the Member ... on account of the injury or illness is less than the actual loss suffered by the Member"" n23

II. WHAT RULES APPLY UNDER ERISA?

A. ERISA Background

"ERISA comprehensively regulates, among other things, employee welfare benefit plans that 'through the purchase of insurance or otherwise,' provide medical, surgical, or hospital care or benefits in the event of sickness, accident, disability, or death." n24 By a combination of expansive express preemption provisions and implied preemption of conflicting state law, ERISA is designed to "establish [employee benefit plan] regulation as exclusively a federal concern." n25

ERISA expressly preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA. n26 But this express preemption is subject to an exception (the "insurance saving clause"), providing that nothing in ERISA "shall be construed to exempt or relieve any person from any law of any State which regulates insurance." n27 The insurance savings clause, in turn, is subject to the "deemer clause" providing that (with certain exceptions) no employee benefit plan "shall be deemed to be an insurance company." n28

These preemption provisions create a distinction between ERISA plans that are funded and administered without insuring the benefit liability ("self-funded plans") and those that provide benefits by purchasing insurance ("insured plans"). "[I]f a plan is insured, a State may regulate it indirectly through regulation of its insurer and its insurer's insurance contracts; if the plan is uninsured, the State may not regulate it." n29 For a law to be deemed a "law ... which regulates insurance" within the meaning of the "insurance saving clause" it must satisfy two requirements: "First, the state law must be specifically directed toward entities engaged in insurance. Second, ... the state law must substantially affect the risk pooling arrangement between the insurer and the insured." n30

In addition to the express preemption provisions, ERISA impliedly preempts state law that conflicts with ERISA. The Congressional intent was "that a federal common law of rights and obligations under ERISA-regulated plans would develop." n31 As a result, all suits to enforce ERISA plan obligations are deemed to arise under federal law and are removable to a federal court, even if pleaded under state law. n32 "[A]ny state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear [C]ongressional intent to make the ERISA remedy exclusive and is therefore preempted." n33

"ERISA ... contains almost no federal regulation of the terms of benefit plans." n34 Consequently, the rights of beneficiaries depend almost exclusively on interpretation of the plan.

In the first instance, all ERISA claims decisions are made by those who administer the plan called upon to provide the benefits, subject to judicial review if the claimant brings a civil enforcement action. The administrators are fiduciaries and the standard of review is "guided by principles of trust law." n35 That standard depends on the powers conferred on the administrator by the plan: "A trustee may be given power to construe disputed or doubtful terms, and in such circumstances the trustee's interpretation will not be disturbed, if reasonable." n36 But a denial of benefits under ERISA "is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." n37 If the plan does give the administrator interpretive discretion and the administrator has a conflict of interest (as when the administrator is an insurer that must pay benefits from its own funds) the court must take account of that conflict as one, case-specific factor that may act as a tie-breaker whenever other factors are closely balanced. n38 By refusing to approve insurance policies granting the insurer interpretive discretion, a state regulator can effectively prohibit insured plans from escaping *de novo* review of claims decisions. n39

B. ERISA and State Law Restrictions on Subrogation

ERISA preempts any state-law restrictions on subrogation by self-funded plans. In *FMC Corp. v. Holliday*, n40 FMC maintained a self-funded health benefit plan. Holliday, a daughter of a Plan participant, was injured in an auto accident. FMC paid a portion of her medical expenses pursuant to the Plan. Her father also brought a negligence action on her behalf against the driver of the auto in which she had been riding as a passenger. The negligence claim was settled and FMC sought reimbursement for its medical payments (in accordance with the terms of the Plan). The Hollidays refused, relying on a Pennsylvania statute precluding any right to subrogation or reimbursement from a claimant's tort recovery. n41 The Supreme Court held the Pennsylvania statute preempted. n42

The Pennsylvania statute "related to" the Plan by directly restricting its right to subrogation or reimbursement:

"Pennsylvania's antisubrogation law prevents plans from being structured in a manner requiring reimbursement in the event of recovery from a third party. It requires plan providers to calculate benefit levels in Pennsylvania based on expected liability conditions that differ from those in States that have not enacted similar antisubrogation legislation. Application of differing state subrogation laws would therefore frustrate plan administrators continuing obligation to calculate uniform benefit levels nationwide." n43

On the other hand, the Pennsylvania statute was aimed at the insurance industry, so it could be saved by the insurance saving clause. n44 But the deemer clause prevented Pennsylvania from treating the Plan as an insurance

company. n45

It is doubtful that state common law imposing a made-whole requirement can be applied even to insured plans. n46 At least in most jurisdictions, that requirement is not specifically directed at the insurance industry, having arisen from the law of suretyship n47 and presumably applicable to all sorts of subrogation, not just subrogation by insurers. n48 There may be a possibility that jurisdictions prohibiting insurers from contractually overriding the made-whole rule impose that prohibition only on insurers, in which case it might be saved by the insurance saving clause. And, of course, a state insurance law or regulation imposing a made-whole requirement on insurance subrogation would govern an insured plan.

But even if state law is preempted, the possibility remains that the federal courts might adopt the made-whole requirement as a default rule under the federal common law of employee benefit plans.

C. Federal Common Law and the Made-Whole Requirement

1. The leading cases

There is a multi-way split in the circuits on issues relating to the made-whole requirement. Before analyzing the issues, we first review the leading cases. Putting aside the question of what legal rules are proper, the reader is invited to note how insensitive many of the decisions are to the language of the plans they are purporting to interpret.

a. Seventh Circuit. The Seventh Circuit addressed the made-whole requirement in *Cutting v. Jerome Foods, Inc.* n49 The beneficiary in that case had received \$90,000 in medical benefits from the Plan, had recovered \$126,000 from uninsured motorist coverage and \$500,000 on a product liability claim, and estimated her total damages at \$1 million (meaning that she had not been fully compensated). The Plan document provided that the Plan would be subrogated to "all claims" by the covered individual against a third party to the extent of "any and all payments" made (or to be made) by the plan." n50

In analyzing whether the made-whole requirement should be applied to an ERISA benefit Plan, the court found the choice to present a "close question," resolved in that case by the fact that the Plan gave the administrator discretion to interpret the Plan, requiring deference to the administrator's interpretation precisely because the question was close. n51 The court explained why it could be sensible to allow a reimbursement claim even where the beneficiary had not been made whole:

"A 'make whole' rule does not enable the insured to gamble on double recovery, as he would be doing without subrogation. The rule comes into play only if without it the operation of the subrogation clause would, by making the insured in effect pay back the policy benefits with money he has received for another loss caused by the injury that gave rise to the policy claim, leave him with an uncompensated injury. That would be the consequence of subrogating Jerome Foods to Mrs. Cutting's tort claim to the extent of the plan's medical benefits; the uncompensated nonmedical costs that she incurred as a result of the accident would be \$ 90,000 greater if subrogation is permitted. One can see why many state courts have thought that the inclusion of a boilerplate subrogation clause was not intended to have this effect - the effect, practically speaking, of curtailing coverage. To put this differently, rejection of "make whole" makes subrogation a lot like assignment. If insurance contracts required the insured to assign any tort claim he might have to the insurer, the price of the insurance would be lower but *effective* coverage would also be lower. The insured would recover only the policy limits, and not his full damages, even in a case in which a judgment had been secured against the tortfeasor, and collected, for those damages."

These arguments need not be thought decisive in favor of the make-whole rule. It is true that rejecting make whole would bring subrogation closer to assignment, but that would not necessarily be a bad thing. Assignment, by shifting the insured's tort rights to the insurance company, reduces the price of insurance and thus enables the insured to obtain more coverage, in effect trading an uncertain bundle of tort rights for a larger certain right, which is just the sort of trade that people seek through insurance. (The counterargument is that the make-whole rule is most likely to apply in a case of

catastrophic loss, such as the present, where full insurance is rare.) It can also be argued against the make-whole rule that it is administratively more complex, requiring the medical insurer to calculate the insured's total medical and nonmedical loss, and therefore that it makes insurance (or its equivalent in this case) more expensive to the insured - and makes it more expensive to him for the additional reason that he will have to pay for the additional coverage that the rule in effect provides. And no one's demand for insurance is unlimited. The counterargument on the administrative-complexity front is that subrogation (which the make-whole rule would eliminate in cases such as the present) involves an agency problem because of the insured's entitlement to any excess recovery that the insurer-subrogee obtains. The insurer, having no (or very little) interest in making money for the insured, may fail to press hard for an excess recovery. To which it can be replied that the make-whole rule simply shifts the disincentive to press hard from the insurer to the insured. n52

b. Ninth Circuit. In *Barnes v. Independent Automobile Dealers Ass'n Health Benefit & Retirement Plan*, the Ninth Circuit adopted the made-whole requirement as a "default rule" (one to be applied in the absence of a contrary provision in the Plan), finding that the requirement is a "general equitable principle of insurance law." n53

It further reasoned that the made-whole requirement:

"is consistent with ERISA's purpose of protecting participants in employee benefit plans. Because the make-whole rule does not permit an insured to recover from the tortfeasor and if the recovery would exceed the damages, it is also consistent with ERISA's related purpose of maintaining the interest of other employees in their benefit plans." n54

Despite the references to "the insured," the case involved a self-funded plan. n55 The Plan allowed benefits to be withheld pending determination of a third party's liability for the expenses and provided that, upon payment, the Plan "is subrogated to all rights of recovery to the extent of its payment." n56 But the Plan did not grant the administrator discretionary authority to construe the Plan, so review was *de novo*. n57 n58

Barnes's car was rear-ended and she incurred over \$23,000 in medical expenses; she recovered \$25,000 from the tortfeasor and \$5,000 of medical expenses from her auto insurer. n59 She claimed to have suffered over \$8,900 in lost wages and valued her tort claim (disregarding the tortfeasor's policy limit n60) at \$65,000, and the Plan did not dispute that. Accordingly, she had not been made whole, even if the Plan were required to pay the whole \$18,000+ in unpaid medical bills. The Ninth Circuit observed that it "would not apply the interpretive 'make-whole rule' as a 'gap-filler' if the subrogation clause in the Plan document specifically allowed the Plan the right of first reimbursement out of any recovery Barnes was able to obtain even if Barnes were not made whole." n61 But, relying on California insurance cases, it found "no such language." n62

Selection of the made-whole requirement as a default rule was presumably based on the belief (almost universal among state courts) that most insureds would prefer to pay a slightly higher premium for the greater protection provided by insurance with subrogation/reimbursement rights limited by the requirement that the insured first be made whole. Default rules are often set by what most parties probably would have expected, had they considered the issue. n63 But the Seventh Circuit's point in *Cutting* was that, even if that is what most insureds would prefer, not all insureds would agree. Insurance buyers could reasonably choose to pay a lower premium for the narrow coverage that results from giving the insurer priority in any third-party recovery. That is why the common law does not deny them that option.

c. Eleventh Circuit. In *Cagle v. Bruner*, n64 the Eleventh Circuit also adopted the made-whole requirement as a default rule. Bruner's son was injured in an auto accident, and he sought benefits from his union's Benefit Fund ("Fund"). During the son's hospitalization, the Fund demanded that Bruner sign a subrogation agreement and suspended payment when she refused to do so. The agreement provided that the Fund would be reimbursed in full from the proceeds of any recovery received because of the injury. n65 The Fund's trustees had discretion to construe the Plan, so their decisions would be set aside only if arbitrary and capricious. n66 The Plan provided that if the beneficiary or a

dependent "recovers the amount of medical expense paid by the Fund ... the Fund has the right to be reimbursed therefor through subrogation." n67

The court concluded that the Fund was not arbitrary and capricious in demanding reimbursement without any specific showing that medical expenses had been recovered from the tortfeasor, because the Plan called for reimbursement of the "amount of medical expenses paid by the Fund." n68 If the Fund were limited to reimbursement from recoveries identified as paid for medical expenses "Plan participants could destroy the Fund's subrogation rights by negotiating with the tortfeasor to label all or most of the damages received from the tortfeasor as 'pain and suffering,' even when they actually are intended to compensate for medical expenses." n69

However, the court held "that the make whole doctrine is a default rule in ERISA cases." It found that the relevant Plan language was "standard subrogation language, which we think does not demonstrate a specific rejection of the make whole doctrine." n70 While the trustees had discretion to interpret the Plan, the court disagreed with the Seventh Circuit that this permitted the trustees to override the made-whole requirement:

"the make whole doctrine exists because parties to an insurance contract do not always explicitly address what happens when the insurer pays less than the insured's total loss, and the insured achieves a recovery from a third party. The effect of the doctrine is to imply into ambiguous insurance contracts (including ERISA plans) a default provision governing that situation. Either the make whole doctrine is implied into the plan (the default scenario), or it is not (if there is clear language rejecting it). There is no interpretive question for the Fund to consider." n71

The court affirmed a declaration that the made-whole requirement applied to the Fund's claim for reimbursement. n72

d. Sixth Circuit. In *Copeland Oaks v. Haupt*, n73 the Sixth Circuit adopted the made-whole requirement as a default rule. Brooke Haupt, minor daughter of Plan participant Jeffrey Haupt, incurred serious and permanent injuries in an auto accident. The driver's insurance policy with Hartford provided coverage of \$100,000 for bodily injury liability and \$5000 for medical expenses, and Hartford paid the \$5000 and offered to settle the liability claim for \$100,000. A state court ordered that \$30,000 of the settlement be paid to the attorney for the Haupts and the remaining \$70,000 to a trust for Brooke's benefit. The Plan paid \$300,000 in medical expenses after the Haupts signed subrogation and reimbursement agreements, but (after the settlement) Brooke disaffirmed the agreement on the ground of her minority. Copeland Oaks sued, and all payments by Hartford were deferred.

The administrator had discretion to interpret the self-funded Plan, which provided that:

"The Covered Person agrees to recognize the Plan's right to subrogation and reimbursement. These rights provide the Plan with a priority over **any** funds paid by a third party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs or expenses." n74

The Sixth Circuit relied on an unpublished opinion in *Marshall v. Employers Health Insurance Co.*, n75 in which it had utilized the made-whole requirement as a default rule "unless there is a clear contractual provision to the contrary." n76 It reasoned that:

"Such a rule is consistent with the equitable principle that [an] insurer does not have a right of subrogation until the insured has been fully compensated, unless the agreement itself provides to the contrary. Also, the make-whole rule is merely a default rule. If a plan sets out the extent of the subrogation right or states that the participant's right to be made whole is superseded by the plan's subrogation right[,] no silence or ambiguity exists." n77

For plan language to displace the default rule "it must be specific and clear in establishing **both** a priority to the funds recovered **and** a right to any full or partial recovery," and the language before the court failed to establish a priority right to a partial recovery. n78 Nor did it matter that the trustees had discretionary authority to construe the Plan, for the same reasons given by the Eleventh Circuit in *Cagle*. n79 But the record did not establish that Brooke had

not been made whole, so it was necessary to remand for determination of that issue. n80

The rules established by Copeland Oaks were applied in *Hiney Printing Co. v. Brantner*, n81 where the district court had properly found that the employee, Brantner, would not be made whole. n82 The Plan contained both a subrogation provision and a reimbursement provision:

"RIGHT OF SUBROGATION

"The Plan shall be subrogated to the extent of any payments under this Plan of health coverage to all of the Plan Member's right of recovery therefore irregardless [sic] of the entity or individual from who the recovery may be due. . . . Any amounts so recovered, however designated, shall be apportioned as follows: this Plan shall be reimbursed to the extent of its payments under this plan of health coverage. If any balance then remains from such recovery, it shall be applied to reimburse the Plan Member and any other policy providing benefits to the Plan Member as their interest may appear.

"REIMBURSEMENT

"If the Plan member recovers damages from any party or through any coverage named above, he must hold in trust for the Employer the proceeds of the recovery, and must reimburse us to the extent of payment made." n83

Hiney Printing, whose Plan was self-funded, contended that this language unambiguously established a right to priority over the insured as to any recovery. The Sixth Circuit disagreed, denying any right to subrogation or reimbursement. As to the subrogation provision, it reasoned that:

"While it may be true, as Hiney Printing argues, that the language contained in the subrogation provision establishes first priority to any funds recovered from a responsible party, *Copeland Oaks* commands that to avoid the application of the make-whole rule, the Plan must also unambiguously establish a right to any full or partial recovery. This the subrogation provision fails to do. Nor does the phrase 'to the extent of any payments' clearly disavow the make-whole rule. While this phrase may establish the Benefit Plan's subrogation rights regarding any amount it paid towards Brantner's medical expenses, it suffers from the same ambiguity as the plan language in *Copeland Oaks*: it does not address whether this right applies when Brantner has not been fully compensated for her injuries. We therefore find the subrogation provision ambiguous because it is silent as to whether the right of subrogation applies to partial recovery, and accordingly, the make-whole rule applies." n84

The court found no reason to regard the made-whole requirement any less applicable to the reimbursement provision, and it too failed to address priority to partial recoveries. n85

e. Fifth Circuit. While the Sixth, Ninth, and Eleventh Circuits have embraced the made-whole requirement, other circuits have not. The Fifth Circuit's decision in *Sunbeam-Oster Co. Group Benefits Plan v. Whitehurst* n86 took the lead in viewing the made-whole requirement more skeptically. Whitehurst, an employee, was severely injured when an 18-wheel tractor-trailer collided with his car. The self-funded Plan paid \$137,000 in medical expenses (up to the time briefs were filed in the appeal). Whitehurst's wife and minor child had seen him being pried from the car, and the three filed a negligence suit against the truck's driver, owner, and insurer. They collectively settled for the insurance limits of \$500,000, plus \$9,000 for property damage to the car. The \$500,000 payment was not allocated between medical expenses and the other claims settled. n87 The district court determined that Whitehurst's tort claim for his own injuries was worth \$2 million and his wife and child together had suffered another \$500,000 in damages. n88 Applying the made-whole requirement, the district court denied the Plan's claim for reimbursement, and it appealed. n89

The Plan's Summary Plan Description ("SPD") excluded "charges for which payment or reimbursement is received by or for the individual as a result of legal action or settlement." n90 Its section on "subrogation" provided that:

"Subrogation allows the Plan to recover duplicate benefit amounts. For example, if you are injured by another individual and incur \$1000 in covered expenses and you sue that individual and recover \$1000 the Sunbeam-Oster Plan does not pay benefits for those expenses. If the plan has already paid benefits, it has the right to recover payment from you."

Before Whitehurst's accident, the Plan issued to participants (but did not file with the Department of Labor) an "Insert and Summary of Material Modification" replacing the quoted language with the following:

"The Plan has subrogation and reimbursement provisions which allow the Plan to recover for benefits it pays which are duplicated from another source. The Plan provides an automatic lien on any funds subject to reimbursement or subrogation.

"Reimbursement gives the Plan the right to collect from you money that you receive in a settlement or lawsuit that covers expenses that the Plan has already paid for. . . .

"Reimbursement Example -- You are injured and receive \$ 1,000 in covered expenses from the Plan. The person who caused your injury agrees to settle with you and pays you the \$ 1,000. The Sunbeam-Oster Plan has a legal right to reimbursement from you of the \$ 1,000." n91

The district court's ruling rested on the conclusion that the SPD was silent as to priority of reimbursement when a beneficiary obtained only a partial recovery, leaving a choice among Plan Priority, a Make Whole priority for the beneficiary, or Pro Rata Sharing. It concluded that the SPD's references to "duplicate benefit amounts" and "benefits ... duplicated from another source" "merely preclude the participant for receiving a 'windfall' or 'double recovery'" and did not establish a Plan Priority. n92 The Fifth Circuit disagreed, opining that state law was preempted and that "the statutory context of ERISA" rendered commercial insurance policies "far from analogous." n93

It reasoned that insurance policies are subject to strict rules of construction favorable to the insured, rules not applicable to ERISA SPD's. n94 If the provisions here had been part of an insurance policy "they would surely have been drafted with more particularity and with a plethora of legalistic boilerplate."

"Instead, though, the particular provisions that here created the Plan's reimbursement right appeared in the SPD, a document that is expressly required by ERISA to be 'written in a manner calculated to be understood by the average plan participant,' and need only be 'sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan.'" n95

There was no requirement for any more detailed plan document, and the Fifth Circuit held that. "[i]n light of these congressional imperatives and common industry practices, we should not (and will not) penalize the Plan, or other similar ERISA plans for that matter, for lack of technical precision or verbosity by labeling the Plan 'silent' or 'ambiguous' when it uses the kind of direct, jargon-free language that is mandated by ERISA for all summary plan descriptions and does not expressly address every conceivable factual variation of recovery, depending on which combination of source and fraction is under consideration at the time. In other words, the fact that the SPD for the Plan does not express a reimbursement priority for each possible combination or permutation - here, the beneficiary's partial recovery from the tortfeasor's insurer - is not a valid reason for branding the SPD as silent and subjecting it first to a search for the intent of the parties and then to a default rule of interpretation if their intent cannot be discerned." n96

The Fifth Circuit agreed with the district court that it did not matter whether the governing Plan document was the original SPD or the "Modification": "under either the central thrust of the Plan's reimbursement rights is made amply clear." n97 The Plan is entitled to obtain reimbursement for "duplicate benefit amounts" or "benefits duplicated from another source." n98 According to the Fifth Circuit, this language clearly dictated judgment for the Plan:

"When this language is read in context and viewed in light of all the circumstances, it can only mean that the Plan is entitled to be paid back by the beneficiary all amounts that the Plan has paid to the beneficiary, or on his behalf, to the

full extent - but only to the extent - that the beneficiary recovers from another source (such as insurance purchased individually, a tortfeasor, the insurer of a tortfeasor, or the like). Far from the kind of silence that would be tantamount to ambiguity, the only silence here is the understandable absence of separate, specifically articulated rules for situations of partial recovery and total recovery with variations depending on the nature of the source of recovery. This signifies nothing more than that, regardless of source, the rule is the same for total and partial recoveries. Again, the absence of more particularized and technical legal language addressing the partial recovery situation cannot be grounds for supplanting the Plan Priority rule when recovery is partial, and thereby penalizing the Whitehursts' fellow employees. This is doubly so when ERISA dictates that summary plan descriptions be simple and understandable by employees of varying backgrounds, and when the governing subrogation and reimbursement provisions express a reasonable and, indeed, the generally understood, meaning of these concepts.

"That judges and lawyers, who by education and experience are primed to discover ambiguity in contract language, might find gaps or contradictions in a summary plan description's ordinary, conversational language does not mean that the language is necessarily ambiguous or silent to the point of default for ERISA purposes." n99

Having decided that the Plan was clear, the court had no need to decide (and did not decide) what default rule it would apply if a plan were unclear. Nonetheless, having reviewed the various arguments and the authority for them, the court observed that "we have serious doubts whether we would ever approve or adopt the Make Whole rule as this circuit's default rule for the priority of recovery in reimbursement or subrogation between an ERISA plan and its participant or beneficiary under circumstances such as the ones we consider today." n100

f. Eighth Circuit. The Eighth Circuit followed *Sunbeam-Oster* under different Plan language. In *Waller v. Hormel Foods Corp.*, n101 the Wallers were injured in a head-on collision with a car being driven on the wrong side of the road. The self-funded Plan paid \$157,000 in medical expenses. The Wallers were offered \$200,000 (the available liability and underinsured motorist policy limits) for their tort claims. The Plan demanded full reimbursement, citing the following provision from the SPD, which apparently functioned as the governing Plan document:

"In the event of any payment by the company for health care expenses, the company shall be subrogated to all rights of recovery, which you or your dependent receiving payment may have against any person or organization." n102

The district court agreed that this language gave the Plan priority over the Wallers as to any recovery, but awarded part of the proceeds to the Wallers' attorney as a fee. n103 The Eighth Circuit affirmed that construction of the Plan.

The Plan did not define "subrogation," a term not familiar to laypersons. But the district court and the Eighth Circuit agreed that "this neither defeats reasonable expectations nor creates ambiguity" n104 A dictionary defined the term as substitution of one creditor for another, and the Eighth Circuit agreed with the district court that:

"the audience for which the plan was written - the average plan participant in an employer-funded plan would read this provision as meaning that the Plan has a "first priority" or "first dollar" claim to any recovery arising out of an injury up to the amount of medical benefits the Plan has paid on account of that injury." n105

The court rejected the argument that the term "subrogated" incorporated the made-whole requirement generally applied to insurance policies:

"[T]here is good reason not to read ERISA plans like insurance policies. 'The very heart of the bargain when the insured purchases insurance is that if there is a loss he or she will be made whole. The cases that originally applied subrogation to insurance contracts . . . never envisioned the use of subrogation as a device to fully reimburse the insurer at the expense of leaving the insured less than fully compensated for his loss.' Employer-funded medical benefit plans should not be viewed in this fashion." n106

Nor, for the reasons given in *Sunbeam-Oster*, did the Eighth Circuit agree that there was any ambiguity or silence giving room for application of a made-whole default rule. n107

Another aspect of the made-whole issue was presented by a case in which Deborah Shank, a Wal-Mart employee, was severely injured in an auto accident. The Wal-Mart Plan paid all of her medical expenses, totalling \$469,216. Shank obtained a settlement of \$700,000, which was reduced to \$417,477, after deducting fees and litigation costs. The court entertaining the tort action ordered that amount placed in a special needs trust for Shank. The Plan's Administrative Committee sued Shank, her husband, and the trustee for reimbursement of its payments. n108

ERISA authorizes a plan fiduciary to sue for "appropriate equitable relief ... to enforce ... the terms of the plan." n109 The Supreme Court had held that this permits an action to obtain reimbursement. n110 But it did not decide whether equitable relief of that sort was "appropriate" if the beneficiary had not been made whole. n111 The Eighth Circuit was not persuaded that this requirement should be imposed as a matter of federal common law. Courts should hesitate to create remedies beyond those created by Congress, and should "generally adopt new rules of federal common law only if they are necessary to fill gaps left by the express terms of ERISA and to effectuate the purposes of the statute." n112 *Waller* had concluded that the made-whole requirement originated in purposes of insurance policies not shared by ERISA plans, and the court saw nothing to counsel a different result in *Shank*. n113

The Plan language was extremely clear and explicit:

"The Plan has the right to . . . recover or subrogate 100 percent of the benefits paid by the Plan on your behalf . . . to the extent of . . . [a]ny judgment, settlement, or any payment made or to be made, relating to the accident These rights apply regardless of whether such payments are designated as payment for . . . [m]edical benefits [or] [w]hether the participant has been made whole (i.e., fully compensated for his/her injuries). . . . The Plan has first priority with respect to its right to reduction, reimbursement and subrogation." n114

The purposes of ERISA required that this be enforced:

"Among the primary purposes of ERISA is to ensure the integrity of written plans and to protect the expectations of participants and beneficiaries. Ordinarily, courts are to enforce the plain language of an ERISA plan 'in accordance with 'its literal and natural meaning.'" We therefore do not apply common law theories to alter the express terms of a written plan." n115

While Shank's personal situation was difficult, other interests must also be considered:

"Shank would benefit if we denied the Committee its right to full reimbursement, but all other plan members would bear the cost in the form of higher premiums. Reimbursement and subrogation provisions are crucial to the financial viability of self-funded ERISA plans, and, as a fiduciary, the Committee must 'preserve assets to satisfy future, as well as present, claims,' and must 'take impartial account of the interests of all beneficiaries.'" n116

While ERISA's purpose is to protect beneficiaries, that protection extends only to "'contractually defined benefits.'" n117 So, the limitation to "appropriate" equitable relief could not be utilized to protect other interests of the beneficiary from reimbursement claims.

g. First Circuit. In *Harris v. Harvard Pilgrim Health Care, Inc.*, n118 the First Circuit rejected treating the made-whole requirement as a default rule. Michael Harris sustained personal injuries in a motorcycle accident, and HPHC, the Plan administrator, paid \$102,874.29 in medical expenses. Harris and his wife eventually settled their tort claims for \$737,500, \$264,727.31 of which went for attorneys fees and expenses. They claimed not to have been made whole, because they had settled for two-thirds of the amount of their damages (in light of arguable comparative negligence). n119

The Plan did not give the administrator discretion to construe its terms. n120 The relevant terms were these:

"H.4. SUBROGATION. If another person or entity is, or may be, responsible to pay for expenses or services related to the Member's illness and/or injury which [HPHC] paid or provided, then [HPHC] is entitled to subrogation rights against such person or entity. [HPHC] shall have the right to proceed in the name of the Member, with or without his or her consent, to secure right of recovery of its cost, expenses, or the value of services rendered under this Agreement. *[HPHC] is also entitled to recover from a Member the value of services provided, arranged, or paid for, when the Member was reimbursed for the cost of care by another party.*

"H.5. MEMBER COOPERATION. The Member agrees to cooperate with [HPHC], and to provide all requested information, and *to assign to [HPHC] any monies received for services provided or arranged by [HPHC]*. The Member will do nothing to prejudice or interfere with the rights of [HPHC]." n121

The district court granted HPHC's request for reimbursement and the First Circuit affirmed. While recognizing that it was possible to adopt the made-whole requirement as federal common law, it declined to do so because it believed that such common law rules should be adopted "only as necessary to effectuate legitimate ERISA policy objectives." n122 Echoing *Sunbeam-Oster*, it reasoned that:

"Where an ERISA plan requires - without qualification - that plan participants reimburse the plan for benefits paid, the plan should not be construed to depend upon an implied contingency such as the 'make whole' doctrine, particularly since ERISA specifically envisions that covered plans be written in straightforward language comprehensible by the average plan participant. In such circumstances, 'the absence of more particularized and technical legal language addressing the partial recovery situation cannot be grounds for supplanting the Plan Priority rule.' Similarly, the instant ERISA plan explicitly 'entitled [HPHC] to recover from a Member the value of services provided, arranged, or paid for, when the Member was reimbursed for the cost of care by another party.'" n123

The court also noted that the costs of any benefits to the Harrises would be borne by other Plan members in the form of higher premiums. Moreover, determining whether participants such as the Harrises had indeed been made whole could require extensive litigation in the district court. Accordingly, the district court had properly required reimbursement here. n124

h. Third Circuit. In *Bill Gray Enterprises, Inc. Employee Health & Welfare Plan v. Gourley*, n125 the Third Circuit declined to adopt a common-law made-whole requirement that would override contrary Plan language, but did not address possible use of a default rule where Plan language is unclear. As the court viewed the case, the primary issue was whether the Plan's purchase of stop-loss insurance rendered it an insured plan, governed by Pennsylvania insurance law restrictions on subrogation. n126 Finding that the Plan was still considered self-funded and immune to state-law restrictions, n127 it turned to interpretation of the Plan, as applied to the facts before it.

Gourley, an employee of Bill Gray Enterprises, was severely injured when his car was struck by an uninsured drunk driver. The Plan paid \$141,401.35 for his medical expenses, though the stop-loss insurer funded all of the payments exceeding \$40,000. The Gourleys sued the tavern that served the drunk driver and obtained a judgment for \$1,182,500 for Gourley and \$67,500 for his wife (for loss of consortium). But the tavern was uninsured and filed for bankruptcy, leaving the judgment uncollectible. The Gourleys collected \$300,000 from their underinsured motorist insurer, and the Plan sued for reimbursement. n128

The Plan provided that when a Covered Person had a claim against a third party with respect to medical or other charges for which the Plan paid benefits:

"The Covered Person must:

"(1) assign or subrogate to the Plan his or her rights to recovery when this provision applies;

"(2) authorize the Plan to sue, compromise and settle in the Covered Person's name to the extent of the amount of medical or other benefits paid for the Injuries under the Plan and its expenses incurred by the Plan in collecting this

amount; [and]

"(3) reimburse the Plan out of the Recovery made from the other person, the other person's insurer or the third party the amount of medical or other benefits paid for the Injuries under the Plan and the expenses incurred by the Plan in collecting this amount;

"Amount subject to subrogation or reimbursement. All amounts recovered will be subject to subrogation or reimbursement. In no case will the amount subject to subrogation or reimbursement exceed the amount of medical or other benefits paid for the Injuries under the Plan and the expenses incurred by the Plan in collecting this amount." n129

The Plan administrator was given discretionary authority to interpret the Plan, so its interpretation was reviewed only for abuse of discretion. n130 But the first question was whether the Plan language was ambiguous: if not, any action inconsistent with the unambiguous meaning would be arbitrary and capricious. If the Plan terms were ambiguous, then the court would determine whether the administrator's interpretation was reasonable. n131 Gourley argued that the Plan was ambiguous in describing whether reimbursement is required when a Covered Person receives payments unrelated to medical costs and that his own insurance company might not be a "third party." The Third Circuit held that the language was unambiguous, stating that "'[a]ll amounts received will be subject to subrogation and reimbursement.'" n132 The term "third party" "clearly refers to any person or entity other than the Plan and the covered individual." n133 The court declined to adopt a common-law rule that would override Plan language. n134 But the Plan language unambiguously did not create any right of reimbursement of amounts received by Mrs. Gourley, who had received no benefits from the Plan, so the administrator's contrary interpretation was arbitrary and capricious. n135 The uninsured motorist carrier, having fully discharged its contractual obligations to the Gourleys (an in the absence of any evidence of fraud in doing so), had a good defense to the Plan's subrogation claim. n136

i. Fourth Circuit. The Fourth Circuit has not passed on use of the made-whole requirement as an interpretive rule, as the cases that have come before it have involved very clear requirements that the Plan be reimbursed first. n137 It has refused, for reasons similar to those in *Harris*, to adopt a federal common-law rule overriding Plan requirements for reimbursement in those cases where the beneficiary has not been made whole. n138

j. D.C. Circuit. In *Moore v. CapitalCare, Inc.*, n139 the Moores did not challenge the district court's ruling that the Plan unambiguously granted the Plan priority with respect to the proceeds of the tort claim. n140 Moreover, the Plan granted the administrator discretionary authority to construe the Plan, and the administrator's construction was reasonable. n141 So, the court did not address what default rule might be applicable if the Plan did not address priority. n142 While invited to adopt the made-whole requirement as a common-law rule overriding Plan language, n143 the court failed to do so, without discussion.

2. Analysis

a. a. ERISA and ERISA-based common law should not override plan terms on this issue. One issue on which there appears no division of authority is that ERISA and ERISA-based common law will not be applied to impose a made-whole requirement that is *contrary* to the provisions of the relevant Plan. ERISA allows benefit plan sponsors broad freedom to design welfare benefit plans that they believe will best serve the needs of participants, given the amounts available to finance those benefits. Reimbursements from participants who have not been made whole can be used to finance other benefits the Plan may provide. Viewed another way, when benefits must be paid from a fund (rather than from the assets of an insurer or plan sponsor), failure to recover reimbursements called for by the Plan may deplete the fund and impair its ability to pay promised benefits to others. Harsh as the result may be for participants required to reimburse plans when the participants have not been made whole, ERISA does not provide a proper basis for overriding Plan terms.

b. Courts should defer to reasonable interpretations by administrators with that authority. There is a

division in the cases regarding the ability of an administrator with discretionary authority to interpret a Plan in a way that overrides any default rule favoring a made-whole requirement. The Sixth and Eleventh Circuits say that, absent explicit language negating any made-whole requirement, there is no interpretive issue. n144 The Seventh and D.C. Circuits say that an administrator with discretionary authority may interpret the Plan to negate any made-whole requirement if the language of the Plan can reasonably be read in that way. n145 The latter result seems clearly correct. Precisely because courts are not free to override Plan terms on this issue, the role of any default rule is purely interpretive. If the Plan has provided an alternative interpretive mechanism, by granting the administrator interpretive authority, courts cannot properly displace reasonable interpretations by relying on a default rule that produces a different result. n146

c. Regardless of what the default rule may be, courts should pay careful attention to the Plan language being construed. One striking fact that emerges from review of the leading cases is how little attention courts on either side of the "made whole" issue have paid to the language of the Plans they purport to be interpreting. For example, the Sixth Circuit has found that Plans did not address priority in the event of a partial recovery even though they had the following language:

"The Covered Person agrees to recognize the Plan's right to subrogation and reimbursement. *These rights provide the Plan with a priority over any funds paid by a third party to a Covered Person relative to the Injury or Sickness,* including a priority over any claim for non-medical or dental charges, attorney fees, or other costs or expenses." n147

RIGHT OF SUBROGATION

"The Plan shall be subrogated to the extent of any payments under this Plan of health coverage to all of the Plan Member's right of recovery therefore irregardless [sic] of the entity or individual from who the recovery may be due. . . . *Any amounts so recovered, however designated, shall be apportioned as follows: this Plan shall be reimbursed to the extent of its payments under this plan of health coverage. If any balance then remains from such recovery, it shall be applied to reimburse the Plan Member and any other policy providing benefits to the Plan Member as their interest may appear.*" n148

In each instance, but especially in the latter, the italicized language calls for a Plan priority that makes sense only in the context of an incomplete recovery. And, in each case, the language had been interpreted that way by an administrator with interpretive discretion. At a minimum, each of those interpretations was reasonable, and the Sixth Circuit ought not to have rejected it.

On the other hand, the Fifth Circuit found that the Plan clearly rejected any made-whole requirement by calling for reimbursement of "duplicate benefit amounts" or "benefits it pays which are duplicated from another source." n149 But where the beneficiary has not been made whole, there is no way to show that the benefits have been "duplicated" by the tort recovery. Where a victim of a tortious injury has suffered both losses covered by a collateral source and losses not covered by that source and the assets available to the tortfeasor are inadequate to pay for the remaining recoverable damages, the collateral source has no right (absent contract language addressing the issue) to compel the victim and the tortfeasor to allocate any settlement to the portion of a loss that was covered by the collateral source. n150 Essentially, the Fifth Circuit took Plan language that unambiguously *codified* the made-whole requirement and read that language to *negate* the requirement.

The Eighth Circuit held that the made-whole requirement was negated by language stating that "the company shall be subrogated to all rights of recovery which you or your dependent receiving payment may have against any person." n151 That holding was based on an effort to determine how the average layperson would understand the word "subrogated," even though the court recognized that this word was unfamiliar to laypersons. n152 Because the drafter of the Plan chose to use a technical legal term, participants ought to be entitled invoke the technical meaning, and many courts hold that this includes the made-whole requirement. n153 At a minimum, this created an ambiguity that would make the default rule significant.

The First Circuit held that the made-whole requirement was negated by language stating that the Plan "is ... entitled to recover ... the value of services provided ... when the member was reimbursed for the cost of care by another." n154 The court made much of the requirement to reimburse the Plan, without noting that the obligation depended on a showing that the third party had reimbursed the member "for the cost of care." This is subject to exactly the same criticism as with the Fifth Circuit's decision in *Sunbeam-Oster*.

Courts called upon to interpret ERISA plans should pay careful attention to Plan language before resorting to default rules. Courts on both sides of the "made whole" issue appear to begin their analysis with a preferred outcome, though courts preferring Plan priority seem more prone to attributing dubious results to a supposedly unambiguous meaning of the Plan language. Moreover, while courts ought not to apply default rules where the Plan language really does resolve the issue, courts ought not to presume that Plan language is truly complete and resolves all possible issues: using an appropriate default rule that reflects what likely would have been intended is better than distorting language that truly does not address an issue in order to declare the Plan unambiguous.

d. ERISA-based common law should adopt the made-whole requirement as a weak default rule. Just as both sides of the "made whole" debate had relied on dubious interpretations of the plans at issue, both have also relied on dubious analysis.

Those supporting the made-whole requirement have looked to insurance law as the appropriate analogy. n155 But ERISA common law is based on trust law, not insurance law. n156 Insurance law regards satisfying the reasonable expectations of insureds as a primary objective of policy interpretation. n157 Trust law, on the other hand, is almost exclusively concerned with the intent of the settlor. Accordingly, the reasonable expectations of participants have far less importance under ERISA than under insurance law.

On the other hand, those refusing to adopt a make-whole default rule have assumed that negating that rule would require dense and detailed language unsuitable for an ERISA SPD. n158 If that would be a problem at all, the problem would occur only under a "strong" default rule requiring something close to "magic language" to negate it. n159 It would not be a problem under a "weak" default rule that required only that the language identify and respond to the problem of partial recovery. n160 It is actually relatively easy for plan sponsors who desire to override any make-whole requirement to insert appropriate specific language in plan documents - even the SPD. And sponsors typically have the benefit of expert consultants in designing plans and estimating their costs. So, absence of such language suggests that the sponsor has not regarded the issue as important. Thus, where a Plan is truly silent or ambiguous, a default rule applying a made-whole requirement would not upset any real expectations of the sponsor and would satisfy the reasonable expectations of the participant (as reflected in the almost universal insurance law rule).

Where a Plan is truly silent or ambiguous (and the administrator lacks interpretive discretion), the ERISA-based common law must supply some default rule, and the made-whole requirement is an appropriate one. Applying a default rule does not "alter" the terms of a Plan if the Plan does not address the issue in question.

Return to Text

n1 State law is examined in more detail in Barker, William T., "Sonnenschein Nath & Rosenthal on Insurance Subrogation and the Made-Whole Rule: When Does and Should It Apply Under State Law," *LexisNexis Emerging Issues Analysis*, 2009 *Emerging Issues* 4529 (Oct., 2009).

n2 Robert E. Keeton & Alan I. Widiss, , at 135 (1988).

n3 Id.

n4 Restatement (Second) of Torts § 920A(2) ("Payments made to or benefits conferred on the injured party from other sources [than the tortfeasor or others acting on the tortfeasor's behalf] are not credited against the tortfeasor's liability, although they cover all or a part of the harm for which the tortfeasor is liable.").

n5 Collateral Source Rule and Contract Damages, 71 *Cal. L. Rev.* 56, 82 (1983) (recognizing that availability of subrogation "is widely considered the optimal solution for the whole problem of collateral benefits on the ground that it prevents both the defendant from taking an undeserved advantage of the benefit and the plaintiff from being overcompensated"); *see also* (The plaintiff's assertion that he was entitled to recover for his full loss against the defendant railroad and also retain the proceeds that his insurance carrier sought by way of subrogation "could not be urged successfully. . . . Good morals and important considerations of public policy forbid that conflagrations should be made profitable.").

n6

[6] Courts resisting subrogation commonly assume that the insured has paid a premium to cover the entire loss insured, with no allowance for possible recovery by way of subrogation or reimbursement. That is an unwarranted assumption. But insurers litigating the permissibility of subrogation would be well advised to make a factual showing that potential subrogation/reimbursement recoveries have been properly accounted for in setting the premium.

In fact, past losses under similar policies are typically used to project future losses for which the premium must provide, and any subrogation/reimbursement recoveries for those past losses are treated as credits against those losses, so that the projections of future losses are automatically based on net losses after recoveries.

n7 *See also* A Michael Polinsky, *An Introduction to Law and Economics*, 53-55 (2d ed. 1989) (where one party to the transaction is risk averse (as most insureds are) and the other is risk-neutral (as insurers are), the risk is better allocated to the risk-neutral party).

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[8] *Cutting v. Jerome Foods, Inc.*, 993 F.2d 1293, 1297-98 (7th Cir.) (Posner, J.), *cert. denied*, 510 U.S. 916 (1993).

n9 See Jeffrey E. Thomas, *New Appleman on Insurance Law Library Edition* §§ 5.06[1] (public policy limits the terms to which contracting parties may agree), 5.06[2][b] (public policy influences interpretation of insurance policies), 5.05[2] (policies construed to satisfy the reasonable expectations of insureds, at least if ambiguous); *Cutting*, 993 F.2d at 1297 (7th Cir. 1993) (made-whole rule "exists only when the parties are silent. It is a gap filler."). See also note 62, below.

n10 See Johnny C. Parker, *The Made-Whole Doctrine: Unraveling the Enigma Wrapped in the Mystery of Insurance Subrogation*, 70 Mo. L. Rev. 723, 724-37 (2005) (discussing legal or equitable subrogation rule commonly applied by the courts). Indiana has a statute which reduces any subrogation lien or claim regarding personal injuries or death proportionately to any reduction of the tort claimant's recovery by comparative fault or uncollectability resulting from limited liability insurance or other causes. Ind. Code § 34-51-2-19. In effect, this mandates pro rata sharing of the recovery.

n11 See, e.g., *Cain v. State Farm Mut. Auto. Ins. Co.*, 121 Cal. Rptr. 200, 207 (Cal. Ct. App. 1975).

n12 See, e.g., *State Farm Fire & Cas. Co. v. Knapp*, 484 P.2d 180, 185 (Ariz. 1971); *21st Century Ins. Co. v. Super. Ct.*, 98 Cal. Rptr. 3d 516, 518 (Cal. 2009); *Allstate Ins. Co. v. Reitler*, 628 P.2d 667, 670 (Mont. 1981). But see *Aetna Cas. & Sur. Co. v. Assocs. Transports, Inc.*, 512 P.2d 137, 142-43 (Okla. 1973) (even though personal injury claim is ordinarily nonassignable, where tortfeasor had knowledge of insurer's rights and settled with insured without providing for insurer's claim, insurer entitled to sue on claim for medical payments it had made).

n13 See, e.g., *Peller v. Liberty Mut. Fire Ins. Co.*, 34 Cal. Rptr. 41, 42 (Cal. Ct. App. 1963) (noting such questions but disposing of them on the ground that the legislature had codified the prohibition on assignment).

n14 E.g., *Progressive West Ins. Co. v. Superior Ct.*, 37 Cal. Rptr. 3d 434, 442 (Cal. Ct. App. 2005).

n15 See cases collected in Annot., *Subrogation rights of insurer under medical payments provision of insurance policy*, 19 A.L.R.3d 1054, § 3 (1968, supplemented to 10/14/2009).

n16 A state-by-state examination of the cases is found in Johnny C. Parker, *supra* note 10, 70 *Mo. L. Rev.* at 738-773. Prof. Parker concludes that the made-whole requirement cannot be modified by contract in 16 states. *Id.* at 774.

n17 See cases cited in Barker, William T., "Sonnenschein Nath & Rosenthal on Insurance Subrogation and the Made-Whole Rule: When Does and Should It Apply Under State Law," *LexisNexis Emerging Issues Analysis*, 2009 *Emerging Issues* 4529 n.32 (Oct., 2009).

n18 See cases cited in *id.* n.33.

n19 See cases cited in *id.* n.34.

n20 See case cited in *id.* n.35.

n21 See cases cited in *id.* n.36.

n22 See cases cited in *id.* n.37.

n23

[23] *Samura v. Kaiser Found. Health Plan, Inc.*, 22 *Cal. Rptr. 2d* 20, 23 (*Cal. Ct. App.* 1993), *cert. denied*, 511 *U.S.* 1084 (1994). These rules apply regardless whether the insurer is seeking subrogation or reimbursement. *Progressive West Ins. Co. v. Superior Ct.*, 37 *Cal. Rptr. 3d* 434, 442 (*Cal. Ct. App.* 2005).

n24 *Pilot Life Ins. Co. v. Dedeaux*, 481 *U.S.* 41, 44 (1987), quoting 29 *U.S.C.* § 1002(1).

n25 *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981).

n26 29 U.S.C. § 1144(a).

n27 29 U.S.C. § 1144(b)(2)(A).

n28 29 U.S.C. § 1144(b)(2)(B).

n29 *FMC Corp. v. Holliday*, 498 U.S. 52, 64 (1990); see *Metropolitan Life Ins. Co. v. Mass.*, 471 U.S. 724, 740-47 (1985).

n30 *Kentucky Ass'n of Health Plans v. Miller*, 538 U.S. 329, 341-42 (2003).

n31 *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110 (1989); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56 (1987).

n32

[32] *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 52-57 (1987).

n33 *Aetna Health, Inc. v. Davila*, 542 U.S. 200, 209 (2004).

n34 *Metropolitan Life Ins. Co. v. Mass.*, 471 U.S. 724, 732 (1985).

n35 *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 111 (1989).

n36 *Id.*

n37 *Id. at 115.*

n38 *Metropolitan Life Ins. Co. v. Glenn*, 128 S. Ct. 2343, 2350-52 (2008).

n39 *Standard Ins. Co. v. Morrision*, No. 08-35246 (9th Cir. Oct. 27, 2009); *American Coun. of Life Insurers v. Ross*, 558 F.3d 600 (6th Cir. 2009).

n40 *FMC Corp. v. Holliday*, 498 U.S. 52 (1990).

n41 *Id. at 54-55.*

n42 *Id. at 65.*

n43

[43] *Id. at 60.*

n44 *Id. at 61.*

n45 *Id. at 61-64.*

n46 *But see Kavelaris v. MSI Ins. Co.*, 631 N.W.2d 665 (Wis. Ct. App. 2001) (made-whole requirement held not preempted as to insured plan); *Moore v. CapitalCare, Inc.*, 461 F.3d 1 (D.C. Cir. 2006) (applying made-whole requirement to an insured plan, but not addressing preemption because no argument was made based on D.C. local law).

n47 *E.g.*, Jeffrey A. Greenblatt, Comment, *Insurance and Subrogation: When the Pie Isn't Big Enough, Who Eats Last?*, 64 U. Chi. L. Rev. 1337, 1339-40 (1997) ("Subrogation finds its roots in suretyship"); *Amer. Contractors Indem. Co. v. Saladino*, 9 Cal. Rptr. 3d 835, 839 (Cal. Ct. App. 2004) ("Payment of a principal's debt by a surety is the prototypical situation in which the equitable right to subrogation arises. 'Subrogation is the right to recover from the debtor-obligor. A surety, e.g., pays the principal debtor's obligation to the creditor, and in equity is substituted for the creditor, or subrogated to his rights against the debtor.'" (quoting 11 B.E. Witkin, Summary of California Law, Equity § 169, at 849 (9th Ed. 1990) (emphasis by Witkin))).

n48 *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50 (1987) (Mississippi common law subjecting an insurer to punitive damages for bad faith denial of claims not saved because not aimed at the insurance industry: "Even though the Mississippi Supreme Court has identified its law of bad faith with the insurance industry, the roots of this law are firmly planted in the general principles of Mississippi tort and contract law. Any breach of contract, and not merely breach of an insurance contract, may lead to liability for punitive damages under Mississippi law.") *But see UNUM Life Ins. Co. v. Ward*, 526 U.S. 358, 369-72 (1999) (notice-prejudice rule is saved; even though it has roots in more general doctrines, "it is an application of a special order, a rule mandatory for insurance contracts" and "grounded in policy concerns specific to the insurance industry").

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[49] *Cutting v. Jerome Foods, Inc.*, 993 F.2d 1293 (7th Cir.) (Posner, J.), *cert. denied*, 510 U.S. 916 (1993).

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[50] *Id.* at 1299.

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[51] *Id.* at 1298-99.

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[52] *Id. at 1298.*

n53 *Barnes v. Independent Auto. Dealers Ass'n Health Benefit & Retirement Plan*, 64 F.3d 1389, 1394 (9th Cir. 1995).

n54 *Id. at 1395* (citations omitted).

n55 *Id. at 1391.*

n56 *Id. at 1393.*

n57 *Id. at 1392.*

n58

n59 *Id. at 1391, 1395.*

n60 The court noted that the summary judgment evidence indicated that the tortfeasor had few assets, so that the release given by Barnes did not prejudice the plan. *Id. at 1396 n.3.*

n61 *Id. at 1395* (citing *Samura v. Kaiser Found. Health Plan, Inc.*, 22 Cal. Rptr. 2d 20, 23 (Cal. Ct. App. 1993), cert. denied, 511 U.S. 1084 (1994), as an example of language so providing). See quotation at note 23, above.

n62 *Id.* at 1395-96.

n63

[62] *See, e.g.*, Frank H. Easterbrook & Daniel R. Fischel, *The Economic Structure of Corporate Law*, 89 *Colum. L. Rev.* 1416, 1433 (1989) (courts should choose default terms "that the parties would have selected with full information and costless contracting"). There are arguments that courts should sometimes select "penalty" default rules, not on the basis of what the parties actually want, but for the purpose of providing incentives for one party to reveal information that will allow tailoring of the transaction in a more optimal manner. *See, e.g.*, Ian Ayres & Robert Gertner, *Filling Gaps in Incomplete Contracts: An Economic Theory of Default Rules*, 99 *Yale L.J.* 87 (1989). But the latter arguments concern contracts whose terms are bargained between the parties, and have little relevance to the sort of adhesion contracts involved in the usual insurance policy or employee benefit plan.

n64 *Cagle v. Bruner*, 112 F.3d 1510 (11th Cir. 1997).

n65 *Id.* at 1512-13.

n66 *Id.* at 1517.

n67 *Id.*

n68 *Id.* at 1518.

n69 *Id.* at 1519.

n70 *Id.* at 1521.

n71

[70] *Id.* at 1522.

n72 *Id.*

n73 *Copeland Oaks v. Haupt*, 209 F.3d 811 (6th Cir. 2000).

n74 *Id.* at 813 (emphasis in the plan).

n75 *Marshall v. Employers Health Ins. Co.*, Nos. 96-6063, 96-6112, 1997 U.S. App. LEXIS 36769 (6th Cir. 1997).

n76 *Copeland Oaks*, 209 F.3d at 813.

n77 *Id.*, quoting *Marshall*, 1997 U.S. App. LEXIS 36769, at *12.

n78 209 F.3d at 813-14 (emphasis original).

n79 *Id.* at 813.

n80 *Id.* at 814.

n81 *Hiney Printing Co. v. Brantner*, 243 F.3d 956 (6th Cir. 2001).

n82 *Id.* at 960.

n83 *Id.* at 958.

n84

[83] *Id.* at 959.

n85 *Id.* at 959-60.

n86 *Sunbeam-Oster Co. Group Benefits Plan v. Whitehurst*, 102 F.3d 1368 (5th Cir. 1996).

n87 *Id.* at 1370.

n88 *Id.* at 1372.

n89 *Id.*

n90 *Id.* at 1371.

n91

[90] *Id.* The Modification eliminated a provision relating to individually purchased auto no-fault insurance not at issue in the case. *Id.* The opinion suggests that the Plan administrator had no discretion to construe the Plan, *id.* at 1378, so it would appear that review was *de novo*.

n92 *Id.* at 1373-74.

n93 *Id.* at 1374.

n94 *Id.* at 1374-75.

n95 *Id.* at 1374-75.

n96 *Id.* at 1375.

n97 *Id.*

n98 *Id.*

n99 *Id.* at 1375-76.

n100 *Id.* at 1378.

n101 *Waller v. Hormel Foods Corp.*, 120 F.3d 138 (8th Cir. 1997).

n102 *Id.* at 139.

n103

[102] *Id.*

n104 *Id.* at 140.

n105 *Id.*

n106 *Id.*

n107 *Id.*

n108 *Admin Comm. of Wal-Mart Stores, Inc. Assocs. Health & Welfare Plan v. Shank*, 500 F.3d 834 (8th Cir. 2007).

n109 29 U.S.C. § 1132(a)(3).

n110 *Sereboff v. Mid Atlantic Med. Servs., Inc.*, 547 U.S. 356 (2006).

n111 *Shank*, 500 F.3d at 837.

n112 *Id.*

n113 *Id.* at 838.

n114 *Id.*

n115 *Id.* (citations omitted).

n116 *Id.* (citations and footnote omitted).

n117 *Id.* at 839 (emphasis by the court).

n118 *Harris v. Harvard Pilgrim Health Care, Inc.*, 208 F.3d 274 (1st Cir. 2000).

n119 *Id.* at 276-77. Because the Harris settlement does not appear to have been impacted by limited amounts of insurance or assets to satisfy any judgment, it arguably was a fair estimate of the full value of the tort claim. If the full value of the tort claim was recovered, it could be argued that that did make the Harrises whole in the relevant sense, even if they did not recover the full amount of their damages. But no argument of that sort appears to have been presented in the case.

n120 *Id.* at 277 n.3.

n121 *Id.* at 276 (emphasis by the court).

n122 *Id.* at 280.

n123 *Id.* (citations to *Sunbeam-Oster* omitted).

n124

[123] *Id.* at 280-81.

n125 *Bill Gray Enterprises, Inc. Employee Health & Welfare Plan v. Gourley*, 248 F.3d 206 (3d Cir. 2001).

n126 *Id.* at 209.

n127 *Id.* at 213-15.

n128 *Id.* at 211.

n129 *Id.* at 210.

n130

[129] *Id.* at 217-18.

n131

[130] *Id. at 218.*

n132

[131] *Id. at 219-20.*

n133

[132] *Id. at 220.*

n134

[133] *Id. at 220 n.13.*

n135

[134] *Id. at 221.*

n136

[135] *Id. at 221-23.*

n137

[136] *Kress v. Food Employers Labor Rel. Ass'n Health & Welfare Fund*, 391 F.3d 563, 566 (2004) (Plan excluded medical expenses that Trustees determined were the responsibility of a third party, but Plan would advance payment for such expenses based on agreement "to reimburse the Fund in full from any recovery you or your eligible dependent may receive"); *Paris v. Iron Workers Trust Fund*, No. 99-1558, 2000 U.S. App. LEXIS 6883, at *8 (4th Cir. April 17, 2000) (Plan provided that "[b]y accepting benefits from the Fund, the injured person agrees that any amounts recovered by the injured person ... will be applied *first* to reimburse the Fund." *Id. at *3* (emphasis added)).

n138 *Kress*, 391 F.3d at 568-71.

n139 *Moore v. CapitalCare, Inc.*, 461 F.3d 1 (D.C. Cir. 2006).

n140 *Id.* at 10 n.10.

n141 *Id.* at 11.

n142 *Id.* at 10.

n143 *Id.* at 10 n.10.

n144

[143] See text at notes 70 and 78, above.

n145 See text at notes 51 and 129, above.

n146 See *Metropolitan Life Ins. Co. v. Glenn*, 128 S. Ct. 2343, 2353 (2008) (Roberts, C.J., concurring in part and concurring in the judgment) ("Ensuring that reviewing courts respect the discretionary authority conferred on ERISA fiduciaries encourages employers to provide medical and retirement benefits to their employees through ERISA-governed plans--something they are not required to do").

n147 *Copeland Oaks v. Haupt*, 209 F.3d 811, 813 (6th Cir. 2000) (italics added).

n148 *Hiney Printing Co. v. Brantner*, 243 F.3d 956, 960 (6th Cir. 2001) (italics added).

n149 *Sunbeam-Oster Co. Group Benefits Plan v. Whitehurst*, 102 F.3d 1368, 1375-76 (5th Cir. 1996).

n150 *E.g.*, *Amer. Contractors Indem. Co. v. Saladino*, 9 Cal. Rptr. 3d 835, 839 (Cal. Ct. App. 2004) ("Payment of a principal's debt by a surety is the prototypical situation in which the equitable right to subrogation arises. 'Subrogation is the right to recover from the *debtor-obligor*. A surety, e.g., pays the principal debtor's obligation to the creditor, and in equity is substituted for the creditor, or *subrogated* to his rights against the debtor.'" (quoting 11 B.E. Witkin, Summary of California Law, Equity § 169, at 849 (9th ed. 1990) (emphasis by Witkin)); *id.* at 843 ("where the surety is only liable for a portion of the obligation - the principal debtor is entitled to designate how the debtor's payments to the original creditor should be applied," relying on Calif. Civ. Code § 2822), 844 ("A surety has no right to compel the debtor's payment to be credited to the portion on which the surety is liable." (quoting H. Walter Croskey, Rex Heeseman, & Susan M. Popik, Cal. Prac. Guide: Insurance Litigation, 6:3633, at 61-95 (2003) (emphasis by the court omitted))).

n151 *Waller v. Hormel Foods Corp.*, 120 F.3d 138, 140 (8th Cir. 1997).

n152 *Id.*

n153 *E.g.*, cases cited in Barker, William T., "Sonnenschein Nath & Rosenthal on Insurance Subrogation and the Made-Whole Rule: When Does and Should It Apply Under State Law," *LexisNexis Emerging Issues Analysis*, 2009 *Emerging Issues* 4529 (Oct., 2009).

n154 *Harris v. Harvard Pilgrim Health Care, Inc.*, 208 F.3d 274, 280-81 (1st Cir. 2000).

n155

[154] See text at notes 52, 69, and 75, above.

n156 See text at note 35, above.

n157 See Jeffrey E. Thomas, *The New Appleman on Insurance Law*, Library Edition, § 5.05[2] (policies construed to satisfy the reasonable expectations of insureds, at least if ambiguous).

n158 See text at notes 93-94, 97, 104, 121, above.

n159 See text at notes 76 and 82, above, for examples of such "strong" default rules.

n160 The language quoted at notes 23 and 81 and in note 123 arguably should satisfy even a "strong" default rule and certainly should satisfy a "weak" one. The language quoted at note 72 should satisfy at least a "weak" default rule.

RELATED LINKS: Jeffrey E. Thomas, *New Appleman on Insurance Law* Library Edition sections 5.05 and 5.06
■ 1-5 *New Appleman on Insurance Law* Library Edition 5.05

Sonnenschein Nath & Rosenthal on Insurance Subrogation and the Made-Whole Rule: When Does and Should It Apply Under State Law
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Ravis on the Permissible Discovery in ERISA Litigation

2009 Emerging Issues 4503

Ravis on the Impact of MetLife v. Glenn on Permissible Discovery in ERISA Litigation

By Talia Ravis

October 22, 2009

SUMMARY: The Supreme Court decision in Metropolitan Life Ins. Co. v. Glenn and its progeny have broadened the scope of permissible discovery in ERISA litigation. Discovery is now allowed to determine if the plan administrator had a conflict of interest and if that conflict played a role in the administrators decision to deny benefits to the plaintiff employee. The introduction of evidence extrinsic to the administrative record has also been allowed.

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ARTICLE: Introduction. The scope of discovery under the Employee Retirement Income Security Act of 1974 ("ERISA") is generally determined by the applicable standard of review. In the past, discovery was often permitted under the *de novo* standard of review and under the heightened arbitrary and capricious standard of review, but generally very limited, or not allowed at all under the abuse of discretion standard of review (also known as "arbitrary and capricious" standard of review).

However, on June 19, 2008, everything changed when the Supreme Court issued its long awaited decision in *Metropolitan Life Ins. Co. v. Glenn*. n1 ERISA defense attorneys will argue that this bearing had no decision on discovery in ERISA litigation, but case law from around the country interpreting the meaning of *Glenn* has proven otherwise: This decision had a far-reaching affect on the courts' approach to handling discovery requests in ERISA cases. This article provides an understanding of *Glenn's* vast impact on the current state of discovery in ERISA litigation.

Understanding the Supreme Court's Ruling in *Glenn*. In *Glenn*, the Court stated, "Congress' desire was to offer employees enhanced protection for their benefits" citing *Varity Corp. v. Howe*, n2 (discussing congressional purposes in enacting ERISA). In discussing the standard for evaluating an insurer's conduct, the Court specifically pointed out that:

ERISA imposes higher-than-marketplace quality standards on insurers. It sets forth a special standard of care upon a plan administrator, namely, that the administrator "discharge [its] duties" in respect to discretionary claims processing "solely in the interests of the participants and beneficiaries" of the plan. [29 U.S.C.] § 1104(a)(1); it simultaneously

underscores the particular importance of accurate claims processing by insisting that administrators "provide a full and fair review' of claim denials," *Firestone*, 489 U.S. at 113 (quoting [29 U.S.C.] § 1133(2)); and it supplements the marketplace and regulatory controls with judicial review of individual claim denials, see [29 U.S.C. §] 1132(a)(1)(B).
n3

The *Glenn* Court addresses an insurer's conflict of interest when the insurer both determines an employee's eligibility for benefits and pays the benefits out of its own pocket. In *Glenn*, MetLife served as both the administrator and the insurer of the Sears, Roebuck & Company long-term disability plan, an ERISA governed employee benefit plan. The plan gave MetLife discretionary authority to determine whether a claim was valid, as well as obligated MetLife to pay valid benefits claims. The Court in *Glenn*, in revisiting *Firestone Tire & Rubber Co. v. Bruch*,ⁿ⁴ confirmed that a court should be guided by principles of trust law and therefore must view a plan administrator in the same respects as a trustee of a common-law trust. Accordingly, a benefit determination is to be considered a fiduciary act.

Under this analysis, the Court held that when a plan administrator both evaluates claims for benefits and pays benefits claims, a conflict of interest arises that must be considered by the courts. The Supreme Court explained that when judges review the lawfulness of benefit denials, they should take into account several different considerations, including a conflict of interest. This means that a reviewing judge must take into account the conflict when determining whether the trustee substantively or procedurally has abused its discretion.

Glenn mandates a more critical review of benefit determinations than required by previous standards. In situations where an insurer acts in the dual role of claim administrator and the payor of claims, *Glenn* has changed the law. In contrast to the minimal level of discovery previously allowed, *Glenn* calls for a much more probing review based on the higher standard of conduct imposed on insurers.

Glenn confirms the applicability of *Firestone*, and trust law, and for purposes of the appropriate standard of review, directs the use of a "combination-of-factors method of review."ⁿ⁵ Under such a review, courts will "take account of several different considerations of which a conflict of interest is one."ⁿ⁶ The Court explained:

In such instances, any one factor will act as a tiebreaker when the other factors are closely balanced, the degree of closeness necessary depending upon the tiebreaking factor's inherent or case-specific importance. The conflict of interest at issue here, for example, should prove more important (perhaps of great importance) where circumstances suggest a higher likelihood that it affected the benefits decision, including, but not limited to, cases where an insurance company administrator has a history of biased claims administration. See *Langbein*, [Trust Law as Regulatory Law, 101 Nw. U. L. Rev. 1315, 1317-1321 [2007] (detailing such a history for one large insurer). It should prove less important (perhaps to the vanishing point) where the administrator has taken active steps to reduce potential bias and to promote accuracy, for example, by walling off claims administrators from those interested in firm finances, or by imposing management checks that penalize inaccurate decisionmaking irrespective of whom the inaccuracy benefits.ⁿ⁷

The Court also provided guidance in assessing the importance of a conflict of interest indicating that procedural irregularities that benefit the insurance company require more weight to be placed on the conflict. The Court described the circumstance of MetLife encouraging Glenn to apply for Social Security disability benefits and then ignoring the agency's finding when terminating Glenn's benefit. The Court stated:

This course of events was not only an important factor in its own right (because it suggested procedural unreasonableness), but also would have justified the court giving more weight to the conflict (because MetLife's seemingly inconsistent positions were financially advantageous).ⁿ⁸

Thus, a Court may accord a conflict additional weight when an insurer's conduct results in a financial gain and that conduct is suspect for reasons such as procedural unreasonableness or inconsistency. There is no requirement of direct evidence of influence, *i.e.*, a smoking gun.

The Court rejected standard of review tests, such as the sliding-scale method of review applied by the Sixth Circuit. The Court explained:

Neither do we believe it necessary or desirable for courts to create special burden-of-proof rules, or other special procedural or evidentiary rules, focused narrowly upon the evaluator/payor conflict. In principle, as we have said, conflicts are but one factor among many that a reviewing judge must take into account. Benefits decisions arise in too many contexts, concern too many circumstances, and can relate in too many different ways to conflicts -- which themselves vary in kind and in degree of seriousness -- for us to come up with a one-size-fits-all procedural system that is likely to promote fair and accurate review. Indeed, special procedural rules would create further complexity, adding time and expense to a process that may already be too costly for many of those who seek redress. n9

Importantly, *Glenn* also described the applicable standard only in terms of the trust law "abuse of discretion" standard, and never used the administrative law "arbitrary and capricious" standard. This is important because the lower courts have applied an administrative law paradigm to restrict courts' review to the "administrative" record. *Glenn* clearly indicates that much evidence outside the record will be relevant to determining whether an insurer abused its discretion. For instance, the Court indicated a company's history of biased claims administration could increase the importance of the conflict of interest factor and the steps taken by the company to reduce potential bias and promote accuracy could reduce the importance of the conflict factor. This type of extrinsic evidence is not typically in the "administrative record."

Various Courts' Interpretation of the Meaning of *Glenn*. Since the Supreme Court handed down its decision in *Glenn*, many courts around the country have analyzed *Glenn*'s impact on the applicable standard of review and its resultant impact on allowable discovery pertaining to the insurer's conflict of interest as well as its impact on the decision-making process. While many courts have cautioned that *Glenn* does not necessarily *change* the applicable standard of review, several courts around the country have interpreted *Glenn* to have opened the door to allowing various types of discovery into conflicted insurers' practices regarding benefit determinations. For example, the Eighth Circuit evaluated *Glenn*'s application to the ERISA standard of review in *Chronister v. Unum Life Ins. Co. of America*:

There is no doubt that *Glenn* changed ERISA review in some ways. First, the Supreme Court determined specifically that when the entity that administers the plan "both determines whether an employee is eligible for benefits and pays benefits out of its own pocket" a conflict of interest exists. *Glenn*, 128 S. Ct. at 2346. Prior to *Glenn*, this Court held the opposite. Similarly, under this Court's pre-*Glenn* precedent, a financial conflict of interest would not trigger less-deferential review unless the claimant could show that the conflict was causally connected to the specific decision at issue. *Glenn* makes clear that, while a causal connection might be important in determining the appropriate level of scrutiny for a plan administrator's decisionmaking, such a connection is not required. *Glenn*, 128 S. Ct. at 2351. ("The conflict of interest should prove more important where circumstances suggest a higher likelihood that it affected the benefits decision.") Under *Glenn*, courts must analyze the facts of the case at issue, taking into consideration not only the conflict of interest, but also other factors that might bear on whether the administrator abused its discretion. n10

In *Waikken v. Unum Life Ins. Co. of Am.*, n11 another Eighth Circuit case, the court stated, "We are instructed by *Glenn* to give importance to this conflict of interest, perhaps great importance," *Glenn* [128 S. Ct. at 2351], depending on how closely the other factors are balanced."

In *Wilcox v. Wells Fargo & Co. Long Term Disability Plan*, n12 the court connected *Glenn*'s impact on the standard of review to discovery which should be allowed as a result of the Supreme Court's decision, when it held that *Glenn* "materially altered the applicable standard of review applicable to the review of a plan administrator's denial of benefits under ERISA, permitting consideration of evidence outside the administrative record to determine the appropriate weight to accord the conflict of interest factor."

In *Hogan-Cross v. Metro. Life Ins. Co.*,ⁿ¹³ the court stated, "Thus, the [*Glenn*] Court made clear that not all conflicts are created equal. Their significance in any given case depends upon all of the circumstances, including those suggesting a higher or lower likelihood that the conflict affected the decision."

The impact of *Glenn* can clearly be seen in the Seventh Circuit, where discovery as to the conflict of interest issue was essentially barred prior to *Glenn*. Earlier this year, Judge Hamilton, Chief Justice of the Southern District of Indiana, eliminated ERISA's ban on discovery when he made the following statement regarding discovery in ERISA benefit disputes:

"*Glenn* is not a case about discovery, but the Supreme Court's discussion of what evidence is relevant to a judge's decision necessarily requires that parties are allowed to conduct discovery outside of the administrative record. The Supreme Court wrote that the conflict "should prove more important (perhaps of great importance) where circumstances suggest a higher likelihood that it affected the benefits decision, including, but not limited to, cases where an insurance company administrator has a history of biased claims administration," but that the conflict also "should prove less important (perhaps to the vanishing point) where the administrator has taken active steps to reduce potential bias and to promote accuracy, for example, by walling off claims administrators from those interested in firm finances, or by imposing management checks that penalize inaccurate decision-making irrespective of whom the inaccuracy benefits." [128 S. Ct.] at 2351. *This passage of Glenn makes very clear that evidence of these considerations will be relevant, and such evidence is unlikely to appear in sufficient detail in the administrative record, at least in pending cases. If this information is relevant, it needs to be discoverable.* This is particularly true since the Court cautioned against the creation of "special burden of proof rules or other special procedural or evidentiary rules, focused narrowly on the evaluator/payor conflict." *Id.* Based on these teachings of *Glenn*, the previous opinions of the Seventh Circuit that made discovery in such cases nearly impossible to obtain appear to be superseded." n14

Courts around the country are allowing for conflict discovery on a daily basis, on account of *Glenn*. The above-referenced cases are just a sampling of courts' decisions that are opening the door to conflict discovery, and as a result, are greatly impacting the ways in which ERISA cases are currently being litigated.

Allowable Discovery As a Result of *Glenn*. Requested and allowable discovery in an ERISA benefit dispute will vary from case to case, depending on the pertinent facts and circumstances. Prior to *Glenn*, courts frequently allowed for discovery under the *de novo* standard of review, or in a case where the conflict of interest was a factor involving a self-insured plan administrator. Generally however, as a result of *Glenn*, the courts have been granting discovery pertaining to the insurer's conflict of interest as recognized in the fully insured context where the insurer is the payor of benefits in addition to the entity determining benefit eligibility. The conflict can be evidenced in various ways, and the cases discussed below give several examples of the types of discovery courts have allowed plaintiffs to pursue in order to determine the level of conflict surrounding the defendant's benefit determination, and, as a result, whether that conflict impacted the defendant's decision to deny the plaintiff's benefits.

In *Hogan-Cross v. Metro. Life Ins. Co.*,ⁿ¹⁵ the court found that information bearing on the manner in which a conflicted plan administrator compensates its outside consultants could be highly pertinent. The court stated, "Maintenance of compensation arrangements that create economic incentives for consultants to recommend denial or termination of benefits would have a material bearing on the likelihood that the administrator's conflict affects its benefit determinations." The court required the defendant to provide the approval and termination rates and statistics regarding long-term disability claims administered by MetLife in litigation. The court also required MetLife to provide the bases for and amounts of compensation paid to employees and outside consultants involved in evaluating plaintiff's eligibility for benefits.

In *Gessling*, discussed above, the court ruled that *Glenn* superseded *Semian v. Life Ins. Co. of North America*,ⁿ¹⁶ (discovery only allowed in "exceptional circumstances" where plaintiff had to make a *prima facie* showing of good

cause by pointing out the identity of the conflict) and allowed limited discovery into areas where the conflict could have affected the benefit decision. The scope of the discovery was limited into areas where the insurance company had a history of biased decision-making, but also included discovery into steps the insurance company has taken to reduce bias and promote accuracy. Further, one can infer from the ruling in *Gessling* that discovery issues under *Glenn* do not require a "good cause" showing by claimant.

Upon remand, the District Court of Arizona in *Wilcox v. Wells Fargo Long Term Disability Plan*,ⁿ¹⁷ limited discovery to the following areas: (1) whether any of the employees or consultants involved in deciding plaintiff's claim had a financial incentive to deny the claim; (2) defendant's general approval and termination rates for long-term disability claims involving fibromyalgia; (3) steps defendant has taken to reduce bias and promote accuracy, such as walling off claims administrators from those interested in firm finances; and (4) any factors or evidence considered by defendant in denying plaintiff's claim that are not contained in the administrative record. The court did not permit discovery into the training or experience of the claims handlers or the reserves for the claim or claims manuals or guidelines.

In *Walker v. Metro. Life Ins. Co.*ⁿ¹⁸ the court found gaps in the administrative record pertinent to the conflict of interest and MetLife's reliance on Network Medical Review ("NMR") and their reviewing physicians. The court propounded its own interrogatory to MetLife "to state and order the number of claims it has accepted or granted and rejected or denied after a review by a physician retained through NMR from 2005 through 2007." The court then ordered a trial in order to "fully vet MetLife's exercise of discretion and the role played by its conflict therein." Several additional orders pertaining to the expense and costs incurred in the defendant having to produce the information have issued, along with a new order to produce statistical numbers back to 2000.

In *Horton v. Liberty Life Assurance Co. of Boston*,ⁿ¹⁹ the court allowed discovery into a potential conflict of interest without commenting on the scope and extent of plaintiff's discovery.

In *Santos v. Hartford Life Insurance Co.*,ⁿ²⁰ the court, relying on *Glenn* allowed plaintiff's request for information about the criteria for selection of individuals for peer reviews and independent medical exams as they relate to potential bias. The court also allowed discovery into the history of the number of claims made and number of those claims granted or denied and the efforts by the insurance company to reduce bias of claims personnel, promote accuracy and wall off claims administrators. The court denied any discovery into the underlying rationale of the insurer's decision to deny benefits to the plaintiff.

In the Tenth Circuit, the District Court of Colorado issued a decision in *Kohut v. Hartford Life and Accident Ins. Co.*ⁿ²¹ The court reversed the Magistrate Judge's Recommendations which prevented the plaintiff's some limited discovery and remanded the case back to the Magistrate Judge to allow discovery. The court did not state what discovery was allowed.

In a 2009 ruling out of the Northern District of Indiana, the court allowed for discovery pertaining to the identifications and compensation of employees, consulting physicians, and other third-parties involved in the claim determination, claim approval and denial rates, as well as one defendant's policies and procedures regarding benefit eligibility determinations.ⁿ²²

Conclusion. As one can glean from the discussion above, *Glenn's* impact on discovery in ERISA litigation has been far-reaching. In what seems to be an effort by the courts to narrow the David-and-Goliath inequities between the insured plaintiff versus insurer defendant, *Glenn* would appear to be providing plaintiffs with greater opportunities to shore up their case while attempting to hold insurers accountable for their actions in determining claimants' eligibility for benefits.

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n1 128 S. Ct. 2343 (2008).

n2 516 U.S. 489 (1996).

n3 *Glenn*, 128 S. Ct. at 2350.

n4 489 U.S. 101 (1989).

n5 128 S. Ct. at 2351.

n6 *Id.*

n7 *Id.*

n8 128 S. Ct. at 2352.

n9 128 S. Ct. at 2351.

n10 *Chronister v. Unum Life Ins. Co. of America*, 563 F.3d 773, 775 (8th Cir. 2009) (emphasis added).

n11 531 F.3d 575, 582 (8th Cir. 2008).

n12 287 *Fed. App'x* 602 (9th Cir. 2008).

n13 568 *F. Supp. 2d* 410, 415 (S.D.N.Y. 2008).

n14 *Gessling v. Group Long Term Disability for Employees of Sprint/United Mgmt. Co.*, 2008 U.S. Dist. LEXIS 96623 at *1-3 (S.D. Ind. Nov. 26, 2008) (emphasis added).

n15 568 *F. Supp. 2d* 410 (S.D.N.Y. 2008).

n16 436 *F.3d* 805, 815 (7th Cir. 2006).

n17 2009 U.S. Dist. LEXIS 2977 (D. Ariz. Jan. 8, 2009).

n18 2009 U.S. Dist. LEXIS 64707 (N.D. Cal. Nov. 10, 2008).

n19 2008 U.S. Dist. LEXIS 96840 (N.D. Cal. Nov. 12, 2008).

n20 254 *F.R.D.* 643 (E.D. Cal. Jan. 16, 2009).

n21 2008 U.S. Dist. LEXIS 103924 (D. Colo. Dec. 16, 2008).

n22 *See Garvey v. Piper Rudnick LLP Long Term Disability Ins. Plan*, 2009 U.S. Dist. LEXIS 94694 (N.D. Ill. Oct. 9, 2009).

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When Bankruptcy Hits, Are Directors and Officers Stuck With the Bill?

2009 Emerging Issues 3504

Reed Smith LLP on Emerging Risks in Insurance: When Bankruptcy Hits, Are Directors and Officers Stuck With the Bill?

By David Rosenfield

April 2, 2009

SUMMARY: When an insured entity goes into bankruptcy, increasingly, insurers are refusing to allow policy proceeds to be used in defense of insured directors and officers for fear that a court will find them to be property of the insured debtors estate and thus subject to the United States Bankruptcy Codes automatic stay provision. This commentary suggests such a result is wrong, both legally and for public policy reasons.

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ARTICLE: INTRODUCTION

Imagine you are an officer of a corporation that was flourishing prior to the recent economic downturn. You may never have given much thought to your corporation's directors and officers ("D&O") insurance program because even if you had been sued, your company indemnified you. If there was D&O insurance to cover that lawsuit, the company dealt with that. If any issues about that coverage ever arose, those issues never directly affected you.

Now imagine your company has gone into bankruptcy. And further imagine that-as is so often the case when companies go into bankruptcy-a lawsuit has been filed against your company, a lawsuit that names you as a defendant as well. The lawsuit against the bankrupt company is stayed automatically pursuant to the United States Bankruptcy Code (the "Code"). But the Code doesn't protect you as an individual, and the lawsuit against you proceeds. Before, your legal fees were always paid by your company (who was in turn indemnified by its D&O insurance carrier) or by the insurer itself. But now that your company is in bankruptcy, it is no longer able to indemnify you for your legal costs.

When you turn to your company's D&O insurer, you find it is also unwilling to pay your legal fees, citing fears that a court will find the insurance policy proceeds to be part of your bankrupt company's estate and thus subject to the automatic stay. The insurance carrier is concerned that any payments it made to you would violate the stay and not count toward its policy's limits. Suddenly, you face the prospect of paying the legal fees necessary to defend yourself in a lawsuit brought against you because of your service to a company that is now no longer able to assist you.

This situation seems unfair. When a corporation goes bankrupt, its directors and officers face not only the loss of corporate indemnification, but also the possible loss of D&O insurance that is supposed to backstop that indemnification. Their personal assets may be at risk, and the cost of simply defending the litigation may be crushing.

In light of the foregoing, this commentary analyzes an emerging issue of law which may become increasingly pertinent as today's recession leads to more and more corporate bankruptcies, and further, as more and more lawsuits are brought against those corporations, often as a result of activity which led those companies to declare bankruptcy in the first instance. In doing so, this commentary posits that D&O policies are intended primarily for the benefit of the individual directors and officers, rather than for the benefit of the corporations for whom those directors and officers serve. As a result, when an insured corporation declares bankruptcy, that should not preclude the directors and officers of that corporation from accessing insurance policy proceeds to defend themselves against litigation brought based on their service to the now bankrupt entity. Such a result would be contrary to an emerging trend of case law, as well as to the fundamental principles of fairness and public policy.

ANALYSIS

Insurance Policies Often Belong to the Insured Debtor.

Early cases dealing with the issue of whether an insured's bankruptcy stays the proceeds of the insured's insurance policies did not distinguish between insurance policies and the proceeds of those policies. See, e.g., *In re Johns-Mansville Corp.*, 40 B.R. 219 (S.D.N.Y. 1984) (where a debtor corporation filed for Chapter 11 bankruptcy after an onslaught of litigation stemming from its asbestos manufacturing, the insured's "insurance policies and their proceeds .. constituted 'substantial property of the [insured's] estate which will be diminished if and to the extent that third party direct actions against the insurance carriers result in plaintiffs' judgments."); *Minoco Group v. First State Underwriters Agency of New England Reinsurance Corp. (In re Minoco Group)*, 799 F.2d 517 (9th Cir. 1986) (refusing to allow two D&O carriers to cancel insurance policies issued to the insured debtor, reasoning that the policies were property of the insured debtor's estate and that allowing for cancellation of them would impair the debtor corporation's reorganization efforts).

More recently, however, courts have begun to distinguish between insurance policies and the proceeds of those policies for the purposes of determining whether they belong to an insured debtor's estate. In doing so, courts have agreed that insurance policies themselves belong to the party that purchased them. See, e.g., *Feld v. Zale Corp (In re Zale Corp.)*, 62 F.3d 746, 757-58 (5th Cir. 1995); *La. World Exposition, Inc. v. Fed. Insurance Co. (In re La. World Exposition, Inc.)*, 832 F.2d 1391, 1399 (5th Cir. 1987); *A.H. Robins Co. v. Piccinin*, 788 F.2d 994, 1001 (4th Cir. 1986); *In re First Cent. Fin. Corp.*, 238 B.R. 9 (Bankr. E.D.N.Y. 1999). However, there has been less agreement regarding how to treat the proceeds of insurance policies.

Insurance Policy Proceeds Generally Should Belong to the Individual Directors and Officers of the Insured Debtor.

The issue of who owns the right to the proceeds of insurance policies issued to a bankrupt corporation arises as a result of the Code's automatic stay provision. The Code provides that the filing of a bankruptcy petition operates as an automatic stay of "an act to obtain possession of property of the estate or property from the estate or to exercise control over property of the estate." 11 U.S.C.S. § 362(a)(3). The Code defines property of the estate as including "all legal or equitable interests of the debtor in property as of the commencement of the estate." 11 U.S.C.S. § 541(a)(1). Whether a particular insurance policy's proceeds should be deemed part of an insured debtor's estate and thus subject to the stay is a fact-specific inquiry. See *In Re First Cent.*, 238 B.R. at 17; Appleman on Insurance 2d § 146.8 (LexisNexis). See generally Nancy D. Adams, When Two Worlds Collide: Understanding D&O Coverage in the Bankruptcy Setting, 18 Coverage 26, 29-30 (ABA Jan./Feb. 2008). However, to avoid unjust situations like the one discussed above, the proceeds of D&O policies should not be deemed an asset of the bankrupt estate.

Courts that have grappled with this issue have considered a number of factors in determining who owns the proceeds of D&O insurance policies. Many of these factors weigh heavily in favor of finding insurance policy proceeds to belong to the insured directors and officers of an insured debtor, rather than to the insured debtor.

Courts considering this issue often look first to whether the policy provides coverage not only for individual directors and officers but also for the claims against the entity itself (known as "entity coverage"), as opposed to simply reimbursing the entity for amounts spent to indemnify insured directors and officers (known as "Side B coverage").ⁿ¹ If there is no entity coverage, courts are likely to find that the policy proceeds are not an asset of the insured debtor corporation's estate, reasoning that any right the debtor has is based entirely on the existence of claims against the debtor's directors and officers. See, e.g., *In re La. World Exposition, Inc.*, 832 F.2d at 1399 (finding that where the policy only provided direct coverage to the directors and officers and reimbursement coverage to the corporation, the debtor did not have a direct interest in the policy's proceeds and thus the proceeds were found not to be part of the debtor's estate).

Moreover, where a policy provides only for Side B coverage and the bankrupt entity is not paying the directors and officers' legal costs, the company has no claim to insurance proceeds and there is even further reason for courts to hold that the insurance proceeds are not an asset of the bankrupt estate. See *In re Zenith Labs, Inc.*, 104 B.R. 659, 665-66 (D.N.J. 1989) (finding policy proceeds not to be part of the insured debtor's estate where the policy provided only for Side B coverage and no action had been initiated in the debtor's name against any director or officer); *Youngstown Osteopathic Hosp. Ass'n v. Ventresco* ("*In re Youngstown Osteopathic Hosp. Ass'n*"), 271 B.R. 544, 550 (Bankr. N.D. Ohio 2002) (where the debtor was not required to indemnify the directors and officers, and therefore was not entitled to reimbursement under the policy, the proceeds were not property of the estate).

Some courts have held that, even where a policy provides for entity coverage, the primary purpose of D&O coverage is to protect individual corporate officers and directors. As one court explained, even where the policy provides for entity coverage, "[i]n essence and at its core, a D&O Policy remains a safeguard of officer and director interests and not a vehicle for corporate protection." *In re First Cent.*, 238 B.R. at 15. This principle serves the very important purpose of allowing corporations to attract and keep qualified persons to serve as officers and directors. See *Adelphia Communs. Corp. v. Associated Elec. & Gas Ins. Servs.* (*In re Adelphia Communs. Corp.*), 285 B.R. 580, 585 (Bankr. S.D.N.Y. 2002) (vacated and remanded on other grounds). See also *Arten & Hadden, LLP*, 335 B.R. 666, 672 (Bankr. N.D. Ohio 2005) (quoting *In re First Cent. Fin. Corp.*, 238 B.R. at 18 n.11) (stating "[T]he mere appendage of entity coverage to this Policy .. does not provide sufficient predicate, per se, to metamorphose the proceeds into estate property").

Even if the policy provides for entity coverage, a court may consider whether there are actual claims against the entity. Where claims have not been asserted against the debtor, any harm to the debtor is purely speculative. *In re CHS Electronics, Inc.* 261 B.R. 538 (Bankr. S.D. Fla. 2001); *In re Medex Regional Laboratories, LLC*, 314 B.R. 716, 722-23 (Bankr. E.D. Tenn. 2004); *In re First Cent. Fin. Corp.*, 238 B.R. at 17-18 ("If entity coverage is hypothetical and fails to provide some palpable benefit to the estate, it cannot be used by a trustee to lever himself into a position of first entitlement to policy proceeds.").

Courts also may look to certain policy provisions as evidence that the primary intended beneficiaries of the policy are insured directors and officers rather than the insured corporation. For example, many D&O insurance policies contain priority (or order) of payment clauses, which often stipulate that if Loss (i.e., defense costs, judgments or settlements) from any Claim exceeds the remaining available limits of liability, then the policy proceeds should first be used to pay the Loss of insured persons rather than the insured corporation. Several courts have cited to these provisions in support of finding policy proceeds not to be part of an insured debtor's estate. See, e.g., *Miller v. McDonald* (*In re World Health Alternatives, Inc.*), 369 B.R. 805, 808-811 (Bankr. D. Del. 2007) (finding that the priority of payments clause was evidence that the policy proceeds were primarily intended for the benefit of directors and officers). See also *In re Adelphia Communs.*, 285 B.R. at 585 (while finding policy proceeds to be part of the debtor's estate, the court expressly noted that the policies did not have a priority of payments provision, "providing in substance that payments on

account of the defense costs of directors and officers come ahead of payments for indemnification coverage and/or entity coverage"). See also *In re Classicstar, LLC*, No. 07-bk-51786, GeoStar's Mot. Re. Ins. Proceeds at 8-10 (Bankr. E.D. Ky. June 2, 2008) and June 18, 2008 order granting same; *Pure Weight Loss, Inc.*, No. 2:08-bk-10315 (JKF), Mot. Regarding Ins. Proceeds at 3-4 (Bankr. E.D. Pa. June 20, 2008) and July 16, 2008 order granting same.

Many D&O policies also contain clauses that explicitly provide that in the event of bankruptcy, the corporation waives any automatic stay or injunction which might otherwise apply in order to permit the use of policy proceeds to benefit insured persons of the insured corporation. See, e.g., *Classicstar, LLC*, Geostar's Mot. Re. Ins. Proceeds 8-10 and order granting same; *Pure Weight Loss, Inc.*, Mot. Regarding Ins. Proceeds 3-4 and order granting same. These clauses are intended to provide comfort to officers and directors that they will not lose insurance coverage for a covered Claim in the event of their company's bankruptcy. However, it is unclear whether such clauses can override the Code's automatic stay, and courts have not addressed the enforceability of such clauses.

Another factor is whether the policy, like most D&O policies, is a "wasting" policy, meaning that payments for Loss under the policy erode the policy's limits of liability, reducing the amount available to pay future Loss. In such cases, the individual directors and officers can argue that such policies are intended to be paid on a first come, first served basis and that, as such, the insured directors and officers should be able to access the policy proceeds as they incur defense costs or other Loss, irrespective of a corporation's bankruptcy status. See, e.g., *In re First Cent.*, 238 B.R. at 14.

Several courts also have noted that because the insured debtor could never actually receive and keep policy proceeds, those proceeds should not be found to be part of the insured debtor's estate. See *In the Matter of Edgeworth*, 993 F.2d 51, 55 (5th Cir. 1993) (stating that "[t]he overriding question when determining whether insurance policy proceeds are property of the estate is whether the debtor would have a right to receive and keep those proceeds when the insurer paid a claim" and finding that since the malpractice proceeds at issue were payable to insured parties who sued the debtor but not the debtor, they could not be held to be part of the insured debtor's estate); see also *In re Pelullo*, 1999 U.S. Dist. LEXIS 14920, at *8 (E.D. Pa.) (citing *Edgeworth* and finding that policy proceeds were not assets of the debtor's estate when they could only be used for the debtor's defense costs); *In re Sfuzzi, Inc.*, 191 B.R. 664, 668 (Bankr. N.D. Tex. 1996) (citing *Edgeworth* and finding that policy proceeds used to fund proposed settlement were not assets of the debtor's estate because the debtor would not be keeping the proceeds).

Finally, where an insurance program provides for substantial limits of liability, the insured directors and officers can argue that it is fundamentally unjust to find the insured debtor to be entitled to all of the insurance proceeds, despite often being only one of many insureds under the policy and despite being only one of many defendants in a given action.

Even Where Policy Proceeds Are an Asset of the Bankrupt Estate, the Automatic Stay Should Often Be Lifted to Allow for the Payment of Proceeds to Insured Directors and Officers.

Section 362(d)(1) of the Code provides relief from the automatic stay "for cause." n2 Despite holding that the insurance policy proceeds in question belonged to an insured debtor and were thus subject to an automatic stay, several courts have lifted the automatic stay to allow for the distribution of proceeds to individual directors and officers to defend themselves against Claims brought against them. In so doing, courts sensibly have weighed the harm it would cause to deny the funds to the individual directors and officers against the harm reducing the availability of the funds would bring to the bankrupt corporation.

For example, in *Exec. Risk Indem. v. Boston Reg'l Med. Ctr. (in Re Boston Reg'l Med. Ctr., Inc.)*, 285 B.R. 87 (Bankr. D. Mass. 2002), the court authorized the payment of expert costs, reasoning that "irreparable harm" to the individual directors and officers would result from their inability to present expert testimony-harm which was far greater than any harm the debtor might potentially suffer if the policy proceeds were reduced. Similarly, in *In re Cybermedical, Inc.*, 280 B.R. 12, 18 (Bankr. D. Mass. 2002) the court granted relief from the automatic stay to allow

former directors and officers of the debtor to use policy proceeds to defend themselves against the trustee's complaint (and further rejected the trustee's request that the underwriters be required to submit fee requests prior to advancing defense costs to ensure that such fees were reasonable). See also *In re Arter & Hadden, L.L.P.*, 335 B.R. at 673 (finding cause to lift the automatic stay because the Executive and Management Committee members could suffer "substantial and irreparable harm if prevented from exercising their rights to defense payments" to defend themselves against the trustee's complaint); *In re Allied Digital Techs. Corp.*, 306 B.R. 505, 513 (Bankr. D. Del. 2004) (concluding that the policy proceeds were not part of the debtor's estate, but that even if they were, cause existed for stay relief).

CONCLUSION

Returning to our unfortunate officer discussed at the outset of this article, it is easy to understand why a court considering such facts should find that the policy proceeds at issue belonged to the individual officer and thus were not subject to the Code's automatic stay upon the debtor corporation's bankruptcy. It is a relief to note that the court considering that particular case did in fact so hold. *Pure Weight Loss, Inc.*, No. 2:08-bk-10315 (JKF), July 16, 2008, Order Granting Mot. Regarding Ins. Proceeds. (Bankr. E.D. Pa. June 20, 2008).

What's troubling nonetheless, however, is that the officer involved in that case had to overcome many obstacles in order to gain the blessing of a court before his insurer would agree to continue distributing policy proceeds for his benefit. Left without the two pillars of insurance protection ordinarily afforded to directors and officers as a result of their insured entity's bankruptcy, corporate indemnification and the backstop of insurance coverage, this particular officer faced the bleak prospect of funding his own defense while the debtor's bankruptcy court deliberated as to who owned the insurance proceeds which the officer sought to access.

As more and more companies continue to declare bankruptcy, and as directors and officers of those companies continue to face litigation stemming largely from those bankruptcies, courts must act swiftly and clearly in granting those directors and officers continued access to D&O insurance policy proceeds. The arguments discussed in this commentary should lend further comfort to those courts that find themselves in the unenviable position of having to make such determinations.

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n1 The third type of protection D&O insurance policies provide, and the type of coverage which brings to light the issues discussed in this article, is direct protection to the individual directors and officers, known as "Side A coverage." Where Side A coverage exists in conjunction with Side B coverage and/or entity coverage, an entity's bankruptcy will likely bring into play the issues discussed in this article, and consequently result in an insurer's reluctance to distribute policy proceeds to insured directors and officers. One way around this issue, however, is for a corporation to purchase stand-alone Side A coverage, which typically supplements a full D&O policy. Under this scenario, regardless of whether entity and/or Side B coverage also exists, separate limits of liability exist for the stand-alone Side A coverage, meaning such coverage will not be deemed property of the debtor's estate and an insurer has no grounds for withholding policy proceeds as a result of the insured entity's bankruptcy.

n2 Stating that "[o]n request of a party in interest and after notice and a hearing, the court shall grant relief from the stay provided under subsection (a) of this section, such as by terminating, annulling, modifying, or conditioning such stay--(1) for cause, including the lack of adequate protection of an interest in property of such

party in interest" (emphasis added). The Code does not define "cause." Rather, "cause" is a fact-specific inquiry determined on a case-by-case basis. See *In re Laguna Associates Ltd. Partnership*, 30 F.3d 734, 737 (6th Cir. 1994). See also *In re Plastech Engineered Products, Inc.*, 382 B.R. 90, 109 (Bankr. E.D. Mich. 2008) (determining cause requires consideration of many factors).

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Ernst & Young 2009 Insurance Outlook--US Life Insurance

2009 Emerging Issues 3359

Ernst & Young 2009 Insurance Outlook--US Life Insurance

By Ernst & Young

February 8, 2009

SUMMARY: Ernst & Young presents its 2009 outlook for the U.S. life insurance industry.

PDF LINK: [Click Here for Enhanced PDF of Commentary](#)

ARTICLE: The US life insurance industry will be dealing with the multiple lingering after-effects of the global financial crisis and deepening recession for some time to come. Both issues will continue to impact the balance sheets, operating performance, competitive positioning and even ownership of an important percentage of the industry. Yet effects will not be universally negative; opportunities will emerge as well. Insurers need both to adapt to this changed financial landscape and, at the same time, to deal with important underlying trends that have been developing for the past several years. In our view, in 2009, life insurers must:

1. Shift product and investment focus to align with risk
2. Retool risk modeling and measurement
3. Anticipate changes in the regulatory environment
4. Expect changes in accounting requirements
5. Address increasing expense imperatives
6. Capitalize on the retirement income market

Shift product and investment focus to align with risk

The implications of the current economic crisis may take months or perhaps years, to evaluate fully. Once the immediate crisis passes, insurers will have to adjust to an environment that has fundamentally changed -- both for them and for the consumer. The consumer is responding to the crisis with a different risk appetite and at least a temporary move away from variable separate account to fixed general account products. Variable annuity sales were down 18% in

the third quarter of 2008 compared with the third quarter of 2007. Sales in the second half are expected to have contracted even more dramatically. Fixed annuities are the beneficiary of this change, showing a 46% increase in sales in the third quarter of 2008. Universal life also increased its market share to 44%, up from a 41% share in 2007. Longer term, variable products may remain an important part of the product set but with reduced guarantees and higher pricing. Variable products are already rebounding with a wave of new generation products that have differing income guarantees at higher prices. Flexibility in choice of investment products will continue to be reined in, and fees for guaranteed income and withdrawal benefits are likely to rise.

Insurers face balance-sheet challenges after enjoying several years of very strong capital adequacy ratios. Based on an analysis of statutory reports, Conning Research & Consulting estimates the US life industry has realized and unrealized capital losses from bonds, preferred and common stocks of more than US \$35 billion through the third quarter, representing a 12% drop in surplus. This is before the additional turmoil that occurred in October and November. Conning now projects a 25% drop in surplus at year-end and continuing erosion in 2009, with additional asset markdowns and impairments possible.

These losses will not be evenly distributed across the industry, and competitive differentiation in capital strength and rating agency responses will emerge. Capital from external sources will be more costly and less dependably available than in the past, whether through debt or equity issuance. Some capital will nonetheless be raised, out of necessity even if on unfavorable terms, under rating agency pressure or regulatory requirement.

Some consolidation is also likely, under the same pressures. In this environment, it is clear that capital generated through internal operating performance will be critical for stability, to fund growth and to take advantage of emerging competitive opportunities.

General account investment performance will reemerge as a key competitive point of differentiation for life insurers. Life companies that are able to shift their focus quickly to guaranteed return products and generate superior fixed returns will gain at least a short-term advantage. In the deepening recession, with an expectation of increasing corporate defaults, this will be no small challenge. With declining reliance on rating agencies and bond insurers to support credit risk assumptions, investment departments will be forced to substantially strengthen their own analytics and research.

Operating challenges will accumulate to produce a squeeze on profits, when companies post reserves against guarantees, reduced fee income and less investment income as portfolios are de-risked. Threats to profitability in 2009 and 2010 also include the possibility of higher taxes and the increased costs of responding to rating agency downgrades and competitively mandated product changes.

Retool risk modeling and measurement

In the year ahead, life companies will need to incorporate risk management lessons learned in 2008 into their risk management processes. Insurers will go beyond refreshing models to focus on expanding information used for risk analysis and to understand better the realities of new and continually volatile financial market conditions.

A major lesson learned is that risk models generally do not provide reliable answers to how much remote-event risk is being borne by an organization. Risk models may provide insight into the proper application of information or into the additional data that is needed, but they should only play a part in the overall risk management process.

When it comes to modeling priorities, line managers and corporate functions will have increasing responsibility to ensure that lessons learned are incorporated into models. Adjustments may be needed to improve the modeling of changing economic and capital markets conditions. Policyholder behavior can significantly influence results through variable lapses, shifts in investment preferences and variations in premiums and deposits in response to changing

economic conditions.

On the asset side, modelers will pursue more complex credit ratings transition matrices, correlations between asset classes and sectors, the importance of maintaining liquidity under stress scenarios and methods of projecting both the deterioration and recovery of assets over time. Outputs from models and scenario tests will also need to be examined critically against real-world experience, with an increased respect for extreme and hypothetical worst-case scenarios.

Improved due diligence in the management of models can drive innovation in areas such as asset liability modeling. Models may also continue to provide insight to managers, and an opportunity to illustrate effects to third-party audiences in characteristics such as unexpected correlations, rates of decay or deterioration and aggregation risks. But the effort to improve models will fall flat without supervision by managers who are accountable and knowledgeable about real world trends and influences.

Anticipate changes in the regulatory environment

Will 2009 be the year that federal regulation gets a firm foothold in the insurance industry? Recent market events, including the federal involvement in banking, have added a sense of urgency to these discussions. Momentum for change in the regulatory structure of insurance is building, and the near-term uncertainty over the outcome presents challenges for the industry.

It is almost certain that the industry will face increased regulation as an outcome of the current crisis in the financial services industry. Regulation is likely to be more intrusive, encompassing more continuous monitoring of activities and financial performance, perhaps with higher standards of solvency over the longer term (even though there may be some loosening of standards to help companies out of the current crisis.)

The form of federal supervision favored in the US Treasurys 2008 report, *Blueprint for a Modernized Financial Regulatory Structure*, is the optional federal charter (OFC) -- allowing insurance organizations the opportunity to choose the form of regulatory oversight that they find most appropriate. At this stage, it appears OFC is giving way to the increased likelihood that federal regulation will be applied to some degree to all insurance and financial services sectors.

The case for regulatory convergence can be strongly made in the life industry, where geography matters little in product design or consumer preference. Life insurers operating internationally would welcome dealing with a single federal regulator for their US operations, especially if the regulations are harmonized with Solvency II, which is being developed in the European Union (EU). The life industry has already taken steps toward consistent product filings through the Interstate Insurance Product Regulation Commission, popularly called the Interstate Compact. Thirty-three states are members of the compact, and legislation is pending in five other states. In addition, the Securities and Exchange Commission (SEC) already has jurisdiction over insurance products that are considered securities, such as variable annuities.

The strongest argument for state control of life insurance regulation centers on consumer protection. A compromise on consumer protection may be reached by allowing state regulators to continue in that role while federal regulators address solvency and guaranty fund issues. Within the present state-based insurance regulatory structure, the guaranty fund is not designed to respond to events like the financial crisis of 2008. It is designed to handle specific failures of an individual entity, but not systemic failures that might broadly imperil the industry. States are hampered in addressing system-wide events because the process lacks the principle of a lead regulator, and the dollar value is potentially too large. State regulation is also structured to act by seizing a company when a situation forces the equivalence of bankruptcy, but is limited in the capability and tools to head off problems before they cause collapse.

Rating agencies currently act as a form of shadow regulators and may be able to influence behavior more

proactively, but they need to address the lack of consistency and transparency. Federal regulation could alter the competitive landscape of the life insurance industry and may result in banking and insurance converging more than has been seen so far. Opportunities to accelerate geographic expansion through both organic and acquisition channels will develop for those prepared to exploit those changes. Value will likely be created by those who can quickly adopt and defend strong regional and superregional market presence.

Expect changes in accounting requirements

Accounting issues will be critical in 2009 as companies prepare for the conversion to a market-consistent framework for financial reporting. This has been emerging for some time but will gain heightened urgency in the wake of the 2008 financial crisis. With the SEC's 2008 pronouncements regarding the convergence of US Generally Accepted Accounting Principles (GAAP) with International Financial Reporting Standards (IFRS), companies are beginning to prepare for the anticipated change to a market-consistent framework. Implementing principles-based and market consistent accounting challenges nearly every established system and operational facet of an insurance company. At the same time, once insurance companies are under a market-consistent system, their income statements and balance sheets could become more volatile as assets and liabilities are subject to market valuations.

This has been painfully evident in the unfolding financial crisis of 2008, even with only some assets marked to market and liabilities not marked to market at all. IFRS 4 Phase II and Solvency II have planned EU implementation dates of 2012 or early 2013. Between now and then, US companies need to build the infrastructure to accommodate the upcoming changes. This task would be a large operational undertaking, even in the best of times, but the financial crisis and recession have increased the challenge.

As companies plan for the upcoming changes, the definition of the market consistent framework itself may undergo changes as the impact of the financial crisis, and the role played by mark-to-market accounting of thinly-traded instruments, is better understood. The International Accounting Standards Board has allowed companies in certain circumstances to reclassify some financial instruments out of the trading category and into the held-to-maturity category, which is carried on a cost basis, to help resolve the credit crisis, while reaffirming the need for transparency in asset valuations in general. Under direction from Congress, the SEC is currently exploring modifications to mark-to-market rules as well, and is expected to issue a report on its findings on 2 January 2009. At present, it appears that the SEC will maintain mark-to-market rules but seek to refine their application.

Thus, companies need to be prepared for an uncertain roll-out of these requirements, both as to pace and particulars. This can increase the risks associated with some longer-term strategic decisions where changing accounting or related tax regimes may alter the nominal value of the decision. Company managements must at least keep up with their peers in adopting systems and information capabilities to respond to these changes as they unfold.

Address increasing expense imperatives

Given the current economic turmoil, both assets and net premiums are likely to fall in real terms in 2009, forcing insurers to significantly reduce expenses to maintain their competitiveness. This may prove more difficult for smaller companies because they lack the economies of scale enjoyed by larger players. But regardless of the amount of assets under management, 2009 will be a year when all insurers look to reduce expenses.

Total business processes, both core and noncore, combined with IT systems costs, comprise about 52% of total general business expenses. While insurers have traditionally outsourced non-core processes, in 2009 they will be pressed to reduce expenses associated with core functions as well. Many may turn toward alternative sourcing, which is the outsourcing of core tasks such as actuarial support, billing and collection and claims adjudication, to further reduce

expenses. Because these functions are core to their businesses, insurers need to consider the strategic risks of poorly executed alternative sourcing initiatives. Successfully managing alternative sourcing arrangements, therefore, requires a focused approach that incorporates four key considerations:

1. A clear understanding of the business case underlying the alternative sourcing and its impact on an insurers ability to achieve longer-term and strategic goals
2. A business plan to identify the service provider and transfer the process that considers the impact of changes to organizational and governance structures
3. The establishment of an early and close working relationship between insurer and service provider to identify and solve problems
4. Ongoing monitoring of the process by the insurer, who retains the ultimate responsibility for process quality

Outsourcing core functions also carries some risk associated with the long-term stability of the service provider. This is particularly true of service providers that are located in developing regions and emerging economies that may carry their own risk of either economic or political instability.

An alternate implication of pressures for expense reduction may be to seek scale through increased consolidation and Merger and Acquisition (M&A) activity. While the current economic environment may increase the availability of willing sellers in search of business combination solutions, the challenges of financing a transaction may be prohibitive for even the largest acquirers until the capital markets recover. At the same time, history has shown that the greatest challenge that companies face following an acquisition or merger involve managing the integration of business functions and business culture of the acquiring and acquired companies. The same key considerations may be applied to the successful integration of a merger or acquisition as would apply to a business collaboration achieved through outsourcing.

In a year of economic uncertainty and increasing pressure to reduce expenses, alternative sourcing or M&A might be good tactical choices, yet insurers must manage the strategic implications in 2009 and beyond.

Capitalize on the retirement income market

Consumers and employers have increased concern for the volatility and risk associated with investing for retirement income. This may cause both groups to seek alternative solutions to differentiate between planning for basic retirement income and longevity risk and investing for lifestyle opportunity. Insurance carriers, with their capabilities in combining insurance and investment expertise and scale, are positioned to develop products to meet these changing needs.

The impact of the 2008 financial crisis on individual 401(k) plans, IRAs and other retirement vehicles may have a lasting effect on consumer attitudes to retirement savings and investing. Many individuals have seen 25% 50% of their retirement savings wiped out in the crashes of the third and fourth quarter. This has presented a stark reminder of the risk being accepted coinciding with individual choice in personal retirement savings programs. At the same time, new appreciation of the risk of asset and income guarantees on savings products will force insurers to respond with tighter products and higher pricing.

More than half of the US \$17.6 trillion in US retirement accumulations at yearend 2007 is in defined contribution plans and IRAs, reflecting the long-term decline of defined benefit pensions. This concentration of assets, the recognition of longevity risk and concerns over the collapse of financial markets have individuals and employers seeking alternatives to funding income needs in retirement.

Recently, a number of innovative group products have been developed to allow savers in 401(k) plans to create predefined streams of retirement income that are guaranteed for life. In 2009 and beyond, insurers will continue to build on the idea of blending income guarantees with noninsurance asset accumulations subject to the risks that have pummeled the variable annuity product. Careful consideration of guarantee features, capital costs and prices will be needed. By refining their use of underwriting and risk segmentation, companies can create competitive products that help consumers manage the retirement income and longevity risks they face.

Accounting, regulatory and market forces are also stimulating an increase in the number of frozen defined benefit plans in the US as employers seek solutions to their own investment and longevity risk problems. This will create opportunities for financial services companies to meet the evolving needs of plan sponsors. Life insurers can capitalize by buying out frozen pension plans. In fact, US regulators have already signaled their willingness to consider changing regulations that currently bar buyouts between unrelated entities.

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Ernst & Young 2009 Insurance Outlook -- Europe

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Ernst & Young 2009 Insurance Outlook -- Europe

By Ernst & Young

February 8, 2009

SUMMARY: Ernst & Young presents its 2009 outlook for European insurers.

PDF LINK: [Click Here for Enhanced PDF of Commentary](#)

ARTICLE: Financial services and insurance companies face enormous challenges in 2009 as they manage through the economic downturn and respond to shifts in market and consumer expectations. As with the rest of the world, Europe is headed into a recession, with unemployment expected to rise through 2010. For most insurers, operating results have deteriorated, resulting in lower investment income and the soft cycle affecting underwriting gains. Top-line growth is projected, but at a slower pace. As companies adapt to the changing financial landscape, opportunities will emerge to strengthen balance sheets, improve overall efficiencies and capitalize on innovative products in areas such as health insurance and retirement income. This Outlook discusses key considerations for European insurers in 2009:

1. Balance risks and opportunities
 - Life insurance and retirement-income services
 - General insurance
 - Health insurance
2. Rethink growth strategies in Central and Eastern Europe
3. Strengthen balance sheets and capital adequacy
4. Readdress operating issues
5. Prepare for changes in global regulatory oversight

BALANCE RISKS AND OPPORTUNITIES

Life insurance and retirement-income services. The fundamentals that began the slide have continued, and 2009 is expected to show further erosion in top-line growth and earnings. Life sales declined in 2008 in Western Europe, led by unit-linked products, although life sales increased in Central and Eastern Europe (CEE) and new pension and annuity premiums continued to grow in Europe overall. Life operating results deteriorated as investment income declined and fees were lower on plummeting values of asset-based products. Variable life and annuity products with embedded options and guarantees will continue to be negatively impacted by depressed equity markets. Deferred policy acquisition write-offs and/or reserve increases related to product guarantees will further drive down earnings in 2009.

Contract-holders values in unit-linked products and other asset-based funds declined substantially throughout 2008, and consumer sentiment has shifted as retirement savings have eroded and the illiquidity of some accounts place the retirements of millions of Europeans in jeopardy. Unit-linked product sales will continue to decline, and consumers will seek more traditional products as they focus on protection.

Product features will be more transparent going forward. Retirement products will provide for more clearly defined retirement income streams, and both life and retirement offerings will provide some upside participation in profits and investment earnings, with the investment portfolio managed centrally by the insurer. The insurers that come out on top will accurately judge consumer sentiment and will develop and bring to market products that meet savings and living benefit needs of various consumer segments. Retirement plans present an enormous opportunity for insurers and reinsurers. The challenge will be to develop more sophisticated asset-liability management techniques to maximize returns while managing longevity risk and efficiently deploying capital. Reinsurance will play a major role in managing these risks, and capital markets transactions will reemerge as solutions by the end of 2009.

General insurance. General insurance rates continued to decline during 2008. Despite an upswing in the rating cycle, there will be little top-line growth in 2009 as demand for primary insurance shrinks. Commercial insurance will be impacted by depressed property prices, recession in Western Europe and the slowing of CEE economies. We expect that insurers will curtail certain businesses, such as credit insurance. There may be opportunities for insurance mergers and acquisitions at a future date. However, transactions will be delayed until more capital is available and private equity investors can once again access the debt market. Motor rates will remain stagnant. Profit margins will be squeezed. There will be further asset write-downs, investment income will fall further, and loss ratios will increase as a result of lower rates and higher losses. These losses will be triggered by both the financial crisis -- such as D&O, E&O and credit insurance losses -- and a more litigious environment in Europe.

Early indications are that renewal pricing negotiations will support firming for a few selective risks and markets that have managed to decouple from the rest. Overall, competition and cash flow underwriting are keeping prices down. Prices are expected to firm in mid-2009, in part because insurers need for capital protection and capital-raising strategies will increase demand for reinsurance, and reinsurers will drive pricing up. Catastrophe bonds and sidecars, as alternatives to traditional reinsurance, are not likely to play a significant role in increasing reinsurance capacity in the short term, and therefore will not provide an alternative to rising prices.

Inflation risk, of concern coming into 2008, has subsided with the European Central Bank projecting average euro-zone inflation declining from an annualized 2.1% in October (3.8% overall for 2008) to 1.4% and 1.8% in 2009 and 2010, respectively. Even inflation in CEE, high in some of the countries, has subsided as recession dampens the economies of the developed countries and some emerging countries have constrained their heated economies in exchange for International Monetary Fund (IMF) safety-net funding. Inflation is not expected to have a major impact on losses in 2009.

Health insurance. Health insurance presents accelerated growth opportunities in Europe for 2009, for both life and nonlife companies. Today, all countries have some form of private medical health insurance that is supplemental to a public health system, covering copayments and services not provided by the public system and/or topping out services such as private hospital rooms. There are a few major health insurers operating in Europe in an otherwise highly fragmented marketplace, in part because of a culture of local healthcare delivery. However, the market will need to

consolidate to achieve quality and cost-containment objectives, and governments have started to look to private insurers to achieve these goals and bring more discipline to the sector.

Some of the cost drivers that need to be addressed include: (1) the escalating cost of the public system, particularly in the current economic environment; cost-shifting from the public system to consumers will continue to occur in 2009; (2) the cost of healthcare for an aging population; (3) consumers demands for better care and more timely access; and (4) the potential for government outsourcing of parts of the public systems, which is more likely to rise to the top of political agendas.

Product and marketing strategies will vary. For example, emerging markets are more likely to respond to critical illness and hospital cash policies than to comprehensive managed care policies. Significant investments are required, particularly in countries, such as Poland, where insurers are developing highly integrated business models, by building and owning parts of the healthcare delivery system. But, there are risks. Rates may be controlled by governments, administrative fees may be limited and medical and demographic underwriting may be restricted. Health insurance can be highly politicized, and the rules of the game could change in a short period of time, as demonstrated by Slovakia's recent attempts to nationalize private health insurance organizations.

Companies will have the ability to expand and enter new markets if they have proven expertise in provider contracting, medical management, disease management, care for the aged and administrative infrastructures for billing and reimbursement. Market entry takes planning, time and investment. For those who are serious about this sector, 2009 will be a critical year for positioning, in advance of market shifts and to gain an early-mover advantage.

RETHINK GROWTH STRATEGIES IN CENTRAL AND EASTERN EUROPE

In the beginning of 2007, it appeared CEE economies were sufficiently decoupled from the US and Western Europe to weather the financial crisis with only limited negative impact. But, the financial contagion that has spread to CEE countries is resulting in slower growth, plummeting stock markets and frozen credit markets. CEE insurance markets are projected to grow, but at a slower pace. Insurers should focus on simple and transparent protection products, such as savings, endowment and health. Longer term, as these businesses expand, demand will continue to increase for property-casualty insurance and for reinsurance for natural catastrophes and commerce (such as shipping, ports and pipelines). Insurers should target specific market segments, such as takaful, to expand their franchises in CEE countries. With greater capital and more political risks, Western European expansion will slow from its 2007 pace, and timeframes for realizing acceptable returns will be shorter. Multinational insurers will not pull back entirely from their expansion strategies, but capital to support these decisions will be scrutinized more carefully. In spite of slowing growth, companies must focus on human resources -- both domestics and multinationals have a shortage of skilled staff in the region, particularly in underwriting and actuarial science.

STRENGTHEN BALANCE SHEETS AND CAPITAL ADEQUACY

Investment valuations and income Insurers exposures to various asset classes and securities of specific troubled companies vary, but few companies have escaped the impact of declining asset values and investment returns. Determining asset fair values is a difficult process that requires both quantitative and qualitative assessments. In its October 2008 Global Financial Stability Report, the IMF estimated that globally only 55% of expected ultimate write-downs of \$1.4 trillion, related to US-originated and securitized mortgage, consumer and corporate debt, have been taken. Continued write-downs are to be expected. In October, the International Accounting Standards Board (IASB) issued amendments to IAS 30 and IFRS 7, and the US Securities and Exchange Commission

provided broader GAAP guidelines on market-valuing securities, bringing accounting practices in the US and

Europe more in line. Other changes are being contemplated by the IASB and, in the US, for statutory accounting by the National Association of Insurance Commissioners. Investment income will continue to decline in 2009. Central banks cut core interest rates October through December, with the Bank of England, European Central Bank and Swiss National Bank cutting rates by 200 bps, 175 bps and 175 bps, respectively. Further cuts are not ruled out, even though the key US and Swiss rates stood at a mere 1% at the end of November. There will be further cuts based on declining conditions.

Other pressures on income include increased costs of hedging, losses associated with ineffective hedges and foreign-exchange volatility. These factors will further erode companies capital.

Capital adequacy. How adequate capital is defined is changing, as rating agencies revisit requirements and the European Commission and individual countries consider modifications to proposed Solvency II regulations. For insurers, rating agency definitions are the primary driver, as companies focus squarely on capital protection and capital-raising strategies that will keep them at targeted ratings. Companies should complement the Solvency II regime with additional testing such as short-term liquidity testing and cash flow analysis that allows for a more holistic approach to anticipating the impact of adverse events. Furthermore, insurers should be cautious when discounting long term liabilities for financial reporting and for solvency tests. Such discounting may be permissible, and could take pressure off capital in the short term, but is likely to lead to reserve increases in future years when the credit turbulence subsides. Companies must be clear on the quality of capital components: what is tangible and what is the result of permissible accounting calculations.

Solvency II and its envisaged policies and risk-based approach of regulation extend great benefits to policyholders and to the industry and further supports financial stability. It is our expectation that the key principles will be implemented in a timely manner and issues regarding group supervision will be resolved in a way that addresses the concerns of those involved. The current financial crisis should also give further impetus for insurers to implement appropriate enterprise-wide risk management frameworks and to improve their management of capital and liquidity. In particular, the experience of the current crisis has demonstrated the need for contingency planning and scenario analysis to prepare firms for extreme and adverse events.

Companies will continue to seek the most efficient approach to allocating capital. Although sales of closed block and runoff businesses have slowed somewhat in 2008, they will improve as sellers look to free up capital to reinvest in core businesses and as acquirers focus on managing tail risk. Capital for potential acquisitions will be difficult to raise, but some insurers will have access to funds from government safety nets and others will take advantage of buying opportunities to make acquisitions in 2009.

READDRESS OPERATING ISSUES

Distribution. In prior periods, distribution of complex products had become difficult due to the amount of training required to sell these products. With the financial crisis driving simpler and more transparent product structures, insurers will realize increased productivity in traditional distribution channels and begin to more aggressively distribute products through web-based and social-networking mechanisms.

Distribution is a critical success factor in every insurance sector. In developing markets, distribution arrangements are evolving and many recent acquisitions and joint ventures have included long term distribution arrangements (10 years or more) with sellers and joint venture partners, particularly for bancassurance. In addition, a growing number of insurance companies have acquired financial advisors to complement their distribution mix. Distributors also have been consolidating to acquire expertise in niche markets and grow market share.

Innovation is critical, and companies are beginning to leverage web-based and mobile technology investments to reach new markets. Technology acquisitions made in the past 18 months will begin to be deployed in 2009, helping to

attract a broader spectrum of policyholders by reducing administrative hassles and improving customer service.

Expense Control. Cultural market restrictions and legal factors have historically limited European insurers ability to maximize expense reductions. Yet, Western European insurers made a large number of acquisitions in 2007 that have not yet been fully integrated. Cost-reduction initiatives are expected to increase substantially in 2009. Cost management and operational transformation will come from a deployment of technology, which provides a platform for growth and diversification. Insurers and distributors made numerous acquisitions of technology companies in 2007 and financial benefits and service quality will be realized as these technologies are deployed in 2009. Effective use of technology in general will be a key element of achieving operating efficiencies.

Outsourcing of business processes, IT infrastructure and applications have been increasing in recent years as outsourcing providers expanded in CEE countries. These arrangements are expected to expand, helped by the proximity and lower cost of CEE outsourcers.

PREPARE FOR CHANGES IN GLOBAL REGULATORY OVERSIGHT

IFRS 4 Phase II, Solvency II, and market consistent embedded value have planned implementation dates of 2012. Between now and then, all insurers need to build the infrastructure to implement the upcoming changes. This would be a large operational undertaking even in the best of times, but the credit crisis and recession have increased the challenge. The financial crisis will undoubtedly drive greater regulatory scrutiny, with regulators requiring greater disclosure and compliance. Market consistent valuations will come under pressure. An integrated-model approach may be discarded or delayed. Models may be significantly overhauled to add focus on liquidity and structural asset-liability management and to capture all activities of all entities in the group.

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Ernst & Young 2009 Insurance Outlook -- Far East

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Ernst & Young 2009 Insurance Outlook -- Far East

By Ernst & Young

February 8, 2009

SUMMARY: Ernst & Young presents its 2009 outlook for insurance companies in the Far East.

PDF LINK: [Click Here for Enhanced PDF of Commentary](#)

ARTICLE: The expansion of western European and US insurance companies into Asia will continue but at a slower pace, and some multinationals will divest Asian operations to raise capital, creating opportunities for other brave or heavily committed domestic and multinational insurers.

Governments of both developed and emerging nations continue to take unprecedented individual and collaborative steps, applying financial stimulus and evaluating necessary policy changes to stabilize and restore confidence in the financial system. Understandably nervous regulators are locking capital within each country, making it difficult for some structures to operate. In this context, these issues and considerations for insurance companies in the Far East are the focus of our Outlook.

1. Mitigate risks and seize opportunities
 - Property-casualty insurance
 - Life insurance
 - Health insurance
 - Reinsurance
2. Strengthen balance sheets and capital adequacy
3. Expand markets and distribution
4. Access new market segments
5. Monitor operating efficiencies and expense control

MITIGATE RISKS AND SEIZE OPPORTUNITIES

Property-casualty insurance. The financial crisis, catastrophe losses and a decline in top line growth are setting the stage for lower earnings in 2009. With further write-offs expected, investment income is unlikely to rebound quickly as companies investment strategies focus on earnings and credit quality. Overall, prices are not firming for renewals, but some relief in the property/casualty rate cycle is expected later in the year. Rates for certain lines in some countries will continue to be depressed as tariff regimes keep rates artificially low or as intense competition results in rate-slashing. The experience of the Indian market where, in the aftermath of the tariff abolition, rates for certain coverages fell by as much as 80%, illustrates this trend. This situation requires a more sophisticated approach to market segmentation, acquisition and retention strategies, and assessment of long-term customer profitability and value.

Natural catastrophes are always a wild card. Multinational insurers and reinsurers suffered from US hurricanes and other insured catastrophe losses totaling over USD20 billion in 2008. Domestic Asian insurers were impacted by their own catastrophes, such as the snowstorms in southern China and the Sichuan province earthquake. Insurers are pushing pricing increases more aggressively in 2009, and cannot count on repeats of the benign catastrophe years of 2007 and 2006.

Although at a slower pace, top line growth will probably continue in 2009, as demand increases for both personal and commercial insurance. In spite of the spreading recession in developed Asian countries, economic momentum continues, assisted by bail-outs such as Chinas USD586 billion infrastructure fund. Insurers and reinsurers have benefited from real estate development, and growth in manufacturing and import/exports that are expanding shipping and energy projects for gas and oil pipelines. Increased individual wealth has resulted in more insurable risks. And in China, underinsurance is still an issue, as evidenced by the Sichuan province earthquake in May. Overall losses were estimated at USD16 billion to USD48 billion, yet only about 2.5% of that amount was insured.

Earnings in 2009 are also at risk because growing economies increase exposures and unforeseen factors can influence pricing adequacy. Government-mandated risk-sharing pools, inflation, changing economic circumstances and tort reform are just a few of the factors for insurers to consider in managing growth, earnings and capital. Different variables must be considered for pricing and reserving when companies write new exposures such as commercial flood insurance. Mandatory risk-sharing pools (e.g., Indias Motor Third Party Insurance Pool for commercial vehicle business) provide hard-to-insure coverage and risk sharing among all market players; they are a cost of doing business that is likely to increase insurer losses.

Life insurance. Life insurance and savings/annuity product growth continued in 2008, although with mixed results country to country. For example, Chinas domestic life insurance premiums grew by 62%, based on PRC GAAP, in the first nine months, while Korea experienced modest growth of only 3.5% in the six months ended September 30. Overall growth will slow dramatically in 2009 as a result of financial market turmoil and erosion of the value and image of unit-linked products. Insurers need time to reposition their product portfolios and retrain distribution forces. Sensibly, some life insurers are investing in this area and realizing retention levels that western operations aspire to achieve. A few companies have shifted quickly to protection and are now outperforming the market. Some multinationals may withdraw from markets, or restrain sales, as they increase reserves and write-off deferred acquisition costs related to in the money guarantees.

The prognosis for the life insurance sector in 2009 is a rocky one. While many multinationals continue to expand in Asia, a shortage of capital could constrain their growth. As consumers shift from unit-linked to more traditional products, the demand is for long-term investment offerings with guarantees. Longer term, the industrys challenge is to develop and sell products that meet consumer needs, but do not expose companies to undue risk; and premium growth will vary from country to country. Countries such as China, where investment-linked products have yet to grow in popularity, may see less disruption. The ongoing emphasis on private pensions throughout Asia, and favorable tax incentives, will help prop up the market. Life insurers with mutual fund and asset management businesses are best positioned to provide alternatives for consumer savings. The insurers most likely to come out on top are those with

adequate capital, strong multinational or domestic brands, and a product portfolio able to meet the needs of a more risk-averse consumer.

Health insurance. The health insurance market will continue to experience long term growth, and those companies contemplating entry should use 2009 to set their strategies. Markets vary from country to country in terms of products offered, which range from critical illness and hospital cash policies to western-style managed care products. Penetration is still low in most countries but growing, as evidenced by the Korean market, where most of the growth in nonlife insurance premiums in the first half of 2008 was in the health insurance sector. Many newly industrialized and emerging countries are encouraging private health insurance to limit government funding and will be even more motivated to do so in the current financial crisis.

Growth is expected in the health sector by domestic insurers, such as LIC in India, which entered the health market in the past year. Multinationals already invested in the sector, such as Swiss Re in India and China and BUPA in Australia, will continue to expand. A few of the larger US health insurers that are focusing primarily on expatriate business will start to look for other opportunities. The shortage of capital and the longer-term nature of the opportunity will slow the pace of investment. However, that will not be the case in countries such as India, where regulators are encouraging additional investment and have proposed changes in insurance laws, including lower capital requirements for standalone health insurers.

Although opportunities are abundant, there are other considerations. Significant investments are required to contract a broad and high-quality health care delivery network, to establish medical/disease/ case management capabilities, and to develop administrative processes and systems such as billing and reimbursement. Human resource shortages present another challenge, and the ability to fully underwrite risks is limited in some countries. Interested companies should begin to evaluate the level of investment required by health care providers, other insurers, and government to help mature individual markets. Joint venture partners are essential to success, and must be selected wisely, to ensure that the full continuum of operating capabilities is assembled.

Reinsurance. Growth in infrastructure and commerce in developing economies requires the spreading of large risks, which will likely increase the demand for insurance in 2009. A new focus on financial solvency in countries such as China and Korea is driving regulation that requires this increased use of reinsurance. As indicated in Guy Carpenters 2008 study on World Catastrophe Reinsurance Markets, global rates have dropped by 10% on average in 2008 as opposed to 6% in 2007, including a 6% drop in Asia/Pacific region. Reinsurance demand is expected to place upward pressure on rates in 2009, reversing the previous two-year trend.

STRENGTHEN BALANCE SHEETS AND CAPITAL ADEQUACY

Few insurers have escaped the impact of declining asset values and investment income. Domestic insurers in some countries have been protected by regulatory limitations on equity holdings, but a common situation is over-exposure to cross-company domestic holdings in equities and corporate debt, and to troubled western institutions. Asset write downs may well continue. In its October 2008 Global Financial Stability Report, the International Monetary Fund estimated that globally only 55% of ultimate expected asset write downs of USD1.4 trillion, related to US-originated and securitized mortgage, consumer and corporate debt, have been taken.

Property-casualty insurers earnings are depressed in spite of the fact that many insurance markets are experiencing top line growth. Results are impacted by general business conditions, tariff regimes where rates may be inadequate, the soft rate cycle, and competition. Inflation has subsided in many countries, but continues at high enough levels in developing markets to influence the future payout of property and liability claims by insurers and reinsurers.

With this confluence of financial events, capital sufficiency is of greatest concern to insurers. The good news for Chinese insurers, but for few others, is that they raised large amounts of capital in an up market in 2007 (the three largest Chinese life insurers raised USD12.8 billion). But, numerous plans to raise capital are now on hold and it is

likely that capital raising programs such as Korean companies expected future IPOs have been set back, perhaps for years.

With new capital unavailable, failure of insurers becomes more likely, whether through risky investment practices or through increased vulnerability to other market shocks. Problems are particularly likely in the smaller to mid-sized life insurance market. Larger companies may be forced to sell subsidiaries to raise capital, exiting or refocusing their Asian operations. There may also be mergers and investments by Asian insurers in western-domiciled multinationals.

In current conditions, balance sheet risk is high and capital adequacy is difficult to evaluate. Counterparty risks add to uncertainty. Hedging strategies may be ineffective or difficult to evaluate, costs have increased significantly and pricing is highly erratic. Foreign exchange exposures and volatility increase risks and earnings fluctuations for companies with cross-border operations and with currencies pegged to the U.S. dollar (USD). Governments around the region have lowered interest rates to stimulate credit. The lower rates have generally led to higher policyholder liability reserves and strain in meeting regulatory solvency requirements. The complexity of accounting in the current environment should make insurers cautious in analyzing capital adequacy, to distinguish capital backed by tangible vs. intangible assets.

EXPAND MARKETS AND DISTRIBUTION

Many Asian insurers are joint ventures between companies from developed countries and domestic insurers, and, in some instances, domestic non-insurance companies. In several countries, foreign direct investment regulations limit ownership by offshore companies. For example, ownership is limited to 26% in India (anticipated to rise in the near future to a limit of 49%) and to 20% and 25% by single or multiple investors, respectively, in China (although foreign insurers may own 100% of a nonlife subsidiary and 50% of a life joint venture). Multinationals are seeking local knowledge and distribution, while their domestic partners are seeking product innovation, operating processes, systems and insurance know-how.

Less mature insurance markets are frequently characterized by numerous small, local or regional insurers that are not highly regulated and lack the underwriting discipline of more mature markets. These companies tend to under-price risks, and, in certain instances such as motor, where insurance is increasingly mandatory, contribute to the negative perception of the industry because of poor claim service. In 2009, consolidation and efforts to improve solvency regulations may accelerate, thereby setting the stage for improving consumers perceptions of the industry over the long-term.

Domestic insurers dominate the landscape in certain countries. In Korea, for example, the largest three insurance groups constitute more than 60% of the life and nonlife insurance market. Tariff regimes can shield local players from the rigors of true competition. Yet when tariffs are removed, as they were in India for motor insurance at the beginning of 2007, companies are often not fully prepared to operate in a more competitive environment. Tariff regimes, in general, can arbitrarily cap premiums and lead to pricing inadequacies.

Retail insurance markets are slowly developing, with variable standards. Multi-channel distribution strategies with geographic breadth are keys to growth in 2009. Until a few years ago, tied agencies were the predominant distribution channel, but growth and profitability were depressed by agent turnover, and poor policyholder retention. Multinational insurers invested heavily in distribution in 2007 and early 2008, particularly in bancassurance, many through long-term distribution partnerships. Yet while the growth of bancassurance is significant, this recent activity conceals a largely sub-optimal use of channel. Independent agency and broker distribution has also been growing, as entrepreneurs seize an opportunity where Internet and mobile technologies are beginning to be exploited. Companies will continue to pursue multichannel distribution and geographic feet-on-the ground expansion in 2009, looking specifically for distribution partnerships while investing heavily in training agents and sales representatives.

ACCESS NEW MARKET SEGMENTS

Insurers are exploring two promising potential market segments: micro-insurance and takaful. As with health insurance, investments in these segments may slow in 2009 due to capital constraints. But, for those companies with the interest and ability to invest, there are opportunities to be innovative.

Micro-insurance. The target population for micro-insurance includes people who are insurable but have no access or only informal access to insurance. They are mostly poor but have the means, perhaps with some subsidies, to pay an insurance premium. Micro-insurance offers opportunities, but companies need to be aware of risks before entering these markets. Countries such as India and China are helping define this market by mandating that insurers serve rural areas and the urban poor. In India one third of the 1.1 billion population is below the poverty line, and in China 800 million of the countrys 1.3 billion people live in rural areas. Other countries, such as the Philippines, Bangladesh and Indonesia, are also focused on developing micro-insurance markets. Simple products such as life and savings plans are most common, but health and agriculture are emerging to fill large unmet demand. Innovation is required to: effectively assess market needs, determine how insureds would buy and use services, provide simple products and processes, and utilize nontraditional distribution channels such as nongovernmental organizations, microfinance organizations and trade unions.

Takaful. An estimated 1 billion Muslims live in Asia, representing more than half the worlds Muslim population. Takaful targets Muslim communities with insurance that is structured to be Shariah-compliant. The underlying concept is not unlike that of a conventional mutual insurance company, although details of the corporate structure differ.

Takaful business has been growing at a rate of 10-20% per year and is expected to continue at a robust pace. Companies operate in over 23 countries inside and outside of Asia, and a retakaful market is being developed in the region that is attracting major conventional reinsurance players such as Munich Re and Tokio Marine. This market segment, too, requires innovation to effectively assess market needs and design products and processes that are responsive to those needs.

MONITOR OPERATING EFFICIENCIES AND EXPENSE CONTROL

The financial crisis has accelerated the need to achieve operating efficiencies and control expenses. Many companies will consider some restructuring in 2009 to meet these demands. However, differences among countries in business infrastructure, culture and regulations, and the existence of numerous joint venture arrangements, continue to present barriers to maximizing efficiencies. Those companies that are successful in leveraging technology and process improvements, and build a culture of continuous improvement, will increase their ability to grow profitably. Customer service will improve, and acquisitions can be integrated more easily onto a common operating platform. Multinationals and larger domestic companies have the most opportunity to achieve real cost savings as they benefit from economies of scale. Smaller companies will be at a disadvantage, and may show signs of consolidating in 2009.

As margins continue to be squeezed, IT and business process outsourcing may increase. Outsourcing initiatives require a rethinking of the entire business process, as companies consider which processes are core and should be retained, and which can most effectively be outsourced. Although recent IT industry scandals in India may increase the due diligence potential outsourcers will undertake before trusting their business to providers, regulators may look unfavorably on cross-border outsourcing, particularly of customer facing functions or policyholder data.

Human resource challenges in Asia include a shortage of qualified staff, particularly in technical areas such as underwriting, actuarial and finance. Similarly, companies will have difficulty finding experienced talent in process improvement, and may need innovative ideas to attract and retain the right capabilities.

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Levine on Eight for '08: Insurance Measures in Review

2009 Emerging Issues 3252

Ken Levine and Sheri Holtz Levine on Eight for '08: Insurance Measures in Review

By Ken Levine and Sherri Levine

December 15, 2008

SUMMARY: "Eight for '08" reviews in an in-depth and readable fashion key state and federal legislative efforts on insurance topics such as catastrophic loss, suitability, bad faith civil liability, health care reform and federal regulatory efforts. The commentary highlights common themes and provides a singular reference for significant legislation and various related regulatory pronouncements that will affect the insurance industry for years to come.

PDF LINK: [Click Here for Enhanced PDF of Commentary](#)

ARTICLE: EIGHT FOR 08: INSURANCE MEASURES IN REVIEW

INTRODUCTION

At the risk of stating the obvious, 2008 has been an historic and memorable year. From the historic presidential election, creating for many a new opportunity for hope, to the floods in the Midwest or the collapse of Wall Street, resulting for many in lost opportunity and fear, 2008 will be a year that is hard to forget. In addition to the major headlines of the year, 2008 was also a memorable year for state and federal efforts pertaining to insurance. For some, it was a year creating opportunity for hope; for others, 2008 resulted in lost hope and lost opportunity. In honor of this memorable year for insurance regulation memorable for that which occurred as well as that which did not below are some highlights from 2008 in eight insurance topics: (1) Life Settlement Agreements/Stranger-Originated Life Insurance; (2) Suitability; (3) Bad Faith Civil Liability; (4) Property and Casualty: Flood and Other Natural Disaster; (5) Health (Autism, Mental Health Parity, and Accessibility/Affordability); (6) Producer Licensing; (7) Interstate Compact; and, (8) Federal Regulatory Effort.

LIFE SETTLEMENT AGREEMENTS and STRANGER-ORIGINATED LIFE INSURANCE

The year 2008 proved legislatively significant for the viatical and life settlement industries. According to one report, approximately 60 bills were introduced in legislatures across the nation. Life Settlement Solutions Market Watch, Regulatory and Compliance Update (Sept. 2008). Of those some 60 bills, 14 bills were signed into law. Two bills were vetoed: California (S.B. No. 1543, vetoed Sept. 30, 2008) and Rhode Island (Sub. A for S.B. No. 2603, vetoed July 3, 2008).

Most of the newly-adopted Acts serve as extensive revisions to existing statutes, to provide increased accountability and consumer protection against fraud, stranger-originated life insurance (STOLI) policies, and other unscrupulous practices. Hawaii and West Virginia, two states that previously did not regulate life settlement agreements, adopted new regulatory programs. Three states Maine, Arizona, and Indiana addressed STOLI transactions without adopting extensive revisions to the current regulatory approach. Florida adopted clarifying amendments to section 627.404, FLORIDA STATUTES, addressing insurable interest requirements, effective July 1, 2008. See 2008 Fla. Sess., Comm. Sub. for S.B. 648. The National Association of Insurance Commissioners (NAIC) and National Conference of Insurance Legislators (NCOIL) model acts provided the basis for most of these bills. A listing of states following the NAICs Viatical Settlements Model Act (amended June 4, 2007) and the states following the NCOIL Life Settlements Model Act (adopted Nov. 17, 2007) is provided below.

State

Legislation

Model

Effective Date

Connecticut

Sub. for H.B. No. 5512, Act No. 08-175 (*codified at § 38a-465, Ct. Gen. Stat.*)

NCOIL

Oct. 1, 2008

Hawaii

H.B. No. 94, Act No. 177 (*codified at §§ 431E-2, et seq., Haw. Rev. Stat.*)

NCOIL

June 16, 2008

Iowa

S.F. No. 2392, Ch. No. 2007-1155 (*codified at §§ 508E.1-508E.1A, et seq., Iowa Code*)

NAIC

July 1, 2008

Kansas

S. Sub. for H.B. No. 2110, Ch. No. 2008-96 (June 9, 2008) (*codified at K.S.A. 2007 Supp. §§ 40-5001, et seq.*)

NCOIL

July 1, 2008

Kentucky

H.B. No. 348, Acts No. 32 (*codified at KRS §§ 304.15-020, and 304.15-700 to 304.15-725*)

NCOIL

July 15, 2008

Nebraska

L.B. No. 853, Laws 2008, LB853, §§ 1, *et seq.* (*codified at §§ 44-1101, et seq., Rev. Stat. Neb.*)

NAIC

July 18, 2008

Ohio

H.B. No. 404, Sess. Law No. 94 (*codified at §§ 3916.01, et seq., Ohio Rev. Code*)

NAIC

Sept. 11, 2008

Oklahoma

S.B. No. 1980 and S.B. 565, Laws 2008, c. 183 (*codified at §§ 36-4055.1 to 17, Ok. Stat.*).

NCOIL

Nov. 1, 2008

West Virginia

S.B. No. 704, Act No. 2008-124 (*codified at §§ 33-13C-1 to 18, W.Va. Code*)

NAIC

May 29, 2008

Hawaiiis Act sunsets in 2010.

Some provisions of the Ohio Act, such as Division (A) of section 3916.20, OHIO REV. CODE, addressing licensing, are effective December 11, 2008.

All of the newly-adopted acts employ various schemes to deter STOLI transactions and similar investment practices with the potential for negatively affecting the life insurance market by making life insurance significantly more expensive and less available. See Testimony of Mary Jo Hudson, Director, Ohio Department of Insurance, before the House Insurance Committee of the Ohio Legislature (Jan. 15, 2008). Some states, such as Ohio, Iowa, and Nebraska, increased the amount of time a life insurance policy must be held before a viatical agreement may be signed from two to five years. West Virginias new legislation also set this threshold at five years. Even in these states, it is possible to enter into a viatical settlement if the viator undergoes certain life changing events, such as terminal or chronic illness, the death of a spouse or child, divorce, retirement from full-time employment, or bankruptcy. These programs also allow for viatical agreements prior to two years after the issuance of a life insurance policy in limited circumstances where it can be proven, for example, that at all times during that period, the policy was (a) purchased with unencumbered assets, (b) no agreement to transfer ownership exists, and (c) neither the policy nor the insured has

been evaluated for settlement.

The NAIC and the NCOIL model acts, and their recently-enacted state progeny, prohibit fraudulent life settlement acts. Certain specified acts, including STOLIs, or omissions will qualify as fraudulent if there is an intent to defraud for the purpose of depriving another of property or for pecuniary gain. Other acts or omissions may likewise qualify as fraudulent without a similar showing of fraudulent intent.

Other methods used to deter fraudulent practices, and found as common elements, if not identical language, throughout the new acts address advertising and promotional materials, required disclosures to the viator as well as the insurer, proof of financial responsibility requirements for providers and brokers, annual reporting to the regulating entity disclosing information related to policies settled within five years since issuance, requirements to obtain affidavits or similar documents confirming that the insured is of sound mind and under no undue influence to enter into a contract as well as consenting to the release of medical records, new or revised broker and provider registration requirements, new or revised disclosure requirements, increased examination powers, required fraud warnings, requirements to adopt anti-fraud measures, and continuing education requirements for brokers. In addition, life insurers will not be held responsible for the acts or omissions of a provider or broker in connection with a viatical settlement transaction unless the insurer received some form of compensation in connection with the transaction. Listed below are examples of some of the mentioned revisions:

(a) Advertising and Promotional Materials. Various efforts to assure clear and truthful advertising of the risk and benefits of viatical agreements include requiring the filing of promotional, advertising and marketing materials with the regulating entity (i.e., Superintendent or Commissioner of Insurance), and prohibiting the use of certain words such as free, no cost, or the like.

(b) Annual Statements. Annual statements to be filed by March 1st of each year are now required in those states adopting or revising their regulatory programs. In addition to information required as adopted by agency rule, most of the newly required annual statements require detailed information relating to viatical agreements settled within the previous five years, such as total number settled and aggregate face amount. The details of this new requirement vary from state to state, but to provide an example, Connecticut registered viatical providers will be required to file in their annual statements, at a minimum, for any policy settled within five years of policy issuance, the total number, aggregate face amount and life settlement proceeds of policies settled during the immediately preceding calendar year, a breakdown of the information by policy issue year, the names of the insurance companies whose policies have been settled and the brokers that have settled said policies. 2008 Conn. Pub. Acts 08-175, § 5(a).

With the adoption by the Ohio General Assembly of House Bill 404, effective September 11, 2008, viatical settlement providers, as part of the application for registration process, are now required to provide proof of financial responsibility in the amount of \$250,000. In addition to the annual statement required by March 1st, viatical settlement providers in Ohio are required to file by May 1st of each year, an independently audited financial statement and unaudited financial statements on a quarterly basis within 45 days after the end of each quarter.

(c) Anti-Fraud Measures. Providers and brokers are required to adopt anti-fraud measures reasonably calculated to detect, prosecute, and prevent fraudulent life settlement acts. In addition, many states have adopted mandatory reporting requirements for persons engaged in the business of viatical settlements having knowledge or a reasonable suspicion that a fraudulent settlement activity has occurred or will occur and discretionary reporting for any other person having knowledge or a reasonable belief of a fraudulent viatical settlement act. See §§ 33-13C-14(c)(1) and (2), W.VA. CODE.

(d) Continuing Education Requirements. Some states like Connecticut, Hawaii, Iowa, Nebraska, and Ohio require brokers to attend on a biennial basis 15 hours of continuing education. Oklahoma requires 8 hours.

Ohios House Bill 404 imposes new requirements on life insurance companies too, creating, as referred to by some, a shared responsibility by all parties to protect consumers and prevent stranger originated life insurance policies.

Pursuant to section 3916.05(B), OHIO REVISED CODE, an insurance company that issues life insurance policies in Ohio shall include questions in its life insurance applications that are reasonably structured to identify and prevent stranger-originated life insurance. Insurers are required to file amended applications including such questions within 12 months following the adoption of rules by the Superintendent of Insurance. Life insurers are also required to file, on or before June of each year, a description of the measures taken by the insurance company to detect and prevent stranger-originated life insurance. § 3916.021, OHIO REV. CODE.

Two more examples of Ohios shared responsibility approach, with regard to licensing revisions, include: (a) requiring that any business licensed as a viatical settlement broker must maintain at least one person who is individually licensed as a broker to be responsible for the licensees compliance, § 3916.031, OHIO REV. CODE; and, (b) requiring that viatical settlement providers provide, as a condition of licensing, information concerning their providers receipt and use of life expectancy information and life expectancy providers, and a written plan of policies and procedures used to determine life expectancies. § 3916.03(C)(1)(c), OHIO REV. CODE.

In virtually all Acts adopted during 2008, STOLI transactions are specifically defined and listed as a prohibited fraudulent life settlement act or activity. Few of the definitions are identical, but among the subtle differences are two key elements: (a) the policy is purchased for the benefit of a third party beneficiary; and (b) the third party beneficiary has no insurable interest. In addition to identifying STOLI transactions among the list of prohibited activities, several states, such as Arizona, have declared STOLI transactions as violations of insurable interest laws and unfair trade practice laws. States addressing STOLI during 2008 without adopting extensive statutory revision include the following:

State

Legislation

Effective Date

Arizona

H.B. No. 2513, Laws 2008, Ch. 240, § 1 (*codified at* § 20-443.02, Az. Rev. Stat.)

Sept. 26, 2008

Indiana

H.B. No. 1379, Pub. Law No. 112-2008, §§ 3 and 4 (*codified at* §§ 27-8-19.8-7.8 and 27-8-19.8-20.1, In. Code)

July 1, 2008

Maine

LD2091 (HP 1477), Chapter Law 543 (*codified at* 24-A MRSA § 6802-A)

June 30, 2008

SUITABILITY

During 2008, Florida, Connecticut, and Idaho passed legislation affecting suitability determinations in annuity transactions. Concurrently, the Financial Industry Regulatory Authority adopted new suitability standards for variable annuities and the U.S. Securities and Exchange Commission pressed forward with federal regulation of equity-indexed

annuities.

During Floridas regular 2008 legislative session, the Florida Legislature passed Senate Bill 2082, known as the John and Patricia Siebel Act, to amend section 627.4554, FLA. STAT. The amended statute retained some standard information from the 2004 legislation and clarified or added new information which the agent, or insurer in direct sales, must obtain from the consumer to analyze suitability. For example, the agent must continue to determine the applicants tax status, investment objectives, and such other information used or to be considered relevant by the agent (with the term relevant replacing the term reasonable in this latter criterion). The bill clarified the financial status inquiry, by replacing that term with an examination of the applicants annual income; existing assets, including investment holdings; liquid net worth and liquidity needs; and, financial situation and needs. Further, SB 2082 added several new criteria: personal information, including the age and sex of the parties to the annuity and the ages and number of any dependents; the source of the funds to purchase the annuity; the applicants intended use of the annuity; and, the applicants risk tolerance. 2008 Fla. Laws ch. 237, §§ 9 and 13. These new criteria appear to have been culled from the Financial Industry Regulatory Authoritys (FINRA) new suitability standards for variable annuities, adopted by way of FINRA Rule 2821(1)(B)(2), effective May 5, 2008, as to all registered representatives.

This information must now be transcribed onto a Florida Department of Financial Services (FDFS)-adopted form, signed by the agent and the applicant, and, within 10 days of execution, forwarded on to the insurer or any third-party contracted by the insurer to supervise the agents suitability compliance. The consumers refusal to provide this information must also be documented on a FDFS-adopted form. Also on a FDFS-adopted form, before consummating an annuity exchange, the agent must indicate the differences between the consumers current and proposed annuity contracts.

The Florida Legislature also furnished the FDFS with an objective standard for determining the propriety of an agents suitability recommendation. The agent must now have an objectively reasonable basis for believing that the recommendation is suitable based on the facts disclosed by the consumer. This objective basis, coupled with the revised consumer information criteria for the agents analysis of suitability, arguably will enable the FDFS to apply an objective measure against the agents conduct.

In contrast with the Connecticut and Idaho statutory amendments, discussed below, Florida suitability law remained focused on the states senior population. Notwithstanding, during 2008, Florida endeavored by other means to address suitability in annuity transactions with other segments of the state. For example, by rule effective July 28, 2008, Florida seeks to ensure suitability in the sale of any annuity product by an [insurance producer or] insurer to an active duty service member of the United States Armed Forces. FLA. ADMIN. CODE rr. 69B-240.001(2) (2008) (applicable as to producers) and 69O-142.200(2) (2008) (applicable as to insurers). For legislative authority to promulgate this rule, the FDFS drew from its broad grant of rulemaking authority under Floridas Unfair Insurance Trade Practices Act, FLA. STAT. §§ 626.9541(1) and 626.9611 (2007). Under this new rule, the sale of an annuity to an enrollee of the Servicemembers Group Life Insurance (SGLI) program is deemed unsuitable unless, after a needs assessment, the producer and/or insurer demonstrate(s) that the applicants SGLI death benefit, together with any other military survivor benefits, savings and investments, survivor income, and other life insurance are insufficient to meet the applicants needs. FLA. ADMIN. CODE rr. 69B-240.001(6)(v) and 69O-142.200(6)(v) (2008); see also FLA. ADMIN. CODE rr. 69B-240.001(4)(f) and 69O-142.200(4)(h) (2008) (defining life insurance as including annuities, concerning regulation of producers and insurers, respectively).

A second example may be found in another statutory section amended by SB 2082. The Florida Legislature amended section 626.99(4)(a), FLORIDA STATUTES, to require that all annuity contracts, regardless of the purchasers age, provide an unconditional refund for a period of at least 14 days. 2008 Fla. Laws ch. 237, §8. A prior version of this bill limited this free look period to purchasers of annuities who were 75 years or older. This expanded free look period is intended to provide all annuity consumers adequate time after the transaction to review the suitability of their purchase. A third example may be found in a new requirement for agent continuing education. SB 2082 requires that, regardless of the age of any consumer to whom an agent intends to market an annuity, persons holding a life license in

Florida must complete at least 3 hours of FDFS-approved continuing education coursework on the subject of suitability in annuity and life insurance transactions. *Id.* at § 3 (amending FLA. STAT. § 626.2815(3)(k)). SB 2082 included a couple of amendments which suggest that the insurer retains ultimate responsibility for the actions of parties which it appoints, but leaves this question somewhat unanswered with regard to parties transacting the insurers products either without proper authorization or in contravention of the supervisory system the establishment of which the insurer ensured.

First, SB 2082 now specifically authorizes the Florida Office of Insurance Regulation (FOIR) to order the insurer to rescind the contract and either fully refund all premium paid on the contract or the accumulation value, whichever is greater. The fact that this penalty is directed at the insurer, without reference to the agent, suggests the insurers administrative exposure for harm to a senior by violation of the Florida suitability law, whether caused by the insurer or the agent. Second, in an apparent effort to temper this administrative penalty, SB 2082 amends the law to indicate that nothing in the amended statute shall subject an insurer to criminal or civil liability for the acts of independent individuals not affiliated with that insurer for selling its products, when such sales are made in a way not authorized by the insurer. Presumably, a way not authorized signals that the insurer can avoid evidence of a violation of Floridas suitability statute in a civil or criminal proceeding if the agent either lacked due authorization to represent the insurer by appointment, failed to adhere to the supervisory system enabled by the insurer, or otherwise exceeded the authority delegated the agent by way of other agreement or authorization. Insurers, thus, should endeavor to assure that a specific and clear supervisory system is established and followed, that business may only be produced by duly-authorized agents, and that the parameters of an agents authority are clearly delineated. The Sunshine States governor signed Senate Bill 2082 into law on June 30, 2008, with an effective date as to the suitability provisions, as amended, to take effect on January 1, 2009.

Meanwhile, Connecticut lawmakers amended that states authorizing legislation to enable the Connecticut Insurance Department (CID) to match the agencies suitability regulations with the National Association of Insurance Commissioners (NAIC) broadened version of the NAICs Suitability in Annuity Transactions Model Regulation (Suitability Model). During June 2006, the NAIC amended the Suitability Model to make it applicable to purchases and exchanges involving annuity consumers of all ages. By 2008, in keeping with the NAICs revision of the Suitability Model, the CID determined to broaden the scope of the Connecticuts regulations to address the suitability of recommendations to any annuity consumer regardless of age. The statutory authority for the CIDs rules, though, specifically limited the scope of regulation to seniors. To address this qualification, the CID proposed legislation to remove the term seniors from Section 38a-432a of the Connecticut General Statutes.

House Bill 5158 passed the Connecticut General Assembly on May 7, 2008, and the Governor signed the bill into law on June 12, 2008, repealing section 38a-432a, CONNECTICUT GENERAL STATUTES, and re-enacting the same language less any reference to seniors. On June 17, 2008, the CID formally published for adoption the agencies rules on Suitability in Annuity Transactions, indicating the agencies intent to remove all references to seniors. The 30-day comment period following publication passed without the CID receiving any comment. The CIDs suitability rule thus sets forth the standards and procedures for producer recommendations, commencing July 17, 2008, to all consumers that result in a transaction involving annuities.

The fifty-ninth Idaho Legislature passed House Bill 411, amending section 41-1940, of the Idaho Code, to remove reference to seniors in keeping with the NAICs amended Suitability Model. Thus, Idaho, like Connecticut, broadened the requirement for suitability determinations to annuity purchasers of all ages. In contrast to Connecticut, Idahos operative suitability provisions are set forth in the Idaho Code, facilitating a self-executing statutory implementation in lieu of Connecticuts additional step for implementation by way of rulemaking. The Gem States governor signed House Bill 411 into law on March 19, 2008, and the broadened version of the statute became effective on July 1, 2008.

The sale of equity-indexed annuities has grown dramatically since the introduction of these products during the mid-1990s. By 2008, more than \$123 Billion had been invested in indexed annuities. Public Meeting, U.S. Securities and Exchange Commission (Dec. 17, 2008) (opening statement of SEC Chairman Christopher Cox). The U.S. Securities

and Exchange Commission (SEC) actively observed the escalating sale of these products and identified the need for federal intervention in the traditional regulatory bailiwick of state insurance regulators, to guard against inappropriate sales to persons, particularly seniors, who misunderstood the product. On June 25, 2008, the SEC proposed rule 151A, to be codified at 17 C.F.R. § 230.151A, to regulate indexed annuities as securities under the Securities Act of 1933 (the Securities Act). On December 17, 2008, the SEC voted 4 to 1 to adopt proposed rule 151A for application to annuities issued on or after January 12, 2011.

Rule 151A defines the terms annuity contract and optional annuity contract for purposes of clarifying the status of indexed annuities under federal securities law. Specifically, section 3(a)(8) of the Securities Act, 15 U.S.C. § 77c(a)(8), exempts from regulation as a security [a]ny insurance or endowment policy or annuity contract or optional annuity contract, issued by a corporation subject to the supervision of the insurance commissioner . . . of any State or Territory of the United States or the District of Columbia. The rule removes from the Security Acts exemption an annuity contract or optional annuity contract under which: (a) the amounts payable by the insurer are calculated, in whole or in part, by reference to the performance of a security, including a group or index of securities; and, (b) the amounts payable by the insurer under the contract are more likely than not to exceed the amounts guaranteed under the contract. Indexed Annuities and Certain Other Insurance Contracts, Securities Act Release No. 8933 (June 25, 2008) [73 Fed. Reg. 37,752, 37,774 (July 1, 2008)]. The first prong of this two-factor test clearly ties the benefits of the annuity to the performance of an equity-based index. As to the principles-based standard of the second prong, the rule further specifies that an insurers determination with regard to amounts payable versus amounts guaranteed will be conclusive if, among other things, both the insurers methodology and the insurers economic, actuarial, and other assumptions are reasonable. *Id.* (to be codified at 17 C.F.R. § 230.151A(b)(2)(i)).

The SECs proposal of this rule did not go unnoticed. The National Association of Insurance Commissioners, several individual state insurance commissioners, the National Conference of Insurance Legislators, the Financial Industry Regulatory Authority (FINRA), members of Congress, trade associations, and various affected insurance and securities industry participants, filed some 4,800 comments with the SEC. A majority of these comments, most of which represented insurance interests, voiced strong opposition to the SECs potential displacement of state insurance departments current regulation of these equity-indexed annuities as a form of fixed annuities. Not surprisingly, many comments in support of the rule came from FINRA and representatives of the securities industry. For its analysis, the SEC posited that senior investors will now be able to benefit from the federal Securities Acts requirements concerning registration and disclosure, as well as protection against fraud, misrepresentation, and sales practice abuses. On the other hand, the SEC also estimated significant costs to insurers with the adoption of the rule, stating:

For purposes of the PRA, we have estimated an annual increase in the paperwork burden for companies to comply with the proposed rules to be 60,000 hours of in-house company personnel time and \$72,000,000 for services of outside professionals. We estimate that the additional burden hours of in-house company personnel time would equal total internal costs of \$10,500,000 annually, resulting in aggregate annual costs of \$82,500,000 for in-house personnel and outside professionals.

Securities Act Release No. 8933, 73 Fed. Reg. 37,752, 37,770 (July 1, 2008) (footnote omitted). Of course, printing and providing prospectuses, registration of persons as broker-dealers, actuarial analysis to determine amounts payable versus amounts guaranteed, and other expenses will necessarily add to these figures, and will weigh heavily on an insurers determination as to whether to forego the revenue generated by the sale of these products. It may be that these costs are pushed down to the consumers of these products, making these products a less attractive purchase when compared to other products.

Perhaps in a subtle attempt to mitigate against additional costs or to appease the concerns of state insurance regulatory officials, the SEC also proposed to exempt insurance companies from the periodic reporting requirements of sections 13 and 15(d) of the Securities Exchange Act of 1934 (Exchange Act), 15 U.S.C. §§ 78m(a) and 780(d), respectively, concerning indexed annuities and other securities that are now to be registered under the Securities Act. The SEC formally indicated the basis for proposing this rule as follows: We have proposed this exemption because the

concerns that Exchange Act financial disclosures are intended to address are generally not implicated where an insurers financial condition and ability to meet its contractual obligations are subject to oversight under state law and where there is no trading interest in an insurance contract. Securities Act Release No. 8933, 73 *Fed. Reg.* 37,752, 37,771 (July 1, 2008). Accordingly, rule 12h-7, to be codified at 17 *C.F.R.* § 240.12h-7, will provide insurers with an exemption from Exchange Act reporting with respect to indexed annuities and certain other securities that are regulated as insurance under state law, provided that the insurer and its financial condition remain subject to state insurance regulatory supervision and examination (assuming that the securities are not publicly traded), as well as other criteria. In contrast to the some 4,800 comments filed as to rule 151A, the SEC received 12 comments on rule 12h-7, all in favor of the new rule but suggesting slight textual revision.

Notwithstanding the anticipated tempering effect of rule 12h-7, the regulatory impact of rule 151A will have lasting repercussions for those competing to offer indexed annuities. These repercussions will adversely affect the competition among insurers and issuers of the product and the ability of the product to compete effectively against other products. The life insurance industry, though, tends to stand resilient in the face of adversity. One should not be surprised to learn of new products to replace the indexed annuity offerings of insurers who seek refuge from federal regulation.

BAD FAITH CIVIL LIABILITY

Since the adoption of Washingtons Insurance Fair Conduct Act of 2007, two more states have adopted legislation addressing insurer conduct: Colorado and Minnesota. The titles of the bills alone demonstrate the differences in manner in which these states have approached this issue. Colorados House Bill No. 08-1407 is entitled An Act Concerning Strengthening Penalties for the Unreasonable Conduct of an Insurance Carrier, and Making an Appropriation in Connection Therewith. Minnesotas Senate File No. 2822, on the other hand, is described as an Act Providing for penalties and recovery of attorney fees for certain insurance claims practices. The difference in approaches brings to mind the age-old question of how one approaches life, by looking at a glass as half-empty or as half-full; and, now, how one views insurers, as good faith actors or bad faith actors.

Colorados House Bill 08-1407, effective August 5, 2008, codified at sections 10-1-205(3)(d), 10-2-804(4), 10-3-1108(1)(a), 10-3-1114, 10-3-1115, 10-3-1116, 10-3-105(4)(c), 10-16-106.5 (5) (b), COLORADO REVISED STATUTES, prohibits an insurer from unreasonably delaying or denying payment of a claim for benefits owed to or on behalf of any first-party claimant, and creates a private cause of action to recover reasonable court fees and attorney costs and two times the covered benefit. Denial or delay is considered unreasonable if there was no reasonable basis for the action. In cases where the court finds an action brought pursuant to the Act to be a frivolous action, the court must award costs and attorney fees to the defendant.

In addition to creating a cause of action, House Bill 08-1407 amends section 10-3-1108, COLORADO REVISED STATUTES, to increase the monetary penalties for engaging in unfair or deceptive acts or committing other violations from \$1,000 to \$3,000 for each act or violation, and to increase the aggregate penalty from \$10,000 to \$30,000 unless the insurer knew or reasonably should have known that the insurer was in violation of new provisions prohibiting unreasonable delay or denial of payment. For this willful conduct, the bill increases the penalty to \$30,000 for each act up to an annual aggregate amount of \$750,000.

Other highlights of House Bill 08-1407 include:

(a) Amending section 10-3-1116(2), COLORADO REVISED STATUTES, to prohibit policies, contracts, and plans from containing any provision reserving discretion to the insurer to interpret the terms of the contracts.

(b) Revising the current definition of restitution to include costs and expenses for lost time from work and attorney fees. § 10-3-105(4)(c), COLO. REV. STAT.

House Bill 1407 does not apply to workers compensation, title, or life insurance.

Minnesotas Senate File No. 2822, Chapter 208, Laws 2008, effective August 1, 2008, codified at section 604.18, MINNESOTA STATUTES, raises the standard for seeking penalties against insurers by allowing the award of taxable costs when an insured can show that the insurer lacked a reasonable basis for denying benefits and that the insurer knew of the lack of a reasonable basis for denying or acted in reckless disregard of the lack of a reasonable basis. S.F. No. 2822, § 1, Subd. 2 (2008). Pursuant to subdivision 3 of the bill, a court may award, in addition to permissible pre- and post-judgment interest and costs, an amount equal to one-half of the proceeds awarded that are in excess of an amount offered by the insurer at least ten days before the trial begins, or \$250,000, whichever is less and attorneys fees actually incurred not to exceed \$100,000. Attorneys fees must be separately accounted for and not duplicative of the fees for the insurers attorneys. Punitive and exemplary damages are not allowed.

Subdivision 4 of the bill describes the procedure for seeking recovery. First, a claimant must file suit in court, but may not initially seek recovery under the Act. After initiating the action, the claimant may file a motion to amend the pleadings to claim recovery of taxable costs. The motion may be opposed by one or more affidavits showing no factual basis for the claim. If the court finds prima facie evidence in support of the motion, the court may grant the motion. An award of taxable costs is determined in a proceeding subsequent to any determination of the amount to which the insured may be entitled.

Insurance policies exempted from the Minnesota Act include workers compensation, health, nonprofit dental coverage, life insurance, annuities and fidelity insurance, as well as bonds. Section 2 of the bill clarifies that the Act only applies to causes of action that occur on or after the effective date.

PROPERTY AND CASUALTY: FLOODS AND OTHER NATURAL DISASTERS

Midwestern Response

Much of the Nation was effected by various storms and flooding throughout 2008. However, the Midwest suffered the brunt of the resulting flood damage. Iowa alone suffered estimated losses of approximately \$4 billion in damage to agriculture and \$4 billion in damage to businesses. Nonetheless, no Midwestern state enacted a legislative response in the form of an insurance mandate to these conditions. However, various states did employ regulatory means to govern the market.

For example, several states, such as Illinois and Indiana, issued directives setting in place moratoriums on policy cancellations and nonrenewals. For Illinois policyholders, Director Michael McRaith issued a bulletin, on June 17, 2008, to All Companies and Other Entities Licensed or Authorized to Transact Insurance Business in the State of Illinois. The Director recognized the disruption in mail service, due to flooding and displacement, and the possibility of inadvertent cancellations and nonrenewals of policies caused by this disruption. The bulletin directed that the following safeguards be immediately implemented for all lines of business, regardless of whether an insured resided in a county designated as disaster area:

(a) Tolling of Cancellations and Nonrenewals. The bulletin required that insurers reinstate any policy, with no lapse in coverage, cancelled or nonrenewed by notice issued on or after June 10, 2008. Further, the bulletin prohibited insurers from issuing any new cancellation or nonrenewal notices to affected policyholders until August 18, 2008, or a later time if deemed reasonable given an individual policyholders circumstance. The Division expected that any doubt as to this reasonableness standard would be resolved in favor of the policyholder.

(b) Other Insurance-Related Time-Period Extensions. The bulletin further required that insurers grant policyholders an extension of any policy provisions or other requirements that imposed a time limit for an insured or claimant to perform any act, such as the submission of a claim or proof of loss, reporting of information, submission of bills, or payment of funds. The Division set sixty days as the minimum period of time for this extension or, again, longer if deemed reasonable given an individual policyholders circumstance.

(c) Time-Period Extension for Repairs. The bulletin also required that insurers provide policyholders with an

extension of at least sixty days within which to repair affected property which cannot be repaired within any time period set forth in the operative policy, or within the statutory ninety-day time period for repairs prior to termination due to condition of the property.

(d) Cancellation or Nonrenewal Due to Increase in Risk. Although otherwise allowed under Illinois law, the bulletin prohibited insurers from canceling or nonrenewing policies covering property due to increase in the risk originally accepted or due to the geographic location of the risk.

(e) Other Exceptions to Policy Requirements or Rating or Underwriting Rules. The bulletin also required that insurers consider exceptions to any other policy requirements, or rating or underwriting rules, not otherwise identified in the bulletin, when such requirements or rules are not met as a result of the disaster. An example might be the use of network providers for non-emergency medical treatment.

(f) Medicare Beneficiaries. The bulletin required that insurers receiving inquiries from Medicare beneficiaries, regarding disaster-related health care delivery disruptions, provide these beneficiaries with the latest available Medicare information.

(g) Insurer Websites. Insurers were directed to post on their websites all actions taken to implement the requirements of the bulletin.

(h) Availability of the Division. Insurers were required to advise Illinois consumers of the availability of and contact information for the Division for filing a complaint regarding any disaster-related dispute or issue.

(j) Notice of Noncompliance; Grace Periods. The bulletin also directed any insurer unable or unwilling to comply with the directives of the bulletin to inform the Division in writing of the reasons for the insurers noncompliance. Where permitted by law, the Division would consider exceptions to insurer-specific requirements, such as grace periods for license renewals. Likewise, insurers were not required to file policy or rating manual changes with the Division in order to comply with any of the foregoing directives.

Iowa Governor Chet Culver suggested that the Iowa Legislature reconvene for a special session as floodwaters continued to ravage the Hawkeye State. Many prominent legislators agreed. Charlotte Eby, *The Need for a Special Session is Growing*, THE WATERLOO CEDAR FALLS COURIER, July 27, 2008. However, this suggestion never evolved into a session as the states budget continued to recede with the economy. The Division of Insurance issued Bulletin 08-08, on June 12, 2008, concerning Disaster Planning, wherein the Commissioner proclaimed: I am calling upon the Iowa insurance industry to provide maximum consideration to your insureds in the coming days. Four days later, the Division issued Bulletin 08-09, entitled *Deferral of Premium Payments and Policy Time Frames for Flood and Tornado Victims*, which supplements and expands on Bulletin 08-08. Unlike the directives of the Illinois bulletin, Iowa bulletin 08-09 expressly qualified itself as a request. Specifically, the Commissioner indicated a request that all insurance companies and other entities authorized to transact business in this state give their customers affected by this disaster the option of deferring payments coming due before the end of June, interest free, for up to 60 days from the original premium due date. Further, companies were requested to extended any contractual time limits by an additional 60 days or, like Illinois, any longer period that may be deemed reasonable under the specific circumstances related to the subject insured or claimant. The compulsory language of the bulletin came in the form of the Illinois directive: that noncomplying insurers notify the Division of their noncompliance. On June 24, 2008, the Division issued Bulletin 08-09a as a clarification of Bulletin 08-09 in the form of answers to questions apparently posed by insurers attempting to comply.

For Indiana policyholders, the Indiana Department of Insurance re-released a Consumer Alert, though also identified as a News Release and as Bulletin 163, on June 9, 2008. This document, unlike the directives of the Illinois bulletin, set forth various answers to common questions posed by Indiana residents concerning flood insurance.

The Wisconsin Commissioner of Insurance issued a similar set of answers to commonly asked questions. These

answers came in the form of a press release issued on June 12, 2008, targeting policyholders with Insurance Commissioner Offers Answers to Storm Damage Questions. Perhaps coincidental, perhaps not, the Commissioner issued a Bulletin to All Property and Casualty Insurers, on July 17, 2008, to remind these recipients of the statutory requirements for the proper issuance of notices for the renewal and nonrenewal of personal and commercial policies aside from workers compensation policies.

In contrast, legislation was introduced in the Minnesota Senate on February 21, 2008, mandating a flood insurance noncoverage disclosure for homeowners insurance policies issued in that state. The Governor signed Senate File No. 2980 into law on May 13, 2008, becoming 2008 Session Law Chapter No. 293, codified at section 65A.302, MINNESOTA STATUTES, and effective August 1, 2008. This new law requires that insurers annually notify policyholders in writing with a notice entitled, Important Information About Damage Caused by Flooding, in at least 18-point type. The notice must disclose that the policy does not cover damage caused by flooding and disclose sufficient information to allow the policyholder to contact the National Flood Insurance Program to inquire about purchasing flood insurance. The goal of this legislation was to eliminate much of the confusion that occurs when residents first learn that they are not insured against flood damage after a storm.

Southeastern Response, including Gulf Coast

Alabama passed two significant measures during 2008. First, Senate Bill 3 authorizes captive insurance companies to sell residential insurance along the Alabama coast. Proponents of the bill said the measure should create and encourage competition in the homeowners' insurance business along the coast because companies have cut back coverage since Hurricanes Ivan and Katrina. Governor Bob Riley signed Senate Bill 3 into law on May 8, 2008, designated as Act No. 2008-391, and codified at section 27-31B-3, and sections 27-31C-1 to 27-31C-9, CODE OF ALABAMA.

Alabamas second legislative measure, in the form of Senate Bill 296 codified the legal authority for Alabamas insurer of last resort, the Alabama Insurance Underwriters Association (AIUA). The joint underwriting association provides wind coverage on real estate on or near the Gulf Coast. The AIUA has been created and operated in accordance with a plan of operation approved by the Alabama Commissioner of Insurance. Now, as a creature of statute, the AIUA may carry over unexpended surplus from year-to-year, without lapse or transfer to the States General Fund for redistribution. Senate Bill 296 also authorizes the AIUA to deposit for its own account interest and investment earnings, and to issue bonds, surplus notes and other debentures, and accept goods, loans, and grants. This legislative authorization is intended to bolster the AIUAs financial viability. Governor Riley signed Senate Bill 296 into law on May 8, 2008, designated as Act No. 2008-392 (codification forthcoming).

Louisiana passed Senate Bill 160, authorizing insurers to file with the Insurance Commissioner a written petition for authorization to increase a policy deductible up to 4% of the value of the property being insured for named storms or hurricanes on a homeowners policy that has been in effect for more than three years. The legislation requires the Commissioner to promulgate rules to describe the prerequisite contents of the petition, including a requirement that the insurer itemize for the insured the premium savings based on the increase in the insureds deductible. Additionally, the bill prohibits insurers from including in a homeowners policy any provision which would apply more than one deductible to a loss resulting from a single incident. Governor Bobby Jindal signed Senate Bill 160 into law on July 9, 2008, designated as Act No. 854, and codified at sections 22:635.3(D), (E), and (F) and 636.2(E), (F), and (G), LOUISIANA REVISED STATUTES.

Louisiana also passed Senate Bill 44, which authorizes a "third invitation" for grants under the Insure Louisiana Incentive Program, provides for the recovery of unearned grants, and requires any unused money from the program to be used for a homeowner policy premium assistance program to reduce homeowner insurance premiums. Governor Jindal signed Senate Bill 44 into law on June 21, 2008, designated as Act No. 390, and codified at sections 22:3304(C), (D), and (F), and 36:696(B), and sections 22:3309(E) and 3312, LOUISIANA REVISED STATUTES.

Florida passed Senate Bill 2860, entitled the Homeowners Bill of Rights Act, signed into law on May 28, 2008, designated as Chapter No. 2008-66, and codified at various sections in chapters 215, 624, 626, and 627, FLORIDA STATUTES. This bill includes many provisions, covering an extensive range of insurer conduct, rate regulation and appeal, and a host of other issues. Some aspects of the bill are summarized below:

(a) Insurance Capital Build-Up Incentive Program. Revises the requirements for the Program, which provides for surplus note loans to insurers of up to \$25 Million, repayable over 20 years at the 10-year Treasury bond rate, as approved by the State Board of Administration (SBA).

(b) Notice to OIR of Nonrenewal. Requires an insurer planning to nonrenew more than 10,000 policies within a 12-month period to notify OIR 90 days before issuing any notices of nonrenewal.

(c) Payment of Undisputed Claim Amounts. Prohibits an insurer from failing to pay undisputed amounts of partial or full benefits owed under first-party property insurance policies within 90 days after determining the amount and agreeing to coverage, unless payment of the undisputed benefits is prevented by specified circumstances.

(d) Required Filing of Claims-Handling Procedures. Authorizes the Office of Insurance Regulation (OIR) to order an insurer to file its claims handling practices and procedures as a public record based on findings of a market conduct examination.

(e) Extension of Prohibition on Use and File. Extends for one additional year, until December 31, 2009, the current prohibition on insurers using the use and file option for property insurance rate increases.

(f) Repeal of Rate Arbitration Statute. Repeals the option for an insurer, for any property and casualty insurance rate filing (or any other filing), to appeal a rate filing disapproved by OIR to an arbitration panel in lieu of an administrative hearing.

(g) Expedited Hearings on Rate Filings. Provides for an expedited hearing process for rate filings.

(h) Required Use of Models Approved by Florida Commission on Hurricane Loss Projection Methodology. Requires that for purposes of a rate filing insurers must use a model or method found to be accurate or reliable by the Commission on Hurricane Loss Projection Methodology.

(i) Hurricane Mitigation Premium Credits. Requires OIR to develop, by February 1, 2011, a proposed method for insurers to establish windstorm mitigation premium credits (discounts) that correlate to the numerical rating of a structure pursuant to the uniform home rating scale.

(j) Extension of Rate Freeze. Extends the freeze on rate increases in Citizens Property Insurance Corporation (Citizens) from January 1, 2009, to January 1, 2010.

(k) Assessments for Citizens Deficits. Revises the required assessments to fund a deficit in each of Citizens three accounts (high risk, personal lines, or commercial lines).

(l) Access to Claims and Underwriting Files. Provides that a policyholder who has filed suit against Citizens has the right to discover the contents of his claims file to the same extent that discovery would be available from a private insurer.

(m) Disclosure of Windstorm Mitigation Rating. Effective January 1, 2010, requires disclosure of a homes windstorm mitigation rating, for a home insured by Citizens in the wind-borne debris region with an insured value of \$500,000 or more.

(n) Increased Notice of Nonrenewal. Increases the required notice of nonrenewal of a personal or commercial residential insurance policy from 100 days to 180 days if the policy has been written for five years or more.

(o) Public Hurricane Loss Model. Allows insurance companies to use, for a fee, the Public Hurricane Loss Model to determine rate requests in advance of filing.

(p) Multi-Policy Discount. Allows insurers to offer a multi-policy discount if the policyholder has wind-only coverage with Citizens or an insurer that has removed a policy from Citizens, provided that the same insurance agent services both policies.

(q) Transparency in Rate Regulation. For residential property insurance rate filings, requires the OIR to provide information on an Internet website of: all assumptions made by any OIR actuary; the overall rate change requested by the insurer; a statement describing any assumptions that deviate for actuarial standards of the Casualty Actuarial Society; and, a certification by the OIRs actuary that the actuaries recommendations are consistent with accepted actuarial principles.

Atlantic Coast Response

Maryland passed House Bill 1353, entitled the Omnibus Coastal Property Insurance Reform Act, and signed into law on May 13, 2008, as Chapter No. 540, codified at sections 19-208 through 19-211, CODE OF MARYLAND. The bill makes numerous changes to the law governing property insurance in coastal areas of Maryland, briefly described below:

(a) Hurricane and Storm Policies. The bill prohibits an insurer, issuing a homeowners policy, from adopting an underwriting standard that requires a deductible that exceeds 5% of the Coverage A-Dwelling Limit of the policy in the case of a hurricane or other storm unless the insurer has filed the underwriting standard for approval at least 60 days before the insurer proposes to implement that underwriting standard. The insurer must also provide the policyholder with an annual statement explaining the manner in which the deductible is applied.

(b) Loss Mitigation Discounts. The bill requires an insurer to offer at least one actuarially justified premium discount on a homeowners policy to a policyholder who submits proof of improvements made to the insured premises as a means of mitigating loss from a hurricane or other storm. These improvements must be inspected by a licensed contractor, and the insurer must be allowed to inspect the improvements.

(c) Risk Planning Models. Under the bill, insurers that use a catastrophic risk planning model or other model in setting homeowners insurance rates, or in refusing to issue or renew homeowners insurance because of the geographic location of the risk, must file a description of the specific model with the Commissioner and make arrangements to explain the model to the Commissioner.

(d) Material Reduction Plans. The bill prohibits an insurers withdrawal or reduction in writings unless in accordance with an approved plan of material reduction filed with the Commissioner at least 60 days before implementing the plan. The bill creates procedures for insurers to implement plans to reduce homeowners coverage in the State. A material reduction is defined as a reduction of homeowners policies in force for an insurer on a statewide basis by 3% or more due to cancellations or nonrenewals solely because the subject of the risk or the insureds address is located in a certain geographic area of the State.

(e) Department of Housing and Community Development. The bill requires the Department of Housing and Community Development to review current statewide building codes and develop enhanced codes for coastal regions of the State that promote disaster-resistant construction in these regions.

The provisions of the bill apply to all homeowners insurance policies issued, delivered, or renewed in the State on or after October 1, 2008, except for those concerning material loss mitigation discount plans, which apply to such policies issued, delivered, or renewed in the State on or after June 1, 2009.

National Flood Insurance Program Reauthorization

The most memorable event with regard to federal efforts to tinker with property and casualty insurance turned out to be somewhat of a non-event the simple reauthorization of the National Flood Insurance Program (NFIP) until March 2009. Despite efforts by both the House and the Senate to address the financial solvency of the program and propose other program reforms as part of the NFIP reauthorization, the key differences between the House and the Senate reauthorization packages could not be resolved before being eclipsed by the \$700 Billion Wall Street bailout package. In the end, the NFIP was reauthorized until March 6, 2009, as part of the Homeland Security Appropriations bill, H.R. 2638.

The unresolved differences between the House and Senate versions of the NFIP reauthorization legislation boiled down to two issues: 1) wind coverage, and 2) loan forgiveness. The House bill, H.R. 3121, entitled the Flood Insurance Reform and Modernization Act of 2007, would have expanded the NFIP to make wind coverage available in the form of a multiperil policy. Senate Bill 2284, proposed forgiveness of almost \$20 Billion of debt incurred as a result of Hurricane Katrina and other storms since 2005, and did not include any provision for wind coverage.

As described in Senate Report 110-214, the purpose of SB 2284 was to adopt key reforms to ensure that the program can continue to operate, is self-sustaining, and adequately identifies areas at risk of flood loss. The concern of the Senate sponsor was that the program would become nonfunctional causing policyholders to leave the program, leaving themselves unprotected and leaving the federal government subject to being called upon in the case of disaster. Senate Report 110-214, at 2. According to the Report, the Congressional Budget Office (CBO) could not predict when this would occur, but cautioned the program faces a future with inadequate resources to pay its obligations. *Id.* The CBO also projected that the proposed Senate reforms combined with the debt forgiveness would increase premium revenue over the next ten years by close to \$19 Billion and reduce outlays by about \$10.6 Billion relative to then-current law. *Id.* at 4. Some of the reforms would have included: 1) increasing the ceiling on average annual rate increases from 10% to 15%, 2) phasing out subsidized premiums for some policyholders, 3) requiring larger deductibles, 4) prohibiting FEMA from subsidizing new or previously unsubsidized policies; and 5) increasing civil penalties from \$350 to \$2,000 for lenders that do not enforce the mandatory flood insurance requirement. *Id.* at 6.

There was an attempt to amend SB 2284 to include wind coverage provisions offered by Senator Wicker of Mississippi. The amendment was defeated with only 19 Senators voting in support. Another amendment that received much attention, but ultimately was withdrawn by its sponsor, was Senator Bill Nelsons proposal to create a federal loan program for states that have created reinsurance funds.

HEALTH

Autism

During 2008, several states passed measures to require insurance coverage for individuals with autism, including Arizona, Louisiana, Florida, Pennsylvania, Connecticut, Illinois, and Massachusetts. Most of these measures will be discussed below. With the addition of the legislation in these states, some 27 states and the District of Columbia now have enacted legislation to afford coverage to insureds afflicted with autism spectrum disorders. According to a study by the Centers for Disease Control and Prevention, autism is now considered the most prevalent developmental disability in the United States.

The Arizona Legislature enacted House Bill 2847, also referred to as Stevens Law and signed into law on March 21, 2008, which prohibits certain insurers from excluding or denying coverage for a treatment or imposing dollar limits, deductibles and coinsurance provisions based solely on a diagnosis of an autism disorder, Aspergers syndrome, or pervasive developmental disorder. Stevens Law also prohibits the denial of coverage for medically necessary behavioral therapy services. Insurers affected by the law include hospital service corporations, medical service corporations, health care service organizations, group disability insurers, and blanket disability insurers; however contracts issued to an individual or small employer (an employer who employs at least two but not more than fifty employees) are exempt. Limited benefit coverage contracts and contracts for out-of-state service are also exempt. Coverage for behavioral

therapy is limited to a \$50,000 maximum benefit per year for an eligible child up to the age of nine and \$25,000 maximum benefit per year for an eligible child between the ages nine to sixteen. Stevens Law is codified at sections 20-826.04, 20-1057.11, 20-1402.03, and 20-1404.03, ARIZONA REVISED STATUTES, and applies to policies, contracts, and other evidence of coverage issued or renewed on or after June 30, 2009.

Legislation adopted by the Louisiana Legislature and signed into law on July 1, 2008, focuses on early detection and treatment. House Bill 958 (Act No. 648), codified at section 22:215.26, LOUISIANA REVISED STATUTES, requires coverage by most private insurance plans delivered or renewed on or after January 1, 2009, for the diagnosis and treatment of autism spectrum disorders in children less than seventeen years of age. Health coverage plans issued to employers with fifty or fewer employees and individually underwritten, guaranteed renewable policies are exempt from the new requirements. Insurers are prohibited from limiting the number of visits an individual may make to an autism services provider; however, annual and lifetime benefits are limited to \$36,000 per year and a \$140,000 lifetime maximum. Parity language included in the bill allows for financial requirements such as copayments and deductibles but only to the same extent that other medical services covered by the plan are subject to the same provisions. Treatment of autism spectrum disorders is defined to include five categories of care: 1) habilitative or rehabilitative care, 2) pharmacy care, 3) psychiatric care, 4) psychological care, and 5) therapeutic care.

On May 20, 2008, Florida Governor Charlie Crist signed into law the Steven A. Geller Autism Coverage Act (SB 2654) (the Geller Act). This Act requires coverage by group health plans and HMOs for screening, intervention and treatment of autism spectrum disorder in children younger than eighteen years of age, or children who have been diagnosed with a developmental disorder by the age of eight or younger and are still in high school. Small employers and individually written plans are specifically excluded from the mandate. Health plans and HMOs subject to the Act are required to provide coverage for well-baby and well-child screening for the presence of autism spectrum disorder and treatment through speech therapy, occupational therapy, physical therapy and applied behavior analysis provided by certified providers. Parity language requires that coverage may not be subject to dollar limits, deductibles, or coinsurance provisions less favorable to an insured than those that apply to physical illnesses, except as otherwise provided by the Act. However, pursuant to sections 627.6686(4) and 641.31098(4), FLA. STAT., coverage is limited to \$36,000 annually and \$200,000 over a life and treatment must be prescribed by a physician in accordance with a treatment plan. Coverage may also be subject to other general exclusions and limitations of the insurers policy or plan, such as coordination of benefits, participating provider requirements, and other managed care provisions.

Floridas Window of Opportunity Act is that portion of SB 2654 which sets forth the process for creating a Developmental Disabilities Compact through a workgroup comprised of private insurers, consumer groups, and other interested parties. Group insurance plans or HMOs who have signed the compact by April 1, 2009, and complied with the terms of the compact by April 1, 2010, will not be subject to the Geller Act autism mandates. If the compact workgroup is unsuccessful in drafting a compact, the autism mandate provisions of the Geller Act take effect April 1, 2009. The compact language was added to SB 2654 by the Florida House. One source has raised the possibility that such provisions might constitute an unconstitutional delegation of legislative authority. See Florida Senate House Message Summary (May 2, 2008).

Pursuant to section 624.916, FLA. STAT., the Florida Office of Insurance Regulation (FOIR) is charged with convening a workgroup for the purpose of negotiating a compact that includes a binding agreement among the participants relating to insurance and access to services for persons with developmental disabilities. Statutorily required members of the workgroup include: representatives of Florida licensed health insurers; representatives of licensed HMOs; representatives of employers with self-insured plans; two designees of the Governor, one of whom must be a consumer advocate; and, a designee of both the Senate President and the House Speaker. The Act sets forth four components that must be included in the agreement: a) a requirement that each signatory increase coverage for certain behavior analysis, services, and therapies when medically necessary due to the presence of a developmental disability; b) procedures for clear and specific notice to policyholders identifying the amount, scope, and conditions under which coverage is provided; c) penalties for documented cases of denial of claims for medically necessary services; and, d) proposals for new product lines that would complement traditional health insurance.

The workgroup held its first meeting on October 14, 2008. One of the key topics discussed centered on whether applied behavioral analysis should be considered a reasonable and necessary treatment for a developmental disabled person. FOIR Media advisory on Workgroup Discussing Coverage Options (Oct. 15, 2008). The group was charged with drafting specific proposals for coverage for the next meeting, which was scheduled for November 20, 2008. On November 18, 2008, the meeting was cancelled because no draft proposals had been submitted to the workgroup Chair.

Pennsylvania also enacted legislation, signed into law on July 9, 2008, requiring certain private insurers to provide coverage for diagnostic assessments and treatment of autism spectrum disorders. Like Florida, Arizona and Louisiana, House Bill 1150 (Act No. 62, codified at § 635.2, PA. STAT.) caps coverage at \$36,000 per year; but, coverage is for children or adults up to the age of 21, and Pennsylvania does not impose a lifetime maximum. Pennsylvanias new requirements do not apply to small employer group plans.

Illinois likewise passed legislation in the form of Senate Bill 934 (to be codified at 215 ILCS 5/356z.14). This bill responded to a complimentary veto message as to House Bill 4255 by Governor Rod R. Blagojevich. This revised legislation passed both Houses on November 20, 2008, and, on November 11, 2008, was sent to the Governor for signature into law. The Governor approved the bill on December 12, 2009. Senate Bill 934 will require insurers to provide to individuals who are under 21 years of age coverage of up to \$36,000 annually for the diagnosis and treatment of autism spectrum disorders not already covered by health insurance or a managed care plan. Thus, this mandate applies only to fully insured individual and group policies, not to self-insured benefit plans.

Connecticut and Massachusetts both took a different approach. The Connecticut Legislature amended its mental health parity law to include autism, by way of Substitute House Bill No. 5696, signed into law on June 5, 2008. Effective January 1, 2009, individual and group health insurance policies providing coverage for basic hospital expenses and basic or major medical surgery are required to provide coverage for physical therapy, speech therapy and occupational therapy services for the treatment of autism spectrum disorders as set forth in the DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (4th ed.) [DSM-IV] to the extent such services are a covered benefit for other diseases and conditions under such policy. Public Act No. 08-132, §§ 1 and 2. The General Court of the Commonwealth of Massachusetts also amended its mental health parity law to include on a nondiscriminatory basis autism and other disorders, such as eating disorders, obsessive-compulsive disorder, post traumatic stress disorders, panic disorder and more, effective July 1, 2009. Chapter 256 of the Acts of 2008.

Mental Health Parity

Congress \$700 billion emergency economic assistance bill served as one of the most memorable legislative events in 2008. The passage of this Act ironically shared the spotlight with one of the 110th Congress most anticipated pieces of health insurance legislation, H.R. 1424, the Paul Wellstone and Pete Domenici Mental Health and Addiction Equity Act (the Wellstone Act). The irony lies in the fact that H.R. 1424 was used as a legislative vehicle to bail out Wall Street. Comprehensive mental health parity has been a goal for more than a decade, since the passage of the Mental Health Parity Act of 1996, which addressed parity requirements related to lifetime and annual dollar limits for mental health coverage. By contrast, governmental bail-out bills are rarely popular, nor does the average citizen perceive there to be much parity in such legislative efforts.

H.R. 1424 passed the House on March 5, 2008. From March 7, 2008, to October 1, 2008, H.R. 1424 simply rested on the Senate Legislative Calendar. In a flurry of activity between October 1 and October 3, 2008, amendments addressing the metastasized economic crisis were added to H.R. 1424, and the bill was renamed as the Emergency Economic Stabilization Act of 2008, the Energy Improvement and Extension Act of 2008; and the Tax Extenders and Alternative Minimum Tax Relief Act of 2008. President Bush signed the bill into law on October 3, 2008. The Wellstone Act is found at Section 512, Title V, Subtitle B, of Division C, the Tax Extenders and Alternative Minimum Tax Relief Act of 2008.

The Wellstone Act is intended to achieve more comprehensive and permanent parity by eliminating the sunset

provisions of the 1996 Act and expanding coverage to substance-related disorders as well as prohibiting discrimination with regard to financial requirements, treatment limitations, and out-of-network coverage. According to House Report 110-374, Part II, true parity is accomplished by amending the Employee Retirement Income Security Act of 1974 (ERISA), the Public Health Service Act of 1944 and the Internal Revenue Code so that all group health plans with 50 or more employees, whether they are self-funded or fully insured, equitably provide the delivery of physical and mental health benefits. The individual health market is not affected by this Act, nor does it apply to Medicare patients.

It is not the purpose of the Act to mandate mental health and substance use coverage. Group plans that do not currently provide mental health benefits are not affected by this Act. However, if a group plan provides mental health or substance use coverage, the plans mental health benefits must be equivalent to the plans physical health benefits. So, if a plan does not require cost-sharing among the plan and plan participant or beneficiary, such as a copayment or deductible, on medical and surgical benefits, the plan cannot impose cost-sharing with regard to mental health or substance use benefits. If a group plan includes such a requirement, out-of-pocket costs must be the same for both types of coverage. In addition, criteria for medical necessity determinations and reasons for denial of reimbursement under the plan must be made available by the plan administrator to current or potential participants, beneficiaries, or contract providers upon request.

The Wellstone Act also includes a cost exemption provision to relieve group plans of purported financial hardship imposed by these federal requirements. Under this exemption, if the new requirements result in an increase during a plan year of the actual total costs by an amount that exceeds 1% , or 2% in the case of the first year to which the requirements apply, of the actual total plan costs, such requirements do not apply to the plan for the following plan year. This cost exemption only applies for one plan year and the determination as to whether the exemption applies must be made after the plan has complied with the Acts requirements for the first six months of the plan year involved. Cost exemption determinations must be certified by a qualified and licensed actuary who is a member in good standing of the American Academy of Actuaries.

Pursuant to subsection (e) of the Wellstone Act, the amendments made by this section shall apply with respect to group health plans for plan years beginning after the date that is 1 year after the date of the enactment of this Act, regardless of whether regulations have been issued to carry out such amendments by effective date, except that the amendments made by subsections (a)(5), (b)(5), and (c)(5), relating to striking of certain sunset provisions, shall take effect on January 1, 2009. Collective bargaining agreements ratified before the enactment of H.R. 1424 are subject to a different effective date: The Wellstone Act shall not apply to plan years beginning before the later of (A) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after enactment of this Act, or (B) January 1, 2009.

In addition to mental health parity, on May 21, 2008, President Bush signed into law H.R. 493, prohibiting discrimination on the basis of genetic information with respect to health insurance and employment. The newly enacted law, Public Law 110-233, prohibits group health plans from adjusting premiums or contribution amounts on the basis of genetic information and from requesting or requiring genetic testing. This new measure employs excise taxes as for enforcement.

Accessible/Affordable Health Care

No end-of-the-year wrap-up would be complete without a discussion on health care reform and access to affordable health care. However, health care reform has the potential to become all-consuming. This discussion briefly examines three different reform packages and one ballot initiative, to sample the national temperament for measures addressing access and affordability.

Florida

On May 21 2008, Governor Charlie Crist signed into law CS/CS/SB 2534, Chapter No. 2008-32, Florida Laws,

effective upon becoming law, creating two new programs designed to provide affordable access: a) the Cover Florida Health Access Program, and b) the Florida Health Choices Program.

The Cover Florida Health Access Program does not rely on mandates. Rather, the Program creates a partnership program where private insurers negotiate with the state to provide affordable health for uninsured Floridians. Pursuant to the Act, Cover Florida plans must be portable, issued on a guaranteed-issue basis to enrollees, subject to exclusions for pre-existing conditions, and provide for cost containment through limits on services and caps on benefits and copayments. Cover Florida plans are required to provide *inter alia*, at a minimum, coverage for preventative services, screening, office visits, outpatient and inpatient surgery, urgent care, prescription drugs, durable medical equipment, and diabetic supplies. Persons eligible for coverage must be between the ages of 19 and 64, and cannot be covered by private insurance or eligible for coverage through a public health program such as Medicare, Medicaid or Floridas KidCare, and not have been covered for the past six months unless coverage was terminated for certain reasons. Interestingly, the bill expressly states that the Program is not an entitlement, clarifying that there is no cause of action for failure to make coverage available to eligible persons.

As an update, in late October, after a thorough bid process, United HealthCare and BlueCross Blue Shield were selected to provide statewide coverage under the Cover Florida Health Access Program. Regional plans were also chosen to provide coverage in northeast and southeast Florida.

The second program created by the Florida Legislature, the Florida Health Choices Program, is designed to be a single, centralized market for the sale and purchase of various products that enable individuals to pay for health care, including: health insurance plans, HMO plans, prepaid services, service contracts, and flexible spending accounts. Program participants may purchase these products over the Internet or through the services of a participating health insurance agent. The bill requires that the Program utilize methods for pooling the risk of individual participants and preventing selection bias. Policies sold as part of the Program are not subject to the licensing requirements, or various offering or coverage mandates, of the Florida Insurance Code.

Other matters covered by CS/CS/SB 2534 include:

(a) Amending Floridas Health Flex Plan Program, a program created to offer basic affordable health care to low income, uninsured residents, by expanding the population eligible to purchase such programs by raising the family limit income from 200 to 300 percent of the federal poverty level and extending the expiration date to July 1, 2013; and,

(b) Amending section 627.6562, FLORIDA STATUTES, to allow insurance policyholders the option to insure their unmarried, dependent children who are not married, without dependents of their own, and are either residents of the State or students, coverage until the age of 30.

Florida Senate Bill No. 2534 affected the following statutory sections of Florida law: sections 112.363, 408.909, 408.9091, 408.910, 409.814, 624.1265, 624.91, 627.602, 627.6562, 641.31, FLORIDA STATUTES.

Minnesota

Minnesota Governor Tim Pawlenty signed Senate File No. 3780, into law on May 29, 2008, as Chapter 358, Minnesota Laws 2008. This comprehensive health care reform bill addressed various issues such as health improvement and certification requirements for health care homes. Relevant to this discussion, Articles 3 and 4 of the bill addressed access and affordability. Here, the bill aims to increase access through better sharing of information to identify persons eligible for MinnesotaCare and modifying outreach requirements to make the application and renewal process easier to understand.

Specifically, Article 3 contains provisions relating to increasing access and improving the continuity of care. Article 4 of the bill contains provisions related to health insurance purchasing and making health coverage more affordable. The provisions related to the reform described in Article 4 include:

- (a) Establishing an electronic prescription drug program;
- (b) Recommending an essential health benefit set;
- (c) Developing a system of quality incentive payments to providers who meet specified targets;
- (d) Developing a method to calculate providers' relative cost of care and relative quality of care;
- (e) Developing a peer grouping system for providers;
- (f) Establishing uniform definitions for baskets of care, starting with a minimum of seven baskets;
- (g) Requiring employers with eleven or more current full-time equivalent employees in the State to establish a cafeteria or premium-only plan under *Section 125 of the Internal Revenue Code*;
- (h) Developing a proposal to provide employees with income below 300 percent of the federal poverty guidelines or less and with employer-subsidized coverage with a subsidy;
- (i) Establishing a health care review council.

S.F. 3780 also raised the income limit of \$50,000 to \$57,500 for parents on Minnesota Care and increased limit for adults with no children from 200 to 250 percent of the federal poverty level guidelines.

Minnesota Senate File No. 3780 affected the following statutory sections of Minnesota law: sections 43A.23, 62J.495, 62J.497, 62U.01 to 62U.09, 124D.1115, 145.986, 256B.0751 to 256B.0754, 256.01, 256.962, 256B.057, 256L.04 to 256L.07, 256L.15, MINNESOTA STATUTES.

New Jersey

On July 7, 2008, Governor Corzine of New Jersey commended the Legislature of the Garden State for actually doing something about universal health care, rather than just engaging in dialogue, with the passage of S1557, P.L.2008, ch. 38. Press Release, Office of the Governor, Governor Signs Progressive FamilyCare Legislation (July 7, 2008). S1557 adopts reform in three key areas:

- (a) Health care coverage, including expanding eligibility for the New Jersey FamilyCare Program to include parents whose income is between 133 percent and 200 percent of the federal poverty level and providing a KidsFirst mandate requiring health insurance coverage for all children 18 years or younger by July 2009;
- (b) Individual and small employer health reforms, such as revising the rating system for individual plans and reducing the number of standard plans a carrier must offer from five to at least three plans;
- (c) Increasing dependent coverage so that coverage does not terminate before the dependent reaches 30.

New Jersey Senate Bill No. 1557 affected the following statutory sections of New Jersey law: sections 2:14-17.29k, 17:22A-41.1, 26:2H-18.59j, 26:15-1, 26:15-2, 30:4J-11, 30:4J-11.1, 30:4J-12, 30:4J-18, 30:4J-19, 54:50-9, 54A:8-6.2, 17:22A-41.1, 17:48-6.19, 17:48A-7.13, 17:48E-30.1, 17B:27-30.5, 17B:27A-2, 17B:27A-2.1, 17B:27A-3, 17B:27A-4, 17B:27A-4.5, 17B:27A-4.7, 17B:27A-6, 17B:27A-7, 17B:27A-9, 17B:27A-11, 17B:27A-12, 17B:27A-16.5, 17B:27A-17, 17B:27A-19, 17B:27A-19.11, 17B:27A-19.16, 17B:27A-23, 17B:27A-25, 26:2J-10.3, 30:4J-18, 30:4J-19, NEW JERSEY STATUTES.

Wisconsin

Voters in 22 counties across Wisconsin showed overwhelming support for health care reform, by voting in the

2008 election in favor of a non-binding advisory referendum that posed the following question: Shall the next state Legislature enact health care reform legislation by December 31, 2009, that guarantees every Wisconsin resident affordable health care coverage with benefits that are substantially similar to those provided to state legislators? Without providing more detail as to how such coverage would be provided, it is difficult to speculate on the exact disposition for this measure in Wisconsin. Perhaps Wisconsinites are eager for major health care reform, or it may be that they simply want parity with the privileged few.

PRODUCER LICENSING

NARAB II

On September 17, 2008, the U.S. House of Representatives passed by voice vote H.R. 5611, the National Association of Registered Agents and Brokers Reform Act of 2008. Drafted with the assistance of the National Association of Insurance Commissioners, individual state insurance commissioners, and industry representatives, the bill, also referred to as NARAB II, received strong bipartisan support, including 48 bipartisan cosponsors.

H.R. 5611 proposes to amend the Gramm-Leach-Bliley Act to re-establish the National Association of Registered Agents and Brokers, a nonprofit corporation the purpose of which is to provide a mechanism through which licensing, continuing education, and other nonresident insurance producer qualification requirements and conditions can be adopted and applied on a multi-state basis while preserving states rights in licensing, supervision, enforcement, consumer protection, and unfair trade practices. The purpose of the bill, to paraphrase primary sponsor Representative David Scott, is to address the problem of reciprocity that has become worse as more and more agents operate across state lines, making it apparent that true nonresident licensing reform for insurance agents could only be achieved through legislation at the Federal level. 154 Cong. Rec. H8368 (daily ed. Sept. 17, 2008) (statement of Rep. Scott).

Despite its strong support in the House and support from industry groups such as the Independent Insurance Agents and Brokers of America, the National Association of Insurance and Financial Advisors, the National Association of Mutual Insurance Companies, the Property Casualty Insurers Association of America, and the Council of Insurance Agents and Brokers, H.R. 5611 has advanced no further in the Senate since the bill was referred to the Senate Committee on Banking, Housing and Urban Affairs on October 2, 2008.

California Broker/Agent Distinction

As background, on October 29, 2004, the California Court of Appeal for the First Appellate District decided the case of *Krumme v. Mercury Insurance Company*, 123 Cal. App. 4th 924, 20 Cal. Rptr. 3d 485, 2004 Cal. App. LEXIS 1832 (Cal. App. 1st Dist. 2004), cert. denied, 2005 Cal. LEXIS 597; 2005 Daily Journal DAR 768 (Cal. 2005). In *Krumme*, the court held that Mercury Insurance Company producers acting as brokers were considered agents and not brokers; and, as such, were not entitled to collect any broker fees. The court identified various functions of these producers as qualifying them as agents transacting on behalf of Mercury, such as: binding authority for Mercury; use of application forms, and rating and underwriting guidelines supplied by Mercury; advertisement that they represent Mercury in the same manner as appointed agents; and, other evidence of direct dealings with Mercury. Mercury, on the other hand, argued that the California Insurance Code did not differentiate a broker from an agent, and utilized the term broker-agent.

Debate over *Krumme* resonated among industry, consumer groups, the Department of Insurance, and others, in the years that followed the ruling. Some argued that the ruling in *Krumme* replaced California's totality of circumstances standard with an any one act test for determining an agency relationship. In reflecting upon the *Krumme* decision, the California Assembly attempted, in the Assembly's Third Reading Analysis, to place *Krumme* in a historic context, indicating: But there are two important elements to the decision: (1) the Court did nothing to change the longstanding common rule that whether a person is acting as a broker or an agent depends on the totality of circumstances; and (2) the Court rejected the any one act theory. The analysis further stated that certain groups have read more into the

Krumme Courts conclusions with regard to the application of a five-part test to determine broker or agent, and that the Insurance Staff were unable to locate any case that has held that any standard such as the one act test has replaced the totality of circumstances standard.

Confusion as to the roles and responsibilities of brokers and agents would hang over personal lines brokers and agents, insurers and consumers in California for more than three years after the *Krumme* decision. Finally, on February 22, 2008, Assembly Bill 2956 was filed for introduction in the California Assembly. By September 25, 2008, both Houses of the Legislature passed the bill, and Governor Arnold Schwarzenegger signed the measure into law as Chapter 304, Statutes of 2008, codified at *sections 1621, 1623, and 1732, of the CALIFORNIA INSURANCE CODE*. The new law, which only applies to admitted line producers, clarifies the distinction between a broker and an agent by establishing a new rebuttable presumption for qualification of a producer as a broker. No longer will the presumption of broker exist if a producer is simply licensed as a broker and acts like a broker. To enjoy the presumption, a producer must be licensed as a broker, maintain a specified bond, and disclose specific information to the consumer in a written agreement. The required disclosures are intended to eliminate any questions consumers may have regarding the role of the broker vis--vis the consumer or the insurer, the basic services the broker will provide, and the fees to be charged or the compensation the broker may receive from the insurer.

The presumption of broker status is rebutted if one of four conditions is present: (1) the licensee is appointed as an agent of the insurer for the particular type of insurance being transacted; (2) the licensee is authorized by written agreement with the insurer to obligate the insurer without first obtaining notification from the insurer to accept the risk; (3) the licensee is authorized by written agreement with the insurer to appoint other licensees as agents of the insurer; or (4) the licensee is authorized by written agreement with the insurer to pay claims on behalf of the insurer. In the absence of one of these conditions, the presumption of broker is rebutted based on the totality of circumstances indicating that the producer is acting on behalf of the insurer, putting to rest the notion that the any one act test is the correct standard for distinguishing a broker from an agent.

According to Senate staff, the bill was not intended to alter or affect existing caselaw regarding the significance or weight to be accorded factors that indicate that a broker-agent is acting on behalf of an insurer. Assembly Concurrence in Senate Amendments to AB 2956, p. 2 (Assembly Floor Aug. 13, 2008). Furthermore, section 1732 now clarifies that a broker may on behalf of an insurance company, collect and transmit premium or return premium and deliver policies and other documents evidencing insurance without such actions being construed to qualify the broker as an agent.

INTERSTATE COMPACT

The Interstate Insurance Product Regulation Commission (IIPRC) welcomed several new member states during 2008. For membership, each compacting state enacted into law the Model Interstate Insurance Product Regulation Compact (Compact). The IIPRC continued its efforts to expand its charge, to provide a uniform central filing point under one set of rules, for speed-to-market product review for asset-based insurance products to meet the demands of a competitive global insurance market while maintaining a heightened level of consumer protection. Wisconsin became the 31st state to join the Compact, with the enactment of 2007 Wisconsin Act 168, on March 25, 2008, to create section 14.82, WIS. STAT.

By mid-year Louisiana and South Carolina also joined the Compact, bringing to 54 percent the national premium volume represented by the IIPRC. The Governor of South Carolina signed Act 339 into law on June 11, 2008, codified at sections 38-95-10, et seq., SOUTH CAROLINA CODE. This Act becomes effective January 1, 2009, and will expire on June 1, 2014, unless extended by the South Carolina General Assembly. Louisiana House Bill 369 evolved into Act 353 upon approval by the Governor on June 21, 2008, with an effective date of August 15, 2008, codified at sections 22:1450.51 and 1450.52, LOUISIANA REVISED STATUTES.

In contrast, legislators in California, New Jersey, and New York introduced measures to adopt the Compact. However, these efforts failed to achieve passage during 2008. Legislation was introduced in California by way of Senate

Bill 1434 on February 21, 2008. The bill was to be heard before committee on March 27, 2008, but that hearing was cancelled at the request of the bills author. A second hearing was set for April 16, 2008, at which the committee received testimony. No further action was taken on the bill, while the deadline for passage of the bill out of its house of origin elapsed on May 30, 2008, and last day for passage of any bill occurring on August 31, 2008.

The New York Legislature passed Senate Bill No. S5053 on June 18, 2008. However, the Assemblys companion, Assembly Bill No. A8068, languished in committee. Meanwhile, in New Jersey, the Senate Commerce Committee reported favorably on Senate Bill No. 949. By October 23, 2008, the Assembly Financial Institutions and Insurance Committee reported favorably, with committee amendments, on the measure via Assembly Bill No. 2614. No further action occurred.

Since its inception in 2006, by 2008, the IIPRC adopted 44 uniform standards for the streamlined review of asset protection insurance products such as life, annuity, disability income, and long-term care insurance products. By early August 2008, the IIRC approved its 100th life insurance product.

FEDERAL REGULATORY EFFORT

Throughout 2008, there was much discussion regarding insurance industry regulatory reform at the federal level. But, as has been the case time and again, there was more action and political intrigue than solid results.

On March 31, 2008, the United States Treasury Department released its Blueprint for a Modernized Financial Regulatory Structure, which included various short-term, intermediate, and long-term recommendations for improving the countrys financial regulatory structure, enhancing financial innovation and strengthening consumer protection. The federal charter debate was clearly back in the spotlight. With regard to the insurance sector, the Blueprint recommended creating an optional federal charter, similar to the current dual-chartering system for banking, to encourage a more competitive U.S. industry. As contemplated by the Blueprint, an Office of National Insurance within the Treasury Department would oversee the new structure. The Blueprint also recommended, as an intermediate step, that Congress create a Federal Office of Insurance Oversight within Treasury to establish a federal presence in insurance for international and regulatory issues.

On March 17, 2008, Representative Paul E. Kanjorski, Chairman of the Subcommittee on Capital Markets, Insurance, and Government Sponsored Enterprises, Representative Deborah Pryce, Ranking Member of the Subcommittee, and others, introduced H.R. 5840, the Insurance Information Act of 2008. Somewhat similar in concept to the Blueprints recommendation, but bearing various modifications, H.R. 5840 proposed establishing the Office of Insurance Information within the Department of Treasury to: (a) receive, analyze, collect and disseminate information regarding all lines of insurance, except health insurance; (b) establish federal policy on international insurance matters and ensure consistency between state insurance laws and agreements relating to such policy and entered into with foreign governments; and (c) advise the Treasury Secretary on major domestic and international insurance policy issues.

On June 10, 2008, Chairman Kanjorskis subcommittee conducted a hearing on H.R. 5840, and on July 9, 2008, the subcommittee and full committee approved the bill with modifications addressing protection of confidential information and state preemption. Modifications were based on concerns raised at the hearing on June 10. The Subcommittee had also previously conducted a hearing on April 16, 2008, to discuss various state and federal proposals on insurance regulatory reform. Having completed the committee process and ready for the House Floor, H.R. 5840 was eventually scheduled to be considered by the House of Representatives on the suspension calendar, a calendar typically reserved for non-controversial bills. This set in motion a response from those opposed to the bill, including various consumer groups and the National Conference of Insurance Legislators. Allegations were made of disingenuous remarks linking the need for legislation with the recent AIG financial predicament as well as a failure to fully air all of the issues.

On September 16, 2008, Congressman Jackie Speier, representing San Francisco and San Mateo, California, released a harsh statement criticizing the bill for setting a dangerous precedent by allowing preemption of any state

insurance law or regulation deemed discriminatory toward foreign companies. In her statement, Representative Speier recognized California as having adopted some of the strongest consumer protection laws in the country. To quote Representative Speier, H.R. 5840 is the camels nose under the consumers tent toward abolishing hard-won [state] protections. Press Release, Office of Congresswoman Jackie Speier, Insurance Information Act Bad for Consumers (Sept. 16, 2008). On September 17, 2008, fellow Californian and Speaker of the House, Representative Nancy Pelosi removed H.R. 5840 from the House calendar.

CONCLUSION

Year 2008 saw no shortage of legislative proposals, at both the state and federal level, which will have a lasting effect upon the insurance industry. State legislatures and agencies, as well as the Congress and the SEC, diligently sought to address eight areas of significant interest to the industry discussed in this commentary. Indeed, 2008 will likely be cast as a trend-setting year for each of these topics and as a catalyst for related topics.

For constituents struggling with autism or mental health disorders, 2008 will likely be seen as the year upon which new hope was built. With regard to insurer conduct and bad faith civil liability, the two vastly differing approaches adopted in Colorado and Minnesota will likely provide models for legislative proposals in other states during 2009. There was much anticipation in 2008 with regard to the reauthorization of the National Flood Insurance Program. In the end, no significant changes were made. For some, this non-event will be remembered as the best possible result; while, for others, the year will be seen as one of lost opportunity. In contrast, major changes were adopted in various Gulf region states with the hope of protecting homeowners and affected state budgets from devastating loss. Despite the historic losses in the Midwestern States wrought by the floods of 2008, no major legislative responses were adopted. Future events will educate many legislators and regulators as to which approach best served their respective constituencies. Likewise, 2008 will serve as the prelude to the forthcoming discourse on the financial underpinnings of the industry. The demise of various financial giants affiliated with the industry may never be understood completely, but it is highly likely that 2008 will be remembered as the year that set the stage for change. As with each topic, depending on each participants unique perspective, opportunity abounds.

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Ken Levine is widely regarded as one of the nations premier insurance and warranty regulatory lawyers. With almost two decades of regulatory and administrative experience, Mr. Levine has represented purchasers in some of Floridas largest mergers and acquisitions, and represented several of the countrys largest trade associations in administrative proceedings, bid protests, rule challenges, and negotiated solutions, before numerous agencies of the State. During the early 90s, Mr. Levine served in various legal capacities at the Florida Department of Insurance (now the Florida Office of Insurance Regulation), including service as senior counsel in the Chief of Staffs Office and as the agencys Hearing Officer. He also led the Departments prosecutions of unauthorized insurers in federal courts from Florida to California; and successfully negotiated, through the U.S. Department of Commerce, to save from preemption by NAFTA various provisions of the insurance codes of Florida and of the various states in the Southeastern Zone of the NAIC. After having managed an office and the practice groups of two of Floridas largest law firms, Mr. Levine now serves as the senior partner of The Levine Law Group, in Tallahassee, Florida.

Sheri Holtz Levine has held positions directly involved with legislative and regulatory policy development at both the federal and state levels. Ms. Levine began her legal career twenty years ago in the Office of the General Counsel for the Florida Department of Natural Resources. She then moved to Washington, to serve as a legislative advisor to a prominent Florida Congressman on policy issues affecting proposed federal legislation. This experience returned Ms. Levine to various senior-level positions with the Florida House of Representatives. During her tenure in the House, Ms. Levine served as a Council Attorney, a Staff Director, and as a House Council Director, while also honoring a distinguished appointment by both the Florida Speaker of the House and the Florida Senate President to serve as the first Staff Director for the Joint Legislative Committee on Everglades Oversight. These experiences have enabled Ms.

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The authors express a special note of appreciation to their diligent research assistant, Ashley Paradela.

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Shidlofsky on Additional Insured Status in Strict Eight Corners States

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Lee Shidlofsky on Additional Insured Status in Strict Eight Corners States

By Lee H. Shidlofsky

December 4, 2007

SUMMARY: Insurance coverage can oftentimes be won or lost depending on whether a particular jurisdiction follows a strict "eight corners" analysis for determining the duty to defend or permits the introduction of extrinsic evidence. This issue is particularly relevant in the additional insured context. The Supreme Court of Texas will have the opportunity to determine whether the "eight corners" rule should be more lax in the additional insured context.

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ARTICLE: Recent Texas Law Regarding the "Eight Corners" Rule Keeps Texas a Strict State-Maybe

In general, using evidence not available in a petition or insurance policy (i.e., "extrinsic evidence") in order to create (or defeat) a duty to defend violates a strict "eight corners" rule where only the petition and insurance policy are to be used in determining the insurer's obligation to defend its insured. Nevertheless, most jurisdictions recognize an exception to that rule when an insurer knows or reasonably should know facts that would establish coverage. Most commentators agree with this view as well.

Despite this majority approach, on June 30, 2006, the Supreme Court of Texas stuck with the general rule when it decided *GuideOne Elite Ins. Co. v. Fielder Road Baptist Church*, 197 S.W.3d 305 (Tex. 2006). There, the Court declined to adopt an exception to the "eight corners" rule in regard to analyzing an insurer's duty to defend. The Supreme Court, however, specifically limited its decision to situations when the extrinsic evidence is "relevant both to coverage and the merits" In other words, the Court refused to adopt any exception to the "eight corners" rule for "liability only" or "overlapping/mixed fact" scenarios:

[W]ere we to recognize the exception urged here, we would by necessity conflate the insurer's defense and indemnity duties without regard for the policy's express terms. Although these duties are created by contract, they are rarely coextensive.

Importantly, though, the Supreme Court did not disapprove of other case law and commentary that discussed a "coverage only" exception to the "eight corners" rule. As the Court recognized, authority exists for admitting extrinsic

evidence in "coverage only" situations—at least when the "coverage only" evidence involves fundamental, undisputed and easily ascertained coverage facts. While allowing extrinsic evidence in circumstances such as these technically violates a strict "eight corners" rule, considering "coverage only" evidence does not violate the contractual underpinnings of the duty to defend. And, insurers still will have to defend groundless, false, or fraudulent claims that otherwise state a potential for coverage. Under a "coverage only" exception, for example, insurers only will be able to avoid the duty to defend in situations when the insured has not paid premiums for a defense (e.g., when the defendant is not listed as an insured, or where the property is not scheduled on the policy). The Supreme Court, however, did not expressly say one way or the other whether it would recognize a "coverage only" exception.

Subsequent to the issuance of *Fielder Road*, one court noted the following:

Although the Texas Supreme Court explicitly rejected the use of extrinsic evidence that was relevant both to coverage and to the merits of the underlying action, it did not rule on the validity of a more narrow exception that would allow extrinsic evidence solely on the issue of coverage. In fact, the language of the opinion hints that the court views the more narrow exception favorably. For example, the court specifically acknowledged that other courts recognized a narrow exception for extrinsic evidence that is relevant to the discrete issue of coverage and noted that the Fifth Circuit had opined that, were any exception to be recognized by the Texas high court, it would likely be such a narrow exception.

[*Bayou Bend Homes v. Scottsdale Ins. Co.*, 2006 U.S. Dist. LEXIS 48887 (S.D. Tex. July 18, 2006).] More recently, one federal court expressly concluded that a "coverage only" exception exists in Texas. [See *B. Hall Contracting Inc. v. Evanston Ins. Co.*, 447 F. Supp. 2d 634, 647 (N.D. Tex. 2006) (holding that "coverage only" extrinsic evidence can be considered in the duty to defend analysis).] Likewise, the Fifth Circuit interpreted *Fielder Road* so as to permit extrinsic evidence in "coverage only" scenarios. [See *Liberty Mut. Ins. Co. v. Graham*, 473 F.3d 596 (5th Cir. Dec. 21, 2006).]

Even if admission of "coverage only" facts is allowed, an insurer should not be permitted to use such evidence to contradict allegations in a petition. Likewise, when a potential for coverage can be found from the face of a pleading, an insurer should not be permitted to develop extrinsic evidence through discovery in an effort to defeat the duty to defend. [See *Fair Operating, Inc. v. Mid-Continent Cas. Co.*, 193 Fed. Appx. 302 (5th Cir. Aug. 1, 2006) (affirming district court's order refusing insurer's request to undertake discovery of extrinsic evidence).]

A Strict "Eight Corners" Approach Impacts Additional Insured Status. The D.R. Horton case is just one example of how a strict "eight corners" approach to the duty to defend can affect additional insured status. In D.R. Horton, the Houston Court of Appeals addressed whether extrinsic evidence can be used to trigger the duty to defend for an additional insured. In 2002, James and Cicely Holmes sued D.R. Horton, alleging their house contained latent defects causing the propagation of toxic mold. The Holmeses' petition, however, was silent as to the subcontractors used by D.R. Horton to construct the home. More particularly, the Holmeses' petition did not name a single subcontractor, nor did it reference any damage caused by those subcontractors. D.R. Horton had extrinsic evidence, which demonstrated that the alleged damages were caused, at least in part, by work performed by its masonry subcontractor.

Knowing this, and because D.R. Horton required each subcontractor to name it as an additional insured under the subcontractor's CGL policy, D.R. Horton tendered the lawsuit to masonry subcontractor's liability carriers. Those insurers, however, refused to defend the homebuilder because the Holmeses' petition did not mention the use of or otherwise reference the masonry subcontractor (or any other subcontractor, for that matter). The insurer's refusal stemmed from language in the additional insured endorsement that limited liability to claims arising from the masonry subcontractor's work for the homebuilder.

In the declaratory judgment action against the additional insured carriers, D.R. Horton sought to introduce extrinsic evidence that the alleged damages were caused by the masonry subcontractor (i.e., the named insured). The trial court refused to allow the introduction of the evidence. The court of appeals, despite recognizing that D.R. Horton "produced

a significant amount of summary judgment evidence that . . . links [the masonry subcontractor] to the injuries claimed by the Holmeses," concluded that the trial court was right to exclude the evidence. Specifically, although never explaining its basis for such a classification, the court of appeals held that the extrinsic evidence before it related to both coverage and liability. Thus, the appellate court completely side-stepped the ongoing debate regarding an exception to the "eight corners" rule. As a result, the court of appeals affirmed the trial court and held that the masonry subcontractor's insurer had no duty to defend D.R. Horton. Moreover, because there was no duty to defend, and because the duty to defend is broader than the duty to indemnify, the appellate court also ruled that there was no duty to indemnify.

D.R. Horton has filed a petition for review with the Supreme Court of Texas, which requested full briefing in January 2007. In its petition, the homebuilder refutes the appellate court's finding that the extrinsic evidence at issue related to both liability and coverage. Rather, D.R. Horton argues that the extrinsic evidence it sought to introduce went solely to coverage. (i.e., additional insured status). Finally, D.R. Horton urges the Supreme Court to take Fielder Road one step further by expressly adopting a "coverage only" exception to the "eight corners" rule.

Discussion. Provided the Supreme Court of Texas takes the D.R. Horton case, it will have the opportunity to significantly direct insurance law throughout Texas and perhaps other jurisdictions that follow a strict "eight corners" approach to determining the duty to defend. Notably, the Supreme Court can soften the "eight corners" test by allowing a "coverage only" exception, or it can solidify the test by disallowing any exception to the rule. The latter result will cause significant problems in the additional insured context, as outlined by D.R. Horton.

To be more specific, by ruling against D.R. Horton, the court will significantly affect the rights of the homebuilder and its subcontractor vis-à-vis their bargained-for contract. That contract required the subcontractor to provide insurance covering D.R. Horton, which it did. Nevertheless, because the plaintiff-homeowner likely did not know the significance of that contractual requirement, and because the homeowner only is in contractual privity with the builder, it did not name or otherwise mention the subcontractor in its lawsuit against the builder. As such, in light of the fact that the additional insured must be sued for the acts of its subcontractor in order to trigger the subcontractor's policy, the subcontractor's insurer escapes a significant defense (and possible indemnity) liability. Moreover, the homebuilder (or its own insurer) is faced with what could be a costly lawsuit, and must go at it alone despite, as is the case with D.R. Horton, evidence proving that coverage should exist.

The same situation occurs in states where workers' compensation is considered the exclusive remedy for an injured worker with regard to its employer. When that worker, however, is employed by a subcontractor that agrees to perform work for a general contractor, the worker typically may still seek a remedy against the general contractor. Again, in these situations, the general contractor oftentimes requires the subcontractor to provide insurance under which the general contractor is made an additional insured. In a suit, however, between the injured worker and the general contractor, the worker cannot name its employer because of the workers' compensation bar and thus typically focuses its allegations only on the general contractor. [See, e.g., *Transport Int'l Pool, Inc. v. Continental Ins. Co.*, 166 S.W.3d 781 (Tex. App.-Ft. Worth 2005, no pet.) (refusing to allow a general contractor the right to introduce extrinsic evidence to prove up the negligence of a subcontractor)]. Accordingly, the general contractor, just as the homebuilder in D.R. Horton, does not get the benefit of its contract and is left to fund its own defense.

The Supreme Court of Texas has the opportunity to honor the contracts between these parties if it accepts the petition for review in D.R. Horton. Only time will tell, though, whether the court will keep things strict in Texas or take the first step in softening the rule while recognizing the contractual agreements made between parties such as those in a contractor-subcontractor relationship involving additional insured status. Moreover, as noted, this issue is not limited to Texas and applies to all states that adhere to a strict "eight corners" approach to the duty to defend.

For further discussion of the "eight corner" rules, New Appleman Insurance Law Practice Guide § 4.05[5][d] and New Appleman Premium Online Checklists § 15.05

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Supreme Court of TX Weigh-In on Property Damage and Occurrence

2008 Emerging Issues 1315

Lee Shidlofsky on the Supreme Court of Texas' Weigh-In on "Property Damage" and "Occurrence" in the Realm of Construction Defect Claims: Lamar Homes v. Mid-Continent Casualty Company

By Lee H. Shidlofsky

December 4, 2007

SUMMARY: In recent years, the "property damage" and "occurrence" issues in the context of construction defect claims have been widely litigated. A number of states have conflicting case law, causing confusion for insureds and insurers alike across the country. Over the last few years, state supreme courts have weighed in on the issues several times. The Supreme Court of Texas addressed these issues in Lamar Homes v. Mid-Continent Cas. Co.

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ARTICLE: Confusion in Texas and Across the United States Leads to Certification of Questions by the Fifth Circuit Court of Appeals

What constitutes "property damage" and an "occurrence" in the realm of construction defect claims against an insured general contractor for the acts and/or omissions of its subcontractors are perhaps the most litigated insurance issues over the last several years. In Texas alone, prior to the Supreme Court of Texas weighing in on the matter, at least twenty decisions in the residential construction context had been handed down by both the state appellate and federal district courts. Meanwhile, across the country, a split in authority continued to exist as the supreme courts in Pennsylvania and South Carolina favored the insurer, but the high courts of Tennessee, Wisconsin, and Kansas favored the insured. [*Kvaerner Metals Div. of Kvaerner U.S., Inc. v. Commercial Union Ins. Co.*, 908 A.2d 888 (Pa. 2006); *L-J, Inc. v. Bituminous Fire & Marine Ins. Co.*, 621 S.E.2d 33 (S.C. 2005); but see *Travelers Indem. Co. of Am. v. Moore & Associates, Inc.*, 216 S.W.3d 302 (Tenn. 2007); *Lee Builders, Inc. v. Farm Bureau Mut. Ins. Co.*, 137 P.3d 486 (Kan. 2006); *Am. Family Mut. Ins. Co. v. Am. Girl, Inc.*, 673 N.W.2d 65 (Wis. 2004).] Florida will soon enter the fray. [*J.S.U.B., Inc. v. U.S. Fire Ins. Co.*, 906 So.2d 303 (Fla. Ct. App. 2005), *pet. granted*, 925 So. 2d 1032 (Fla. 2006).]

For those reasons, the Fifth Circuit Court of Appeals certified questions involving these issues (as well as a bad faith issue) to the Supreme Court of Texas:

1. When a homebuyer sues his general contractor for construction defects and alleges only damage to or loss of use of the home itself, do such allegations allege an "accident" or "occurrence" sufficient to trigger the duty to defend or indemnify under a CGL policy?

2. When a homebuyer sues his general contractor for construction defects and alleges only damage to or loss of use of the home itself, do such allegations allege "property damage" sufficient to trigger the duty to defend or indemnify under a CGL policy?

3. If the answers to certified questions 1 and 2 are answered in the affirmative, does Article 21.55 of the Texas Insurance Code apply to a CGL insurer's breach of the duty to defend?

Texas Favors the Insured. On August 31, 2007, in a 6-3 opinion, the Supreme Court of Texas "conclude[d] that allegations of unintended construction defects may constitute an 'accident' or 'occurrence' under the CGL policy and that allegations of damage to, or loss of use of, the home itself may also constitute 'property damage' sufficient to trigger the duty to defend under a CGL policy." Addressing the third certified question, the court said, "We further conclude that the prompt-payment statute, formerly article 21.55, and now codified as sections 542.051-.061 of the Texas Insurance Code, may be applied when an insurer wrongfully refuses to promptly pay a defense benefit owed to the insured."

The Court rejected Mid-Continent's three main arguments against coverage. First, the Court dismissed Mid-Continent's claim that a CGL policy's purpose is to protect the insured from tort liability, not claims for defective performance under a contract. Second, Texas' high court brushed aside Mid-Continent's belief that defective work cannot be an "occurrence" because it is not accidental or, in other words, that a general contractor should *expect* that faulty workmanship will result in damage to the project itself. Finally, the Court refused Mid-Continent's argument that extending CGL coverage to a general contractor for damage to the project itself transforms a CGL policy into a performance bond.

In dismissing the contract versus tort distinction, the Court noted that Mid-Continent's reliance on the economic-loss rule was misplaced finding that it "is not a useful tool for determining insurance coverage." Moreover, the Court noted that "the CGL policy makes no distinction between tort and contract damages" and that the "insuring agreement does not mention torts, contracts, or economic losses; nor do these terms appear in the definitions of 'property damage' or 'occurrence.'" In other words, the Court, in following precedent, held that "the label attached to the cause of action-whether it be tort, contract, or warranty-does not determine the duty to defend." [*See Farmers Tex. County Mut. Ins. Co. v. Griffin*, 955 S.W.2d 81, 82 (Tex. 1997).]

Turning to Mid-Continent's second argument, the Court refused to accept "foreseeability" as "the boundary between accidental and intentional conduct," as that would render insurance illusory. The Court found that Mid-Continent's "argument includes a false assumption that the failure to perform under a contract is always intentional (or stated differently 'that an accident can never exist apart from a tort claim')." Thus, as the Court said, "a claim does not involve an accident or occurrence when either direct allegations purport that the insured intended the injury (which is presumed in cases of intentional tort) or circumstances confirm that the resulting damage was the natural and expected result of the insured's actions, that is, was highly probable whether the insured was negligent or not." Moreover, the term "occurrence" is not defined "in terms of the ownership or character of the property damaged by the act or event. Rather, the policy asks whether the injury was intended or fortuitous, that is, whether the injury was an accident." No one alleged that Lamar Homes intended or expected its work or its subcontractors' work to damage the home, so the Court concluded that the complaint in the underlying construction defect lawsuit alleged an "occurrence."

Addressing Mid-Continent's third argument, the Court concluded that coverage under a CGL policy and a performance bond are not necessarily mutually exclusive:

Any similarities between CGL insurance and a performance bond under these circumstances are irrelevant,

however. The CGL policy covers what it covers. No rule of construction operates to eliminate coverage simply because similar protection may be available through another insurance product.

With respect to the "property damage" requirement, the Court recognized that the "definition does not eliminate the general contractor's home" and that "allegations of cracking sheetrock and stone veneer are allegations of 'physical injury' to 'tangible property'" so as to qualify as "property damage."

Part of the Court's foundation for its affirmative answers to the first two certified questions was the presence of exclusions J5, J6 and L, otherwise known as the "business-risk" exclusions, which eliminate coverage for many construction-related losses. The "subcontractor exception" to exclusion L would be virtually meaningless, however, if faulty workmanship could not be "property damage" caused by an "occurrence" in the first place. The Court said that "when a general contractor becomes liable for damage to work performed by a subcontractor-or for damage to the general contractor's own work arising out of a subcontractor's work-the subcontractor exception preserves coverage that the 'your work' exclusion would otherwise negate."

In reaching this conclusion, the Court analyzed the evolution of the CGL policy and noted that inclusion of the "subcontractor exception" language was a purposeful addition to the CGL policy. *Id.* Likewise, although not in the policy issued to Lamar Homes, the Court noted that ISO has promulgated an endorsement (CG 22 94) that eliminates the "subcontractor exception" to exclusion L. *Id.*

Finally, the Court turned to the "prompt payment of claims" statute and, in particular, to the issue of whether a claim for breach of the duty to defend constitutes a "first-party claim" within the meaning of the statute. The Court recognized that a split existed between federal district courts, which had concluded that the statute applied to a breach of the duty to defend, and the state appellate courts that had concluded otherwise. Finding that a claim for breach of the duty to defend is a "first-party claim," the Court noted that "this loss belongs only to the insured and is in no way derivative of any loss suffered by a third party." Moreover, a "first-party claim" is not synonymous with a claim under a "first-party insurance policy." Further, the Court refused to accept Mid-Continent's position that the statute does not apply because the benefits are payable to the attorney rather than to the insured. Similarly, the Court rejected the contention that the statute was "unworkable in the context of the insured's claim for defense benefits" because "[a]s one amicus in this case submits, when the insurer wrongfully rejects its defense obligation, the insured has suffered an actual loss that is quantified after the insured retains counsel and begins receiving statements for legal services. These statements are the last piece of information needed to put a value on the insured's loss."

The Dissent Refuses to Read the Clear Terms of the CGL Policy. Justice Brister's dissent, which was joined by Justices Hecht and Willett, primarily focused on three things while refusing to find coverage: (i) the economic loss rule; (ii) the business risk rationale; and (iii) a law review article published in 1961. According to the dissent, "[s]elling damaged property is not the same as *damaging* property." In other words, the dissent contends that "Lamar Homes was sued for breaking promises, not for breaking property." Although contrary to what Lamar Homes argued, the dissent contended that "[e]very crack, stain, dent, leak, scratch, and short-circuit arising from a subcontractor's work (which will be most of them) must be repaired by the builder's insurer, who may have to pay the builder to repair its own home." Such a contention is without merit and ignores the business risk exclusions explicitly included in the CGL policy. In addition, both in its briefing and at oral argument, Lamar Homes readily acknowledged that a mere defect-in and of itself-does not constitute "property damage."

Moreover, while the dissent concedes that "the CGL policy does not distinguish between contract and tort claims, or mention economic loss," it nevertheless would hold that allegations of defective construction do not constitute "property damage" because such allegations are for pure economic loss. Likewise, the dissent concedes that "the subcontractor exception creates something of an anomaly when used in the construction industry" and that "the subcontractor exception has effectively rendered the CGL policy's your-work exclusion meaningless when issued to a general contractor," but nevertheless would rule against coverage based on the "property damage" definition. This reasoning, of course, violates well-established contract interpretation principles that require the policy to be read as a

whole and to give meaning to all parts of a policy.

Finally, despite readily acknowledging the split in authority in Texas, as well as nationwide, the dissent characterized the Court's opinion as adopting a minority view. The majority, on the other hand, contends that "[a]fter examining the dissent's list, we conclude that the dissent has neither discovered a majority rule nor analyzed this case to fit within it."

The dissent did not address the article 21.55 issue.

Conclusion

Although most "property damage" and "occurrence" cases like *Lamar Homes* arose in the context of residential construction, the Court's holdings are in no way limited to the residential construction defect context. Whether the insured is a homebuilder that builds ten homes a year or a large commercial contractor that builds stadiums, the definitions of "property damage" and "occurrence" are the same. Likewise, for the most part, the business risk exclusions are the same. Accordingly, at least in those policies that do not have endorsement CG 22 94, or similar endorsement, that eliminates the subcontractor exception, *Lamar Homes* should have far-reaching implications on how defective construction claims are adjusted. In particular, virtually every construction defect claim against a general contractor implicates the "property damage" and "occurrence" requirements. Moreover, the "prompt payment of claims" statute will provide CGL insurers an incentive to think twice before denying a defense.

At bottom, the clear difference between the majority opinion and Justice Brister's dissent is that the former applied the policy as written, while the latter relied on extraneous legal theories such as the economic loss rule and the business risk rationale, largely ignoring the actual policy language.

Finally, the Court acknowledged that it has similar issues pending in six separate petitions for review, but issued only the *Lamar Homes* opinion. In one such case, *Pine Oak Builders, Inc. v. Great American Lloyds Insurance Company*, LexisNexis 2007 Tex. LEXIS 741 (Tex. App.-Houston [14th Dist.] July 6, 2006, pet. granted), the Court granted the petition. That case involves the same issues decided in *Lamar Homes*, but also contains issues as to the proper "trigger" theory to be applied to "property damage" cases as well as whether a "coverage only" exception exists to the "eight corners" rule. Aside from *Pine Oak Builders*, it will be interesting to see whether the Court uses the other pending cases to further clarify its stance on the "property damage" and "occurrence" issues or whether it will simply issue one-page opinions that follow form to *Lamar Homes*. Stay tuned for further details.

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Heintz & Kanemitsu on Aero-Jet Gen. Corp. v. Commercial Union Ins. Co.

2008 Emerging Issues 1317

John E. Heintz and Marla H. Kanemitsu on Aero-Jet General Corp. v. Commercial Union Insurance Company

By John E. Heintz and Marla H. Kanemitsu

December 4, 2007

SUMMARY: A California Court of Appeal has held that insurance companies are not liable under the terms of standard comprehensive general liability policies to indemnify policyholders for settlement agreements. This Emerging Issues Analysis discusses the implications of the courts decision and provides some practice tips for counsel representing policyholder clients contemplating settlement of a claim for which its insurer has denied coverage.

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ARTICLE: Overview

In an opinion that could wreak havoc for policyholders, a California Court of Appeals recently held that insurance companies are not liable under the terms of standard comprehensive general liability (CGL) policies to indemnify policyholders for settlement agreements. That opinion, *Aerojet-General Corp. v. Commercial Union Insurance Co.*, 155 Cal. App. 4th 132 (Ct. App. 2007), held that insurance companies are only obligated to indemnify policyholders for amounts they are ordered to pay by a court, not amounts they agree to pay as a result of a settlement agreement. Thus, a policyholder who decides to settle litigation against it, instead of allowing the suit to proceed to judgment, in effect forfeits its rights to coverage for the claim.

The *Aerojet* decision has far-ranging implications for policyholders whose insurers have denied coverage. This commentary discusses some of those implications and provides some practice tips for counsel representing policyholder clients contemplating settlement of a claim for which its insurer has denied coverage.

Background

The *Aerojet* case involved a dispute over insurance coverage for environmental claims. In 2000 and 2001, various California state agencies sued Aerojet alleging it was liable under CERCLA and related laws for the costs to remedy alleged groundwater contamination in the San Gabriel Valley. *Aerojet*, 155 Cal. App. 4th at 136. All of Aerojet's excess insurers denied coverage for the suits. In 2002, Aerojet settled the suits for approximately \$175 million. Aerojet then sued its excess insurers seeking indemnification for the settlement. *Aerojet*, 155 Cal. App. 4th at 136.

The policies at issue were CGL policies. The policies provided (with some slight variations) that the insurers would indemnify Aerojet for "all sums which the Assured shall become legally obligated to pay, or by final judgment be adjudged to pay, to any person or persons as damages" *Aerojet*, 155 Cal. App. 4th at 136. The excess insurers contended that the term "damages" meant damages "awarded against the insured by a court." *Aerojet*, 155 Cal. App. 4th at 136. They argued that because the environmental suits "were settled and not adjudicated against Aerojet to an award of damages," they were not obligated to indemnify Aerojet for the claims. *Aerojet*, 155 Cal. App. 4th at 136.

The California Court of Appeals agreed with the excess insurers, relying heavily on a case decided in 2001 by the California Supreme Court, *Certain Underwriters at Lloyd's of London v. Superior Court*, 24 Cal. 4th 945 (2001) ("*Powerine I*"). In *Powerine I*, the California Supreme Court held that the duty to indemnify a policyholder for "damages" was limited to "money ordered by a court" and did not "extend to expenses required by an administrative agency pursuant to an environmental statute." *Certain Underwriters at Lloyd's of London v. Superior Court*, 24 Cal. 4th at 971. Reading *Powerine I* literally, the *Aerojet* court held that "the term 'damages' as interpreted in *Powerine I* and used in liability insurance indemnity provisions means only money ordered by a court to be paid." *Aerojet*, 155 Cal. App. 4th at 143.

The court reasoned that because Aerojet had settled its environmental suits and there were no judgments entered in the record, only stipulations and orders for dismissal without prejudice, "the settlement costs are outside the scope of indemnity coverage in [the insurers'] policies." *Aerojet*, 155 Cal. App. 4th at 143.

Implications for Policyholders

Although *Aerojet* arose in the context of a coverage dispute for environmental claims, its scope may be much broader. The "damages" language construed by the court exists in almost all CGL policies. If the decision is upheld on appeal, it could potentially affect all types of policyholders, from non-profits to Fortune 500 corporations. The implications of the decision for policyholders are troublesome.

The Catch-22. The practical effect of the holding is to force policyholders whose insurers have denied coverage into a catch-22 position. If a policyholder enters into a settlement to resolve the underlying lawsuit against the policyholder, under *Aerojet*, the insurance company is absolved of its obligation to provide coverage for the settlement.

If, on the other hand, the policyholder decides to litigate the underlying suit to judgment, the judgment could end up being massive, and the policyholder would be still left to litigate with its insurers over whether the judgment is or is not covered. If it turns out not to be covered, the policyholder would be liable for the full amount of the judgment.

In other words, the policyholder is left to choose between a settlement that it will have to fund on its own, or a potentially larger judgment that might or might not be covered by insurance.

A Possible, But Perhaps Not Very Appealing, Loophole. The *Aerojet* court did allude to one possible escape from this conundrum. The court suggested that if *Aerojet* and the state agencies "sought for the terms of the agreement to be entered as the judgments in the lawsuits," the settlement amount may have been covered. *Aerojet*, 155 Cal. App. 4th at 144.

This option is not without its own potential risks. First, the language is dicta, and it is therefore uncertain whether such a judgment would, in fact, be deemed "damages" by a court.

Second, there is the obvious concern that having a judgment entered against a policyholder may present other problems that would outweigh the possible benefits of this course of action. Companies don't like to have judgments entered against them, as it invites more claims and is a red flag in the financial community. Moreover, insurers may still attack such judgments as collusive.

The Decline of Mediation and Settlement. The likely long-term effect of the *Aerojet* rule will be to discourage mediation and settlement of underlying claims. Any policyholder who knows that a settlement will result, or could result, in a forfeiture of coverage will be far less willing to consider the possibility of settlement.

If the policyholder does consider it at all, it will only be for an amount the policyholder knows it can afford to pay on its own, which, in most cases, will be lower than the settlement offer would be if insurance is potentially available. Such discounted offers may run into resistance both from the plaintiffs' attorneys and any mediators trying to mediate the underlying suit.

The likely result is that the *Aerojet* rule will discourage -- and in many cases foreclose -- mediation and settlement of underlying claims. Thus, whenever insurance is potentially available, settlements will become the exception rather than the rule, an outcome that harms all parties involved, including the courts.

Practice Tips For Policyholder Counsel With Clients Thinking About Settlement

Analyze the Law of the Relevant Jurisdiction, Which Might Follow A Different Rule. Counsel should be aware that the *Aerojet* ruling runs counter to the law in many other jurisdictions. Under most states' laws, when an insurer denies coverage for a third-party claim, the policyholder is entitled to settle the claim for a reasonable amount without jeopardizing its rights to coverage. See *Luria Bros. & Co., Inc. v. Alliance Assurance Co., Ltd.*, 780 F.2d 1082, 1091 (2d Cir. 1986) ("When an insurer declines coverage, as here, an insured may settle rather than proceed to trial to determine its legal liability"); *So. Guar. Ins. Co. v. Dowse*, 605 S.E.2d 27, 29 (Ga. 2004) ("an insurer that denies coverage and refuses to defend an action against its insured, . . . waives the provisions of the policy against a settlement by the insured and becomes bound to pay the amount of any settlement within a policy's limits made in good faith, plus expenses and attorneys' fees.") (internal quotation marks, alteration marks and citation omitted); *Guillen v. Potomac Ins. Co. of Ill.*, 785 N.E.2d 1, 11-12 (Ill. 2003) (noting insurer's concession that "generally speaking, once an insurer breaches its duty to defend, the insured may enter into a reasonable settlement agreement without foregoing its right to seek indemnification"); *Fireman's Fund Ins. Co. v. Sec. Ins. Co.*, 367 A.2d 864, 868 (N.J. 1976) ("Where an insurer wrongfully refuses coverage . . . the insurer is liable for the amount of the judgment obtained against the insured or of the settlement made by him.") (internal quotation marks and citation omitted).

It is therefore important for counsel to analyze choice of law issues carefully and determine how the law of the relevant state treats a policyholder's right to settle a claim when its insurer has breached its duty to defend and denied coverage. In states that have not addressed the issue, counsel for policyholders should inform their clients about the potential risk that the *Aerojet* rule could be applied in their case, and the ramifications of the rule for any settlement the client is contemplating. Failure to do so may have dire consequences for the client and could even put the attorney at risk for a malpractice claim.

Consider Negotiating With the Insurers. Generally, when an insurer denies coverage, policyholders have no obligation to involve the insurers in the defense of the underlying claim or any settlement negotiations. However, in light of *Aerojet*, policyholders who wish to settle a claim, but fear a loss of coverage could result, may want to consider opening a dialogue with their insurers, perhaps even involving the insurers in the settlement negotiations. By doing so, the policyholder may be able to persuade the insurer to agree not to deny coverage on the ground that it only owes coverage for court-ordered judgments.

At first blush, it may seem unlikely that an insurer would ever agree to this, but insurers may have strong incentives to reach such an agreement in some cases. When an insurer denies coverage, particularly in cases involving large insurance claims, the policyholder will challenge the denial in a coverage suit, and the insurer's coverage obligations ultimately will be decided by a court. Indeed, in some cases, insurers who deny coverage are *required* to file a declaratory judgment action to determine whether the denial was justified. See, e.g., *Shell Oil v. ACandS, Inc.*, 649 N.E.2d 946, 949 (Ill. App. Ct. 1995). Thus, in virtually every case, there is some risk to the insurer that it will lose the coverage case and be required to pay indemnity and defense costs for the claim.

A policyholder who is worried that a settlement could jeopardize its coverage rights will in many cases be unwilling or unable to settle the case, and will instead take the case to judgment. This is an incredibly risky venture for insurers. An adverse judgment in the underlying suit could result in massive liabilities and is sure to rack up substantial defense costs, all of which the insurer may ultimately be required to pay.

If the insurer decides that a proposed settlement of the underlying suit is reasonable, and the alternative is a potentially massive judgment and huge defense costs, the insurer may decide that the settlement is in the insurer's best interests. In order to facilitate that settlement, it may be willing to agree not to deny coverage on the ground that it only owes coverage for court-ordered judgments. The policyholder could then enter into the settlement, and the insurers' coverage obligations for the settlement and related defense costs would be decided in a subsequent coverage case.

Conclusion

The *Aerojet* decision should be of concern to all policyholders and their counsel, both inside and outside of California. Although decided under California law, the decision's impact may be much broader as other jurisdictions that have not decided the issue may look to the decision for guidance, or may determine to apply California law to particular claims. Counsel for policyholders considering settlement of underlying liability claims should evaluate the potential impact of the *Aerojet* decision and whether a proposed settlement could negatively impact their clients' coverage rights.

For information on insurance coverage for environmental claims, see *Environmental Coverage for Environmental Claims* 1 Insurance Coverage for Environmental Claims (LexisNexis Matthew Bender).

For sample CGL policies, search Legal>Area of Law -- By Topic>Insurance>Search Forms & Drafting Instructions>ISO Policy Forms.

For information on an insurer's duty to defend under CGL policies, see 22-136 Appleman on Insurance Law and Practice Ch. 136. (2d Ed. LexisNexis Matthew Bender).

For more information on a policyholder's options when an insurer breaches its duty to defend, see 1-5 *The Law of Liability Insurance* § 5.05 (LexisNexis Matthew Bender).

For more information on the meaning of the "as damages" language in CGL policies, 20-129 Appleman on Insurance § 129.2(F) (2d Ed. LexisNexis Matthew Bender).

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Repercussions of the Subprime Mortgage Crisis on CGL Insurance (I of III)

2008 Emerging Issues 2975

Repercussions of The Subprime Mortgage Crisis for The Insurance Industry: Whos Suing Whom and Who Has Coverage for What? Part I of III (CGL Policies)

By Matthew R. Wildermuth

December 2, 2007

SUMMARY: The tentacles of the current "subprime mortgage crisis" are destined to reach into every corner of financial institutions in the United States and abroad, including the insurance industry. In a three-part series, insurance coverage litigation expert Matthew R. Wildermuth, Esq. explores the claims arising out of this crisis. The first of these articles focuses on potential exposures under traditional commercial general liability policies

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ARTICLE: Introduction

The bold-lettered banner hanging in Hillary Rodham Clintons 2008 presidential campaign headquarters may well now read Its the Residential Subprime Mortgage Meltdown, Stupid. There is no escaping its current and potential impact on the U.S. economy and, to a lesser degree, the world economy. On December 6, 2007, the U.S.-based Mortgage Bankers Association reported that the number of mortgage loans at least 30 days past due has now reached its highest point since 1986 as foreclosure starts increased across all loan types [Mortgage Bankers Association, National Delinquency Survey, <http://www.mortgagebankers.org/ResearchandForecasts/ProductsandSurveys/NationalDelinquencySurvey.htm>]. Subprime adjustable rate mortgages (ARMs) showed the worst deterioration, with a full 4.72% of the outstanding loans starting the foreclosure process during the period [Mortgage Bankers Association, National Delinquency Survey, <http://www.mortgagebankers.org/ResearchandForecasts/ProductsandSurveys/NationalDelinquencySurvey.htm>].

The savings and loan crisis of the 1980s and 90s ultimately resonated deeply within the insurance industry as bankers, securities dealers, lawyers, accountants and others faced massive claims from government agencies seeking to recoup amounts the government (and taxpayers) paid to effect the bailout [see, e.g., Federal Deposit Insurance Corporation, Managing the Crisis: The FDIC and RTC Experience 19801994 (1998), <http://www.fdic.gov/bank/historical/managing/history1-11.pdf>]. In light of increasing scrutiny of the usual suspects in widespread financial losses, we can expect increasing pressure to be applied to the liability insurance industry to defend and indemnify parties found to be responsible for some of the losses. The questions then become which policies for what claims? In a three-part series, this commentary will identify the extent to which commercial general liability,

directors & officers liability and professional liability policies, respectively, may respond to coverage issues implicated by the residential subprime mortgage crisis.

The Subprime Mortgage Crisis As Relevant To Liability Insurers

It is beyond the scope of this commentary to address in any detail the causes of the crisis, the viability of the proposed remedies or the ultimate fallout of the subprime mortgage crisis. For purposes of this commentary, suffice it to say that the deepening housing slump has adversely affected the value of the collateral securing individual mortgage loans and that this problem is compounded exponentially by the packaging of large pools of mortgages into funds made available for investment by parties outside the traditional lending food chain. Through the first 10 months of 2007, the projected rate of foreclosure filings against individual property holders subject to the packaged mortgages was 1.8 million nationwide, compared to 1.3 million for all 12 months of 2006, and the home loan default rate has not yet peaked [see Jeannine Aversa (Associated Press writer), *Home foreclosures streak to record high in third quarter*, Dec. 6, 2007, available at www.chicagolawbulletin.com]. This wave of mortgage foreclosures threatens to make the most severe slump in housing even worse by dumping more foreclosed properties onto an already glutted market, further depressing home prices and shaking consumer confidence.

The Bush Administration unveiled on December 6, 2007 a plan designed to mitigate the crisis by allowing subprime borrowers who are living in their homes and are current on their payments to avoid a costly reset of their mortgage interest rate for five years. According to the Wall Street Journal, the plan Treasury Department officials and the big U.S. banks have negotiated is aimed in part at helping slow the rate of decline in home values that typically accompanies high default and foreclosure rates and threatens to push the overall domestic economy closer to recession [see Andy Laperriere, *No Bailouts for Borrowers*, Wall Street Journal, Dec. 4, 2007, at A21]. A New York Times article stated the proposed plan "would allow distressed borrowers who are current on their payments to keep their low introductory rates and escape an increase of 30% or more in their monthly payments when the rates expire" [Edmund L. Andrews & Vikas Bajaj, *Lenders Agree to Freeze Rates on Some Loans*, N.Y. Times, Dec. 6, 2007, at A1]. Apparently, the hope is that by that time, the housing downturn will have stabilized and cleared out the glut of unsold homes, thereby allowing the residential real estate market to correct itself in a less hostile environment.

However, as both newspapers note, the Administrations plan would exclude many subprime borrowers from the proposed relief, including borrowers that currently are late on their payments (approximately 22% of the subprime group). As a result, the plan likely will face objections from low-income borrowers who won't be helped, and from investors who backed now-troubled subprime home loans that are at the heart of the mortgage crisis [see Sudeep Reddy, Douglas Belkin and Jonathan Karp, *Some Cry Foul Over Relief Plan For Borrowers*, Wall Street Journal, Dec. 4, 2007, at D1]. As a result, some critics assail the plan as a band-aid approach designed to stabilize the credit markets until a more comprehensive approach can be implemented (or, more cynically, until after the 2008 elections) [see, e.g., Yves Smith, *A Few More Thoughts on Subprime Rescue Plan*, Naked Capitalism, blog posted Dec. 1, 2007(<http://www.nakedcapitalism.com/2007/12/few-more-thoughts-on-subprime-rescue.html>)].

As pertinent to this analysis, regardless of the success of the plan proposed above, hundreds of thousands of owner-occupied properties already have gone on the auction block, and no part of the proposed plan would require the mortgage holders that foreclosed to give those properties back and let the mortgagors back into their homes. (A less publicized but still problematic symptom of the foreclosure process is that it typically allows the foreclosing mortgage holder to void any existing leases, thereby putting scores of blameless tenants out on the street as well [see Kelly Evans, *Tenants Pay as Landlords Default: Foreclosures Void Leases, Bring Eviction Notices; Bigger-Building Benefit*, Wall Street Journal, Nov. 23, 2007, at A2]). Millions more residential property owners who have mortgages they currently cannot pay (or soon will be unable to pay) will not get relief from the current plan and will be hurt badly. Some yet-to-be determined percentage of borrowers in these groups inevitably will file suit against any participant in the mortgage lending food chain that can be held accountable and is capable of responding to a judgment for damages. Here

is where it gets most interesting for liability insurers.

Indeed, some of the early victims of the crisis have already initiated suit. To provide a realistic framework for evaluating the most prominent insurance coverage issues arising in connection with such claims under a standard CGL policy, I have fictionalized one such complaint obtained from public records in federal court (but only a little the actual facts plead are more egregious) [see *Dodson v. DHI Mortg. Co.*, 2007 U.S. Dist. LEXIS 88131 (E.D. Va. 2007) (originally filed in the United States District Court for the Western District of Texas as Case No. 1:07-cv-00230-SS)]. The allegations include the following claims:

1. Defendant U. O. Lots (U.O.) is a mortgage lender and is a subsidiary of Decepticon Construction, Inc., a large homebuilder (Decepticon).

2. Plaintiffs obtained a mortgage from U.O. to finance construction of their new home at 123 Meltdown Drive to be built by Decepticon for \$930,195 (the new home"). **At the time, the Plaintiffs disclosed to U.O. orally and in writing that their gross annual income was \$131,000 and provided written confirmation of their incomes to U.O. and Decepticon as required by the contract documents. The Plaintiffs thereafter dealt exclusively with mortgage broker Gordon Gecko (Gecko), an employee and agent of U.O. and Decepticon.**

3. Gecko reviewed or had the opportunity to review Plaintiffs numerous income verification documents and to recognize that a combined income of \$131,000, exclusive of other debt obligations, would not permit the Plaintiffs to purchase a home with a purchase price of more than \$900,000. Although Plaintiffs debt-to-income ratio was too high, Gecko nonetheless encouraged Plaintiffs to purchase their new home and created false documents to further the transaction. Specifically, Gecko encouraged Plaintiffs to finance their \$82,000 down payment by borrowing the money against the equity of the home in which Plaintiffs were residing at the time, located at 4 Closure Drive (the "old home) with the assurance that, once their new home was built, they could sell their old home quickly and use the proceeds to finance the new home.

4. Decepticon delayed construction of the new home because it did not have the proper permits. By the time it actually completed construction, the local housing market collapsed and Plaintiffs were unable to sell their old home.

5. Plaintiffs did not and would not have qualified for the mortgage on their new home but for Geckos fraud and misrepresentations. Gecko did not submit Plaintiffs' income verification or accompanying documents to U.O.'s underwriters for review and approval, and instead submitted a stated income loan.

6. Gecko also provided Plaintiffs differing Truth in Lending Disclosure Statements ("TILDS") that contradicted each other and contradicted the oral representations Gecko made regarding the applicable interest rate or rates that Plaintiffs would be paying over the life of their mortgage.

7. U.O.'s disclosures on the Truth in Lending Statements it provided Plaintiffs were deceptive and violated Truth in Lending Act (TILA) [15 U.S.C. § 1601 et seq.] requirements that mandate clear and conspicuous disclosure of loan costs. The net effect of U.O.'s conduct was to create conflicting, misleading and incomprehensible disclosures such that an ordinary consumer would be confused and unable to discern the true cost of the loan at issue as an annual percentage rate.

8. U.O. was negligent in its failure to ensure adequate internal safeguards existed in its underwriting processes to prevent the abuses perpetrated by Gecko. The application for a stated income loan does not relieve U.O. of its obligations to verify the stated income, and this duty could have easily been discharged by U.O. with a simple phone call or confirmation contact from U.O.'s underwriters to Plaintiffs. U.O. and Decepticon failed to act as reasonably prudent mortgage lenders and home builders in the same or similar circumstances should have acted.

9. U.O.'s misconduct was outrageous, willful, malicious, and conducted with such reckless disregard for Plaintiffs' well-being that it violates any and all any boundaries of decency in a civilized society. Plaintiffs seek exemplary and punitive damages to deter U.O. from repeating similar conduct in the future.

The complaint seeks to rescind the home purchase agreement and mortgage loan, restitution and disgorgement, liquidated and exemplary damages and compensation for mental anguish. [For a similar scenario, see Jonathan Karp and Miriam Jordan, *How the Subprime Mess Hit Poor Immigrant Groups*, Wall Street Journal, Dec. 6, 2007, at A1.]

Finally, even a cursory discussion of the current crisis would not be complete without acknowledging that, as one analyst points out, affordability issues alone do not explain the sudden surge in delinquencies and defaults [see US Residential Mortgage Special Report: *The Impact of Poor Underwriting Practices and Fraud in Subprime [Residential Mortgage Backed Securities] Performance*, Fitch Ratings-Structured Finance, Nov. 28, 2007 (the Fitch Report)]. The Fitch Report explains that rapidly increasing home prices allowed borrowers to resell or refinance properties quickly, masking the poor underwriting and fraud associated with the increases in affordability products such as stated income and no money down loans, all of which was exposed when the residential home market plummeted across the U.S. [the Fitch Report]. However, these factors alone did not explain the spike in borrowers underperformance, suggesting that factors such as fraud might be playing a significant role. While several other factors certainly contribute to the current climate, Fitch's audit of a sample of underperforming loan files disclosed the following prevalent characteristics:

- . Fraud based on occupancy misrepresentation (i.e., the borrowers stated intent was to occupy the property but never actually did so, likely in the interest of flipping the property);

- . Failure to flag or follow up on suspicious items on credit reports, particularly very high FICO scores the prospective borrowers obtained by being listed as authorized users on someone else's credit accounts; and

- . Failure to evaluate stated income loans for reasonability (i.e., the implausibility of the represented income in light of the borrowers work history, current assets and lifestyle).

[The Fitch Report.] These chickens can come home to roost at many levels of the mortgage-backed securities food chain, beginning with the defaulting borrower and resonating all the way up and back down the distribution channel based on the representations and warranties provided as the individual loans or aggregations of the loans moved through the stream of commerce. As the Fitch Report explains:

In RMBS [residential mortgage-backed securitization] transactions, reps and warranties are given by the originator, issuer or other appropriate party, covering several areas, including the legality of the mortgage loan, the lien status, and condition of the property. In addition, some of the reps and warranties address compliance with the originators underwriting standards and a smaller number of transactions have specific reps and warranties for fraud. However, there are several challenges to relying on reps and warranties to remove loans from RMBS deals for a breach due to underwriting or misrepresentation/fraud. For many subprime loans, the program guidelines allowed the originator to base qualification on features such as stated income. Assuming that the originators underwriting standards did not require the verification through another means, or that a reasonableness test be conducted, the failure to perform these steps would not be an exception to their underwriting standards. Therefore, if the borrower or broker misrepresented the actual income, it is fraud on their part, but is it a breach of the reps and warranties? The same question would apply to borrowers who have artificially enhanced their FICO [i.e., credit score].

[The Fitch Report at pp. 8-9.] Although most of the agreements that package and pool these risks provide recourse to the extent any party in the chain knew or became aware of a fraudulent submission or

misrepresentation by requiring the transaction partner to repurchase the offending loan(s), the issue of whether such breaches on individual loans support rescission as to the entire pool (requiring the complaining entity to give back any profitable loans as well) or merely support a claim for damages remains a murky issue. This lack of clarity will contribute to the wave of litigation likely to occur at the borrower/originator/lender level.

General Principles Regarding The Scope Of Coverage Under Commercial General Liability Policies

The Insuring Agreement in a typical commercial general liability primary policy (CGL) n1 reads as follows:

We will pay those sums that the insured becomes legally obligated to pay as damages because of bodily injury, property damage, personal injury or advertising injury arising out of an occurrence. We will have the right and duty to defend any suit seeking those damages. We may at our discretion investigate any occurrence and settle any claim or suit that may result.

A fundamental component of the primary CGL policy is the insurers obligation to assume and pay for the insureds defense against claims for which there is any potentiality for coverage. Courts in most states employ the same basic approach to evaluate whether the asserted claims create the potential for coverage:

In determining whether an insurer owes its insured a duty to defend, a court looks to the allegations in the underlying complaint against the insured and compares those allegations to the relevant coverage provisions of the insurance policy ... If the facts alleged in the underlying complaint fall within or potentially fall within the coverage of the policy, the insurer's duty to defend is triggered. [citation omitted] Policies are liberally construed in favor of the insured, and any ambiguities or conflicts are resolved in favor of coverage [*Canadian Radium & Uranium Corp. v. Indemnity Ins. Co.*, 411 Ill. 325, 332 (Ill. 1952)].

[See, e.g., *Employers Ins. v. Ehlco Liquidating Trust*, 186 Ill. 2d 127, 150 (1999) (applying Illinois law); see also *Res. Bankshares Corp. v. St. Paul Mercury Ins. Co.*, 407 F.3d 631, 636 (4th Cir. 2005) (under Virginia law, an insurers obligation to defend an action depends on comparison of the policy language with the underlying complaint to determine whether the claims alleged therein are covered by the policy).]

In contrast, in order for the insurer to be liable under the policy to indemnify its insured in respect of an underlying claim that has resulted in a judgment or a settlement against it, the insured must prove that the facts developed and claims adjudicated following the filing of the complaint actually come within the scope of coverage under the policy and are not subject to any policy exclusions [see, e.g., *Crum & Forster Corp. v. Resolution Trust Corp.*, 156 Ill. 2d 384, 397-398 (1993) (the duty to indemnify arises only in circumstances of actual coverage; if the insurance policy does not cover what is alleged in the claim, the insurer will not have a duty to indemnify based on that claim)]. This framework requires the court to measure the language of the policy against the outcome of the underlying proceeding, without regard to whether the potential for coverage existed at the time the claimant originally sought relief against the insured [see, e.g., *Crum & Forster Corp. v. Resolution Trust Corp.*, 156 Ill. 2d 384, 397-398 (1993)]. In other words, unless the insured is found legally liable for conduct for which the policy actually provides coverage, the insurer has no duty to indemnify the insured even if the potential for coverage required it to defend the claims.

At the risk of oversimplifying the issue, the coverage available under the modern CGL form anticipates application to loss arising from the breach of a duty imposed by law independent of any duties the parties may owe each other pursuant to a contractual relationship in other words, tort liabilities [see generally *Data Specialties v. Transcontinental Ins. Co.*, 125 F.3d 909, 912-913 (5th Cir. 1997)]. The policy presupposes that no contractual relationship exists between its policyholder and any future claimant and therefore expressly excludes its application to liabilities assumed under a

contract (with limited exception). Specifically, policy exclusion b. states that the policy does not apply to bodily injury or property damage for which the insured is obligated to pay damages by reason of the assumption of liability under a contract or agreement.

Similarly, the policy will expressly exclude coverage for Bodily injury, property damage, personal injury or advertising injury due to the rendering or failure to render any professional service, as the relationship between the prospective claimant and the policyholder will be governed by statute, contractual or quasi-contractual agreements and expert standards of care [see, e.g., *Natural Gas Pipeline Co. v. Odom Offshore Surveys, Inc.*, 697 F. Supp. 921, 926 (E.D. La. 1988)]. As the second and third installments of this commentary will address, however, the fact that the modern CGL policy does not respond to losses of this nature is best explained by the fact that economic losses caused by failure to comply with statutorily mandated practices and procedures in the selling and servicing of a residential mortgage loan may well be subject to coverage under errors & omissions/professional liability policies or directors and officers coverage in connection with alleged bad investment advice.

With these principles in mind, we measure the specific allegations of our fictionalized complaint above (Complaint) against the operative policy provisions. First, nothing in the Complaint indicates that there was any physical harm to any tangible property. The policy defines property damage as physical injury to tangible property, including all resulting loss of use of that property or loss of use of tangible property that is not physically injured. Similarly, the Complaint does not allege any loss of use of tangible property (i.e., property that is capable of being handled or touched). Hence, there is no physical injury alleged.

But what about metaphysical injury such as the loss of the value of the home to the borrower? Simply put, economic losses arising out of disappointed commercial expectations are not considered by courts to constitute damage to tangible property as the modern CGL form uses that term. [See, e.g., *Hartford Accident & Indem. Co. v. Case Foundation Co.*, 10 Ill. App. 3d 115, 123-124 (1973) (investments, anticipated profits and financial interests in business ventures are not tangible property).] Similarly, virtually every court that has addressed the issue has rejected the proposition that pure economic losses qualify for coverage as damage to or loss of use of tangible property [*Giddings v. Industrial Indemnity Co.*, 112 Cal. App. 3d 213, 216-217 (1980) (economic loss is not damage or injury to tangible property covered by a comprehensive general liability policy); *Travelers Ins. Cos. v. Penda Corp.*, 974 F.2d 823 (7th Cir. 1992) (damages for inadequate value or consequent loss of profits without any claim of bodily injury or damage to other property is not property damage under the CGL policy)].

Along similar lines, no matter how real the fear and anguish consumers and investors experience as a result of these dramatic changes of fortune may be, such circumstances do not, standing alone, qualify for coverage under the modern CGL policy form. If the underlying economic loss is not covered under the CGL policy (as discussed above), then any derivative claim for emotional distress arising out of that economic loss likewise is not recoverable [see, e.g., *Keating v. National Union Fire Ins. Co.*, 995 F.2d 154 (9th Cir. 1993) (policy covers losses resulting from accidental events which cause bodily injury or property damage, not the giving of professional or investment advice); *First Investors Corp. v. Liberty Mut. Ins. Co.*, 152 F.3d 162, 166-167 (2d Cir. 1998) (CGL insurer had no duty to defend against claim for emotional distress arising out of economic losses caused by securities fraud)].

How about bodily injury? Predictably, borrowers losing their homes suffer anxiety, headaches, nausea and the like. The policy defines bodily injury as bodily injury, sickness or disease sustained by a person, including death resulting from any of these at any time. Though not completely foreclosed as a theory under which coverage might attach, most courts interpret the phrase bodily injury to include only claims for physical injury and to exclude claims for non-physical or emotional harm that is not derivative of a precipitating physical event [Holmes' Appleman on Insurance 2d § 129.2[D][1]]. Moreover, although some courts might construe the policy to cover such claims, the policyholder may win the battle but lose the war upon consideration of whether the harm was the result of an accident or coverage is otherwise barred by an exclusion (addressed below).

Next up is personal injury, defined as means injury, other than bodily injury, arising out of one or more of the

following offenses:

- a. False arrest, detention or imprisonment;
- b. Malicious prosecution;
- c. The wrongful eviction from, wrongful entry into, or invasion of the right of private occupancy of a room, dwelling or premises that a person occupies, by or on behalf of its owner, landlord or lessor;
- d. Oral or written publication of material that slanders or libels a person or organization or disparages a persons or organizations goods, products or services; or
- e. Oral or written publication of material that violates a persons right of privacy.

Of these, only c and e have any potential to the allegations of the Complaint above, and that potential is defeated fairly easily. Much as the borrower may wish to characterize the process by which he or she is forcibly removed from the premises in which he or she lives, a default in payment under the mortgage eliminates the borrowers claim that the actions taken by the owner are wrongful. Similarly, the foreclosing entity is not likely to be liable for a publication that is not privileged (contractually or judicially) unless it acts well outside the scope of what is necessary to exercise its rights under the mortgage. Of the many things that lenders and their agents are being accused of doing wrong, this does not seem to be one of them.

This leaves advertising injury as the last potential avenue for recovery under the CGL policy based on the Complaint at issue here. The policy defines advertising injury to mean injury arising out of one or more of the following offenses:

- a. Oral or written publication of material that slanders or libels a person or organization or disparages a persons or organizations goods, products or services;
- b. Oral or written publication of material that violates a persons right of privacy;
- c. Misappropriation of advertising ideas or style of doing business; or
- d. Infringement of copyright, title or slogan.

Here, too, it appears that only the claim for violation of a persons right of privacy is implicated here. For the reasons discussed above, there is little ground to be gained here.

To the extent a court were to find that the allegations of the Complaint fell within the scope of one of these coverage types, the policyholder would then have to overcome issues regarding the non-accidental nature of the damages. The policy defines an occurrence as an accident, including continuous or repeated exposure to substantially the same general harmful conditions. The Complaint specifically alleges that Gecko, U.O. and Decepticon intentionally misrepresented the facts, willfully violated the Truth in Lending Act [15 U.S.C. § 1601 *et seq.*] and common law and otherwise acted toward plaintiffs in a manner that was malicious.

These allegations expose the policyholders to the defense that the Complaint does not allege an accident. With no accident, there is no occurrence and, therefore, no insurable event. A determination whether the policyholders conduct rises to the level of actual or inferred intent to cause harm likely will involve specific factual inquiries regarding the basis for the policyholders actions, and it would be foolhardy for policyholders to presume that insurers will not exploit the opportunity to make such inquiries in the appropriate cases [*see, e.g., Prime TV, LLC v. Travelers Ins. Co.*, 223 F. Supp. 2d 744 (M.D.N.C. 2002) (the intent component of the "occurrence" analysis requires a subjective inquiry); *Waste Management of Carolinas, Inc. v. Peerless Ins. Co.*, 315 N.C. 688, 696 (1986) ("Whether events are accidental' and constitute an occurrence' depends upon whether they were expected or intended from the point of view of the

insured.")]. Similarly, insurers may assert that such allegations trigger the exclusion for damages expected or intended from the standpoint of the insured. Although application of the expected/intended exclusion requires a slightly different analytical approach from the no accident defense (the latter prevents coverage from attaching in the first instance), discovery regarding its potential application would require the same or a similar inquiry into the policyholders motives.

These allegations also bring into play the standard policy exclusion for personal injury or advertising injury arising out of the willful violation of a penal statute or ordinance committed by or with the consent of the insured. The Complaint alleges that Geckos and U.O.s disclosures regarding material terms of the mortgage, including annual percentage rates and the balloon payment feature, did not conspicuously and clearly disclose the total cost of the credit provided under the mortgage as TILA requires.

The determination of the applicability of this exclusion will depend on whether courts construe the TILA to be a penal or remedial statute. For some purposes, at least, the Seventh Circuit Court of Appeals has treated TILA as a remedial statute [see *Smith v. No. 2 Galesburg Crown Finance Corp.*, 615 F.2d 407, 414-415 (7th Cir. 1980)]. Accordingly, if the coverage claim survives to this point, the exclusion for willful violation of a penal statute might not bar recovery.

Conclusion

Time will tell whether the current crisis in subprime lending is amenable to a short-term fix while the credit markets stabilize or whether the current plan merely postpones an ultimate day of reckoning. Regardless of whose projections carry the day, there will be no shortage of litigation along the way as the interests that suffer the most will seek recourse wherever they can find it. For the reasons set forth above, however, it is unlikely that CGL insurers will bear the brunt of this particular misfortune.

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n1 . By typical CGL policy, I refer to the occurrence-based policy form introduced by the Insurance Services Office in 1986, and subsequently amended, to replace the prior policy form denominated as the comprehensive general liability policy form (also abbreviated at the time as CGL coverage). As pertinent here, the more recent ISO CGL form includes broad coverage for bodily injury and property damage liability (Coverage A) and personal injury and advertising injury liability (Coverage B) subject to reductions in scope by endorsement. See Rupp's Insurance & Risk Management Glossary, <http://insurance.cch.com/RUPPS/commercial-general-liability-policy.htm>.

RELATED LINKS: For Further Discussion of the Insurance Coverage Implications of Subprime Mortgages, see
 ■ Mealey's Emerging Insurance Disputes 17 (2007).

For Discussion of State Responses to Subprime Mortgage Lending, see
 ■ Real Estate Financing Special Alert: More State Governmental Responses to Problems in the Subprime Mortgage Loan Origination Business.

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Rabine on Gutierrez v. Temp Star Services

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Rabine on Gutierrez v. Temp Star Services

By Merle C. Rabine

November 27, 2007

SUMMARY: Recent interest in California Workers' Compensation Appeals Board panel decisions has been fueled by continuing uncertainty of interpretation of parts of Senate Bill 899 and by discussion and debate on the Internet. This Emerging Issues Analysis examines a recent panel decision, *Gutierrez v. Temp Star Services*, 2007 Cal. Wrk. Comp. P.D. LEXIS 50, in which the panel addressed the ongoing problem of determining liability.

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ARTICLE: Despite recent interest in California Workers' Compensation Appeals Board panel decisions, fueled by continuing uncertainty of interpretation of parts of Senate Bill 899 and by discussion and debate on the Internet, most panel decisions are of little interest to anyone other than the parties whose case is being decided. When the Appeals Board wants to announce a position on a substantive or procedural issue, it does so by issuing an en banc decision or significant panel decision [see http://www.dir.ca.gov/WCAB/wcab_dars.htm]. Panel decisions, however, tend to be case-specific with the result determined by the facts of the case. Moreover, while Appeals Board panel decisions are citeable authority, particularly on issues of contemporaneous administrative construction of statutory language [see *Griffin v. WCAB*, 209 Cal. App. 3d 1260, 1264 (1989), fn 2, 54 Cal. Comp. Cas 145], they are not binding precedent, as are en banc decisions, on all other Appeals Board panels and workers' compensation judges [see *Gee v. Workers' Comp. Appeals Bd.*, 96 Cal. App. 4th 1418, 1425 (2002) fn. 6, 67 Cal. Comp. Cas 236].

This commentary examines a recent attempt of an insurer of a special employer to establish that it did not intend to cover employees of a temporary staffing agency (general employer) now covered by the California Insurance Guarantee Association (CIGA). Because the insurer placed in evidence only its policy, which did not explicitly exclude general employees, it failed to meet its burden of proof.

Special employers workers compensation insurance policy is not sufficient to prove that the special employer did not intend to cover general employees as against CIGA without other evidence: *Gutierrez v. Temp Star Services*, 2007 Cal. Wrk. Comp. P.D. LEXIS 50 (Appeals Board panel decision). *Gutierrez v. Temp Star Services*, 2007 Cal. Wrk. Comp. P.D. LEXIS 50 (Appeals Board panel decision) is the latest episode in the ongoing soap opera, CIGA and the General and Special Employers. It has been going on for five years, and the end is not in sight.

When the workers compensation insurance industry started to collapse at the beginning of this century, it turned out that the temporary staffing industry in California was insured by a number of entities that were disappearing into liquidation, with some liabilities assumed by CIGA. The claims of one such temporary staffing agency, Remedy Temp, and its special employers were consolidated at the trial level in 2002 for determination of whether the claims of Remedy Temp employees were covered claims under Calif. Insurance Code § 1063(c)(1) or whether insurance of the special employers was other insurance under Calif. Insurance Code § 1063(c)(9).

On October 31, 2002, Workers' Compensation Judge Robert Hjelle decided that the insurance of the special employers was other insurance, and dismissed CIGA as a party defendant. The Appeals Board affirmed in *Miceli v. Jacuzzi, Inc.*, 68 Cal. Comp. Cases 434 (2003) (Appeals Board en banc opinion). The Court of Appeal also affirmed. However, after rehearing, the Court of Appeal reversed in *General Casualty Insurance v. Workers Comp. Appeals Bd.*, 70 Cal. Comp. Cases 953 (2005) (subsequently ordered depublished by the Supreme Court). After reviewing the policy of Jacuzzi and its insurer, as well as submissions from the Department of Insurance and the Workers Compensation Insurance Rating Bureau, the court determined that neither Jacuzzi nor its carrier intended to cover special employees like Miceli. Therefore, the court held that Jacuzzi's insurance was not other insurance and that CIGA was liable for its covered claim.

On remand, the Appeals Board rescinded the consolidation order and its associated stay of proceedings. The Board stated: Because the consolidation and stay order is rescinded, each case previously covered by that order must now be individually addressed on its own particular facts. With regard to the application of *Insurance Code section 1063.1(c)(9)*, individual consideration of each case may require consideration of the particular insurance policies and endorsements in effect in each case. If it is found in a case that other insurance within the meaning of *Insurance Code section 1063.1(c)(9)* is available to an applicant, an order dismissing CIGA may be appropriate. If it is found that other insurance within the meaning of *Insurance Code section 1063.1(c)(9)* is not available to an applicant, an order dismissing CIGA would not be appropriate, but an order dismissing the general employer may be appropriate. Each case must be addressed on its own facts (*Miceli v. Jacuzzi, Inc.*, 71 Cal. Comp. Cases 599, 605 (2006) (Appeals Board en banc opinion)).

This brings us to Mr. Gutierrez, who suffered an industrial injury on June 10, 1999, in the course of performing duties for special employer Caitac, insured by Tokio Marine, while on the payroll of general employer Temp Star, then insured by Superior National Insurance Co., now liquidated and covered by CIGA. After trial, the WCJ determined that Tokio Marine's insurance policy indicates no intent to extend insurance coverage to special employees such as this applicant.

The Appeals Board panel reversed. The panel stated: Tokio argues in favor of the WCJs view that the intent of the parties is sufficiently evidenced by the provisions in the insurance policy regarding the payment of premiums. However, there is no evidence in the record that Tokio did not receive a premium to provide workers compensation insurance to special employees. Nor is there evidence that Temp Star and Caitac agreed that Temp Star would be solely responsible for providing workers compensation coverage for special employees or that workers compensation coverage for special employees would not be available through Tokio. The policy language regarding payment of premiums is not dispositive regarding the intentions of the parties, and we do not find that such intent can be persuasively inferred from that language *in the absence of other evidence* (emphasis added).

Thus, despite the Court of Appeals decision in *General Casualty (Miceli)*, the insurers of special employers will not escape liability when the general employer is now covered by CIGA on the basis of the insurance policy alone. The problem for the insurers of special employers is that, in 1999, it was very unlikely that anybody was thinking about the consequences of liquidation of insurers of general employers, since the wave of liquidations did not start until 2000. If the insurers of special employers are serious about escaping liability in these cases, they will have to present other evidence in addition to their policies, unless the policies include specific exclusions of special employees. That other evidence might include internal memoranda of special employers about what they did or did not wish to exclude, contracts between the general and special employers, and/or testimony of the participants about what they intended.

Otherwise, this panel decision seems to make it clear that if the insurer of the special employer does not present a serious case, it can expect to lose. CIGA wins again.

For further discussion of "other insurance" and CIGA, see Hanna, *California Law of Employee Injuries and Workers' Compensation* §§ 2.80, 2.84, Herlick, *California Workers' Compensation Law* § 3.34.

For general discussion of lent employees, see *Larson's Workers' Compensation Law* § 67.01 et seq.

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Sumwalt on the Physician-Patient Privilege in Workers Compensation Cases

2008 Emerging Issues 1062

Sumwalt on the Physician-Patient Privilege in Workers Compensation Cases

By Vernon Sumwalt

November 20, 2007

SUMMARY: Popularized by the medical malpractice case of *Crist v. Moffatt*, 326 N.C. 326, 389 S.E.2d 41 (1990), the physician-patient privilege has become one of the most litigated evidentiary issues in workers compensation cases since the North Carolina Court of Appeals endorsed Crist's application in *Salaam v. North Carolina Department of Transportation*, 122 N.C. App. 83, 468 S.E.2d 536 (1996).

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ARTICLE: For years, many appellate decisions in North Carolina have looked at the propriety of communications between parties and medical providers during litigation. Popularized by the medical malpractice case of *Crist v. Moffatt*, 326 N.C. 326, 389 S.E.2d 41 (1990), the physician-patient privilege has become one of the most litigated evidentiary issues in workers' compensation cases since the North Carolina Court of Appeals endorsed *Crist's* application in *Salaam v. North Carolina Department of Transportation*, 122 N.C. App. 83, 468 S.E.2d 536 (1996). This controversy led to the enactment of N.C. Gen. Stat. § 97-25.6 in late 2005, which did not so much change the law as it provided a more detailed map for previous routes to medical information. Still, the last two years of litigation has further developed--and clarified--this issue in cases arising under the North Carolina Workers' Compensation Act.

This Emerging Issues Analysis lays out the basic theory of the physician-patient privilege and provides advice on how to avoid its pitfalls in practice.

Introducing the physician-patient privilege. Most attorneys call this controversy the *Salaam* issue, although this casual reference mischaracterizes the issue as one that originates judicially rather than statutorily.

At common law no privilege existed as to communications between physician and patient. The physician, when called upon to testify, had no right to decline or refuse to disclose information on the ground that such information had been communicated to him confidentially in the course of his attendance upon or treatment of his patient in a professional capacity. *The public interest in the disclosure of all facts relevant to a litigated issue was deemed to be superior to the policy of recognizing, for the benefit of the patient, the inviolability of confidential communications.* Hence, statutes have been enacted in practically every jurisdiction making communications between physician and

patient privileged from compulsory disclosure. . . . In some jurisdictions, the privilege is absolute, and in others qualified.

State v. Martin, 182 N.C. 846, 849, 109 S.E. 74, 76 (1921). The case of *Shelton v. Morehead Memorial Hospital* noted that the physician-patient privilege is qualified in North Carolina. *See* 318 N.C. 76, 86, 347 S.E.2d 824, 831 (1986). As a general rule,

[n]o person, duly authorized to practice physic or surgery, shall be required to disclose any information which he may have acquired in attending a patient in a professional character, and which information was necessary to enable him to prescribe for such patient as a physician, or to do any act for him as surgeon, and no such information shall be considered public records under G.S. 132-1.

N.C. Gen. Stat. § 8-53. Because they are medical doctors, psychiatrists operate under section 8-53 when it comes to communicating with their patients, *e.g.*, *Flora v. Hamilton*, 81 F.R.D. 576, 578-579 (M.D.N.C. 1978); *Greene v. Greene*, 15 N.C. App. 314, 319, 190 S.E.2d 258, 261 (1972), while psychologists operate under a similar privilege codified at N.C. Gen. Stat. § 8-53.3.

The decision by the Supreme Court of North Carolina in *Martin* articulated the policy behind the statutory physician-patient privilege. *See* 182 N.C. at 849, 109 S.E.2d at 76. This policy aims to preserve the patients' privacy and to encourage open discussion between doctors and their patients about important medical concerns. When it comes to litigation, an attorneys' duty to maintain this confidential information is likewise sacrosanct under the Rules of Professional Conduct. *See* 27 N.C. Admin. Code 2, Rule 1.06(a) and (b). Comments 2 and 3 to Rule 1.06 of the Rules of Professional Conduct explain that a

fundamental principle in the client-lawyer relationship is that, in the absence of the client's informed consent, the lawyer must not reveal information acquired during the representation. . . . This contributes to the trust that is the hallmark of the client-lawyer relationship. The client is thereby encouraged to seek legal assistance and to communicate fully and frankly with the lawyer even as to embarrassing or legally damaging subject matter. The lawyer needs this information to represent the client effectively and, if necessary, to advise the client to refrain from wrongful conduct. Almost without exception, clients come to lawyers in order to determine their rights and what is, in the complex of laws and regulations, deemed to be legal and correct. Based upon experience, lawyers know that almost all clients follow the advice given, and the law is upheld.

. . . .

The rule of client-lawyer confidentiality applies in situations other than those where evidence is sought from the lawyer through compulsion of law. The confidentiality rule, for example, applies not only to matters communicated in confidence by the client but also to all information acquired during the representation, whatever its source. A lawyer may not disclose such information except as authorized or required by the Rules of Professional Conduct or other law.

(Emphasis added). Apart from the attorneys' interest in preserving confidentiality and the patients' interest in privacy, N.C. Gen. Stat. § 8-53 negotiates several other competing interests as well. Employers and carriers must have adequate access to medical information in order to investigate claims competently. Medical providers have an interest in avoiding collateral and unnecessary headaches involving the unauthorized disclosure of medical information. *Cf.*, *e.g.*, *Jones v. Asheville Radiological Group, P.A.*, 129 N.C. App. 449, 461, 500 S.E.2d 740, 747 (1998) (J. Greene, concurring in part and dissenting in part), *remanded for further proceedings*, 350 N.C. 654, 517 S.E.2d 380 (1999), *on remand*, 134 N.C. App. 520, 518 S.E.2d 528 (1999) (J. Walker, dissenting), *rev'd and dissent endorsed*, 351 N.C. 348, 524 S.E.2d 804 (2000) (per curiam) (This Court has recognized a claim of medical malpractice based on the authorized disclosure of confidential information.). And, finally, the Industrial Commission has an interest in facilitating the systemic efficiency of the workers' compensation laws in North Carolina. These competing interests are the catalyst behind the volume of workers' compensation cases in North Carolina involving the physician-patient privilege in recent

years. See, e.g., *Perkins v. U.S. Airways, Inc.*, 177 N.C. App. 205, 212, 628 S.E.2d 402, 406 (2006); *Mayfield v. Parker-Hannifin*, 174 N.C. App. 386, 388, 621 S.E.2d 243, 246 (2005); *Terry v. PPG Indus.*, 156 N.C. App. 512, 515, 577 S.E.2d 326, 330 (2003); *Reininger v. Prestige Fabricators, Inc.*, 136 N.C. App. 255, 261, 523 S.E.2d 720, 724 (1999); *Jenkins v. Public Serv. Co. of N.C.*, 134 N.C. App. 405, 518 S.E.2d 6 (1999) (J. Wynn, dissenting), *rev'd and dissent endorsed*, 351 N.C. 341, 524 S.E.2d 805 (2000) (per curiam); *Porter v. Fieldcrest Cannon, Inc.*, 133 N.C. App. 23, 30, 514 S.E.2d 517, 523 (1999); *Pittman v. International Paper Co.*, 132 N.C. App. 151, 155, 510 S.E.2d 705, 708 (1999); *Evans v. Young-Hinkle Corp.*, 123 N.C. App. 693, 695, 474 S.E.2d 152, 153 (1996).

Exceptions to the physician-patient privilege. Oddly enough, the parties in most of this litigation failed to take advantage of the exceptions to the physician-patient privilege, which include the following:

1. Consent of the patient, see N.C. Gen. Stat. § 8-53;

2. Waiver by the patient, see *Capps v. Lynch*, 253 N.C. 18, 116 S.E.2d 137 (1960), or the patient's attorney, see *Pittman*, 132 N.C. App. at 155, 510 S.E.2d at 708, which may be express or implied, see *Adams v. Lovette*, 105 N.C. App. 23, 28-29, 411 S.E.2d 620, 624 (1991); or

3. An Industrial Commission or court order that is necessary to a proper administration of justice and made pursuant to law, N.C. Gen. Stat. § 8-53, such as medical records for treatment of injuries that are either compensable or alleged to be compensable under N.C. Gen. Stat. § 97-25.6 (formerly N.C. Gen. Stat. § 97-25), for independent medical evaluations requested by employers under N.C. Gen. Stat. § 97-27(a), or for independent medical evaluations requested by employees under N.C. Gen. Stat. § 97-27(b).

Plaintiffs' counsel rarely had problems satisfying these exceptions and normally already had in their possession written authorizations from their clients. In contrast, defense counsel and their clients never satisfied these exceptions, not because they tried and failed, but because they failed to try. This raised significant ethical concerns in light of RPC 224, entitled *Communication with Physicians Providing Medical Treatment or Evaluations in Workers' Compensation Cases*, which is a North Carolina State Bar ethics opinion published on October 23, 1997, that made any violation of the physician-patient privilege an automatic violation of professional standards of conduct as well. In contrast to plaintiffs' attorneys, the employers, their insurance carriers, and their attorneys had not made any efforts to satisfy the exceptions to N.C. Gen. Stat. § 8-53 in the published decisions dealing with the physician-patient privilege, even though the exceptions had been available under the published cases and under the plain language of the statute for years.

The consequence was a growing--and unfounded--frustration from employers and insurance carriers. In 2005, the legislature enacted a placebo by passing N.C. Gen. Stat. § 97-25.6, which was little more than a detailed list of options that had always been available under N.C. Gen. Stat. § 8-53:

[C]ommunication with a medical provider may be authorized by (i) a valid written authorization voluntarily given and signed by the employee, (ii) by agreement of the parties, or (iii) by order of the Commission issued upon a showing that the information sought is necessary for the administration of the employee's claim and is not otherwise reasonably obtainable under this section or through other provisions for discovery authorized by the Commission's rules. In adopting rules or authorizing employer communications with medical providers, the Commission shall protect the employee's right to a confidential physician-patient relationship while facilitating the release of information necessary to the administration of the employee's claim.

Upon motion by an employee or provider from whom medical records or reports are sought or upon its own motion, for good cause shown, the Commission may make any order which justice requires to protect an employee or other person from unreasonable annoyance, embarrassment, oppression, or undue burden of expense.

The new statute also allows access to medical records for treatment restricted to a current injury or current condition for which an employee is claiming compensation from that employer and requires the employee to produce such records only when the request is in writing and the records are in the possession of the employee. . . N.C. Gen.

Stat. § 97-25.6 is similar to the scope to which Industrial Commission Rule 607 had previously allowed access to this information.

Practice tip: In worst-case scenarios, such as when plaintiff's counsel will not consent to a disclosure of necessary medical information or cannot because of the desires of the employee, employers and carriers can always get an order by the Industrial Commission allowing access to necessary medical information. However, the party seeking the order must show that it has exhausted less onerous options and that the order is the last resort.

Like other exceptions to the physician-patient privilege, the exceptions in N.C. Gen. Stat. § 97-25.6 are strictly construed and limited to medical records or reports only. *Cf. Sims v. Charlotte Liberty Mutual Ins. Co.*, 257 N.C. 32, 37, 125 S.E.2d 326, 330 (1962). Nevertheless, the new statute also allows access to medical information (i.e., other than records or reports) through use of a medical questionnaire promulgated by the Industrial Commission:

An employer or insurer paying compensation for an admitted claim or paying without prejudice pursuant to G.S. 97-18(d) may communicate with an employee's medical provider in writing, limited to specific questions promulgated by the Commission, to determine, among other information, the diagnosis for the employee's condition, the reasonable and necessary treatment, the anticipated time that the employee will be out of work, the relationship, if any, of the employee's condition to the employment, the restrictions from the condition, the kind of work for which the employee may be eligible, the anticipated time the employee will be restricted, and the permanent impairment, if any, as a result of the condition.

N.C. Gen. Stat. § 97-25.6. Any modification of this medical questionnaire or additional information supplementing its submission to the medical provider would violate the strict construction given to this exception and, thus, fall back within the general prohibition against disclosure under N.C. Gen. Stat. § 8-53. This conduct by an attorney, or an attorney's ratification of such conduct by a non-attorney (*see* 27 N.C. Admin. Code 2, Rule 5.3(c)), would also violate the professional standards set forth in RPC 224.

Practice tip: As a start, use the Industrial Commission's medical questionnaire when there is a medical question requiring investigation. If this is unsuccessful, negotiations with the employee's counsel could lay out a discovery plan under which the parties can agree on how to obtain the necessary medical information from the doctors, which might include depositions. In cases involving unrepresented employees, however, there is a risk in such negotiations because a waiver of the physician-patient privilege carries with it legal consequences from an evidentiary standpoint, and the request for such a waiver could constitute legal advice. Obtaining an Industrial Commission order is still the safest method of getting access to medical information.

Separating the elements of consent and the prohibition against *ex parte* communications. Perhaps the most heated issue dealing with the physician-patient privilege over the past few years deals with the two elements of (1) the patient's consent, and (2) the *ex parte* character of the communication between the doctor and employer or carrier. Both *Crist* and *Salaam* dealt with communications that were both non-consensual and *ex parte*. This left open the question of whether parties could get around the privilege by satisfying only one of the two elements. Needless to say, insurance carriers and employers took the position that they only had to copy the employee (or the employee's attorney) on correspondence to medical providers to circumvent the physician-patient privilege.

The appellate courts disagreed. In *Mayfield v. Parker Hannifin*, the North Carolina Court of Appeals held directly that the privilege prohibits disclosure unless the communication with the medical provider takes place on both (1) a consensual basis, and (2) a non-*ex parte* basis. *See* 174 N.C. App. at 388, 621 S.E.2d at 246; *cf. also Crist*, 326 N.C. at 332-334, 389 S.E.2d at 45-46. What this means is that there are two questions in the analysis of whether disclosure of medical information is allowed. First, is there an exception to the physician-patient privilege that applies? And, second, has the communicating party copied the other side simultaneously and by the same means of transmission as the correspondence to the physician? Both of these questions have to be answered in the positive before disclosure is

allowed.

Practice tip: Always copy the opposing party with communications with treating doctors. A failure to do so will frustrate the admissibility of medical information even if you had the party's consent to communicate. In addition, make every effort to get the employee's consent through appropriate negotiations and, if this fails, the previously mentioned option of getting an Industrial Commission order is always available.

The ironic thing about *Mayfield* is that the North Carolina legislature had been telling parties of this duality for years. N.C. Gen. Stat. § 97-25 had always provided an exception to the provisions of G.S. 8-53 . . . and the prohibition against ex parte communications at common law, at least until the legislature transplanted this language over to N.C. Gen. Stat. § 97-25.6 in 2005. This language indicates that the origin of the physician-patient privilege is statutory, while the prohibition against *ex parte* communications comes from common law. Therefore, the two elements are independent and distinct from one another, just as they have been for years, and both must be satisfied before disclosure is allowed.

The risk of not complying with the proper methods of getting medical information--that is, by satisfying one of the exceptions to the physician-patient privilege through appropriate means and formal discovery--has legal consequences, too. At its heart, the privilege is an evidentiary creature, meaning that a party may get access to medical information early on, only to have it kept out of evidence at a later hearing because the means of getting it were improper. *E.g.*, *Silvers v. Mastercraft Fabrics, LLC*, 2006 N.C. App. LEXIS 1162, at **15-23. This is the whole point behind *Crist* and *Salaam*: When it comes to getting medical information from an opposing party's physicians, everyone must play by the rules.

For general discussion of physician-patient privilege in workers' compensation cases, see *Larson's Workers' Compensation Law* § 127.11[3][c].

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Robinson on Recent Workers' Comp. Cases Involving Retaliatory Discharge Claims

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Robinson on Recent Workers' Comp. Cases Involving Retaliatory Discharge Claims

By Thomas A. Robinson

November 15, 2007

SUMMARY: Should the retaliatory discharge exception be extended to situations in which the injured worker is not discharged, but is only demoted in retaliation for filing a claim? In the Emerging Issues Analysis, Thomas Robinson analyzes two recent decisions- *Trosper v. Bag 'N Save* and *Sims v. Ashley Furniture Industries* -- both of which offer interesting twists on retaliatory discharge claims.

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ARTICLE: Anyone who thinks that workers' compensation law deals primarily with broken bones, low back injuries, and computations of average weekly wages has only to look at recent decisions from around the country to see that the issues examined within the "comp world" are as interesting and intricate as in most any other area of the law. This is particularly true where issues within the comp world intersect with those in tort law. Two recent decisions one from Texas, the other from Florida offer an interesting twist on medical malpractice claims, with the claimed injury in each case **not** being caused by any form of improper medical treatment, but rather by negligent or careless handling of paperwork associated with the worker's condition.

Texas Physician Found Liable for Negligent "Administration" of Paperwork Associated With Workers' Compensation Claim. In what appears to be a case of first impression, not only in Texas, but within the entire workers' compensation arena, a Texas Court of Appeals (Second District) has held a physician liable for negligent "administration" of paperwork associated with a patient's workers' compensation claim. In *Lowe v. Hernandez*, 2007 Tex. App. LEXIS 4507 (Tex. Ct. App. June 7, 2007), the court affirmed an order of a state trial court that entered judgment on a jury verdict in favor of a patient who sued her treating physician to recover economic losses incurred when the physician communicated to the patient's employer an incorrect assessment of the patient's physical limitations following a work-related injury and, based upon the physician's (incorrect) assessment, the employer terminated the patient's employment because it perceived the worker would never be able to perform the essential functions of the job.

In this unusual twist on the usual medical malpractice case, the plaintiff/patient did not contend her treatment had been negligently performed, but rather that the physician's administration of the medical reports and other documentation associated with her workers' compensation claim had been careless and inadequate and that the negligent

administration had been the proximate cause of her economic damage.

Hernandez was a long-term employee of a retail fabric store, rising over the years from part-time salesperson to store manager. One of the functions of her job was to maintain the ability to lift, control, and carry heavy merchandise weighing up to 50 pounds. As a routine part of her duties, she visited customer's homes for the purpose of calculating the required yardage for various decorating projects. During one such visit in 2001, she fell and broke her wrist.

She came under the care of Dr. Lowe, a board-certified orthopedic surgeon specializing in hand and lower arm procedures. Three days after the fall, Hernandez underwent surgery to realign the broken bone and she subsequently followed a rehabilitation regime designed to return her to work. Several months after the surgery, Hernandez asked Dr. Lowe if she could return to work, even on an accommodated basis, and Dr. Lowe agreed she could return as long as she did not use her injured arm. The employer allowed Hernandez to return to work with the limitations. Other employees assisted whenever heavy bolts of cloth needed to be lifted. Sometime later, Dr. Lowe modified his orders, indicating she could work with her injured hand and arm, but that she should not lift anything weighing more than five pounds.

Seven months after her injury and ensuing surgery, Hernandez underwent a functional capacity examination (FCE) to determine her rehabilitation progress. The FCE determined that Hernandez could sometimes lift up to 50 pounds and Hernandez returned to work. When Dr. Lowe completed the final paperwork regarding Hernandez' condition, however, he failed to consider the FCE, noting instead that she should not lift more than five pounds and that her condition had reached MMI. Based upon that medical report, the employer terminated Hernandez because she could not perform the primary functions of the job. Hernandez protested, indicating that she could lift 50 pounds, but to no avail. She confronted Dr. Lowe, who initially indicated the error was only clerical in nature, and she received an updated opinion showing her ability to lift up to 50 pounds, but by this time the job had been given to someone else. She subsequently found employment, but at a much reduced wage. She filed her civil action against Dr. Lowe, alleging that his malfeasance had cost her the difference in pay between the two jobs.

At trial, Dr. Lowe continued that expert testimony was required to show the connection between Hernandez' loss of the job and the five-pound lifting restriction. The trial court disagreed, noting that this was not a case in which the alleged negligence was in the treatment of Hernandez' condition, but rather in the handling of administrative duties. Lay testimony was completely adequate to prove the causal connection between Hernandez' termination and the alleged negligent handling of the paperwork.

Hernandez appears to be the first reported case in which an injured employee has sued his or her physician for negligent administration related to a workers' compensation claim. Where the medical care provider is not a treating physician, but merely an expert called in to render an opinion as to the claimant's condition, the medical expert has no similar duty with regard to the injured worker.

For example, in an earlier case from Arizona, *Hafner v. Beck*, 916 P.2d 1105 (Ariz. Ct. App. 1996), a psychologist hired by the workers' compensation carrier to provide an independent medical examination and who allegedly reported incorrect information to the carrier which resulted in a termination of benefits and therapy was, nevertheless, not liable to the claimant for the erroneous report; no doctor/patient relationship existed between the two and the appellate court indicated that the psychologist's duty was owed only to the carrier.

For further discussion related to the workers' compensation issues related to medical malpractice, see generally *Larson's Workers' Compensation Law* § 112.02[1] et seq.

Florida Nurse May Sue Employer in Tort for Mental Injuries Associated With Laboratory's Improper Release of HIV Test Results. In another recent case involving a medical malpractice tort action associated with a workers' compensation claim, the Florida Supreme Court, in a deeply divided per curiam decision (*Florida Dept. of Corrections v. Abril*, 2007 Fla. LEXIS 1902 (Oct. 18, 2007)), determined that an entity that negligently and unlawfully violates an employee's right of confidentiality and privacy in disclosing the results of HIV testing associated with a

work-related incident may be held responsible for the mental anguish and other psychological injuries associated with the breach of privacy.

Abril, a licensed practical nurse with the Florida Department of Corrections (the employer), gave unprotected mouth-to-mouth resuscitation to an inmate who was subsequently determined to be infected with hepatitis C. At that time it was not known whether the inmate might also be infected with HIV. Abril unsuccessfully sought testing for hepatitis and HIV through the employer's workers' compensation carrier, which contended that the resuscitation did not expose Abril to the risk of infection.

Subsequently, the employer's chief medical officer submitted a blood sample from Abril to a laboratory under contract with the state to provide clinical laboratory services for inmates for HIV testing. In spite of assurances from the lab that the results would only be sent to a "confidentially-secured" fax machine in the employer's medical office, the lab faxed the test results which indicated that Abril was positive for HIV to an unsecured fax machine in the employer's business office and to another fax machine in the employer's Tallahassee health services office.

Incidentally, there was some evidence that the test results were sent in response to a request for the information from another employee who was concerned that the use of the lab for the testing of Abril's blood might not have been authorized. It was later determined, through testing paid for by the employer's workers' compensation carrier, that the lab's HIV test on Abril had produced a false positive and that Abril had not in fact contracted HIV.

Abril and her husband filed a civil action against the lab and also against the employer, contending that both plaintiffs had suffered mental anguish and emotional distress arising from the lab's negligent failure to ensure the confidentiality and privacy of the HIV test results and the subsequent negligence of both the lab and the employer in causing those test results to be improperly disseminated to others.

Note that, as was the case in *Hernandez*, discussed above, Abril and her husband did not contend that the lab had been negligent in its testing procedures; rather, the plaintiffs claimed the lab had been negligent in broadcasting the test results in such a fashion that unauthorized personnel were able to see it, and that because the lab enjoyed a contract with the Department of Corrections the employer the Department was also liable under the doctrine of respondeat superior.

Also at issue was Florida's unusual "impact rule," which generally requires that "before a plaintiff can recover damages for emotional distress caused by the negligence of another, the emotional distress suffered must flow from physical injuries the plaintiff sustained in an impact" (*Reynolds v. State Farm Mut. Auto Ins. Co.*, 611 So.2d 1294, 1296 (Fla. Dist. Ct. App. 1992)). Practitioners should also note that Florida has a similar rule within the workers' compensation scheme; § 440.093, Fla. Stat., generally denies mental claims within the workers' compensation context unless there is some physical injury associated with the mental claim).

In *Abril*, the Supreme Court carved out yet another exception to the state's impact rule, holding it did not apply where the plaintiffs had alleged that emotional injuries resulted from a lab's breach of a duty of confidentiality under § 381.004, Fla. Stat. (special statute requiring that such test results be treated as confidential).

Commentary Regarding Exclusive Remedy Defense. Even a cursory reading of *Abril* discloses the fact that, technically, it isn't a "comp case." That begs the question, of course, as to whether it could or should have been. The employer did not apparently raise and the Supreme Court accordingly did not address the issue of exclusivity in its per curiam decision (the exclusivity issue was not apparently raised at the trial court level either), but practitioners should observe that under the circumstances of this case, the exclusivity defense might well have been interposed by the employer.

Abril's initial claim clearly arose out of her employment-related activity of rendering aid to an inmate. She clearly thought the incident was compensable; she sought to have the initial testing underwritten by her employer's workers' compensation carrier. While the carrier initially refused to pay for HIV and hepatitis testing, it subsequently acquiesced and paid for the second test that showed that the earlier testing procedures performed by the defendant laboratory had

resulted in false positive findings.

The carrier's belated decision to pay for the HIV testing in *Abril* was completely in line with the rule applicable in virtually all the jurisdictions that have ruled on the issue of the compensability of HIV testing following a work-related exposure (or potential) exposure to blood and body fluids. For example, in *Arkansas Dept. of Correction v. Holybee*, 46 Ark. App. 232, 878 S.W.2d 420 (1994), an appellate court approved the Arkansas Commission's holding that diagnostic and preventive measures for AIDS, tetanus, hepatitis and other infectious diseases were reasonably necessary for treatment of a Department of Corrections worker who was bitten by an HIV infected inmate. It disagreed with the employer's argument that reasonable medical care to treat the injury was simply the cleansing, suturing, and bandaging of the bite wound. Connecticut has a similar decision (see *Doe v. City of Stamford*, 241 Conn. 692, 699 A.2d 52 (1997)), as does Oregon (see *K-Mart v. Evenson*, 167 Or. App. 46, 1 P.3d 477 (2000)).

Only Wyoming, in *Williams v. State ex rel. Wyoming Workers' Comp. Div.*, 2 P.3d 543 (Wyo. 2000), has a contra decision. There, in spite of the fact that a police officer coming into contact with another's blood while attempting to break up a brawl, might reasonably be concerned about hepatitis, AIDS, and other diseases spread through contact with body fluids of infected persons, the Wyoming court refused to require the employer to bear the cost of such testing.

The strong rule in workers' compensation is that any injury incurred during medical treatment related to a compensable injury is, itself, also compensable (for an excellent discussion of the employer's liability for such aggravation caused by medical malpractice, see generally *Larson's Workers' Compensation Law* § 10.09[1]). For example, had Abril sustained a physical injury during the HIV testing, she would have been entitled to additional compensation, either in the form of medical expenses or disability payments, or both. Yet the employer would not be liable in tort for the negligent care; it would be liable under the workers' compensation scheme for providing benefits and there its liability would have ended. That her claim was for a mental injury, rather than a physical one, should not make any difference.

Consider the relatively common situation in which an employee sustains an injury arising out of and in the course of her employment and, because of the employer's prior arrangements, the employee is sent to a "company doctor" a physician retained to handle emergencies and other routine medical matters for the employer's injured employees. If the physician negligently harms the employee in the course of the treatment, the employer is liable, not only for the initial care, but for any additional medical costs and increased disability benefits caused by the physician's negligence but only inside the workers' compensation scheme, not outside of it. The employee's sole remedy against the employer is for additional workers' compensation benefits; she may not sue her employer in tort, even under a theory that the physician was the agent of the employer and that the employer is, therefore, liable under the doctrine of respondeat superior.

§ 440.11(1), Fla. Stat., the Florida exclusivity statute, is similar, in all important respects, to that in place in virtually all the other states. It would have been interesting to see how the court would have handled the exclusivity defense, had it been interposed by the employer. For further discussion related to the workers' compensation issues related to exclusivity, see generally *Larson's Workers' Compensation Law* § 100.01 et seq.

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Robinson on Recent Medical Malpractice Cases Relating to Workers' Comp. Claims

2008 Emerging Issues 952

Robinson on Recent Medical Malpractice Cases Relating to Workers' Comp. Claims

By Thomas A. Robinson

November 15, 2007

SUMMARY: Two recent decisions, one from Texas, the other from Florida, offer an interesting twist on medical malpractice claims, with the claimed injury in each case not being caused by any form of improper medical treatment, but rather by negligent or careless handling of paperwork associated with the worker's condition. This Emerging Issues Analysis, written by Thomas A. Robinson, examines the recent Texas case, *Lowe v. Hernandez*.

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ARTICLE: Anyone who thinks that workers' compensation law deals primarily with broken bones, low back injuries, and computations of average weekly wages has only to look at recent decisions from around the country to see that the issues examined within the "comp world" are as interesting and intricate as in most any other area of the law. This is particularly true where issues within the comp world intersect with those in tort law. Two recent decisions—one from Texas, the other from Florida—offer an interesting twist on medical malpractice claims, with the claimed injury in each case **not** being caused by any form of improper medical treatment, but rather by negligent or careless handling of paperwork associated with the worker's condition.

Texas Physician Found Liable for Negligent "Administration" of Paperwork Associated With Workers' Compensation Claim. In what appears to be a case of first impression, not only in Texas, but within the entire workers' compensation arena, a Texas Court of Appeals (Second District) has held a physician liable for negligent "administration" of paperwork associated with a patient's workers' compensation claim. In *Lowe v. Hernandez*, 2007 Tex. App. LEXIS 4507 (Tex. Ct. App. June 7, 2007), the court affirmed an order of a state trial court that entered judgment on a jury verdict in favor of a patient who sued her treating physician to recover economic losses incurred when the physician communicated to the patient's employer an incorrect assessment of the patient's physical limitations following a work-related injury and, based upon the physician's (incorrect) assessment, the employer terminated the patient's employment because it perceived the worker would never be able to perform the essential functions of the job.

In this unusual twist on the usual medical malpractice case, the plaintiff/patient did not contend her treatment had been negligently performed, but rather that the physician's administration of the medical reports and other documentation associated with her workers' compensation claim had been careless and inadequate and that the negligent

administration had been the proximate cause of her economic damage.

Hernandez was a long-term employee of a retail fabric store, rising over the years from part-time salesperson to store manager. One of the functions of her job was to maintain the ability to lift, control, and carry heavy merchandise weighing up to 50 pounds. As a routine part of her duties, she visited customer's homes for the purpose of calculating the required yardage for various decorating projects. During one such visit in 2001, she fell and broke her wrist.

She came under the care of Dr. Lowe, a board-certified orthopedic surgeon specializing in hand and lower arm procedures. Three days after the fall, Hernandez underwent surgery to realign the broken bone and she subsequently followed a rehabilitation regime designed to return her to work. Several months after the surgery, Hernandez asked Dr. Lowe if she could return to work, even on an accommodated basis, and Dr. Lowe agreed she could return as long as she did not use her injured arm. The employer allowed Hernandez to return to work with the limitations. Other employees assisted whenever heavy bolts of cloth needed to be lifted. Sometime later, Dr. Lowe modified his orders, indicating she could work with her injured hand and arm, but that she should not lift anything weighing more than five pounds.

Seven months after her injury and ensuing surgery, Hernandez underwent a functional capacity examination (FCE) to determine her rehabilitation progress. The FCE determined that Hernandez could sometimes lift up to 50 pounds and Hernandez returned to work. When Dr. Lowe completed the final paperwork regarding Hernandez' condition, however, he failed to consider the FCE, noting instead that she should not lift more than five pounds and that her condition had reached MMI. Based upon that medical report, the employer terminated Hernandez because she could not perform the primary functions of the job. Hernandez protested, indicating that she could lift 50 pounds, but to no avail. She confronted Dr. Lowe, who initially indicated the error was only clerical in nature, and she received an updated opinion showing her ability to lift up to 50 pounds, but by this time the job had been given to someone else. She subsequently found employment, but at a much reduced wage. She filed her civil action against Dr. Lowe, alleging that his malfeasance had cost her the difference in pay between the two jobs.

At trial, Dr. Lowe continued that expert testimony was required to show the connection between Hernandez' loss of the job and the five-pound lifting restriction. The trial court disagreed, noting that this was not a case in which the alleged negligence was in the treatment of Hernandez' condition, but rather in the handling of administrative duties. Lay testimony was completely adequate to prove the causal connection between Hernandez' termination and the alleged negligent handling of the paperwork.

Hernandez appears to be the first reported case in which an injured employee has sued his or her physician for negligent administration related to a workers' compensation claim. Where the medical care provider is not a treating physician, but merely an expert called in to render an opinion as to the claimant's condition, the medical expert has no similar duty with regard to the injured worker.

For example, in an earlier case from Arizona, *Hafner v. Beck*, 916 P.2d 1105 (Ariz. Ct. App. 1996), a psychologist hired by the workers' compensation carrier to provide an independent medical examination and who allegedly reported incorrect information to the carrier which resulted in a termination of benefits and therapy was, nevertheless, not liable to the claimant for the erroneous report; no doctor/patient relationship existed between the two and the appellate court indicated that the psychologist's duty was owed only to the carrier.

For further discussion related to the workers' compensation issues related to medical malpractice, see generally *Larson's Workers' Compensation Law* § 112.02[1] et seq.

Florida Nurse May Sue Employer in Tort for Mental Injuries Associated With Laboratory's Improper Release of HIV Test Results. In another recent case involving a medical malpractice tort action associated with a workers' compensation claim, the Florida Supreme Court, in a deeply divided per curiam decision (*Florida Dept. of Corrections v. Abril*, 2007 Fla. LEXIS 1902 (Oct. 18, 2007)), determined that an entity that negligently and unlawfully violates an employee's right of confidentiality and privacy in disclosing the results of HIV testing associated with a

work-related incident may be held responsible for the mental anguish and other psychological injuries associated with the breach of privacy.

Abril, a licensed practical nurse with the Florida Department of Corrections (the employer), gave unprotected mouth-to-mouth resuscitation to an inmate who was subsequently determined to be infected with hepatitis C. At that time it was not known whether the inmate might also be infected with HIV. Abril unsuccessfully sought testing for hepatitis and HIV through the employer's workers' compensation carrier, which contended that the resuscitation did not expose Abril to the risk of infection.

Subsequently, the employer's chief medical officer submitted a blood sample from Abril to a laboratory under contract with the state to provide clinical laboratory services for inmates for HIV testing. In spite of assurances from the lab that the results would only be sent to a "confidentially-secured" fax machine in the employer's medical office, the lab faxed the test results—which indicated that Abril was positive for HIV—to an unsecured fax machine in the employer's business office and to another fax machine in the employer's Tallahassee health services office.

Incidentally, there was some evidence that the test results were sent in response to a request for the information from another employee who was concerned that the use of the lab for the testing of Abril's blood might not have been authorized. It was later determined, through testing paid for by the employer's workers' compensation carrier, that the lab's HIV test on Abril had produced a false positive and that Abril had not in fact contracted HIV.

Abril and her husband filed a civil action against the lab and also against the employer, contending that both plaintiffs had suffered mental anguish and emotional distress arising from the lab's negligent failure to ensure the confidentiality and privacy of the HIV test results and the subsequent negligence of both the lab and the employer in causing those test results to be improperly disseminated to others.

Note that, as was the case in *Hernandez*, discussed above, Abril and her husband did not contend that the lab had been negligent in its testing procedures; rather, the plaintiffs claimed the lab had been negligent in broadcasting the test results in such a fashion that unauthorized personnel were able to see it, and that because the lab enjoyed a contract with the Department of Corrections—the employer—the Department was also liable under the doctrine of respondeat superior.

Also at issue was Florida's unusual "impact rule," which generally requires that "before a plaintiff can recover damages for emotional distress caused by the negligence of another, the emotional distress suffered must flow from physical injuries the plaintiff sustained in an impact" (*Reynolds v. State Farm Mut. Auto Ins. Co.*, 611 So.2d 1294, 1296 (Fla. Dist. Ct. App. 1992)). Practitioners should also note that Florida has a similar rule within the workers' compensation scheme; § 440.093, Fla. Stat., generally denies mental claims within the workers' compensation context unless there is some physical injury associated with the mental claim).

In *Abril*, the Supreme Court carved out yet another exception to the state's impact rule, holding it did not apply where the plaintiffs had alleged that emotional injuries resulted from a lab's breach of a duty of confidentiality under § 381.004, Fla. Stat. (special statute requiring that such test results be treated as confidential).

Commentary Regarding Exclusive Remedy Defense. Even a cursory reading of *Abril* discloses the fact that, technically, it isn't a "comp case." That begs the question, of course, as to whether it could or should have been. The employer did not apparently raise—and the Supreme Court accordingly did not address—the issue of exclusivity in its per curiam decision (the exclusivity issue was not apparently raised at the trial court level either), but practitioners should observe that under the circumstances of this case, the exclusivity defense might well have been interposed by the employer.

Abril's initial claim clearly arose out of her employment-related activity of rendering aid to an inmate. She clearly thought the incident was compensable; she sought to have the initial testing underwritten by her employer's workers' compensation carrier. While the carrier initially refused to pay for HIV and hepatitis testing, it subsequently acquiesced and paid for the second test that showed that the earlier testing procedures performed by the defendant laboratory had

resulted in false positive findings.

The carrier's belated decision to pay for the HIV testing in *Abril* was completely in line with the rule applicable in virtually all the jurisdictions that have ruled on the issue of the compensability of HIV testing following a work-related exposure (or potential) exposure to blood and body fluids. For example, in *Arkansas Dept. of Correction v. Holybee*, 46 Ark. App. 232, 878 S.W.2d 420 (1994), an appellate court approved the Arkansas Commission's holding that diagnostic and preventive measures for AIDS, tetanus, hepatitis and other infectious diseases were reasonably necessary for treatment of a Department of Corrections worker who was bitten by an HIV infected inmate. It disagreed with the employer's argument that reasonable medical care to treat the injury was simply the cleansing, suturing, and bandaging of the bite wound. Connecticut has a similar decision (see *Doe v. City of Stamford*, 241 Conn. 692, 699 A.2d 52 (1997)), as does Oregon (see *K-Mart v. Evenson*, 167 Or. App. 46, 1 P.3d 477 (2000)).

Only Wyoming, in *Williams v. State ex rel. Wyoming Workers' Comp. Div.*, 2 P.3d 543 (Wyo. 2000), has a contra decision. There, in spite of the fact that a police officer coming into contact with another's blood while attempting to break up a brawl, might reasonably be concerned about hepatitis, AIDS, and other diseases spread through contact with body fluids of infected persons, the Wyoming court refused to require the employer to bear the cost of such testing.

The strong rule in workers' compensation is that any injury incurred during medical treatment related to a compensable injury is, itself, also compensable (for an excellent discussion of the employer's liability for such aggravation caused by medical malpractice, see generally *Larson's Workers' Compensation Law* § 10.09[1]). For example, had Abril sustained a physical injury during the HIV testing, she would have been entitled to additional compensation, either in the form of medical expenses or disability payments, or both. Yet the employer would not be liable in tort for the negligent care; it would be liable under the workers' compensation scheme for providing benefits and there its liability would have ended. That her claim was for a mental injury, rather than a physical one, should not make any difference.

Consider the relatively common situation in which an employee sustains an injury arising out of and in the course of her employment and, because of the employer's prior arrangements, the employee is sent to a "company doctor"-- a physician retained to handle emergencies and other routine medical matters for the employer's injured employees. If the physician negligently harms the employee in the course of the treatment, the employer is liable, not only for the initial care, but for any additional medical costs and increased disability benefits caused by the physician's negligence-but only inside the workers' compensation scheme, not outside of it. The employee's sole remedy against the employer is for additional workers' compensation benefits; she may not sue her employer in tort, even under a theory that the physician was the agent of the employer and that the employer is, therefore, liable under the doctrine of respondeat superior.

§ 440.11(1), Fla. Stat., the Florida exclusivity statute, is similar, in all important respects, to that in place in virtually all the other states. It would have been interesting to see how the court would have handled the exclusivity defense, had it been interposed by the employer. For further discussion related to the workers' compensation issues related to exclusivity, see generally *Larson's Workers' Compensation Law* § 100.01 et seq.

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CT Medical Fee Schedule & the Medicare Resource Based Relative Value Scale

2008 Emerging Issues 915

Embry on CT Medical Fee Schedule and the Medicare Resource Based Relative Value Scale

By Stephen C. Embry

November 11, 2007

SUMMARY: Connecticut recently joined a growing list of states that use Medicare Resource Based Relative Value Scales (RBRVS) for setting medical fees in workers' compensation cases. [Conn. Gen. Stat. § 31-280] If experience with other states is of any value in predicting the future, workers in Connecticut may soon find it difficult to find doctors willing to treat them. This article, written by Stephen C. Embry, examines the Connecticut experiment with RBRVS and warns that Connecticut may have adopted a failed strategy that may drive up the cost of providing care while reducing payments for care.

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ARTICLE: Connecticut recently joined a growing list of states that use Medicare Resource Based Relative Value Scales (RBRVS) for setting medical fees in workers' compensation cases. [See Conn. Gen. Stat. § 31-280] If experience with other states is of any value in predicting the future, workers in Connecticut may soon find it difficult to find doctors willing to treat them.

Levine study. A recent study by Steven Levine and Ronald Kent of the Geffen School of Medicine at UCLA examined physician participation in workers' compensation in a number of states that have adopted fee schedules based on low RBVRS multiples. In all of the states studied -- Florida, Hawaii, Texas, West Virginia, Maryland -- doctor participation was very low and had declined with the reduction of medical fees following adoption of the RBRVS model.

Background on RBRVS. RBRVS was developed by Medicare to assign a relative value to most medical procedures. Procedures are evaluated based on the complexity, time and training involved in the service, and payments assigned based upon the relative value of each service. Thus, hip replacement surgery might be assigned a higher value than a routine office visit. A number of states have now adopted this system for workers' compensation fee schedules. Typically the workers' compensation schedule is a multiple of what Medicare will pay. For example, Texas neurologists are now typically paid 125% of what Medicare will pay for a procedure.

Problems with managed care. Part of the problem is that in the era of managed care the direct and overheard costs

involved in providing care to injured workers have dramatically increased. Doctor offices must spend increasing amounts of time and money filling out forms and getting authorization for care rather than treating workers. Doctors are complaining that paper work and preauthorization requirements direct resources away from medical care into insurance company bureaucracy. The aggravation and delays involved in having to get authorization for needed treatment has lead many physicians to drop out of the system. Physician offices in Los Angeles have reported that it is 2.5 to 3 times more costly for them to treat injured workers than to attend a patient whose bill will be covered by Medicare.

Doctors fleeing the workers' compensation system. Consequently, in those states with low RBRV multiples, doctors are fleeing the system, leaving the worker with no care.

In West Virginia less than 23% of orthopedists and only 11% of neurologists are still accepting those hurt at work. In contrast, Levine and Kent report that, in Texas, before the fee schedules, 63% of neurologists would treat injured workers, a figure that has fallen to 9% after "reforms".

Quality of physicians in the workers' compensation system. The Levine and Kent study also found that the quality of doctors remaining in the system has fallen since medical management became the norm. In Texas and West Virginia 50 to 55% of nonparticipating neurologists attended a United States medical school and are Board certified, but only 33% of those treating workers have these qualifications.

Graphic distribution of doctors in the workers' compensation system. The study also revealed that the geographic distribution of willing doctors was being affected. In Texas, prior to the adoption of RBRVS, rural availability of doctors was good. In the five years since adoption of low payments into the Texas workers' compensation system, rural access to physicians has nearly evaporated.

Impact of managed care regulatory burdens. While low rates of pay clearly have had a substantial impact of doctors' willingness to treat injured workers, it also appears that managed care regulatory burdens and added overhead has had an impact. Even though Medicare rates are lower than workers' compensation rates, the insurance company intrusion and interference is less, and doctors will accept lower fees in exchange for less control and aggravation. For example, while Medicare paid less than workers' compensation in Texas, 94% of Lone Star Neurologists will accept Medicare patients, but only about 9% will see any injured workers.

In a study of the cost of providing care in Texas completed in 2002 Brinker, et al., found that the overhead cost for treating injured workers with knee pain was 202% higher for those whose bills were covered by workers' compensation than similar Medicare payments. [Brinker, M.R., et al, "The Effect of Payer Type on Orthopaedic Practice Expense", J. Bone Joint Surgery, 2002 Oct. 84:8116-22] Anyone familiar with modern workers' compensation systems is aware of the frustrations, time delays and regulatory costs associated with insurance company managed care, Delays in payments and meddling in treatment has become endemic. Thus, managed care has become less care.

The California medical crisis. Nor does the drop in participation seem to be isolated in the past. California is now digesting recent legislation reducing workers' compensation benefits and increasing the regulatory burden on its doctors. As a result many doctors are now dropping out of that system and reporting that the reduced fees do not offset the extra costs of doing business in a managed care system. Consequently, orthopedist participation in California has fallen from 92% to 65%, while the percentage of neurologists treating workers has fallen from 80% to 37%. As the full impact of the California reforms work there way through the system, the effect is likely to escalate.

The Connecticut experiment. The Connecticut experiment may not be as hazardous to the health of the medical system as it has been in other states. The stated intention of the Connecticut legislation was not to reduce medical costs, but to simplify the billing process. In the past the Connecticut fee schedule has been based on reasonable and customary charges, which were regularly adjusted based on economic changes in the medical market. New procedures were added as needed. This presented a challenge to the Workers' Compensation Commission that was charged with collecting and analyzing changes in rapidly evolving fields. The driving force for adoption of RBRVS in Connecticut seems to have

been more a practical desire to find an off-the-shelf and comprehensive system for categorizing or coding health care procedures for billing purposes, rather than explicit cost controls. The legislation requires that the new fee schedule be revenue neutral.

The Commission is reportedly working with the medical profession to assure that this is the case. The legislation also provides discretion for the Chairman of the Workers' Compensation Commission to make adjustments where the Medicare schedule may not cover a procedure. The statute also limits "annual growth in total medical fees to increases in the annual percentage increase in the consumer price index for all urban workers."

Nevertheless, the adoption of the Medicare coding system is fraught with potential dangers, arising from structural imperatives and unintended consequences. One of the purposes of the coding system is a reallocation of funds and resources from complex procedures to preventive and office-based care. However, workers' compensation medical services tend to be less amenable to preventive care than the general practice of medicine, since the need for care arises from industrial accidents, rather than life style. Preventive care in workers' compensation is more a matter of encouraging employers to make safety improvements in the workplace, than monitoring cholesterol levels. Artificial constraints on medical costs and cost shifting of medical burdens to workers and physicians may reduce the employer's incentive for safety, thus increasing accidents and ultimately increasing the need for medical care. A system, which through economic disincentives, discourages involvement by orthopedic surgeons and neurologists, while at the same time producing an increased need for their services, is dysfunctional.

The act may also underestimate the powers of momentum and concentration as political motivators. Once the RBRVS system becomes entrenched, initial intentions will tend to fade as the internal rational and momentum of the plan takes over. The functional purpose of the Medicare codes is to encourage low-tech treatment and to discourage highly skilled services. Future policy makers may thus have their attention directed more to the imperatives of the Medicare system than the needs of injured workers. At the very least Medicare's purposes and intents will be incorporated into a workers' compensation system that may have other needs.

The concentration of influence arising from a national coding system is also likely to provide a dangerous opportunity for policy leverage. If payors can reduce their expenditures merely by modifying a single coding system, the desire and efforts to do so are likely to increase. The growth in use of the American Medical Association's *Guides to Evaluation of Permanent Impairment* provides a cautionary model. The stated purpose of the *Guides* is to provide a uniform model for evaluation physical impairment, so that an injury occurring in California could be compared to a similar injury affecting a worker in Connecticut. The *Guides* themselves caution that they are not to be used for measuring vocational disability. However, policy makers are increasingly being encouraged to use the *Guides* as a metaphor for disability, and, ultimately, compensation. This, in turn, has lead to political pressures on the AMA to revise and lower ratings, which is then leveraged into nationwide reduction of benefits for injured workers. At the very least, local policy makers are ceding their powers to national organizations and forces whose purposes and interests may not match local needs.

The debate over how much of medical care should be tied to employment plays an increasingly important role in the national debate on how best to assure public health. The recent transference of medical costs from historic employers in the automobile industry to employee managed health care trusts has potentially monumental consequences, not the least of which is that employers will now have added incentives to shed the cost of work-related injuries and transfer those to workers and union managed health care trusts.

A comparison of the failed states identified in the Levine and Kent article with Connecticut's experience shows that squeezing doctors is neither likely to improve care nor reduce costs. Hawaii, West Virginia, Maryland, Florida, California and Texas are near the bottom in medical payments to doctors, exceeding only Massachusetts. They are also among the states experiencing the greatest problems with medical availability. They generally limit doctor fees to 130% or less of Medicare allowance for similar care. Connecticut, on the other hand, is at the other end of the scale, paying around 200% of Medicare fees and ranking fifth in the nation. Despite the fact that Connecticut actually pays doctors at

a higher rate, its cost of medical care as a percentage of benefits is lower than most of the states with low physician participation problems.

According to the 2004 National Academy of Social Insurance study on "Workers Compensation, Benefits, Coverage and Costs", only 39.6% of Connecticut's benefits went to medical care, while the costs in the failed states were as follows: Maryland 41.4%, West Virginia 47.9%, Florida 59.1% and Texas 60.9%. Only in Hawaii was the percentage of benefits paid for medical care lower at 38.3%. So it does not appear that limits on doctor fees necessarily reduce costs, although it does seem to reduce participation of doctors.

The Connecticut cap on medical total costs, which ties them to the consumer price index, may also prove to be problematic. While it is true that medical costs have been rising faster than consumer prices, it is a mistake to assume that this is *per se* a bad thing. Costs have risen in part because medical science has improved the science of health. We now have surgical treatments allowing replacement and repair of knees, backs and hearts that were undreamed of when workers' compensation was created. These processes cost more, but it is doubtful that anyone would want to return to horse-and-buggy-medicine to save on costs. As our society has grown richer the percentage of income needed to meet basic needs have declined and more of our income now goes to discretionary spending on luxury and enjoyment of life. We spend more on vacations as well as more on medical care because we wish to have not merely more money but better health.

Conclusion. Connecticut thus may have adopted a failed strategy that may drive up the cost of providing care while reducing payments for care. If so, Connecticut workers may soon join those in Texas, West Virginia, Hawaii, Florida and Maryland in finding that Dr Kildare has left the building.

For further discussion of the California medical fee schedule, see Hanna, *California Law of Employee Injuries and Workers' Compensation* §§ 22.05[2], 27.01[8][b][ii], and Herlick, *California Workers' Compensation Law* §§ 4.26, 4.31[6].

For further discussion of the Florida medical fee schedule, see Dubreuil's *Florida Workers' Compensation Handbook* § 16.14

For further discussion of the Maryland medical fee schedule, see 1-10 *Maryland Workers' Compensation Handbook* § 10.3

For further discussion of the Texas medical fee schedule, see *Texas Workers' Compensation Handbook* § 10.06.

For general discussion of hospital and medical benefits, see *Larson's Workers' Compensation Law* § 94.01, et seq.

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Rassp on Controversial Issues in AMA Guides and CA Workers' Compensation Cases

2008 Emerging Issues 914

Rassp on Controversial Issues in AMA Guides and Calif. Workers' Compensation Cases

By Robert G. Rassp

November 11, 2007

SUMMARY: In order to get an accurate permanent disability rating for an injured worker in the CA workers' compensation system, counsel needs to develop the record in all AMA Guides cases by reading the instructions in the AMA Guides and making sure physicians applied the descriptions and measurements in the Guides properly and consistently with those instructions and with the 2005 Permanent Disability Rating Schedule.

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ARTICLE: In order to get an accurate permanent disability rating for an injured worker in the California workers' compensation system, counsel needs to develop the record in all AMA *Guides* cases by reading the instructions in the AMA *Guides* and making sure physicians applied the descriptions and measurements in the *Guides* properly and consistently with those instructions and with the 2005 Permanent Disability Rating Schedule. This article discusses five of the most controversial issues in AMA *Guides* cases, the resolution of which may require judicial determinations and appellate law. These controversial issues are (1) apportionment, duplication, and overlap, and risk factors; (2) spinal injury cases, DRE vs. ROM, (3) muscle strength deficits; (4) complex regional pain syndrome and chronic pain, and (5) sleep disorders and obstructive sleep apnea. The discussion of these issues may give you some skills in how to develop the record so that an accurate rating can be established in a case. (Note: This article is excerpted from the 2008 Edition of *The Lawyer's Guide to the AMA Guides and California Workers' Compensation* (LexisNexis Matthew Bender).)

Apportionment, duplication and overlap. Apportionment, duplication and overlap have been and will continue to be a highly litigated and controversial issue, even in AMA *Guides* cases. The AMA *Guides* in fact make our cases ripe for litigation and controversy on the issue of apportionment. Apportionment in the *Guides* looks somewhat like Cal Lab Code § 4663 [see AMA *Guides*, Chapter 1, pages 11-12]. However, it appears that the authors of AMA *Guides* Chapter 1 confuse causation of an injury with causation of an impairment. California law requires that we distinguish between causation of an injury [see *Reyes v. Hart Plastering* 70 Cal. Comp. Cas 223 (Cal. Wrk. Comp. 2005)], and causation of permanent disability at the time the applicant is permanent and stationary or has reached maximum medical improvement [see *Escobedo v. Marshalls* 70 Cal. Comp. Cas 604 (Cal. Wrk. Comp. 2005); *E.L. Yeager Construction v. WCAB (Gatten)* (2007) 71 Cal. Comp. Cases 1687.

The important point here is that even the authors of the *AMA Guides* mandate the individualization of each person's impairment rating. Cal Lab Code § 4660 mandates that the state utilize a uniform, objective, and consistent method of rating industrial injuries. What is clear from reading *AMA Guides* Chapters 1 and 2 is that the only thing that is "uniform, objective and consistent" as mandated by the Calif. Labor Code is the actual use of the *AMA Guides*. But once you open the *Guides* and use its pages in a given case for a given applicant, any uniformity, objectivity or consistency is discarded in favor of both individualizing a person's impairment rating based in part on the effects of the impairment on that person's ADLs and individualizing apportionment of impairments to "other factors" if appropriate.

How do we deal with a prior award under Cal Lab Code §§ 4663 and 4664 when there is a new injury that occurs after January 1, 2005 and is rated under the *AMA Guides*? Suppose there is a 39-year-old nurse who sustains a low back injury in 1995 that resulted in a no heavy work restriction. That case would rate 30% permanent disability after adjustment for age and occupation. Now, in 2005, the same nurse has another lumbar spine injury. How would apportionment work in this case?

Can you subtract apples from oranges? The 1995 permanent disability was based upon work restrictions. The 2005 permanent disability is based upon a spinal impairment under *AMA Guides* Chapter 15, The Spine. So the 1997 Schedule is based upon loss of ability to compete in the open labor market while the 2005 PDRS is based upon the *AMA Guides* and the DFEC adjustment. Cases under the 1997 Schedule are the apples, and cases rated under the 2005 PDRS are the oranges.

One preliminary note: Since there is a reoccurrence of an injury to the nurse's lumbar spine, the ROM method would apply for rating the 2005 spinal injury [see *Rassp*, 1-3 Lawyer's Guide to *AMA Guides* and *CA Workers' Comp* § 3.15]. One other note is that the following analysis applies regardless of whether the prior injury was industrially related or not. The analysis applies under both Calif. Labor Code § 4664 for a prior award and Cal Lab Code §§ 4663 for a prior non-industrial injury with the same surgical results.

Can the WCJ subtract the prior percentage of permanent disability from the current permanent disability that was rated from permanent impairment to PD using the 2005 PDRS? No. There is no way you can use the direct subtraction of percentages now mandated by Calif. Labor Code § 4664 and current case law [see *Brodie v. Workers' Comp. Appeals Bd.* (2007) 40 Cal.4th 1313, 72 Cal. Comp. Cas 565 (Cal. Wrk. Comp. 2007)]. This is because the percentages of permanent disability derived from impairment ratings are totally different from the ratings based upon work restrictions. Another way to put it is that you would be subtracting apples from oranges, which you cannot do. Therefore, there would be only two ways apportionment can occur in this type of case, both under Cal Lab Code §§ 4663:

1. Have the treating or evaluating physician determine what impairment rating under the *AMA Guides* the prior injury would have been and subtract that impairment rating from the current one; or
2. Default to analyzing apportionment under Cal Lab Code §§ 4663: What approximate percentage of permanent disability is directly caused by the 2005 lumbar spine injury and approximately what percentage of permanent disability is caused by other factors, including the prior 1995 industrial lumbar spine injury?

AMA Guides Chapter 1 permits the first method mentioned above if the physician can rate the prior injury using the *AMA Guides* retrospectively. For example, if the nurse had suffered a one level lumbar disc herniation resulting in a laminectomy from the 1995 injury then a physician today using the *AMA Guides* could reasonably conclude that the nurse had a DRE Category III lumbar spine impairment rating (between 10% and 13% WPI) if the physician can discover through review of records, reviewing the applicant's deposition, etc., that the nurse had surgery and determine her quality of life afterwards.

The physician could then pinpoint approximately where within the DRE III category the nurse was when she was declared permanent and stationary from the 1995 injury, based upon how well the nurse felt or functioned after being

released from care for the first injury. Since the ROM method would be used due to the new injury to the lumbar spine in 2005, the physician would then subtract the DRE III rating from the current ROM rating, which would be consistent with both Calif. Labor Code § 4664 and Cal Lab Code §§ 4663.

Applicant's counsel may object to the first method on the grounds that a retroactive DRE rating under the *AMA Guides* is too speculative. Defense counsel may object since this method does not take into account "other factors" besides the prior ratable injury. However, it is reasonable from an evidentiary standpoint that this method could pass scrutiny by the WCAB as to whether the physician's opinion that gives a retroactive impairment rating constitutes substantial medical evidence. Again, the physician would have to state how and why he or she came to his or her conclusions about a retroactive impairment rating and the rationale for doing so.

We are also faced with the issue under Cal Lab Code §§ 4663 about whether the nurse could argue that her lumbar spine condition improved and she rehabilitated from the prior injury since the presumption of Calif. Labor Code § 4664 cannot apply (remember, you cannot subtract apples from oranges) [see *Kopping v. Workers' Comp. Appeals Bd.* (2006) 142 Cal. App. 4th 1099, 48 Cal. Rptr. 3d 618, 71 Cal. Comp. Cas 1229 (Cal. Wrk. Comp. 2006)].

But what if the nurse injures her neck instead of her lumbar spine in 2005? How does apportionment work when the prior spinal award or injury was to the lumbar spine and the new industrial injury is to the cervical spine? Is there consideration for overlap? Is there such a thing as overlap and duplication in *AMA Guides* cases?

If the nurse has a prior lumbar spine award of 30% permanent disability based upon the 1995 injury and she now has a DRE Category IV 25% cervical spine impairment, is there any adjustment to the cervical spine rating on account of the prior award to the lumbar spine? Maybe not, even though the impairments are within the same region, i.e., the spine. Remember, Calif. Labor Code § 4664(c)(1) and (c)(2) mandate that an impairment rating cannot exceed 100% in a person's life time for any single body region, including the spine. In this case, it is arguable that a cervical spine injury results in separate impairments than a lumbar spine injury.

If the nurse had both cervical and lumbar spine injury in 2005, each impairment rating would be combined using the Combined Values Chart and then rated for permanent disability with any "overlap" being covered by the Combined Values Chart [see 2005 PDRS, page 1-11].

However, the 2005 PDRS at page 1-5 states:

It is not always appropriate to combine all impairment standards resulting from a single injury, since two or more impairments may have a duplicative effect on the function of the injured body part. The *AMA Guides* provide some direction on what impairments can be used in combination. Lacking such guidance, it is necessary for the evaluating physician to exercise his or her judgment in avoiding duplication.

One example would involve a single injury to the elbow and shoulder of the same arm resulting in muscle strength deficits-reduced strength of the elbow would probably overlap with reduced muscle strength in the shoulder. Notice here that the 2005 PDRS refers to multiple impairments resulting from a single injury to the same region. It is doubtful that this rule in the 2005 PDRS would apply to impairments to different regions of the body from the same injury.

Therefore, it is an open question about whether duplication and overlap occur in *AMA Guides* cases. Defendants may want to make the medical-legal argument that there is overlap and duplication for impairments that occur within the same region like in spinal injury cases involving impairments to the cervical and lumbar spine caused by the same injury. Applicant's counsel may argue that Calif. Labor Code § 4664(c)(1) and (c)(2) already account for overlap and duplication as does the application of the Combined Values Chart.

However, in the example above involving the nurse, since the lumbar spinal injury and the cervical spinal injury occurred separately, 10 years apart, there is probably no overlap or duplication unless it can be proved that the effects on the applicant's ADL functioning for each injury overlap in some manner. One can argue that ADL functioning is

affected differently for a lumbar impairment than they are by a cervical spinal impairment.

Risk factors. In the struggle to determine apportionment of permanent disability under Cal Lab Code §§ 4663 and 4664, physicians, attorneys, and judges are now confronted by the role, if any, of risk factors to apportionment to causation. In every case to determine causation of permanent disability, can a physician apportion to "other factors" to include such risk factors as genetics, age, gender, family history, race, national origin, or life-style choices such as smoking, a high cholesterol diet, or lack of exercise?

Remember, a risk factor is not a pathology or a disease process itself. For example, high cholesterol is a risk factor for heart disease and stroke in the long term but it may not be causing disability at a given time. But can apportionment of causation of permanent disability to risk factors be appropriate?

For example, an injured employee may have a strong family history of hypertension or diabetes but there is no direct evidence that the offspring of hypertensive or diabetic parents are doomed to have hypertension or diabetes. So how can a physician conclude with reasonable medical probability that an applicant, who is claiming that stress on the job caused, aggravated, or accelerated the development of his or her hypertension, also has significant apportionment to risk factors, such as a strong family history, when, in fact, there is no evidence that the risk factor itself is causing permanent disability?

This argument sounds quite persuasive but what is missing from the analysis from a defense perspective is that stress is also a "risk factor" that must be considered along with other risk factors. Some people who have significant occupational stress do not develop heart disease or hypertension even though they have a strong family history of those conditions.

The debate continues on the applicant's side that risk factors only are considered for causation of an injury and cannot be considered as part of what causes the permanent impairment-but for the industrial injury or exposure, the applicant would not have suffered a heart attack, stroke, etc. Resolution of the role of risk factors that underlie an industrially related medical condition must be determined by reasonable medical probability with the physician explaining how and why a risk factor is causing permanent disability in accordance with the analysis outlined in the *Escobedo* case discussed above.

The WCAB has reiterated its position that the burden of proving apportionment rests on the defendant and that a defendant's failure to provide an adequate basis for apportionment requires a finding that there is none [*Pullman Kellogg v. Workers' Comp. Appeals Bd.* (1980) 26 Cal. 3d 450 (Cal. 1980), 605 P.2d 422, 161 Cal. Rptr. 783, 45 Cal. Comp. Cases 170]. In order to validly apportion permanent disability to a risk factor, a physician must, with reasonable medical probability, indicate that an applicant personally suffers from an underlying pathology.

Physicians must distinguish between the causation of the applicant's injury e.g., elevated cholesterol levels that placed him or her at greater risk of heart disease or stroke, and the causation of the applicant's disability. Physicians must understand the language of the WCAB in *Escobedo*, which reads: "[T]he percentage to which an applicant's injury is causally related to his or her employment is not necessarily the same as the percentage to which an applicant's permanent disability is causally related to his or her injury."

The debate and discussions over the role of risk factors in causing permanent disability will continue until there are appellate decisions that establish the level of proof required to allow valid apportionment to a risk factor. The question of a genetic pre-disposition to certain diseases will also evolve since the science behind genetic testing for certain pre-dispositions is becoming more accurate, reliable, and available in mainstream clinical medicine. An employee's right to medical privacy concerning genetic testing has yet to be tested in the courts in a California workers' compensation case. However, even if an applicant has a genetic pre-disposition to a disease process, if an industrial injury occurs that lights up the condition, then the discussion about what caused the injury and what caused the

permanent disability will be in the forefront of our case law development in the very near future,

In every case, since medical evidence is driven by reasonable medical probabilities, physicians must indicate in their conclusions how and why risk factors are playing a role in causing permanent disability. The development of the record by legal counsel is crucial in this regard so that a judge can weigh the evidence and determine whether a conclusion that a risk factor is causing permanent disability constitutes substantial evidence.

Spinal injury cases DRE vs ROM. There are inconsistent statements within the text of *AMA Guides* Chapter 15 in reference to when the ROM method applies and when the DRE method applies. In fact, there is controversy about whether there needs to be a "radiculopathy" in order for the ROM to apply. In some places, the text indicates that there has to be some form of radiculopathy for the ROM method to apply, and in the actual spinal disorders rating table (Table 15-7), there is no such requirement, nor is there any definition of what a "soft-tissue lesion" is. Are bulging discs or annular tears examples of "soft-tissue lesions?" In addition, there is no definition of the term "injury" in the *AMA Guides*. The authors of the *Guides* never contemplated the California nuance that repetitive or heavy work activities can be a contributing factor to the onset of the development of an impairment- also known as a continuous trauma "injury."

This raises the point of controversy. Is the determination of which spinal impairment rating method applies-DRE or ROM-a medical determination by a physician, a rating determination by a DEU rater, or a legal determination to be made by a workers' compensation judge? Remember, WCAB Rule of Practice and Procedure, Rule 10602 creates the division of labor between a DEU rater and a WCAB trial judge [see 8 Cal. Code Reg. § 10602]. Rule 10602 mandates that DEU raters indicate the rating formula based upon instructions from the WCJ and that the DEU rater does not determine permanent disability. The ultimate determination of a person's permanent disability is strictly within the purview and powers of a WCJ only. See the discussion on the role of the rater vs. role of the judge in Rassp, 1-2 Lawyer's Guide to *AMA Guides* and CA Workers' Comp § 2.06[4][b]

In many of our cases, we are receiving informal ratings from the DEU that state in essence "Cannot rate as ROM, physician should have used DRE." This creates an unnecessary delay in our obtaining informal ratings to assist the parties to resolve cases prior to trial. The fact is that since the WCJ ultimately determines permanent disability, the judge will be the final arbiter of which spinal impairment rating method applies in a given case-DRE or ROM-because the WCJ has the power to determine permanent disability in each case doing substantial justice in every case as mandated by the California Constitution, Art. XIV § 4.

Counsel is reminded that you hold the keys to developing the record in these cases so that the WCJ can weigh the evidence in favor or against using either the DRE or ROM method in a given case. Use the actual language in the text of the *AMA Guides*. For example, in *AMA Guides* Chapter 15, page 379, the authors state that you use the ROM method:

When an impairment is not caused by an injury, if the cause of the condition is uncertain and the DRE method does not apply, or an individual cannot be easily categorized in a DRE class.

What do these terms mean? A physician, a judge, a rater and an attorney may have different interpretations of each of them. For example, if an individual falls under a DRE Category 1, he or she has a 0% WPI. But if the physician believes the person should have an impairment rating less than 5% but greater than 0% WPI, then perhaps the phrase "an individual cannot be easily categorized in a DRE class" may cause one to argue the rating falls under a "DRE Gap" and that the case should be rated using the ROM method.

The language in the *AMA Guides* is inconsistent and vague when it comes to when you can use the ROM method. One school of thought says that there has to be a radiculopathy in order for the ROM method to apply, while the other school of thought is that there does not need to be a radiculopathy for ROM to be used. The authors of the *AMA Guides*

on page 380 indicate that you use the ROM method:

When there is multiple involvement in the same spinal region (eg, fractures at multiple levels, disc herniations, or stenosis with radiculopathy at multiple levels or bilaterally).

On the same page, the authors go on to say:

Use the ROM method if: .. (d) there is recurrent disc herniation or stenosis with radiculopathy at the same or different level in the same spinal region ..

Does there have to be a "disc herniation with radiculopathy" or just a recurrent disc herniation for the ROM method to apply? Does there have to be radiculopathy from multiple level herniations, recurrent herniation at the same level, or stenosis, or does there only have to be radiculopathy from stenosis and none required for recurrent or multi-level disc herniations? The raters are instructed to indicate that the ROM method applies in these cases only when there is radiculopathy, otherwise they are instructed to use the DRE method.

To add to the confusion, when you apply the ROM method, the first step after deciding to use the ROM method requires you to rate the case under Table 15-7, page 404 of the *AMA Guides*, the spinal disorder rating (and then you combine that rating with the range of motion rating and combine that with the neurological ratings, if any). Table 15-7 provides under Section II(B):

Intervertebral disk or other soft tissue lesions .. Unoperated on , with medically documented injury, pain and rigidity associated with none to minimal degenerative changes on structural tests. [*footnotes omitted*]

The authors do not define "soft tissue lesion", and there is nothing that mentions a requirement that a radiculopathy be present. A rating under this type of spinal disorder alone is 4% WPI for the cervical spine, 2% WPI for the thoracic spine, and 5% WPI for the lumbar spine. You can see how use of the language in the *AMA Guides* can be interpreted to fill in a DRE gap if the medical evidence in the case justifies the rating under the ROM method.

Remember that a radiculopathy is any kind of discomfort that is coming from the spinal nerve roots-pain, numbness, shooting pain, burning, throbbing, stabbing pain, or paresthesias (pins and needles sensation). The authors in the *AMA Guides* also warn us that EMG and nerve conduction studies do not detect all types of radiculopathies. So a person can complain of radicular symptoms without any positive findings on an EMG/NCV testing.

In using the DRE method, the physician must distinguish between the criteria for a DRE Category II and a Category III based at times on the difference between whether a radiculopathy is "non-verifiable" (DRE Category II) or "verifiable" (DRE Category III). The determination of whether a radiculopathy is verifiable or non-verifiable has nothing to do with the credibility of the applicant. The determination is a medical judgment call by the physician based upon the clinical findings.

Muscle strength deficits. Under the *AMA Guides*, can an impairment rating be based upon muscle strength loss? For example, an AME was confronted with a case involving a patient who has carpal tunnel syndrome at the right wrist, right thumb de Quervain's tenosynovitis, and right elbow medical epicondylitis. The AME wanted to use grip strength as a ratable impairment.

He opined in his report that the reason he wanted to use grip strength loss was because of the three diagnoses that occurred in this case which involve three areas that immediately affect the patient's midforearm, which is primarily responsible for grip and pinch strength. The physician stated that he felt the loss of strength was permanent and the best method of rating the overall impairment because there was no loss of motion nor ratable neurological deficits, except, arguably, grade 4 motor deficits for the median and ulnar nerves.

In this case, the physician stated his rationale for his use of the muscle strength loss method of rating impairment,

he followed the instructions in the *AMA Guides* while using the muscle strength loss rating method, and his conclusions may constitute substantial evidence. Bear in mind, however, in no less than four places, the authors of the *AMA Guides* caution physicians not to use grip loss as a primary or even secondary method of evaluating impairments, especially if there are other methods that more accurately reflect the person's impairment.

In fact, there are tables throughout *AMA Guides* Chapters 16 and 17 along with specific instructions that allow the use of muscle strength deficits to be rated in addition to other ratable factors. See *AMA Guides*, Tables 16-31 through 16-35, pages 507-510, for upper extremities, and Tables 17-7 and 17-8, pages 531-532, for lower extremities.

If you have an upper or lower extremity case that involves muscle strength loss, make sure you read and understand the instructions in the *AMA Guides* Chapter 16, page 508, which pertain to the use of the tables for muscle strength deficits:

In a rare case, if the examiner believes the individual's loss of strength represents an impairing factor that has not been considered adequately by other methods in the *Guides*, the loss of strength may be rated separately. .. [T]he impairment due to loss of strength *could be combined* with the other impairments, *only* if based on unrelated etiologic or pathomechanical causes. [*Emphasis in original*]

The authors of this quote do not define the terms, "unrelated etiologic or pathomechanical causes." Perhaps an example of this is if there was a loss of motion of the wrist, thumb or elbow joints because of an injury *and* there is muscle strength deficits due to disuse or other etiologies that are not related to the loss of motion of the joint. The instructions require the physician to state the reason why muscle strength loss is being used as a method of rating impairment either alone or in combination with other methods.

One of the most misunderstood and misquoted instructions in the *AMA Guides* involving muscle strength deficits is set forth in the *AMA Guides*, Chapter 16, Section 16.8a, page 508:

Decreased strength *cannot* be rated in the presence of decreased motion, painful conditions, deformities, or absence of parts (eg, thumb amputation) that prevent effective application of maximal force in the region being evaluated. [*Emphasis in original*]

If you have a case in which ratings based upon muscle strength loss are being described, you must develop the record and have the physician justify his or her use of this method by making sure that all of the instructions in the *AMA Guides* for the use of muscle strength loss are being properly followed.

Complex regional pain syndrome. Complex Regional Pain Syndrome is controversial within the medical community with disagreements among orthopedic surgeons, anesthesiologists, neurologists, physiatrists, and pain management specialists as to the diagnostic criteria, who is most qualified to provide treatment, and what modalities are effective for treatment of the condition.

The condition was discovered during the civil war when about 3% of soldiers wounded in an upper or lower extremity with no bone involvement from the bullet wound (a "through and through wound") would develop hypersensitivity and disuse of the affected limb with changes in the nails, sweating, discoloration of the limb, severe burning pain and sometimes trophic changes in the skin or bone. We have seen this condition arise in some of our cases, usually the result of a fairly innocuous injury or routine surgery and sometimes the applicant completely loses the use of the limb.

The current accepted nomenclature that medical physicians at least have agreed to is calling the disorder Complex Regional Pain Syndrome, Type I RSD and Type II Causalgia. Type II Causalgia involves damage to a nerve and the symptoms follow a predicted and obvious nerve distribution. CRPS Type I RSD does not involve a nerve distribution but involves the entire limb or a major part of one. The symptoms are exactly the same and the consequences of CRPS can be devastating on a person's personal, social and occupational functioning, sometimes resulting in total

incapacitation.

The *AMA Guides* refer to CRPS in Chapter 13, Table 13-22, Page 343, Chapter 16, Section 16.5e, Pages 495-496 and Table 16-16, Page 496, Chapter 17, Section 17.2m, Page 553, Chapter 18, Table 18-2, Page 571, and Chapter 18, Table 18-3, Page 575. Remember, there are different authors for each of the chapters in the *AMA Guides* with some inconsistencies between chapters on the same subjects. In addition, the diagnostic criteria for CRPS has changed since the *AMA Guides* 5th Edition was published in November 2000.

So what if measurements and descriptions of *AMA Guides* 5th Edition are no longer valid based upon current scientific consensus? What if an underlying medical condition has new diagnostic criteria that were not anticipated or accepted when the 5th Edition was published? What if a medical condition that did not result in a ratable impairment is now considered ratable?

We know, for example, that in November 2007, the 6th Edition of *the AMA Guides* will be published, and Chapter 18, Pain, has WPI ratings for pain, whereas the 5th Edition does not. Can a physician assign an impairment rating for pain using the 6th Edition since there is now a consensus to rate pain using a new WPI method in the 6th Edition of the *Guides*? Statutorily, the answer is "no" because Cal Lab Code § 4660(b)(1) mandates the use of the 5th Edition and it would take legislation to change Cal Lab Code § 4660(b)(1) to adopt the use of the 6th Edition of the *AMA Guides*.

However, since the *AMA Guides* 5th Edition allows ratings by analogy using clinical judgment, a physician can rate impairments in cases in which the diagnostic criteria for a medical condition has changed from that listed in the 5th Edition. Because the diagnostic criteria for CRPS has changed since November 2000, new medical criteria for the diagnosis is probably admissible, but the record must be developed in order to show that the diagnostic criteria has changed by consensus and an applicant has the new criteria that results in an impairment based upon the November 2000 version listed in the *AMA Guides* 5th Edition.

In CRPS cases, some points need to be made. First of all, the actual diagnosis is rare. Secondly, there are now diagnostic criteria for a clinical medical practice and stricter diagnostic criteria for research purposes. In a research setting, the diagnostic criteria for CRPS must involve 8 out of 12 symptoms listed in *AMA Guides* Chapter 16, Table 16-16, Page 496. Curiously, there is no equivalent Table for CRPS in lower extremity cases in Chapter 17.

In contrast, in a clinical medical setting, the diagnosis is reached by the physician using clinical judgment and usually involves finding at least 6 out of 12 symptoms, sometimes even less than 6, depending upon the severity and location of the presenting symptoms.

Orthopedic surgeons take the position that they are the most qualified to diagnose and treat CRPS because their clinical practices identify CRPS patients since CRPS emerges in orthopedic patients more often than in other medical specialties. The clinical definitions of CRPS Type I RSD and Type II Causalgia are a result of clinical practitioners who see these patients during their clinical practices. Research medicine is involved to try to find effective and safe treatments for these difficult to treat patients. Academic medicine is trying to develop national standards for diagnosis of CRPS and litigation medicine is trying to determine whether a person actually has a CRPS disorder and what is causing it if the disorder even exists. You have art, science, practicality and politics involved all at once.

The best advice to counsel in these CRPS cases is to utilize *AMA Guides*, Chapter 13, Section 13.8, pages 343 and Tables 13-15 for CRPS of the lower extremity and Table 13-22 for CRPS of the upper extremity. These two Tables and the instructions on page 343 all utilize a clinical medicine criteria for diagnosis of CRPS. In contrast, Table 16-16, which is within the CRPS section in *AMA Guides* Chapter 16, The Upper Extremities, Page 496, utilizes the research medicine criteria for CRPS. Which one do you use in an upper extremity CRPS case? You need to develop the record and make your medical-legal arguments and let the physicians and ultimately the WCJ decide which one applies in a given case.

Chronic pain. In certain cases, we see applicants who have a fairly routine injury such as the development of

carpal tunnel syndrome or a herniated lumbar disc, surgery is performed, and then all heck breaks loose and the applicant becomes severely disabled. These cases, fortunately, are rare in clinical medical practices. The diagnosis and treatment of chronic pain syndromes have developed into a medical specialty in its own right and some discussion is in order here.

In clinical medical practice, it is not so much what the chronic pain syndrome is called; rather, it is more relevant as to what the presenting symptoms are and what is the best way to treat them. The *AMA Guides* refer only once to independently ratable chronic pain syndromes in Chapter 13, The Central and Peripheral Nervous System, Section 13.8, page 343.

Do not confuse a diagnosis of a chronic pain syndrome that is discussed as a ratable permanent impairment in Section 13.8 of the *AMA Guides* and the up to 3% WPI add-on for pain that has a greater than expected effect on a person's ADL functioning as indicated in *AMA Guides*, Chapter 18, and page 1-12 of the 2005 PDRS. In order to have a ratable permanent WPI impairment for a stand-alone diagnosis of a chronic pain syndrome, there must be one of the three diagnosis mentioned in Section 13.8: CRPS-RSD; CRPS Causalgia; or "posttraumatic neuralgia." The instructions in *AMA Guides*, Chapter 13, Section 13.8, page 343, state:

To rate an impairment for causalgia, posttraumatic neuralgia, and RSD in an upper extremity, see Table 13-22. If a lower extremity needs to be rated for causalgia, posttraumatic neuralgia, or RSD, use the station and gait impairment criteria in Table 13-15.

"Posttraumatic neuralgia" is not defined in the *AMA Guides*, so counsel needs to rely on the clinical expertise of the diagnosing physician to determine if this criteria can be used to rate a condition as a "chronic pain syndrome." Bear in mind, "neuralgia" is defined as severe, stabbing, throbbing, or burning pain along a nerve distribution. So there has to be neuropathic pain for a chronic pain syndrome to be ratable as a stand alone impairment. Counsel must develop the record to determine the nature of the chronic pain syndrome and its origin.

Sleep disorders. There is significant disagreement within the workers' compensation community about the role that sleep disorders have on rating permanent disability in cases in which the *AMA Guides* apply.

First of all, sleep that is nocturnal and restful is an ADL pursuant to *AMA Guides* Chapter 1, Table 1-2, page 4. Although case law is pending on this issue, common sense tells us that if a person is suffering from a sleep disorder caused by pain from an industrial injury and because sleep is an ADL affected by the injury, then up to 3% WPI can be added to the underlying impairment rating that is causing the pain.

In fact, conservative physicians will indicate in their reports that sleep disturbance is already included within the impairment rating given for the underlying medical condition. Liberal physicians will want to add up to 3%, arguing that the sleep disturbance is not already included in the underlying rating and that since sleep is an ADL listed in the *AMA Guides*, then up to 3% WPI can be added. Alternatively, liberal physicians will want to rate any sleep disorder that is related to an industrial injury, regardless of its cause, including pain.

So can a sleep disturbance or disorder be ratable in its own right? The answer is "yes" as long as the cause of the sleep disorder is not pain from an underlying injury. There has to be a direct cause or a link between the industrial injury and the sleep disorder other than pain. But how is a sleep disorder diagnosed?

There is an entire chapter of the DSM-IV TR devoted to sleep disorders-how to diagnose, evaluate and categorize them. The authors of the DSM-IV state unequivocally that in order to diagnose a sleep disorder, there must be polysomnography performed in a sleep laboratory. The DSM-IV TR categorizes sleep disorders into different types that include forms of insomnia (not enough sleep), hypersomnia (too much sleep) and such disorders as narcolepsy, sleep disorders associated with a psychiatric condition (e.g., clinical depression), sleep disorders associated with a medical condition (e.g., head injury), and substance induced sleep disorders (associated with use of a substance including medications).

The other problem with sleep disorders is that it is very difficult to predict whether a sleep disorder is permanent. We know that long term use of sleep medication is contraindicated; in fact, long term use of sleep medication can cause a substance induced sleep disorder. The argument is that if a patient needs sleep medication, then there is a sleep disorder that needs to be evaluated without use of medication, much like a hearing loss is evaluated without hearing aids.

But once you have a diagnosis of a sleep disorder under the DSM-IV TR, does the applicant have to be evaluated using the 2005 PDRS for psychiatric conditions, with the limitations of Cal Lab Code § 3208.3, a final GAF score, and a 40% increase for the DFEC adjustment? Remember, Cal Lab Code § 4660(b)(1) mandates that we use the descriptions and measurements of the *AMA Guides* to determine permanent disability.

For now, we are taking a strict approach to the issue of when a sleep disorder can be rated in a workers' compensation case. Case law may clarify some of the controversies that arise in cases that involve an allegation of a sleep disorder.

Since sleep is a function of the brain and central nervous system, we need to look at *AMA Guides* Chapter 13, The Central and Peripheral Nervous System, Section 13.3c, Arousal and Sleep Disorders, page 317, Table 13-4, which is operative in our cases. The instructions on page 317 are controlling:

It is expected that the diagnosis of excessive daytime sleepiness has been supported by formal studies in a sleep laboratory

The clinician can evaluate sleepiness with the Epworth Sleepiness Scale, which assesses the likelihood of dozing . . . in different situations . . . [footnote omitted]

This type of emphatic language in the *AMA Guides* is precisely the tone used in academic medicine to stress a point. If you ask most clinical practitioners, they will almost uniformly agree that you do not need a polysomnogram in every case in order to diagnose a sleep disorder. In a clinical medical practice, if a patient presents to a psychiatrist or psychologist with objective evidence of depression and an anxious state, with a haggard countenance, it is probable that the patient has a ratable sleep disorder.

However, the *AMA Guides* do not have any qualifying language to the contrary, and together with the instructions in the DSM-IV TR, if you have a case in which a sleep disorder is suspected or claimed, then a polysomnogram is required. In addition, a Multiple Sleep Latency Test (MSLT) is also recommended to see how a person's sleep latency (how long it takes to fall asleep) affects ADL functioning. These studies generally take 21 consecutive hours in a sleep laboratory and can cost up to \$3,600 under the current fee schedule.

There is an argument being made by some physicians that for a Class I or Class II sleep disorder rating under Table 13-4, only an Epworth Sleepiness Scale is needed. But if you read the actual instructions in the *AMA Guides* page 317, there is no qualifying language when the authors state "it is expected" that sleep studies be conducted in a laboratory. All an Epworth Sleepiness Scale consists of is a self report visual analog scale of eight questions, worth up to 3 points each. If a patient scores 10 points, he or she has a Class II sleep disorder impairment rating under Table 13-4, which is a 10%-29% WPI stand alone impairment rating.

A Class II sleep disorder rating of 10% WPI to 29% WPI involves "Reduced daytime alertness, interferes with ability to perform some ADLs." This covers just about everyone during our MCLE seminars! Realistically, a person who has a sleep disorder has very serious problems-personally, socially and occupationally-and this diagnosis should never be taken lightly. For example, a patient who wakes up once an hour is not getting adequate sleep and usually is visible in that person's countenance. A sleep study in a sleep laboratory will show restorative sleep with deep delta waves and adequate rapid eye movement time (i.e., at least 90 minutes of REM a night). So again, development of the record is essential if an applicant is claiming a sleep disorder.

Practice Point. Defense counsel is urged to take the deposition of the applicant if a sleep disorder is alleged in order to determine whether the condition is caused by pain from an injury. In addition, other causative factors can be discovered, such as allergies to a pillow, an animal that sleeps in the same room, or a spouse or significant other who snores and disrupts the applicant's sleep patterns. Remember, 25% of the adult population suffers from a diagnosable sleep disorder. People who live in cities have a greater incidence of sleep disorders than the population who lives in rural areas. So the cause of sleep disorders can be multifactorial. A good benchmark to determine, subjectively, if someone has a sleep disorder is if he or she wakes up once an hour or is one who regularly sleeps less than 6.5 hours per night.

Practice Point. Attorneys who represent applicants have to be circumspect before you allege a sleep disorder since, in many cases, if a person has diminished day time alertness, his or her driver's license may be in jeopardy, and physicians have a statutory duty to report anyone who has a neurological condition that may affect his or her ability to safely operate a motor vehicle.

For further discussion of apportionment and risk factors, spinal injuries (DRE vs. ROM), muscle strength deficits, complex regional pain syndrome, chronic pain, sleep disorders, and obstructive sleep apnea, see Rassp, Lawyer's Guide to AMA Guides and CA Workers' Comp §§ 5.06, 5.07, 5.13, 5.14, 5.15, 5.19.

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Sweeny on Wainwright v. Newport News

2008 Emerging Issues 913

Sweeny on Wainwright v. Newport News

By Peter M. Sweeny

November 10, 2007

SUMMARY: Virginia's one major seaport is in its Tidewater Region. Industry and commerce center around Hampton Roads, which is home to one of the largest naval bases in the world as well as major civilian shipping industries. Workers' compensation practitioners in the Tidewater who represent injured workers are often faced with dual jurisdiction. In this Emerging Issues Analysis, Peter M. Sweeny discusses how this common practice was challenged.

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ARTICLE: Virginia's one major seaport is in its Tidewater Region. Industry and commerce center around Hampton Roads, which is home to one of the largest naval bases in the world as well as major civilian shipping industries. Workers' compensation practitioners in the Tidewater who represent injured workers are often faced with dual jurisdiction: the Virginia Workers' Compensation Act [Va. Code Ann. § 65.2-100 et seq.], and the federal Longshore and Harbor Workers' Compensation Act (LHWCA) 33 USCS § 901 et seq.] Frequently, benefits are better under the LHWCA but to preserve their client's state rights practitioners will file a claim with the Virginia Workers' Compensation Commission and advise the Commission that the injured worker is currently receiving benefits under the LHWCA. This common practice was challenged in *Robert B. Wainwright v. Newport News Shipbuilding and Dry Dock Co.*, 50 Va. App. 421, 650 S.E.2d 566 (2007), decided on September 25, 2007.

Background of case. Robert B. Wainwright, a forklift operator for Newport News Shipbuilding and Dry Dock Company, was injured on March 6, 1996. Under Virginia law, the statute of limitations for filing a workers' compensation claim is two years from the date of the accident [Va. Code Ann. §65.2-601]. Thus, Wainwright had until March 5, 1998 to file his claim. While a claim for compensation is must be filed within two years of after the accident, the employee is not required to prove the disability during the two-year period. Rather, the employee must prove that disability occurred within the two-year period [*Metro Machine Corp. v. Lamb*, 33 Va. App. 187, 532 S.E.2d 337 (2000)].

By letter dated April 5, 1996, and filed with the Virginia Workers' Compensation Commission on April 10, 1996, Wainwright asserted a "[c]laim for all benefits to which he is or may be entitled pursuant to the Virginia Workers' Compensation Act." However, Wainwright advised the Commission that a hearing did not need to be scheduled because

he was pursuing a concurrent claim under the LHWCA. Newport News Shipbuilding and Dry Dock responded on October 31, 1997, notifying the Commission that they accepted Wainwright's claim as compensable but that as the claimant "was being paid benefits under the [LHWCA]" there were no issues that needed to be resolved at that time.

In February 1998 an issue developed over Wainwright's request for medical attention. By letter dated February 12, 1998 and received by the Commission on February 20, 1998, Wainwright requested a hearing in connection with his desire to continue receiving treatment from his long-time treating physician and licensed clinical psychologist to whom he had been referred. Wainwright was asserting that the employer was "attempting to medically manage" his claim. Medical management by the employer is prohibited in Virginia [*Schwab Constr. v. McCarter*, 25 Va. App. 104, 486 S.E.2d562 (1997)]. No other issue was raised in Wainwright's letter.

The Commission responded to Wainwright's letter by informing the employer that it was "in receipt of a claim for medical benefits in this case" and directed the employer to submit a response to the claim. The employer responded that it accepted claimant's claim as compensable and that Wainwright was receiving benefits under the LHWCA. As to the issue raised in Wainwright's application for hearing, the employer advised the Commission that continued treatment by the claimant's treating physician was "the only issue to be resolved."

A hearing was held before a deputy on October 2, 1998. The deputy issued her opinion on April 6, 1999, directing the employer to offer the claimant a panel of physicians skilled in chronic pain management from which the claimant was to choose a new treating physician. No other determinations or rulings were made in her opinion, and neither party requested a review of the decision by the full Commission.

No further action was taken in the claim until October 27, 2003, when Wainwright filed a request for a hearing "for payment of indemnity and medical benefits and authorization of a treating physician." Wainwright was actually requesting temporary total disability benefits for the period October 2, 2002 to July 5, 2004; temporary partial disability benefits for a ten-week period beginning July 6, 2004; and resumption of temporary total disability benefits thereafter. In response to this application for hearing, the employer asserted, *inter alia*, that Wainwright's request for disability benefits was barred because it "was not timely filed" within the two-year time limit of Va. Code Ann. § 65.2-601 ("a claim shall be filed with the Commission within two years after the accident.").

A new deputy conducted hearings and on August 9, 2005, issued an opinion that, although Wainwright's April 5, 1996 letter constituted a valid claim for benefits, his October 29, 2003 application was "time barred and/or barred by the doctrine of *res judicata*" because Wainwright "could have sought an award for record purposes' [at the October 2, 1998 hearing] in order to preserve his rights under the [Act]." Wainwright sought a review by the full Commission of this opinion. Upon review the full Commission determined that the doctrine of *res judicata* did not apply to bar Wainwright's claim because his 2003 request for benefits sought compensation for a period that was "different that that sought by him in the previously litigated claim." However, a majority of the full Commission affirmed the deputy's decision denying Wainwright benefits. Reciting the history of the claim, the full Commission held:

Based on the record, it appears that the claimant opted to forego his opportunity to pursue entry of an award of disability benefits at the October 2, 1998 hearing. That issue was before [a deputy] and could have been litigated. We frequently have held that the Commission does not adjudicate cases piecemeal. Issues that are raised and not pursued are deemed abandoned, unless specifically deferred. We find that by choosing not to appeal the Deputy Commissioner's April 6, 1999, Opinion, the claimant abandoned his April 10, 1996, claim for disability benefits.

One Commissioner dissented, concluding that the claimant's request for benefits was not time barred because the claim was not previously adjudicated and because the claimant was disabled due to his injuries within two years of the workplace accident. From this opinion Wainwright sought his appeal to the Virginia Court of Appeals.

The real issue in this case was whether or not Wainwright had abandoned a part of his claim by not pursuing it for seven and a half years after his accident. The employer contended, alternatively, either that Wainwright's April 5, 1996

letter did not constitute a valid claim within the statute of limitations, or that his 2003 claim for benefits was time-barred and subject to the doctrine of *res judicata*. The thrust of the employer's argument was that the claimant should not be allowed to adjudicate his case piecemeal and that the Commission had rightly prevented this.

The Virginia Court of Appeals reversed the Virginia Workers' Compensation Commission, basing their decision on three points, discussed below.

Valid claim was filed within statute of limitations period. First, the court concluded that Wainwright's April 5, 1996 letter making a "[c]laim for all benefits to which he is or may be entitled pursuant to the Virginia Workers' Compensation Act" was a valid claim filed within the statute of limitations. The court noted that the intent and purpose of Va. Code Ann. § 65.2-601 is to require notice to the employer of its potential liability for an injury sustained by an employee. Citing *Cheski v. Arlington County Pub. Schs.* [16 Va. App. 936, 434 S.E.2d 353 (1993)], the court noted that the claim must identify (1) the employer, (2) the date of accident, (3) the location of the accident, and (4) the injuries suffered, as well as (5) fairly apprise the commission that a claim is being made. Whether the information filed with the Commission is sufficient to constitute a timely filing is a question of fact, and the Commission had concluded that the April 5, 1996 letter here constituted a valid claim. Therefore, Va. Code Ann. § 65.2-601 did not dictate the outcome of the case.

No abandonment of claim occurred. The second point is, perhaps, the more far reaching conclusion. The court held that Wainwright had not abandoned his claim for disability benefits and that the Commission's analysis was flawed. The Virginia Workers' Compensation Commission had rested its conclusion on its finding that the issue of disability was raised before the first deputy at the original hearing in October of 1998 "and could have been litigated" but was not pursued by the claimant. The court found that there was no evidence in the record to support this finding.

What is critical here is the Virginia Workers' Compensation Commission's tendency to hold that all issues that existed prior to a decision are disposed of by the decision *even if the issues were not the subject of the hearing*. Neither Wainwright nor his employer raised any other issue at the original hearing other than the question of the appropriate treating physician. As Wainwright was, at the time, being paid disability benefits under the LHWCA, the employer (and the Commission) knew that Wainwright was suffering a disability within two years of the accident. "While a claim for compensation must be filed within two years after the accident, the employee is not required to prove the disability during the two-year period" [quoting *Metro Machine Corp. v. Lamb*, 33 Va. App. 187, 532 S.E.2d 337 (2000)]. The Virginia Court of Appeals found that since Wainwright had filed a valid and timely claim and had suffered disability within two years of the accident, he had not abandoned his claim by seeking a hearing on that claim seven and a half years later.

Claim not barred by doctrine of *res judicata*. As its third point, the court rejected the claim that the doctrine of *res judicata* barred Wainwright's claim. The record was clear that the only issue before the deputy at the original hearing was one other than a claim for disability benefits. In rejection of the Virginia Workers' Compensation Commission's "piecemeal adjudication" argument, the court found that the employer had failed to meet the burden of proving by a preponderance of the evidence that the issue of payment of disability benefits was previously raised and decided by the deputy in her 1999 opinion.

Practical effect of *Wainwright* decision. In light of this decision, Virginia practitioners on both sides of claims will have to carefully review the claims being made and the issues being submitted for decision by the Virginia Workers' Compensation Commission. The defense will now have a harder time making a case that a claimant abandoned a part of his or her claim. Claimants will have to be wary of language being included in defenses or decisions that have a broader reach than the facts and circumstances merit.

For further discussion of the LHWCA, see *Larson's Workers' Compensation Law* § 145.01 et seq. (LexisNexis

Matthew Bender).

For further discussion of the two-year statute of limitations for requesting benefits under the Virginia Workers' Compensation Act, see Virginia Workers' Compensation Law and Practice § 7.08 (LexisNexis Matthew Bender).

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CA WC Panel Decisions: *Kong v. San Francisco* and *Sanchez v. Sunrise Mushroom*

2008 Emerging Issues 910

Rabine on Calif. WC Panel Decisions: *Kong v. San Francisco* and *Sanchez v. Sunrise Mushroom*

By Merle C. Rabine

November 9, 2007

SUMMARY: Recent interest in CA Workers' Compensation Appeals Board panel decisions has been fueled by continuing uncertainty of interpretation of parts of Senate Bill 899 and by discussion and debate on the Internet. This Emerging Issues Analysis examines recent panel decisions involving "overlap" between factors of disability in the 1997 and 2005 Permanent Disability Rating Schedules and unreasonable refusal to submit to surgery under Labor Code § 4056.

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ARTICLE: Despite recent interest in California Workers' Compensation Appeals Board panel decisions, fueled by continuing uncertainty of interpretation of parts of Senate Bill 899 and by discussion and debate on the Internet, most panel decisions are of little interest to anyone other than the parties whose case is being decided. When the Appeals Board wants to announce a position on a substantive or procedural issue, it does so by issuing an en banc decision or significant panel decision [see http://www.dir.ca.gov/WCAB/wcab_dars.htm]. Panel decisions, however, tend to be case-specific with the result determined by the facts of the case. Moreover, while panel decisions are citeable authority, particularly on issues of contemporaneous administrative construction of statutory language [see *Griffin v. WCAB* (1989) 209 Cal. App. 3d 1260, 1264, fn 2, 54 Cal. Comp. Cas 145], they are not binding precedent, as are en banc decisions, on all Appeals Board panels and workers' compensation judges [see *Gee v. Workers' Comp. Appeals Bd.* (2002) 96 Cal. App. 4th 1418, 1425 fn. 6, 67 Cal. Comp. Cas 236].

This commentary examines two recent panel decisions, one involving "overlap" between factors of disability in the 1997 and 2005 Permanent Disability Rating Schedules, and the other involving unreasonable refusal to submit to surgery under Labor Code § 4056. In both cases, the employers failed to sustain their burden of proof of affirmative defenses.

Employer fails to sustain burden of proving overlap between factors of disability under the 1997 and 2005 Permanent Disability Rating Schedules, resulting in no apportionment despite prior awards of permanent disability under Labor Code § 4664(b): *Kong v. City and County of San Francisco*, 2007 Cal. Wrk. Comp. P.D. LEXIS 22. In *Strong v. City and County of San Francisco* (2005) 70 Cal. Comp. Cas 1460 (Cal. Wrk. Comp. 2005)

(appeals board en banc), the appeals board held that when an employee suffers an industrial injury causing permanent disability to one region of the body, and when there is a prior award of permanent disability involving any other regions of the body, Cal Lab Code § 4664 requires apportionment of overlapping permanent disabilities. ("Overlap" occurs when a new injury results in factors of disability that are the same as ones that already existed as the result of a prior injury or condition.)

The Court of Appeal agreed in *Kopping v. Workers' Comp. Appeals Bd.* (2006) 142 Cal.App.4th 1099 [71 Cal. Comp. Cas 1229 (Cal. Wrk. Comp. 2006)]. But the court rejected the appeals board's reading of Labor Code § 4664(b) and held that the employer has the burden of proving overlap.

Since these cases were handed down, it has been clear that the appeals board would have to confront the issue of whether the factors of disability under the 2005 Permanent Disability Rating Schedule (PDRS), which complies with Labor Code § 4664(b) by requiring descriptions and measurement of physical impairments in the AMA Guides, and the factors of disability under the 1997 PDRS (work restrictions, objective and subjective factors of disability) are sufficiently similar to allow for overlap between an injury rated under the 2005 PDRS and prior injuries rated under the 1997 PDRS. The panel decision in *Kong v. City and County of San Francisco* 2007 Cal. Wrk. Comp. P.D. LEXIS 22 (Cal. Wrk. Comp. P.D. 2007) directly confronts this issue.

Applicant, a police officer, sustained a cumulative trauma injury to his heart and cardiovascular system. Prior to this injury, he had three prior stipulated awards: 32% for right knee and left ankle injuries; 30% for bilateral knee injuries; and 38% for a bilateral shoulder injury.

The heart injury was rated under the 2005 PDRS. The rating was 78%, based on percentages of "impairment of the whole person." As to the prior injuries, the bilateral shoulder injury and the bilateral knee injury were rated based upon work restrictions. There was no evidence of the basis of the rating of the right knee and left ankle injuries.

The WCJ found no apportionment to the prior injuries, despite the conclusive presumption in Labor Code § 4664(b) that the permanent disabilities caused by those injuries continue to exist. The panel affirmed, stating: "[W]hile there is no prohibition per se on proving overlapping disabilities between the 2005 PDRS, with its impairment-based system, and prior rating schedules, with their system of subjective and objective factors and work restrictions, defendant failed to carry its burden, under *Kopping*, that there is any overlap between the present heart disability and the prior orthopedic disabilities in this case."

As a practical matter, defendants should not expect to prevail on apportionment under Cal Lab Code § 4664 when the current injury is rated under the 2005 PDRS and the prior injury under the 1997 PDRS unless they can demonstrate that the factors of disability for the prior injury are the functional equivalent of the impairments measured according to the AMA Guides. When the current and prior injuries are to the same body part, it may be possible to examine the medical reports used to arrive at the ratings in the prior awards to see whether descriptions and measurements can be rated under the AMA Guides, even though the AMA Guides were not in use at the time that the medical reports were produced. When the current and prior injuries are to different body parts, it is hard to imagine how the factors of disability can be found to overlap. But nothing in the *Kong* decision limits the creativity of defendants seeking to prove overlap.

Proving overlap between factors of disability under the 2005 PDRS and 1997 PDRS is difficult, but not necessarily impossible. The parties should adjust their expectations accordingly. At the least, it is clear that a defendant that wants to prove apportionment under Cal Lab Code § 4664 must be prepared to prove overlap. Simply submitting the prior awards, even if the basis of those awards can be ascertained, should be expected to fail.

Employer fails to prove that applicant's refusal of surgery was unreasonable and is liable for permanent disability despite Labor Code § 4056: *Sanchez v. Sunrise Mushroom*, , 2002 Cal. App. Unpub. LEXIS 6445 (California Unpublished Opinions 2002), 2007 Cal. Wrk. Comp. P.D. LEXIS 19. Labor Code § 4056 provides that no

compensation is payable for disability caused, continued, or aggravated by an unreasonable refusal to submit to medical or surgical treatment, "if the risk of the treatment is, in the opinion of the appeals board, based upon expert medical or surgical advice, inconsiderable in view of the seriousness of the injury." The employer has the burden of proving that the refusal is unreasonable (*Gallegos v. Workers' Comp. Appeals Bd.* (1969) 273 Cal.App.2d 569 [34 Cal. Comp. Cases 322]).

Unreasonable refusal to submit to medical treatment is a defense that is seldom raised and almost never succeeds. In *Sanchez v. Sunrise Mushroom*, 2002 Cal. App. Unpub. LEXIS 6445 (California Unpublished Opinions 2002), applicant sustained an industrial injury to his right knee and back. All physicians who evaluated him recommended right knee arthroscopy and partial meniscectomy. Applicant refused. The WCJ found his refusal unreasonable and did not award applicant that portion of his permanent disability that resulted from his refusal.

The panel reversed. Applicant was evaluated by an AME, who noted that: "[arthroscopic surgery] is a damned if you [do], damned if you don't decision from the long-term perspective. . . . Bottom line, the patient's refusal to have appropriate has not affected his long-term disability." On the basis of this evidence, the panel found that defendant had not met its burden of proving that the refusal to undergo surgery was unreasonable and that surgery would have reduced disability to a particular extent. It remanded the case to the WCJ to rate applicant's permanent disability without applying *Lab Code § 4056*.

What is interesting about this case is that the WCJ found applicant's refusal to undergo surgery to be unreasonable. The AME had noted that applicant's personality and chronic pain behavior syndrome increased the likelihood of a compromised result from even the most ideal surgical procedure. Furthermore, because of applicant's degenerative joint disease, meniscectomy would likely have speeded up the arthritic process leading to further surgery and likely knee replacement. Unfortunately, the panel opinion does not disclose the WCJ's reason for finding the refusal of surgery to be unreasonable. But the panel was not impressed and had little trouble reversing the WCJ's decision.

In the present medical climate, it is much more likely that applicants will be subjected to unnecessary treatment than that they will refuse required treatment. An applicant might refuse needed treatment based on religious principle, and that would be a difficult case. Otherwise, I think it is very unlikely that a WCJ or a commissioner will conclude that refusal to undergo surgery is unreasonable. This is a defense that is seldom raised and almost never succeeds. The defense burden of proving unreasonable refusal is a very steep, uphill burden. In almost all cases, raising this defense is likely to be a waste of energy.

For further discussion of apportionment of permanent disability, see Hanna, *California Law of Employee Injuries and Workers' Compensation*, §§ 8.05-8.07, and Herlick, *California Workers' Compensation Law* § 7.05, 7.44-7.47.

For further discussion of refusal to submit to surgery, see Hanna, *California Law of Employee Injuries and Workers' Compensation* § 5.05[9], and Herlick, *California Workers' Compensation Law* § 4.27.

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Mayerson on Pins v. State Farm Fire & Cas. Co.

2008 Emerging Issues 874

Mayerson on Pins v. State Farm Fire & Cas. Co.

By Marc Mayerson

November 5, 2007

SUMMARY: In *Pins v. State Fram Fire & Casualty Co.*, the Eighth Circuit ruled that an insurer need not defend an insured where damage was caused by tortious conduct by the insured and not by an accident. In this commentary, Marc Mayerson, insurance lawyer and partner at Spriggs & Hollingsworth and law professor at George Washington University, examines *Pins* in the context of other cases discussing whether an insurer has a duty to defend an insured against intentional torts.

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ARTICLE: Insurers Duty to Defend their Insureds Against Intentional Torts

The duty to defend undertaken by an insurance company is an essential component of the peace of mind coverage provided by liability insurance protection. Given the breadth with which the duty to defend is ordinarily construed by the courts, the defense-cost coverage of a policy is also referred to as litigation insurance that is, insurance against the risk and burden of suits brought against the insured. Disputes have raged over whether that litigation insurance applies, however, to suits against the insured alleging an intentional tort.

In most states, the test for whether an insurer will have a duty to defend is whether the suit against the insured might eventuate in a judgment covered by the duty to indemnify that is, the insurance companys obligation to pay for the damages owed by the insured on account of bodily injury, property damage, or wrongful acts. If the claim against the insured permits proof of a covered indemnity claim, the insurer has a duty to defend. Thus, if a lesser included offense would be covered by the duty to indemnify, the insurer has the obligation to mount a defense. *E.g. Abrams v. General Star Indem. Co.*, 67 P.3d 931 (Ore. 2003) (conversion claim).

Naturally, if an insurer has a duty to defend where the claim or suit against the insured *might* result in a covered judgment, the insurers obligation to defend may apply even though the judgment ends up being uncovered. *E.g. Tanner v. State Farm Fire & Cas. Co.*, 874 So.2d 1058 (Ala. 2003); *Automobile Ins. Co. v. Cook* (N.Y. Jun. 8, 2006). (Note that public policy does not prevent the insurer from having a duty to defend even if that public policy would bar the insurer from indemnifying the insured for its deliberate misconduct. *E.g., Horace Mann Ins. Co. v. Barbara B.*, 4 Cal. 4th 1076

(*Cal. 1993*.) In this way, the duty to defend is broader than the duty to indemnify: a claim might need to be defended even if it need not be paid or even if it is uncertain whether initially the claim will need to be paid by the insurance company. *E.g.*, *Fresno Econ. Import Used Cars, Inc. v. United States F&G Co.*, 142 *Cal. Rptr.* 681, 685 (*Cal. App. 1977*). If the undisputed facts developed in the underlying case show that there is no duty to indemnify, the insurer may be able to terminate its defense prospectively. *See Fircro Inc. v. Fireman's Fund Ins. Co.*, 343 *P.2d* 311 (*Cal. App. 1959*); Marc S. Mayerson, *Insurance Recovery of Litigation Costs: A Primer. for Policyholders and Their Counsel*, 30 *Tort & Ins. L.J.* 997, 1000 *n.16*; *see also Sterlite Corp. v. Continental Cas. Co.*, 458 *N.E.2d* 338, 344 (*Mass. Ct. App. 1983*) (holding that an insurer can, by certain steps, get clear of the duty [to defend] from and after the time when it demonstrates with conclusive effect on the third party that as a matter of fact -- as distinguished from the appearances of the complaint and policy -- the third party cannot establish a claim within the insurance, but that [w]hat is not permitted is that an insurer shall escape its duty to defend the insured against a liability arising on the face of the complaint and the policy by dint of its own assertion that there is no coverage in fact).

But what about the situation where the allegations of the complaint, if true, show there is no duty to indemnify and there is no covered lesser-included offense? Insurers typically argue, often with success, that there is no duty to defend such a complaint. *E.g.*, *Farmland Mut. Ins. Co. v. Scruggs*, 886 *So. 2d* 714 (*Miss. 2004*). The paradigm case involves allegations of an intentional tort against the insured, the essential elements of which negate coverage.

The intentional consequences of an intentional act may still be the basis for coverage, where the legal consequences are not anticipated by the insured. The Illinois Court of Appeal addressed a recurring fact pattern recently, where a contractor cut down trees on the wrong property. Finding it immaterial that the underlying complaint alleges intentional torts, the Illinois court found that the insured did not expect liability for the physical injury of cutting down the trees. *Pekin Ins. Co. v. Miller*, 854 *N.E.2d* 693, 696 (*Ill. App. 2006*)

Pins. In *Pins v. State Farm Fire and Cas. Co.* (8th Cir. Feb. 8, 2007), the Eighth Circuit was called upon to get involved with a domestic love triangle, in which the insured had an affair with someones wife, and the cuckold filed suit for alienation of affections. The policy provided coverage for loss, defined as an accident . . . which results in bodily injury. The insurer conceded that the injury at issue was bodily injury (though without any physical harm being alleged, *cf. Lavanant v. General Accident Ins. Co.*, 595 *N.E.2d* 819 (*N.Y. 1992*)). The insurer denied coverage, however, on the ground that affairs of the heart (or body) are not accidents or, in this case, that the cuckolds injury was expected or intended by the insured.

The Eighth Circuit analyzed the elements of proof for the tort claim of alienation of affections under the applicable law (South Dakota). The court found that intent to injure the marital relationship was the *sine qua non* of the tort. As the court explained, the acts must have been done for the very purpose of accomplishing this result. Slip op. at 4 (citation omitted). The policyholder argued that the record was not sufficient to find conclusively that he expected/intended injury; but distinguishing prior authority, the Eighth Circuit found there were no circumstances where an accidental loss was even arguably possible. Slip op. at 5. The court concluded that proof of the underlying *tort ipso facto* and *ipso jure* meant the injury was expected or intended, holding:

[T]he comfort and consortium injuries alleged by [the husband] were sufficient to state a claim for alienation of affections, and under South Dakota law, [the husband] could not recover on this claim unless he proved that Pins intended to cause those specific injuries. In these circumstances, any loss to [the husband] was expected or intended by Pins and could not be deemed an accident. Therefore, State Farm had no contractual duty to defend.

Slip op. at 5.

Put differently, the court found that State Farm issued a homeowners policy, not a home-wreckers policy.

Notwen. The Eighth Circuits conclusion that there was no duty to defend where the elements of proof by definition negated coverage is consistent with a Tenth Circuit opinion decided two months before, *Notwen Corp. v. Am. Econ. Ins.*

Co., 2006 U.S. App. LEXIS 29645 (10th Cir. 2006). The gravamen of the underlying tort in *Notwen* was that trade secrets were misappropriated and the tortfeasor-insured allegedly used corporate and bankruptcy maneuvers to try to shield its misconduct. While recognizing that unintended consequences of an intentional act still may qualify as covered conduct, the court found that the complaint against *Notwen* admitted of no such possibility. Compare *Cincinnati Ins. Co. v. Eastern Atl. Ins. Co.*, 260 F.3d 742 (7th Cir. 2001). As in *Pins*, the policyholder sought to argue that there was a dispute of fact whether it was culpable and that those facts should be aired out in the underlying action which the insurer should be defending. The Tenth Circuit rejected this argument in part, reasoning:

[T]he argument is patently circular, rendering the exclusion of intentional torts from the liability policy meaningless, at least under the circumstances presented here: it asserts, in effect, that a duty to defend against intentional-tort claims excluded under the policy is nevertheless triggered whenever the insured seeks to defend itself (with the insurers assistance) in a lawsuit alleging intentional-tort claims.

Notwen, 2006 U.S. App. LEXIS 29645, at *9-10.

Cf. Evett v. Corbin, 305 S.W.2d 469, 472 (Mo. 1957).

While courts are reluctant to confer on insureds the power to compel their insurers to defend solely by their incanting a denial of the allegations, policyholders reasonably do expect their insurers to protect them when they are wrongly accused of torts. Whatever conduct may have led to the suit is one that qualifies as a covered act (no violation of an exclusion applies) and the insureds being compelled by external circumstances to pay money to fix something (in this instance, a not-meritorious suit) is a casualty in as much as the infestation of lawyers is as unanticipated as a lighting strike.

Lowell. Many insurance-coverage lawyers are familiar with the California Supreme Courts landmark decision in *Gray v. Zurich Ins. Co.*, 419 P.2d 168 (Cal. 1966), but there is a lesser-known companion case to *Gray* decided concurrently that addresses the important issue of insurers duty to defend against intentional torts: *Lowell v. Maryland Casualty Company*, 419 P.2d 180 (Cal. 1966). Standard liability policies provide that the insurer will defend an insured even if such suit is groundless, false or fraudulent. The California Supreme Court in *Lowell* found this groundless, false or fraudulent language to be key in giving rise to a reasonable expectation that the insurer will defend a suit that, if the allegations were true, would not be covered, but where the insured also could obtain a defense verdict of non-liability. (This is different from an insured not being liable for intentional injury but being held liable of the lesser-included offense of negligently caused injury.) So long as there was a substantial basis for the insureds contention of non-liability, the insurer is required to defend:

The insured could reasonably expect that the insurer would furnish him a defense against the groundless charge that the insured had committed an assault and battery against the third party. The insured would not expect that the insurer could avoid the obligation of defense on the ground that such obligation covered only covered accidents which were indemnifiable under the policy and that an assault and battery was not such an indemnifiable accident. The policy promised a defense even if [the third party] suit is groundless.

419 P.2d at 182.

Lowell was in some regards an easy case because the insured obtained a defense verdict in the tort case and the policy expressly afforded defense to groundless, false or fraudulent claims; the exclusion for assault and battery did not apply (since the insured was found not guilty). See *Travelers Ins. Cos. v. N. Seattle Christian & Missionary Alliance*, 650 P.2d 250 (Wash. Ct. App. 1982). Thus, given that *Lowell* was if defense were not granted an insured who would be left with a gap in coverage for defense costs that incurred to the insurers benefit (by avoiding a potentially larger loss or a change in the course of the mounting of the successful defense, cf. *Arenson v. National Auto. & Cas. Ins. Co.*, 48 Cal.2d 528 (1957)), the court reached out to find an obligation to reimburse the cost of the successful defense. Nevertheless, forty years after *Lowell*, insurers and insureds continue to tangle over the applicability of the duty to

defend to cases of intentional torts.

For further discussion of insurance and intentional torts, see *Appleman On Insurance Law And Practice* (2nd Ed.), Part VI: Liability Insurance.

For a one-stop source for all insurance law research needs, see the Insurance Law Research Task Page, the Insurance Coverage Law Research Task Page, and the Insurance Defense Law Research Task Page.

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Richmond on Excess Versus Primary Insurers: The Bad Faith Battle

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Douglas R. Richmond on Excess Versus Primary Insurers: The Bad Faith Battle

By Douglas R. Richmond

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SUMMARY: Excess insurance presents a special problem. A primary insurer may decline to settle a claim within its policy limits secure in the knowledge that it cannot be held liable for bad faith to its insured because any verdict or judgment that exceeds its limits will be paid by the excess carrier. Here the primary insurer is gambling with the excess insurers money instead of the insureds. But what is the excess insurer to do?

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ARTICLE: INTRODUCTION

The terms primary, excess and umbrella describe types of liability insurance policies. A primary policy provides the first layer of insurance coverage. Primary coverage potentially attaches immediately upon the happening of an occurrence, or as soon as a claim is made. The primary insurer is first responsible for defending and indemnifying the insured in the event of a covered or potentially covered occurrence or claim.

An excess policy provides coverage above an underlying limit of primary insurance. Excess coverage generally is not triggered until the underlying primary limits are exhausted by way of judgments or settlements. A true excess policy does not broaden the underlying coverage; it simply increases the amount of coverage available to compensate for a loss.

An umbrella policy is like an excess policy in that it is written in addition to a primary policy to protect the insured against liability for catastrophic losses that would exceed the limits of affordable primary coverage. An umbrella policy differs from an excess policy in a critical aspect: an umbrella policy typically insures against certain risks that a concurrent primary policy does not cover. Accordingly, the terms excess policy and umbrella policy are not synonymous, although an umbrella policy is much more like an excess policy than it is a primary liability insurance policy. n1 This article will treat excess and umbrella insurers identically, and refer only to excess insurers.

Excess and umbrella policies, like all insurance policies, contain an implied duty of good faith and fair dealing. The implied duty of good faith and fair dealing essentially requires that neither party to a contract do anything to impair or injure the others right to receive the benefits of their agreement. An insurer that breaches its duty of good faith and fair dealing to its insured breaches its contract, and also may be said to commit the tort of bad faith. The prototypical bad

faith claim in the liability insurance context is a situation in which a primary insurer with exclusive control over the settlement of a claim against its insured fails or refuses to settle within its policy limits because it allegedly places its financial self-interest ahead of its insureds interests. In other words, the insurer is seen as gambling with the insureds money.

Excess insurance presents a special problem. A primary insurer may decline to settle a claim within its policy limits secure in the knowledge that it cannot be held liable for bad faith to its insured because any verdict or judgment that exceeds its limits will be paid by the excess carrier. Here the primary insurer is gambling with the excess insurers money instead of the insureds. But what is the excess insurer to do? Because the excess carrier has no contractual relationship with the primary insurer it has no apparent contractual protections, whether express or implied. n2 Bad faith law provides the answer. DISPUTES BETWEEN EXCESS AND PRIMARY INSURERS

Most bad faith cases involving excess coverage grow out of a primary carriers failure to settle a case within its policy limits. A primary insurers failure to settle a case within its policy limits when the facts should require it to do so, thereby exposing its insured to personal liability, is the essence of the third-party bad faith tort. A primary insurers wrongful failure to settle a case within its policy limits is no less offensive when an excess insurer must bear liability for the resulting judgment above the primary carriers limits. n3 Allowing excess insurers to sue primary insurers for bad faith encourages reasonable settlements, prevents primary insurers from obstructing settlement, prevents unfair distribution of losses among primary and excess insurers, and reduces the cost of excess insurance. n4

The theory on which an excess carrier pursues a primary insurer for alleged bad faith may be pivotal. For example, courts typically reject equitable contribution because excess and primary policies do not cover the same risk. n5 A few courts hold that a primary insurer owes an excess insurer a direct duty of good faith and fair dealing. n6 These courts reason that when a primary insurer refuses to settle in bad faith, the excess insurer is in the same position as an insured. n7 Fairness dictates the imposition of a direct duty of good faith on the primary insurer, because the excess carrier relies on the primary carrier to discharge any claims handling and defense obligations. n8 Direct duty jurisdictions reason that an excess insurer may:

[R]ely on [a] primary insurer to act reasonably in (1) discharging its claim-handling obligations; (2) discharging its defense obligations; (3) properly disclosing and apprising the excess carrier of events which are likely to effect that carriers coverage; and (4) safeguarding the rights and interests of the excess carrier by not placing the primary carriers own interests above that of the excess insurer. n9

Furthermore, recognizing a direct duty in favor of an excess carrier is in the public interest as the settlement of good-faith disputes at or near the amount of an expected judgment will be promoted, with the consequence of less litigation over disputes that should not be logically litigated, as well as the result of lower insurance premiums for excess coverage. n10

Most courts reject the direct duty theory. n11 Under the majority rule, the duty to settle that a primary insurer owes an excess insurer derives from the primary insurers duty to the insured, such that an aggrieved excess insurer may sue on an equitable subrogation theory. n12 For an excess insurer to sue a non-settling primary insurer via equitable subrogation the excess insurer must prove that the primary insurer failed to fulfill some duty to the insured, n13 and it must pay some portion of the verdict or judgment at issue. n14 At the very least, the insured must be exposed to an excess judgment. n15

As between direct duty theory and equitable subrogation, the latter represents better contract law and insurance law. Though direct duty proponents may argue that their way avoids equitable defenses (such as estoppel) that might operate to deny an excess carrier redress, that simply is not so; equitable defenses work on legal claims as well as those sounding in equity. n16 A primary insurer in a direct duty jurisdiction also may have perfectly valid defenses to an excess insurers bad faith claim that do not sound in equity.

There are two situations, however, in which the recognition of a direct duty arguably makes some sense, contract law hurdles aside. First, consider the situation in which the plaintiff is willing to settle only for an amount that exceeds the primary insurers policy limits. An insurer generally owes its insured no implied duty to settle where no offer is made within its limits. n17 Under equitable subrogation theory, the absence of a policy limits settlement offer allows the primary insurer to try the case unencumbered by potential bad faith liability even though it is gambling with the excess insurers money. The excess insurer can have rights against the primary carrier no greater than those enjoyed by the insured, which would be none. Second, what of the situation where the insured insists on trying the case despite the risk of a verdict greater than the limits of its primary policy? Perhaps the insured is concerned about its reputation or about business interests that might be harmed by a decision in the case at bar. If the excess insurers right to sue the primary carrier for bad faith is derivative, any claim the excess insurer might have will be foreclosed by the insureds decision to roll the dice. n18

As for the first scenario, why should an excess insurer be given any rights greater than an insured? There is no evidence of such a need. Moreover, this is exactly the risk for which the excess insurer bargained. With respect to the second scenario, it will rarely come to pass. Standard primary liability insurance policies grant the insurer the right to settle as it deems expedient. Such provisions trump the insureds desire for vindication by a jury. Additionally, if the insured irresponsibly insists on a trial, an excess insurer may avoid liability by asserting the insureds breach of its duty of good faith and fair dealing. The excess carrier does not need to be able to sue the primary insurer in light of the defense the insureds conduct affords.

Practice Insight: The theory on which an excess insurer may recover against a primary insurer is unsettled in many jurisdictions. Lawyers handling suits on behalf of excess insurers in these states are safest pleading the excess carriers claim as one for equitable subrogation, but there likely is little harm in alternatively pleading a direct duty.

California Union Insurance Co. v. Liberty Mutual Insurance Co. The case of *California Union Insurance Co. v. Liberty Mutual Insurance Co.* n19 illustrates the burdens primary insurers may bear when trying to resolve a case short of an excess carriers coverage. In that case, a telephone companys (CTI) second-level excess insurer, California Union, sued its underlying insurer, Liberty Mutual, for negligence and bad faith in failing to settle a case within Liberty Mutuals policy limits. Liberty Mutual had issued CTI a \$1 million primary policy and a \$1 million first-level excess policy. California Union had issued a \$4 million excess policy above the Liberty Mutual excess policy.

The plaintiff in the underlying case, Hauck, was catastrophically injured while inspecting a roof. Liberty Mutual provided CTI with a defense to Haucks suit. Hauck initially demanded \$37.5 million to settle. Despite her belief that CTIs liability clearly exceeded the limits of Liberty Mutuals coverage, the responsible Liberty Mutual claims handler refused to offer the companys \$2 million policy limits toward settlement. California Union reserved its entire \$4 million policy limits shortly thereafter based on the advice of its monitoring counsel.

As discovery proceeded the case got worse from the defendants perspective. Even so, Hauck reduced his settlement demand to \$16 million. Liberty Mutuals defense counsel asked for authority to settle the case and California Union formally demanded that Liberty Mutual do so. California Union was prepared to contribute to a settlement but would not do so until Liberty Mutual exhausted its \$2 million policy limits. At a meeting of all concerned on the defense side, Liberty Mutual advised that it had no plans to contribute to any settlement.

A settlement conference was ultimately convened and all of the defendants except CTI settled for a combined \$4.4 million. Despite the fact that Liberty Mutuals defense counsel advised it to offer its \$2 million policy limits in settlement and another excess carrier above California Union urged Liberty Mutual to move quickly toward settlement, Liberty Mutual refused to offer more than \$400,000. Even when it became apparent that Liberty Mutual could settle the case for \$1.6 million, it refused to offer more than \$800,000.

Haucks lawyer tried the case solely against CTI. The jury returned a \$16,038,737 verdict for Hauck, reduced by 40 percent for Haucks comparative fault. One month later, California Union and Liberty Mutual settled with Hauck for

\$5,723,242, with Liberty Mutual paying its \$2 million policy limits and California Union contributing \$3,723,242. California Union then sued Liberty Mutual for bad faith in failing to settle the case.

Both carriers moved for summary judgment in the bad faith action, and the case was decided on their cross motions. Liberty Mutual argued that California Union was equitably estopped from pursuing its claims because the presence of California Unions monitoring counsel at the settlement conferences altered the negotiating landscape because it signaled to Hauck that the excess carrier was concerned by the case, and therefore that more money might be forthcoming. n20 The *California Union* court quickly dispatched this argument.

An excess insurer can be estopped from recovery if its own actions induced the defendant to try the case Likewise, if an excess insurance carrier participates in settlement negotiations and approves the settlement amount, it may have waived its right to challenge the settlement later Neither of those situations exists here, and the mere hiring of monitoring counsel does not create equitable estoppel. n21

Liberty Mutual next asserted that California Union had suffered no harm because it had reserved its entire \$4 million policy limits. This argument failed easily. Under Illinois law, if a primary insurer breaches its duty to settle, the excess verdict itself constitutes damages.

The court ultimately concluded that no reasonable trier of fact could find that Liberty Mutuals actions were reasonable. There was virtually no evidence that Liberty Mutual met its duty of care to CTI and, by way of equitable subrogation, its duty to California Union. The court thus entered summary judgment for California Union, awarding the excess insurer \$3,723,242 (its portion of the settlement) plus interest and costs.

Of course, there may be cases in which the primary insurer mishandles settlement or misjudges the value of the case, but these blunders are meaningless because the plaintiffs damages are so great that the case could never be settled within the primary policy limits. n22 Alternatively, there may be cases in which a primary insurer reasonably believes that there is no chance of a verdict exceeding its policy limits, but an excess verdict in fact results through no fault of the primary insurer. n23 There are also cases in which a primary insurer contributes its full policy limits to a settlement to which the excess insurer also grudgingly contributes despite its belief that the case could have been settled within the primary policy limits. n24 In all of these cases an excess insurer that pays all or part of its policy limits will not be able to prevail on a bad faith claim against the primary insurer. Where the excess insurer contributes to the settlement, there is no excess judgment on which to predicate a bad faith claim. n25 An excess insurers bad faith suit will fail in the other cases either because there is no bad faith or because the primary insurers failures or errors are not the cause of the excess insurers claimed damages. Indeed, the excess insurer has no damages; it paid under its policy not because of the primary insurers bad faith, but because it realized the risk it insured.

Finally, some courts decline to recognize a cause of action for excess insurers against primary insurers, whether by way of equitable subrogation or pursuant to a direct duty theory, even where the primary insurers conduct clearly is blameworthy. n26 These courts reason that excess insurers that are forced to indemnify their insureds for judgments greater than their primary policy limits have suffered no injury. n27 Rather, the excess judgments about which they complain are exactly the risk for which they bargained and collected premiums. n28

To be sure, excess insurers bargain for the risk they accept above the limits of underlying primary insurance and they collect premiums for the risk they assume. But their willingness to assume risk and to price it reasonably is at least to some extent predicated on rational behavior by their underlying primary insurers. Furthermore, this simplistic approach to analyzing a primary insurers liability for bad faith vis--vis an excess insurer sometimes causes courts to incorrectly analyze the issues.

National Surety Corp. v. Hartford Casualty Insurance Co. n29 In this case, for example, the court reasoned that allowing excess insurers to sue primary insurers for bad faith on equitable subrogation theory could cause primary insurers to raise their premiums because they would face assuming and paying the cost of excess insurers economic

risk. n30 Primary insurers would, in turn, pass this cost along to the many insureds who do not purchase excess insurance. n31 But this reasoning represents the height of voodoo economics, because an excess insurer suing a primary insurer for bad faith via equitable subrogation is merely stepping into the insureds shoes. There is no new risk to the primary insurer; only the identity of the plaintiff has changed. The primary insurer is bearing exactly the same risk that exists in the absence of excess insurance--the risk that its reckless or malicious behavior will expose it to extracontractual liability. Indeed, to refuse excess insurers a right of action is to encourage primary insurers to behave irrationally.

Fortunately, the Sixth Circuit recognized the many flaws in the district courts reasoning in *National Surety*, and reversed the decision. n32 In doing so, the court of appeals embraced the majority rule recognizing equitable subrogation. n33

Federal Insurance Co. v. Travelers Casualty & Surety Co. n34 This 2002 Alabama decision, arose out of a \$4.5 million wrongful death verdict against Pearce Construction Co. (Pearce). The case could have been settled before trial for \$350,000. The case was settled for \$4.6 million while on appeal; Pearces primary insurer, Travelers, paid \$1 million, and Pearces excess insurer, Federal, paid the remainder. Federal sued Travelers in federal court to recover the portion of the settlement that it paid. Ultimately, the Eleventh Circuit certified two issues to the Alabama Supreme Court related to Travelers alleged bad faith liability for failing to settle the wrongful death action within its policy limits.

The Alabama Supreme Court held that in the absence of contrary contractual obligations, a primary insurer owes no duty of good faith to an excess insurer with respect to the settlement of a lawsuit against an insured. n35 As the court explained:

In a typical insurance contract, the insured expressly relinquishes to the insurer the right to control the defense and settlement of any action arising under the contract. The insureds reliance on the abilities and good faith of the insurer is therefore necessarily at a maximum. In this case, not only did federal not in any way relinquish the right to Travelers, Federal's policy expressly reserved to Federal [t]he right to participate in the investigation, settlement, or defense of any claim or suit that we feel may create liability on our part under the terms of the policy.

Furthermore, there is a difference in bargaining power between an insurer and an insured in drafting and negotiating the insurance contract. . . . However, in the absence of separate contractual duties, the primary and excess insurance carriers stand on more equal footing. . . . Simply put, the primary-insurer/excess-insurer relationship does not involve the same policy considerations that justify imposing on those insurers the duty of good faith that currently exists between an insured and his insurer. n36

Having dispatched of any direct duty of good faith and fair dealing, the court turned to the doctrine of equitable subrogation and Federal's claim that it should be allowed to sue Travelers as Pearces subrogee. The court rejected this approach as well. Briefly, a subrogated insurer stands in its insureds shoes and may assert only those claims that the insured might validly assert. Where an excess insurer fully satisfies a judgment exceeding an insureds primary policy limits, the insured never suffers personal liability. Simply put, equitable subrogation cannot exist to provide a conduit to assert what are conclusively nonexistent rights. n37

CONCLUSION

There is no questioning the importance or prevalence of excess insurance and umbrella coverage, nor the potential for controversy between them and primary insurers. Recognizing the tension between primary and excess insurers, several insurance industry associations and interested insurers jointly created the Guiding Principles for Primary and Excess Insurers in 1974. These principles are:

1. The primary insurer must discharge its duty of investigating promptly and diligently even those cases in which it is apparent that its policy limit may be consumed.

2. Liability must be assessed on the basis of all relevant facts which a diligent investigation can develop and in the light of applicable legal principles. The assessment of liability must be reviewed periodically throughout the life of a

claim.

3. Evaluation must be realistic and without regard to the policy limit.

4. When from evaluation of all aspects of a claim, settlement is indicated, the primary insurer must proceed promptly to attempt a settlement, up to its policy limit if necessary, negotiating seriously and with an open mind.

5. If at any time, it should reasonably appear that the insured may be exposed beyond the primary limit, the primary insurer shall give prompt written notice to the excess insurer, when known, stating the results of investigation and negotiation, and giving any other information deemed relevant to a determination of the exposure, and inviting the excess insurer to participate in a common effort to dispose of the claim.

6. Where the assessment of damages, considered alone, would reasonably support payment of a demand within the primary policy limit but the primary insurer is unwilling to pay the demand because of its opinion that liability either does not exist or is questionable and the primary insurer recognizes the possibility of a verdict in excess of its policy limit, it shall give notice of its position to the excess insurer when known. It shall make available its file to the excess insurer for examination, if requested.

7. The primary insurer shall never seek a contribution to a settlement within its policy limit from the excess insurer. It may, however, accept contribution to a settlement within its policy limit from the excess insurer when such contribution is voluntarily offered.

8. In the event of a judgment in excess of the primary policy limit the primary insurer shall consult the excess insurer as to further procedure. If the primary insurer undertakes an appeal with the concurrence of the excess insurer, the expense shall be shared by the primary and the excess insurer in such manner as they may agree upon. In the absence of such an agreement, they shall share the expense in the same proportions that their respective shares of the outstanding judgment bear to the total amount of the judgment. If the primary insurer should elect not to appeal, taking appropriate steps to pay or to guarantee payment of its policy limit, it shall not be liable for the expense of the appeal or interest on the judgment from the time it gives notice to the excess insurer of its election not to appeal and tender its policy limit. The excess insurer may then prosecute an appeal at its own expense being liable also for interest accruing on the entire judgment subsequent to the primary insurers notice of its election not to appeal. If the excess insurer does not agree to an appeal it shall not be liable to share the cost of any appeal prosecuted by the primary insurer.

9. The excess insurer shall refrain from coercive or collusive conduct designed to force a settlement. It shall never make a formal demand upon a primary insurer that the latter settle a claim within its policy limit. In any subsequent proceedings between excess insurer and primary insurer the failure of the excess insurer to make formal demand that the claim be settled shall not be considered as having any bearing on the excess insurers claim against the primary insurer.

Although many primary and excess insurers either declined to adopt the Guiding Principles or have withdrawn as signatories to them, at least two courts have specifically applied the Guiding Principles as though they are an industry standard, with liability flowing from of their breach. n38

In summary, bad faith litigation between primary and excess insurers shows no signs of abating. The size of many losses and verdicts gives excess insurers a powerful incentive to vigorously pursue their interests. It is critical for insurance lawyers to understand the contours of bad faith law in this context.

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n1 See *Meyer v. Michigan Mut. Ins. Co.*, 2000 WI App 37, 607 N.W.2d 333, 337 (Wis. Ct. App. 2000) (noting that umbrella policies are viewed as excess liability coverage).

n2 *Elm Ins. Co. v. GEICO Direct*, 2005 NY Slip Op 8619, at *1 (N.Y. App. Div. 2005) (refusing to recognize breach of contract action by excess insurer against primary insurer).

n3 See *New Jersey Mfrs. Ins. Co. v. National Cas. Co.*, 393 N.J. Super. 340, 353-354 (App. Div. 2007) (noting that the presence of excess coverage in no way lessens a primary insurers implied duty to settle within policy limits).

n4 *Truck Ins. Exch. v. Century Indem.*, 76 Wn. App. 527, 530-531 (Wash. Ct. App. 1995).

n5 *Transcontinental Ins. Co. v. Insurance Co. of the State of Pennsylvania*, 148 Cal. App. 4th 1296, 1303-1305 (Cal. Ct. App. 2007); *Home Ins. Co. v. Cincinnati Ins. Co.*, 213 Ill. 2d 307, 315-317 (Ill. 2004). But see *Essex Builders Group, Inc. v. Amerisure Ins. Co.*, 429 F. Supp. 2d 1274, 1288 (D. Fla. 2005) (recognizing equitable contribution claim under Florida law).

n6 See, e.g., *Schwartz v. Twin City Fire Ins. Co.*, 492 F. Supp. 2d 308, 329 (D.N.Y. 2007) (discussing New York law); *Attorneys Liab. Protection Soc'y v. Reliance Ins. Co.*, 117 F. Supp. 2d 1114, 1124 (D. Kan. 2000); *RLI Ins. Co. v. Scottsdale Ins. Co.*, 691 So. 2d 1095, 1096 (Fla. 4th DCA 1997); *Schal Bovis, Inc. v. Casualty Ins. Co.*, 314 Ill. App. 3d 562, 571-573 (Ill. App. Ct. 1999); *Frankenmuth Mut. Ins. Co. v. Continental Ins. Co.*, 450 Mich. 429, 436 n.6 (Mich. 1995); *Baen v. Farmers Mut. Fire Ins. Co. of Salem County*, 318 N.J. Super. 260, 266-267 (App. Div. 1999).

n7 *RLI Ins. Co. v. Scottsdale Ins. Co.*, 691 So. 2d 1095, 1096 (Fla. 4th DCA 1997); *Schal Bovis, Inc. v. Casualty Ins. Co.*, 314 Ill. App. 3d 562, 571-572 (Ill. App. Ct. 1999); *Baen v. Farmers Mut. Fire Ins. Co. of Salem County*, 318 N.J. Super. 260, 266-267 (App. Div. 1999).

n8 *American Centennial Ins. Co. v. Warner-Lambert Co.*, 293 N.J. Super. 567, 577-579 (Law Div. 1995).

n9 *CNA Ins. Co. v. Selective Ins. Co.*, 354 N.J. Super. 369, 382-383 (App. Div. 2002).

n10 *Schal Bovis, Inc. v. Casualty Ins. Co.*, 314 Ill. App. 3d 562, 573 (Ill. App. Ct. 1999).

n11 *Reliance Ins. Co. v. Chitwood*, 433 F.3d 660, 666 (8th Cir. 2006) (quoting *PHICO Ins. Co. v. Aetna Cas. & Sur. Co. of Am.*, 93 F. Supp. 2d 982, 989 (D. Ind. 2000)); *Twin City Fire Ins. Co. v. Country Mut. Ins. Co.*, 23 F.3d 1175, 1178 (7th Cir. 1994).

n12 See, e.g., *Nat'l Sur. Corp. v. Hartford Cas. Ins. Co.*, 493 F.3d 752, 755-760 (6th Cir. 2007) (predicting Kentucky law); *Travelers Indem. Co. v. W. Am. Specialized Transp. Servs.*, 409 F.3d 256, 260-261 (5th Cir. 2005) (applying Louisiana law); *AMHS Ins. Co. v. Mut. Ins. Co.*, 258 F.3d 1090, 1100-1101 (9th Cir. 2001) (interpreting Arizona law); *Westchester Fire Ins. Co. v. General Star Indem. Co.*, 183 F.3d 578, 583 (7th Cir. 1999) (interpreting Illinois law); *Evanston Ins. Co. v. Stonewall Surplus Lines Ins. Co.*, 111 F.3d 852, 858-859 (11th Cir. 1997) (applying Georgia and Wisconsin law); *Greater N.Y. Mut. Ins. Co. v. North River Ins. Co.*, 85 F.3d 1088, 1095 (3d Cir. 1996) (deciding case under Pennsylvania law); *Hocker v. New Hampshire Ins. Co.*, 922 F.2d 1476, 1485 (10th Cir. 1991) (applying Wyoming law); *Essex Builders Group, Inc. v. Amerisure Ins. Co.*, 429 F. Supp. 2d 1274, 1288 (D. Fla. 2005) (applying Florida law); *Twin City Fire Ins. Co. v. Burke*, 204 Ariz. 251, 255 (Ariz. 2003); *Pruyn v. Agric. Ins. Co.*, 36 Cal. App. 4th 500, 521 (Cal. Ct. App. 1995); *Progressive Am. Ins. Co. v. Nationwide Ins. Co.*, 949 So. 2d 293 (Fla. 1st DCA 2007); *Hose v. Younger Bros.*, 878 So. 2d 548, 550-551 (La. Ct. App. 2004); *Hartford Casualty Ins. Co. v. New Hampshire Ins. Co.*, 417 Mass. 115, 123-125 (Mass. 1994); *Insurance Co. of N. Am. v. Travelers Ins. Co.*, 118 Ohio App. 3d 302, 313-314 (Ohio Ct. App. 1997); *American Centennial Ins. Co. v. Canal Ins. Co.*, 843 S.W.2d 480, 482-483 (Tex. 1992); *First State Ins. v. Kemper Nat'l Ins.*, 94 Wn. App. 602, 608-609 (Wash. Ct. App. 1999).

n13 *Gen. Star Indem. Co. v. Vesta Fire Ins. Corp.*, 173 F.3d 946 (5th Cir. 1999) (applying Texas law).

n14 *California Union Ins. Co. v. Liberty Mut. Ins. Co.*, 920 F. Supp. 908, 923 (D. Ill. 1996) (applying Illinois law).

n15 *Auto-Owners Ins. Co. v. Am. Yachts, Inc.*, 492 F. Supp. 2d 1379, 1385-1386 (D. Fla. 2007) (applying Florida law in which release eliminated insureds potential excess liability).

n16 *Twin City Fire Ins. Co. v. Country Mut. Ins. Co.*, 23 F.3d 1175, 1179 (7th Cir. 1994).

n17 See, e.g., *McLaughlin v. Nat'l Union Fire Ins. Co.*, 23 Cal. App. 4th 1132, 1145-1148 (Cal. Ct. App. 1994); *Am. Physicians Assur. Corp. v. Schmidt*, 187 S.W.3d 313, 317 (Ky. 2006); *Texas Farmers Ins. Co. v. Soriano*, 881 S.W.2d 312, 314-315 (Tex. 1994).

n18 Douglas R. Richmond, *Rights and Responsibilities of Excess Insurers*, 78 Denv. U.L. Rev. 29, 74 (2000).

n19 920 F. Supp. 908 (D. Ill. 1996).

n20 920 F. Supp. 908, 919 (D. Ill. 1996).

n21 920 F. Supp. 908, 919 (D. Ill. 1996) (citations omitted).

n22 See, e.g., *RLI Ins. Co. v. General Star Indem. Co.*, 997 F. Supp. 140 (D. Mass. 1998).

n23 See, e.g., *Indem. Ins. Co. of N. Am. v. Transcon. Ins. Co.*, 2005 NY Slip Op 9209 (N.Y. App. Div. 2005) (finding no bad faith).

n24 See, e.g., *RLI Ins. Co. v. CNA Casualty of California*, 141 Cal. App. 4th 75, 80-82 (Cal. Ct. App. 2006).

n25 *RLI Ins. Co. v. CNA Casualty of California*, 141 Cal. App. 4th 75, 80-83 (Cal. Ct. App. 2006).

n26 See, e.g., *Elec. Ins. Co. v. Nationwide Mut. Ins. Co.*, 384 F. Supp. 2d 1190, 1193-1194 (D. Tenn. 2005) (applying Tennessee law); *Fed. Ins. Co. v. Travelers Cas. & Sur. Co.*, 843 So. 2d 140, 145-146 (Ala. 2002); *Stonewall Surplus Lines Ins. Co. v. Farmers Ins. Co.*, 132 Idaho 318, 324-325 (Idaho 1998).

n27 See, e.g., *Nat'l Sur. Corp. v. Hartford Cas. Ins. Co.*, 445 F. Supp. 2d 779, 782-783 (D. Ky. 2006), *affd in part*, *revd in part*, 493 F.3d 752 (6th Cir. 2007).

n28 *Nat'l Sur. Corp. v. Hartford Cas. Ins. Co.*, 445 F. Supp. 2d 779, 784 (D. Ky. 2006).

n29 445 F. Supp. 2d 779 (D. Ky. 2006), *affd in part*, *revd in part*, 493 F.3d 752 (6th Cir. 2007).

n30 *Nat'l Sur. Corp. v. Hartford Cas. Ins. Co.*, 445 F. Supp. 2d 779, 785 (D. Ky. 2006), *affd in part*, *revd in part*, 493 F.3d 752 (6th Cir. 2007).

n31 *Nat'l Sur. Corp. v. Hartford Cas. Ins. Co.*, 445 F. Supp. 2d 779, 785 (D. Ky. 2006), *affd in part*, *revd in part*, 493 F.3d 752 (6th Cir. 2007).

n32 *Nat'l Sur. Corp. v. Hartford Cas. Ins. Co.*, 493 F.3d 752, 761 (6th Cir. 2007).

n33 *Nat'l Sur. Corp. v. Hartford Cas. Ins. Co.*, 493 F.3d 752, 755-760 (6th Cir. 2007).

n34 843 So. 2d 140 (Ala. 2002).

n35 *Fed. Ins. Co. v. Travelers Cas. & Sur. Co.*, 843 So. 2d 140, 143 (Ala. 2002).

n36 *Fed. Ins. Co. v. Travelers Cas. & Sur. Co.*, 843 So. 2d 140, 143-144 (Ala. 2002).

n37 *Fed. Ins. Co. v. Travelers Cas. & Sur. Co.*, 843 So. 2d 140, 145-146 (Ala. 2002).

n38 See, e.g., *United States Fire Ins. Co. v. Nationwide Mut. Ins. Co.*, 735 F. Supp. 1320, 1324-1325 (D.N.C. 1990) (applying North Carolina law); *American Centennial Ins. Co. v. Warner-Lambert Co.*, 293 N.J. Super. 567, 575-579 (Law Div. 1995).

RELATED LINKS: For Discussions of the Tort of Bad Faith in Insurance Law, see William M. Shernoff, Sanford M. Gage, Harvey R. Levine,

- Insurance Bad Faith Litigation, Ch. 1 et seq.;;
- New Appleman Insurance Law Practice Guide, Ch. 6, § 6.01 et seq.;;
- California Insurance Law & Practice, Ch. 13, § 13.01 et seq.

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Robinson on Recent Workers Comp. Cases: Blood Transfusion, Migrant Worker, Etc.

2008 Emerging Issues 774

Robinson on Recent Workers Comp. Cases: Blood Transfusion, Migrant Worker, Etc.

By Thomas A. Robinson

October 19, 2007

SUMMARY: Anyone who thinks that workers compensation law deals primarily with broken bones, low back injuries, and computations of average weekly wages has only to look at recent decisions from around the country to see that the issues examined within the comp world are as interesting and intricate as in most any other area of the law. This commentary, written by Thomas A. Robinson, the contributing writer for Larson's Workers' Compensation Law, surveys recent decisions where appellate courts have been called upon to rule on a host of unusual issues: refusal of blood transfusions on religious grounds, injuries sustained by migrant workers collecting work documents in Mexico, compensability of injuries sustained during horseplay, the effect on continuing disability benefits of earnings from a former workers illegal drug trade, a **\$25,000 penalty for the failure to pay a \$100 phone bill, to name a few.** **Robinson speculates that while an employee who was a member of a well-known and recognized religion, such as Jehovah Witnesses, might be granted workers compensation benefits although medical treatment was declined by the employee, a member of a small, unknown, and unrecognized, religion might not receive the same protection.**

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ARTICLE: Overview

Anyone who thinks that workers compensation law deals primarily with broken bones, low back injuries, and computations of average weekly wages has only to look at recent decisions from around the country to see that the issues examined within the comp world are as interesting and intricate as in most any other area of the law. Within the past few months, appellate courts have been called upon to rule on a host of unusual issues: refusal of blood transfusions on religious grounds, injuries sustained by migrant workers collecting work documents in Mexico, compensability of injuries sustained during horseplay, the effect on continuing disability benefits of earnings from a former workers illegal drug trade, a **\$25,000 penalty for the failure to pay a \$100 phone bill, to name a few.**

Refusal of Blood Transfusion for Religious Reasons as Grounds for Disqualifying Worker or Worker's Survivors From Workers' Compensation Benefits. In *Wilcut v. Innovative Warehousing*, 2007 Mo. App. LEXIS 915 (Mo. Ct. App. June 19, 2007), the Missouri Court of Appeals held that the refusal of a blood transfusion based on religious grounds was not an unreasonable refusal of medical treatment that would support a denial of further workers' compensation benefits to the worker or the worker's survivors. Holding that an injured worker's religious beliefs should

be given the benefit of broad latitude, the appellate court held the Missouri workers' compensation laws contemplated that there might be instances in which medical procedures involving little risk to the worker might nevertheless be refused on religious grounds without that refusal being treated as an intervening cause of further injury or death.

In *Wilcut*, a truck driver was involved in a work-related accident in which he sustained severe injuries. He was taken to a hospital for treatment and died there seven days later. His medical care was complicated by the fact that he refused to accept a blood transfusion on the grounds that it was not permitted by his faith. He instructed his doctors that, as a Jehovah's Witness, he could not receive the transfusion. At the time of his refusal, the truck driver was fully aware of the implications of his decision and had the support of his wife and family.

The employer did not object to the driver's decision, and paid the funeral expenses and death benefits for nearly two years. When the employer later stopped the payments, the widow sought their reinstatement. The law judge determined that the driver's refusal of medical treatment was not unreasonable under the Missouri statute, Mo. Rev. Stat. § 287.140.5., but the Commission found the refusal unreasonable both because the physical risk in receiving the units of blood was minimal, compared to the near certainty that the driver would have survived his injuries if he had been transfused, and because it found that Jehovah's Witnesses could seek forgiveness of their sins within the doctrines of their faith. Noting that the employer had not objected to the decision of the driver, that the Missouri statutory scheme seemed to contemplate that certain medical procedures might be refused on religious grounds, and that the Commission had virtually disregarded the truck driver's religious beliefs, the appellate court held that an employee's religious beliefs be liberally considered. Under these facts, the court held the driver's refusal to accept a blood transfusion was not unreasonable. A spirited dissent filed by Justice Romines means the issue will receive additional review by the Missouri Supreme Court.

Although the Missouri Court of Appeals did not base its findings on waiver grounds, one can legitimately wonder whether the fact that the employer had willingly paid Wilcut's funeral expenses and death benefits for two years to the Wilcut's survivors played some role in the decision.

Wilcut is only the second reported workers' compensation decision involving the refusal of a blood transfusion on religious grounds. In an early California case, *Martin v. Industrial Accident Commission*, 147 Cal. App. 2d 137, 304 P.2d 828 (1956), an employee sustained serious injuries when scaffolding on which he was working collapsed. The employee was taken to the hospital where he was advised that a blood transfusion was necessary. The employee, a Jehovah's Witness, refused any transfusion for religious reasons. The employee and his wife, both orally and in writing, confirmed to hospital authorities and the attending physician that he would rather die than have a transfusion. The employee died shortly after surgery and, according to expert testimony, would probably have survived had he been given transfusions of whole blood. The industrial commission denied the claim. On review, the court affirmed. The court found that there was substantial evidence to support the commission's finding that the proximate cause of the employee's death was not the injury he suffered at work but his unreasonable refusal to accept proper medical care. The court reasoned that the employee could not voluntarily choose to unreasonably forego medical care, whether for religious reasons or any other, and then require the employer to pay compensation for consequences that could have been avoided.

It should be observed that by virtue of a 1984 amendment, the Longshore and Harbor Workers' Compensation Act provides that nothing in the Act prevents an injured employee from relying "in good faith on treatment by prayer or spiritual means alone, in accordance with the tenets and practice of a recognized church or religious denomination," and further, that any employee who relies upon such prayer or spiritual means alone for healing shall not be considered to have unreasonably refused medical or surgical treatment.

33 U.S.C.S. § 907(k) provides as follows:

"(k) Refusal of treatment on religious grounds.

(1) Nothing in this Act prevents an employee whose injury or disability has been established under this Act from relying in good faith on treatment by prayer or spiritual means alone, in accordance with the tenets and practice of a *recognized* church or religious denomination, by an accredited practitioner of such recognized church or religious denomination, and on nursing services rendered in accordance with such tenets and practice, without suffering loss or diminution of the compensation or benefits under this Act. Nothing in this subsection shall be construed to except an employee from all physical examinations required by this Act.

(2) If an employee refuses to submit to medical or surgical services solely because, in adherence to the tenets and practice of a *recognized* church or religious denomination, the employee relies upon prayer or spiritual means alone for healing, such employee shall not be considered to have unreasonably refused medical or surgical treatment under subsection (d)." [Emphasis added]

The Longshore Act provides no guidance in determining which churches or religious denominations are *recognized* and which are not. One might, therefore, encounter a situation in which the members of a small, unknown church might hold beliefs substantially similar to those in a well-known denomination, such as the Jehovah's Witnesses, and might not be protected under the literal terms of the statute.

The Court of Appeals of Oregon considered that question in *Kemp v. Workers' Compensation Department*, 65 Or. App. 659, 672 P.2d 1343 (1983) and held that, to the extent the Oregon statute, ORS 656.010, allowed members of "well-recognized" churches to exercise their right to refuse medical treatment without penalty, but did not allow the same right to members of small, not "well-recognized" churches, it was unconstitutional.

For further discussion of refusal of reasonable medical treatment within the workers' compensation context, see generally 1-10 *Larson's Workers' Compensation Law* § 10.10.

Injuries Before Hiring--Migrant Worker's Acts Related to the Securing of Necessary Work Visa Found Insufficiently Related to Employment to Support Claim. An agricultural worker, a citizen and resident of Mexico, who had worked at a particular Virginia farm during the harvest seasons of 1996-1998 and who was killed in a bus accident in July 1999 as he traveled from Morelas to Monterrey, Mexico to pick up employment papers, including a work visa, which were required to qualify the worker to work again in 1999 for the Virginia farm, did not sustain an injury arising out of and in the course of the employment, held a Virginia court in *De la Rosa Herrera v. Martin*, 49 Va. App. 469, 642 S.E.2d 309 (2007).

Acknowledging that the protections of workers' compensation law are not required to wait until all relevant employment papers have been drafted, signed, and delivered, that in many cases it is sufficient if the employee has been told "to report to work," the appellate court determined that there was insufficient connection to the employment under the facts to bring the worker within the protection of the Virginia Workers' Compensation Act. In spite of the fact that he had worked for the farm for a number of years and anticipated working at that same farm again, the employment contract had not yet been completed. While the employment visa was necessary, so were other documents that could only be completed in Virginia. Accordingly, the Virginia commission had no jurisdiction over the widow's claim.

Herrera appears to be the only reported case involving a migrant worker sustaining an injury prior to the completion of required employment paperwork. As harsh as the decision may appear, particularly in light of the fact that the Herrera had worked for the Virginia farm for several prior seasons and there was little, if any, question that he would again be hired, the Virginia decision is in line with a number of important long-standing decisions within the workers' compensation context. For example, in *Miller v. T. H. Browning Steamship Co.*, 73 F. Supp. 185 (W.D.N.Y. 1947), *aff'd*, 165 F.2d 209 (2d Cir. 1947), the employer had a contract with the seamen's union which required the employer to call upon the union to furnish help before attempting to fill any job directly. The employer called the union for an oiler; the union sent the plaintiff to the ship; and the plaintiff on his way along the deck to report for work fell into an open hatch. Although one gets the impression that the plaintiff would have been hired as a matter of course, still he had not been officially accepted by the employer as an employee, nor had he made any agreement with the employer

that would bind him or prevent him from turning and walking off the ship if he had chosen to do so. On this reasoning, the court set aside a verdict of \$77,000 in favor of the employee under the Jones Act.

Similarly, in *Posey v. Industrial Commission*, 87 Ariz. 245, 350 P.2d 659 (1960), under a union agreement the contractor would requisition employees from the union, the union would furnish, by referral, the employees requisitioned, and "the contractor would notify the union immediately when such employees were hired." One half day's travel time plus transportation expense of \$5 was noted on the claimant's Work Clearance slip. The claimant was injured in an automobile accident en route to the job site. The majority held that the claimant had not been hired, since the master agreement with the union laid down only the conditions of a contract between the contractor and the referred members, who were subsequently hired at the job site. A vigorous dissent emphasized the distinction between a contract for hire relating to a specific master agreement with a union and the definition of an employment contract relating to compensation with its purpose "to protect workmen from economic loss due to injuries attributable to employment."

It is difficult to argue with the dissent in *Posey*: that for compensation law purposes, contract law technicalities should be subordinated to the reality of the relationship existing from the time the claimant begins the journey toward the job pursuant to the overall-contract governing the way hiring is done in this particular employment. The same could be said for the migrant worker, such as *Herrera*, who completes virtually all routine paperwork in his or her home country and only awaits a formal "rubber-stamping" of familiar forms in the United States.

For further discussion related to injuries sustained before hiring, see generally 2-26 *Larson's Workers' Compensation Law* § 26.02[3].

Supervisor's Strong Encouragement Related to Continuing Education Course Found Sufficient to Bring Event Within Employment for Purposes of Workers' Compensation. In *Murphy v. Mt. Sinai Hosp.*, 37 A.D.3d 919, 829 N.Y.S.2d 728 (2007), a New York appellate court sustained an award of disability benefits to a nurse practitioner who suffered multiple injuries in a traffic accident while attending a continuing education conference. A supervisor and mentor admitted that she had supplied the nurse practitioner with a brochure advertising the conference and "strongly encouraged" him to take advantage of the employer's policy advocating employee participation in such courses. That evidence, coupled with the fact that the employer's payment records reflected that the nurse received remuneration for two "conference days", was more than sufficient to support an award of benefits.

Murphy is consistent with the general rule that the compensability of an employee's injury while traveling to or attending conventions, institutes, seminars, and trade expositions generally turns on whether the claimant's contract of employment contemplated attendance as an incident of the work. It is **not** enough that the employer would benefit indirectly through the employee's increased knowledge and experience. Where there is active encouragement, as in *Murphy*, or where the employee is paid a travel allowance or given other substantial benefit, the injury is deemed to be within the course and scope of the employment.

Note generally that while employment connection may certainly be supplied by requiring attendance; it is not necessary (attendance was not, for example, required in *Murphy*). It is also sufficient if attendance, although not compulsory, is urged or expected.

Practitioners and other interested parties should note that the injury need not always be directly connected to the continuing education, seminar, or activity to support an award of compensation benefits. Thus, in *Missouri Dept. of Social Servs. v. Blatter*, 655 S.W.2d 819 (Mo. Ct. App. 1983), a social services employee attending a two-day training seminar was struck and killed by a car while crossing the street from a night club to the employee's hotel. An award was affirmed on the basis that attendance at the night club social gathering had itself been encouraged by the employer.

For further discussion related to the compensability of injuries while participating in various professional

educational pursuits, see generally 2-27 *Larson's Workers' Compensation Law* § 27.03[1][a].

Ohio Court Indicates Earnings From Injured Worker's Illegal Drug Trade May Be Considered in Determining Extent of Disability. In an unusual recent case from Ohio, *State ex rel. Lynch v. Industrial Comm'n*, 171 Ohio App. 3d 453, 2007 Ohio 292, 871 N.E.2d 618, the appellate court determined that it was appropriate to reduce an injured worker's permanent disability benefits by an estimate of the income the worker earned in his illegal drug trade.

This decision appears somewhat at odds with the ordinary rule that in disability claims, since the usual issue being tested is the claimant's ability to command regular income as the result of his or her personal labor, income from a business owned by the claimant should not be used to reduce disability, even though the claimant contributes some work to it. For example, in *Hensley v. Industrial Maint. Overflow*, 166 N.C. App. 413, 601 S.E.2d 893 (2004), review denied, 2005 N.C. LEXIS 522 (N.C. May 4, 2005), a North Carolina court held that neither the income from a tobacco allotment the claimant leased to relatives nor the income from a mobile home park the claimant owned established wage-earning capacity.

In *Lynch*, however, the court was understandably uneasy in treating the claimant's ill-gotten gains with the same respect as those afforded to a legitimate business enterprise. It reasoned that engaging in a continuing criminal enterprise for profit was sustained remunerative employment, just as other legitimate and legal endeavors might be.

For further discussion of post-injury income and disability indemnity payments, see generally 4-83 *Larson's Workers' Compensation Law* § 83.05.

Employer's Choice of Medical Care Provider Does Not Apply to Choice of Pharmacy. An Alabama appellate court, in *Davis Plumbing Co. v. Burns*, 2007 Ala. Civ. App. LEXIS 253 (Ala. Civ. App. April 20, 2007), ruled that while the employer is allowed to choose the physician under Ala. Code § 25-5-77, it may not choose the particular pharmacy from which the claimant will receive medication.

The "choice of doctor" question is one of the most contentious within the workers' compensation world. It arises out of the necessity of balancing two desirable values: the value of allowing an employee, as far as possible, to choose his or her own doctor, and the opposing value of achieving the maximum standards of rehabilitation by permitting the compensation system to exercise continuous control of the nature and quality of medical services from the moment of injury. If the injured employee has completely unlimited free choice of doctor, in some cases he or she may select a doctor, because of personal relationship or acquaintance, who is not qualified to deal with the particular kind of case, or who at any rate is incapable of providing service of the quality required for the optimum rehabilitation process.

Like a number of other states, Alabama allows the employer to make the choice of medical care provider. The court here held that policy did not extend to every level of medical care and did not give the employer a veto over the employee's drug store. *Davis Plumbing* appears to be the only reported case in which a "choice of pharmacy" was at issue. It shows that even in states where there is substantial freedom on the part of the employer in shepherding the employee through the workers' compensation medical process, there are limits beyond which the courts are reluctant to go.

For further discussion related to the responsibility of the employer to provide medical care related to injury, see generally 5-94 *Larson's Workers' Compensation Law* § 94.02[1].

Delaware Adopts "Larson" Test for Horseplay Cases. In *Grabowski v. Mangler*, 2007 Del. LEXIS 301 (Del. July 9, 2007), an exclusivity issue case, the Delaware Supreme Court expressly adopted the "Larson" four-part test for horseplay cases, indicating that the arising out of the employment question depended upon the following factors: (1) the extent and seriousness of any deviation; (2) the completeness of the deviation; that is to say, whether it was co-mingled with the performance of the employment duty or involved an abandonment of that duty; (3) the extent to which horseplay had become part of the employment environment; and (4) the extent to which the nature of the employment might be expected to include some horseplay.

Here a number of co-workers held the worker down and wrapped him from ankles to shoulders in duct tape. Their actions caused injury to the worker's back, and he claimed psychological injuries as well. He sought and received workers' compensation benefits and later sued his co-workers in tort. When they claimed they were immune from tort liability because of the exclusive remedy provisions of the workers' compensation act, the trial court agreed. On appeal, however, the Supreme Court reversed and indicated the trial court should consider the issues utilizing the Larson test.

Among the issues the court will need to consider is whether or not horseplay had become such a pervasive practice at the employer's facility that the employer actively or tacitly acquiesced in the activity. Most of us are familiar with work environments in which clowning around, practical jokes and the like are the norm, where an atmosphere of "one-upmanship" can exist, where the level of prankish activity builds and builds until it is virtually out of control. Courts generally are reluctant to remove those prankish acts from the employment where the employer looks the other way or actively participates.

While courts will seldom explicitly say so in their opinions, they often treat male-dominated work environments--construction and highway maintenance, for example--differently from work inside an office. Following what amounts to a "boys will be boys" attitude, courts often treat incidents of horseplay around the construction or road site as small deviations and allow recovery of workers' compensation benefits. Pranks within the office environment are more likely to be held to have fallen outside the ordinary course of employment.

For further discussion related to the workers' compensation issues related to horseplay, see generally 6-111 *Larson's Workers' Compensation Law* § 111.03[3].

Colorado Court Affirms \$24,900 Penalty for Delay in Paying Phone Bill. A Colorado court recently affirmed the imposition of 83 penalties of \$300 each, totaling \$24,900, against an employer for a three-month delay in paying a \$107.79 cellular telephone bill where the injured worker had been awarded cell phone services necessary to make emergency calls. In *Associated Bus. Prods. v. Industrial Claim Appeals*, 126 P.3d 323 (Colo. Ct. App. 2005), the Colorado court noted that the administrative law judge had imposed a penalty of \$300 per day for the 83 days of non-payment and that the statute, Colo. Rev. Stat. § 8-43-304(1), would have allowed a penalty of up to \$500 per day.

Note that the employer here had voluntarily supplied the cellular telephone as part of the overall medical care provided to the injured worker. This appears to be the only reported case where an employer or carrier has supplied such telephonic equipment on this basis.

Last year, the California Workers' Compensation Appeals Board, in *Tune & Lube v. Workers' Comp. Appeals Board (Derboghossian)* (2006) 71 Cal. Comp. Cas 795 (writ denied) held that the imposition of multiple penalties against an employer, totaling in excess of \$10,000, for the employer's delayed payment of home health care and nursing services provided by the employee's wife, transportation costs, costs of a computer and a scanner, physical therapy costs, and a seeing-eye dog, did not violate the \$10,000 cap on penalties under the Senate Bill 899 amendments to Cal. Labor Code § 5814, when the penalties attached to separate and distinct acts of delayed payment and were awarded against different species of benefits.

Issues connected to the imposition of penalties continue to be some of the most contentious within the workers' compensation law setting. For further discussion related to the imposition of multiple penalties, see generally 1-10 Hanna, *California Law of Employee Injuries & Workers' Compensation* § 10.40[5], and 8-135 *Larson's Workers' Compensation Law* § 135.02.

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Kissiah on Significant 2007-2008 Changes in Georgia Workers' Compensation Law

2008 Emerging Issues 611

Kissiah on Significant 2007-2008 Changes in Georgia Workers' Compensation Law

By Richard C. Kissiah

October 4, 2007

SUMMARY: Significant changes have occurred in the Georgia workers' compensation law in 2007 through legislation passed by the Georgia General Assembly and signed into law by the Governor, through the revision by the State Board of Workers' Compensation of its Rules & Regulations, and through decisions by the Supreme Court of Georgia and the Court of Appeals of Georgia. This commentary was written by Richard C. Kissiah, who practices almost exclusively in the field of workers' compensation law and is the author of Kissiah's Georgia Workers' Compensation Law (LexisNexis Matthew Bender) as well as an author and lecturer on the subject of Georgia workers' compensation law for the Atlanta Bar Association, the State Bar of Georgia, the Institute of Continuing Legal Education, and the State Board of Workers' Compensation.

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ARTICLE: A number of changes have been made in Georgia workers' compensation law. Most of them are effective July 1, 2007. Some of them were effectuated by changes in the Georgia Workers' Compensation Act by the General Assembly that were signed into law by the Governor. Other changes were effectuated by the State Board of Workers' Compensation through its revision of its Rules & Regulations. Still other changes were made by the Georgia courts through case-law decisions interpreting the Act, and the Boards Rules.

Statutory Changes

Increase in Benefit Rates. Section 6 of HB 424 amends O.C.G.A. § 34-9-261 to increase, as to accidents occurring on or after July 1, 2007, the maximum weekly temporary total disability and permanent partial disability benefit rates from \$450 to \$500, and to increase the *minimum* temporary total disability benefit rate from \$45 to \$50. Section 7 of HB 424 amends O.C.G.A. § 34-9-262, as to accidents occurring on or after July 1, 2007, to increase the maximum weekly temporary *partial* disability benefit rate from \$300 to \$334 per week.

Dismissal by Operation of Law. Section 2 of HB 424 ends dismissal by operation of law as to applications for hearing filed on or after July 1, 2007. However, as to applications for hearing filed with the Board on or after July 1, 1985, but prior to July 1, 2007, it still provides that, as to an application for hearing for which no hearing is conducted for a period of five years, the application for hearing shall automatically stand dismissed [O.C.G.A. § 34-9-100(c)].

While dismissal by operation of law as to an application for hearing may be helpful to an employer in a case that is a so-called change in condition case, if it can be said that an application for hearing and an application for change in condition are one and the same thing, dismissal by operation of law of a mere application for hearing probably does not dismiss the underlying claim itself.

Section 2 of HB 424 also creates a *new* dismissal by operation of law provision that applies to the underlying claim itself rather than to a mere application for hearing. It provides that the underlying claim itself shall stand dismissed with prejudice by operation of law, *if*: (1) the claim is an occupational injury claim rather than an occupational disease claim; (2) the claim involves a date of injury on or after July 1, 2007; (3) neither disability benefits nor even medical benefits have been paid with regard to the claim; and (4) no hearing is conducted for a period of five years from the date of the alleged accident [O.C.G.A. § 34-9-100(d)(1) & (2)].

Farm Laborers. In two cases involving employees of the same alligator farm, Prehistoric Ponds, the Court of Appeals held that an employee of an alligator farm would not be included in the definition of farm laborer, so that the employee would be subject to the Act and, as such, eligible for workers' compensation benefits. The Court of Appeals based the decisions on its belief that alligators are considered wildlife, rather than livestock or fur-bearing animals, and its further belief that working with wildlife is not farm labor. However, within Section 1 of HB 424, the Georgia General Assembly has since amended O.C.G.A. § 34-9-2(a) to include, within the definition of farm laborer, and to therefore exclude such individuals from coverage (unless the farmer and farm laborer opt into coverage), any person employed by an employer in connection with the raising and feeding of and caring for wildlife, as such term is defined in paragraph (77) of Code Section 27-1-2.

Time within Which Employer May Appoint a Rehabilitation Supplier. Section 3 of HB 424 amends O.C.G.A. § 34-9-200.1(a) to increase, from fifteen days to twenty days, the period of time from the date of notification that an injury has been determined to be catastrophic, within which the employer has to appoint the employers choice of rehabilitation supplier. It further amends the aforementioned Code subsection to change, from the word will to the word shall the provision that where the employer fails to select a rehabilitation supplier, within that twenty day time period, A rehabilitation supplier shall be appointed by the board to provide services at the expense of the employer.

Medical Evaluations. While it has long been the policy of the Board to include psychiatric evaluations and psychological evaluations within the evaluations allowed under O.C.G.A. § 34-9-202, it seems that some individuals had nonetheless argued that the Board lacked statutory authority to do so. Section 4 of HB 424 should put any such argument to rest. It amends both O.C.G.A. § 34-9-202(a) as to employer-requested medical evaluations and O.C.G.A. § 34-9-202(e) as to employee-requested medical evaluations, to make it clear that such evaluations may include physical, psychiatric, and psychological examinations. Further, just in case there was any doubt, it also amends O.C.G.A. § 34-9-202(a) to make it clear that it applies not only to male employees but also to female employees.

Charges for Prescription Drugs and Other Items & Services. The Board has long had statutory authority over the fees of physicians and the charges of hospitals. A question arose as to whether the Board also had authority as to charges for prescription drugs and as to charges for other items and services under the Act. Section 5 of HB 424 amends O.C.G.A. § 34-9-205(a) to make it clear that the Board has authority not only over the fees and charges of hospitals but also authority as to charges for prescription drugs, and charges for other items and services under this chapter

Drug-Free Workplace Programs. SB 96 amends O.C.G.A. § 34-9-415 to provide for on-site testing and oral testing in drug-free workplace programs. More specifically, the amendment added the following language to subsection (b) of O.C.G.A. § 34-9-415, as to what types of tests are acceptable: Urinalysis conducted by laboratories, testing at the employer worksite with on-site testing kits, or use of oral testing that satisfies testing criteria in this article shall be deemed suitable and acceptable substance abuse testing. It also adds, as to O.C.G.A. § 34-9-415(d)(5), concerning which individuals are permitted to conduct drug testing, two sections: (D) For the purpose of a pre-job offer screening only, a person trained and qualified to conduct on-site testing; or (E) For the purpose of a pre-job offer screening only, a person trained and qualified to conduct oral testing, if an oral test is used. Therefore, in light of these changes, it is

permissible to use on-site and oral testing, and, for pre-job offer screening, to use non-medical, but trained and qualified personnel to conduct the tests.

Subsequent Injury Trust Fund Assessments for Former Self-Insureds. Effective May 18, 2007, O.C.G.A. § 34-9-358 has been amended by SB 131, in pertinent part, to provide, among other things, that: An employer who has ceased to be a self-insurer prior to the end of the calendar year shall be liable to the [Subsequent Injury Trust] fund for the assessment of the calendar year. Such employer who has ceased to be a self-insurer shall continue to be liable to the fund for assessments in subsequent calendar years so long as payments are made on any workers' compensation claims made while in self-insured status.

Georgia Insurers Insolvency Pool. Effective January 1, 2008, HB 408 creates O.C.G.A. § 33-41-20.1 so as to allow an association or industrial insured captive insurance company issuing workers' compensation insurance contracts to be permitted to join or contribute financially to the Georgia Insurers Insolvency Pool under Chapter 36 of this title or any other plan, pool, or association guaranty or insolvency fund in this state.

Georgia Case-Law: Decisions of Note

Penalties May Be Assessed Even Where Income Benefits Are Not Late. O.C.G.A. 34-9-221(b) provides, in pertinent part that, after the employer has paid the first payment of income benefits, all subsequent benefits that are thereafter paid by the employer shall be due and payable in weekly installments; provided, however, that the board may, in its discretion, authorize payments to be made in different installments if it determines that this would be beneficial to all parties concerned. In the *Renu Thrift Store* case, the employer nonetheless, during certain periods of time, paid the claimant on a bi-weekly basis, rather than a weekly basis, even though the employer had no order from the Board authorizing it to do so. The Board assessed a fifteen percent penalty against the employer for each bi-weekly payment. The employer appealed noting, among other things, that each bi-weekly payment was actually one timely payment and one early payment such that none of the payments were late so that a fifteen percent penalty should not have been assessed by the Board. The Court of Appeals upheld the assessment of the fifteen percent penalty as to each bi-weekly payment, effectively noting that even if the payments had been timely, and even if the payment had been early, because they were not *weekly*, as O.C.G.A. § 34-9-221(b) requires, and because there had been no alternate schedule of payments approved by the Board, payments should have been made in weekly installments and the Board was therefore authorized to assess a fifteen percent penalty for those weeks for which the employer failed to pay the claimants income benefits weekly rather than bi-weekly [*Renu Thrift Store, Inc. v. Figueroa, Ga. App. No. A07A1116 (6-20-07), 286 Ga. App. 455, 2007 Ga. App. LEXIS 674*].

Effect of Failure to Pay Penalties. Where an employer who pays income benefits fails to pay statutory late payment penalties due and thereafter controverts overall liability on the claim, the Court of Appeals has long held that the employers failure to pay the statutory late payment penalties bars the employer from controverting overall liability on the claim [*Cartersville Ready Mix Co. v. Hamby, 224 Ga. App. 116, 479 S.E.2d 767 (1996)*].

In the *Fallin* case, the claimant argued that the employers failure to pay late payment penalties owed the claimant prevented the employer from even asserting a change in the claimants condition. The Court of Appeals rejected the claimants contention. It held that while the failure of an employer to pay late payment penalties owed a claimant would prevent the employer from disputing the compensability of the claimants injury, the employers failure to pay the late payment penalties would *not* prevent the employer from asserting that the claimant had undergone a change for the better in his condition [*Fallin v. Merritt Maint. & Welding, Inc., 283 Ga. App. 485, 642 S.E.2d 122 (2007)*].

Catastrophic Designation. In a claim involving an accident occurring on or after July 1, 1997, in which the claimant is seeking catastrophic designation under O.C.G.A. § 34-9-200.1(g)(6), the claimant bears the burden of proving that the on-the-job injury not only prevents him from being able to perform his prior work, but also that it prevents him from being able to perform any work available in substantial numbers within the national economy for which he is qualified. If the claimant simply proves that she is unable to perform her prior work, but offers no evidence

that her on-the-job injury prevents her from being able to perform any work available in substantial numbers within the national economy for which she is qualified, the Board has no authority to determine the presence or absence of that second prerequisite based solely on the Board's own experience. Further, mere testimony from the claimant herself that she has looked for work, without anything else, certainly would not satisfy the claimant's burden of proving the second prerequisite [*Reid v. Georgia Bldg. Auth.*, 283 Ga. App. 413, 641 S.E.2d 642 (2007)].

Liability Between Successive Insurers. In the *TIG Specialty Insurance* case, the first carrier (TIG) insured the employer as of the date of the claimant's 12-20-00 on-the-job injuries. Coverage changed from TIG to a second carrier (Zenith) as of 2-1-02. The claimant's condition worsened to the point where he ceased work, with a doctor's excuse, on 5-8-02. TIG commenced payment of workers' compensation disability benefits to the claimant from the date of his 5-8-02 disability but, almost two years later, in February 2004, TIG requested a hearing to determine whether it was entitled to reimbursement from the new carrier, Zenith. The claimant and Zenith both filed motions to dismiss the first carrier's hearing request. The ALJ denied both motions but the Appellate Division reversed, dismissing TIG's hearing request after concluding that TIG was barred by the statute of limitations provisions of O.C.G.A. § 34-9-221(h), from seeking to shift liability from itself to Zenith.

The Court of Appeals noted that O.C.G.A. § 34-9-221(h), provides, in pertinent part: Where compensation is being paid without an award, *the right to compensation* shall not be controverted except upon the grounds of change of condition or newly discovered evidence unless notice to controvert is filed with the board within 60 days of the due date of first payment of compensation. [emphasis by court]. The Court of Appeals noted that the first carrier had asserted that it was not challenging the claimant's right to compensation, but that it was only disputing which of two successive insurance carriers should be responsible for compensation. The Court of Appeals relied upon its earlier decision in the *Columbus Intermediate Care Home* case to find that the sixty day statute of limitations provision of O.C.G.A. § 34-9-221(h) is inapplicable and should not reach a controversy between two insurance companies wherein the compensability of the claimant's injury goes unchallenged. The Court of Appeals held that this would be true even where, as here, the Board had apparently felt that the claimant's continued right to compensation was in jeopardy, presumably under a theory by the Board that if the first carrier's request for hearing was granted, and if the ALJ found a new injury occurred in May 2002, the second carrier might be able to successfully challenge payment because the claimant had not filed a claim for a May 2002 injury. However, the Court of Appeals noted that there had been no finding of a new injury and that the question of whether there was a new injury was a question of fact to be determined by the ALJ but that the ALJ had been unable to make any such determination because the Appellate Division had dismissed the hearing request. The Court added that, Due process demands that TIG be provided an opportunity to show that Zenith is responsible for such compensation. [*TIG Specialty Ins. v. Brown.*, 283 Ga. App. 445, 641 S.E.2d 684 (2007), citing *Columbus Intermediate Care Home v. Johnston*, 196 Ga. App. 516, 396 S.E.2d 268 (1990)].

Scope of Employment. A majority of the Supreme Court of Georgia affirmed the Court of Appeals decision in the *Ray Bell Construction* case, concluding, as had the Court of Appeals, that while the employee may have initially deviated from the scope of his employment, he had resumed continuous employment by the time of his on-the-job accident so that his accident was a compensable one. However, three members of the Supreme Court of Georgia vigorously dissented from the decision. They felt that the employee had the on-the-job accident at a time when he was performing no duties on behalf of the employer, and that the employee's ultimately fatal accident was simply not a compensable one. The dissenters also believed that the majority had given the doctrine of continuous employment a far broader application than it should have [*Ray Bell Constr. Co. v. King*, 281 Ga. 853, 642 S.E.2d 841 (2007)].

Average Weekly Wage. In the *Caremore* case, the claimant sought to increase her average weekly wage (AWW) to include the value of the meals that her employer allowed her to purchase during her employment, for one dollar per day even though the meals were worth four dollars per day, for the net value to her of three dollars per day for the five days per week that she had worked. The employer argued that the meal subsidy was not a benefit furnished without charge to be included in the computation of her AWW, since the claimant paid a dollar per day for the meals, and pointed out that Board Rule 260(a) provides that, in the computation of AWW, the employer shall include, in addition to salary, hourly pay or tips, the reasonable value of food, housing and other benefits *furnished . . . without charge to the*

employee which constitute a financial benefit to the employee and are capable of pecuniary calculation [emphasis by court]. The Court of Appeals noted that the Act is a humanitarian measure which should be liberally construed to effectuate its purpose, and added that, we are not inclined to give Rule 260(a) the technical reading advocated by Caremore as it does not serve to effectuate the Acts purpose of providing relief to injured workers. Here, as Caremore stipulated that the meals subsidy provided Hollis a net economic benefit, the Board did not err in concluding that such benefit should be included in calculating Holliss average weekly wage. [*Caremore, Incorporated/Wooddale Nursing Home v. Hollis*, 283 Ga. App. 681, 642 S.E.2d 375 (2007)].

Preauthorization. Some employers have argued that the Board went beyond its authority in promulgating Rule 205 concerning preauthorization of treatment or testing. In the *Caremore* case, the employer was sent on 3-4-04 a Form WC-205 by the authorized treating physician seeking preauthorization for an evaluation but the employer failed to respond to it within five business days as the Rule requires. While the employer eventually denied the request on 3-25-04, the claimants attorney argued that Caremores failure to respond within five business days meant that the evaluation, under Rule 205, should be regarded as having automatically been preapproved despite Caremores denial. Caremore eventually preauthorized the evaluation. The Court of Appeals therefore did not address the question of whether Rule 205s automatic preauthorization provision is valid. However, the Court of Appeals held that where there was a failure to timely respond to the Request for Preauthorization, the Board does have the authority to assess civil penalties payable to the Board and attorney fees payable to the claimants attorney where the employer willfully failed to comply with the Boards rules [*Caremore, Incorporated/Wooddale Nursing Home v. Hollis*, 283 Ga. App. 681, 642 S.E.2d 375 (2007)].

Overpayment of Disability Benefits. In the *Renu Thrift Store* case, the employer ultimately realized that, for almost five years, it had overpaid the claimant by almost ten thousand dollars. The employer therefore unilaterally suspended payment of the claimants weekly disability benefits and sought to recoup the overpayments. The Court of Appeals held that the employer was barred, by the statute of repose set forth within O.C.G.A. § 34-9-245, from claiming credit for any workers' compensation disability benefit overpayments that it had made to the claimant more than two years prior to the employers application for reimbursement. It held that this was true regardless of the overpayment provisions of O.C.G.A. § 34-9-243(a). The employer was therefore found to be entitled to only about three thousand dollars of overpayments. It also held that the Board had authority to find the employers unilateral suspension of benefits without a court order to be so unreasonable as to justify an assessment of attorney fees against the employer [*Renu Thrift Store, Inc. v. Figueroa*, Ga. App. No. A07A1116 (6-20-07)].

Failure to Pay Ten Days Advance Notification of Suspension of Benefits. Where an employer unilaterally suspends payment of a claimants temporary total disability (TTD) benefits based upon the claimant having been released to unrestricted work by the authorized treating physician, the employer must pay ten days advance notification of suspension of benefits [O.C.G.A. § 34-9-221(i)]. Where an employer fails to do so, a question arises as to whether the employer should be forced: (1) to retroactively recommence payment of the claimants TTD benefits from the date of the suspension until the date the employer resuspends benefits with the requisite ten days advance notification of suspension; (2) to retroactively recommence payment of TTD benefits until the date of the ALJ award; (3) to retroactively recommence payment of TTD benefits until the date of the hearing; or (4) to simply pay ten days TTD benefits, or the part of the ten days TTD benefits that it has not paid.

In the *Reliance Electric* case, the claimant was paid TTD benefits until her authorized treating physician released her to unrestricted work on 7-25-03. On 7-29-03, Reliance issued a Form WC-2 notice stating that the claimants benefits would be suspended on 8-10-03. It in fact suspended her benefits on that date. However, the WC-2 was not filed with the Board until 8-4-03. The Board treated the date it received the WC-2 notice as being the date the claimant would have received the WC-2 notice. It therefore found that the claimant had received only six days advance payment rather than the statutorily required ten days. The claimant waited until nine months after the suspension to even request a hearing. A hearing was finally held eight months after that. The ALJ ordered the employer to pay TTD benefits from the date of suspension until the date of the award (nineteen months worth of accrued TTD benefits) due to the employers failure to pay the entirety of the ten days advance notice. The Appellate Division held that it was the date of

hearing rather than the date of the award that should have been used so that it ordered the employer to pay TTD benefits from the date of suspension until the date of the hearing (seventeen months worth of accrued benefits).

The Court of Appeals rejected both approaches. It noted that what the Code subsection required was payment of ten days notice, that the claimant had already received six days, and that she was therefore entitled to only four days TTD benefits. The Court of Appeals also noted that the Board certainly has the authority to assess attorney fees payable by the employer to counsel for the claimant if the Board finds the employers failure to pay the requisite ten days advance notice of suspension of benefits is without reasonable grounds [*Reliance Elec. Co. v. Brightwell*, 284 Ga. App. 235, 643 S.E.2d 742 (2007)].

Motion to Set Aside Award. Where an employer receives a notice of an ALJ hearing but chooses not to participate, and where the hearing is held and results in an award which the employer does not appeal, the employer cannot later try to set aside the Boards award and successfully avoid a superior court action to enforce the award, even where the award mistakenly finds the employer to lack insurance that it actually had. This is because the employer easily could have corrected the problem by participating in the proceedings before the ALJ of which it was repeatedly notified, and, at the very least, by timely appealing the ALJs decision [*Winnersville Roofing Co. v. Coddington*, 283 Ga. App. 95, 640 S.E.2d 680 (2006)].

Failure of Superior Court to Serve Parties with Decision. After a superior court judge has decided a case, unless notice of the decision has been waived, it is the duty of the judge to file his or her decision with the clerk of the court in which the case is pending and to notify the attorney or attorneys of the losing party of the decision [O.C.G.A. § 15-6-21(c)]. Yet, in the *Parker* case, neither the employer nor the claimant received a copy of the superior courts judgment with regard to a workers compensation appeal. After the time within which the employer could have applied for discretionary appeal had already expired, the claimants attorney advised the employers attorney of the judgment. The employer filed a motion seeking to vacate and reenter the judgment so that the employer could timely pursue an application for discretionary appeal. The superior court refused to grant the motion.

The Court of Appeals reversed the superior court. As to the superior courts argument that the employer had failed to be diligent, since the employer should have known that the superior court had to rule within twenty days or the workers compensation decision would be automatically affirmed, the Court of Appeals noted that that did not change the fact that the superior court itself had failed to perform its duty mandated by law. It also ruled that the superior court had erred in determining that the provisions of O.C.G.A. § 34-9-105(b) would have divested it of subject matter jurisdiction of the case if it vacated the original judgment, further holding that the *Taylor Timber* case on which the superior court had relied was distinguishable. It ordered the superior court to grant the employers motion and to vacate and reenter the judgment so that the employer would have time within which to file an application for discretionary appeal [*Wal-Mart Stores, Inc. v. Parker*, 283 Ga. App. 708, 642 S.E.2d 387 (2007)].

End of Employment Aggravation. The Court of Appeals held that the Board had properly found that the claimant was *not* entitled to further workers' compensation benefits where her work-related injury had caused a temporary aggravation of a pre-existing condition and where that aggravation had resolved. The Court noted that there was evidence to support such a finding by the Board in the form of the opinion of the claimants authorized treating physician, Dr. Godlewski. The Court acknowledged that there was a conflict in the medical evidence, with Dr. Godlewski testifying that, although a precise medical base line was impossible to determine, he believed that Bembry had returned to the baseline of her pre-injury condition and that the sprains caused by her injury were resolved, but with the claimants personal physician, Dr. Wilson, expressing his definitive opinion that Bembrys previous condition was aggravated by the fall and that she had not returned to her pre-injury baseline. The Court noted that the question of whether to give more weight to the opinion of Dr. Godlewski than to the opinion of Dr. Wilson was a question for the Board rather than the superior court or the Court of Appeals itself to decide. It rejected the claimants contention that Dr. Wilsons opinion should be given more weight than that of Dr. Godlewski because Dr. Godlewski had sought Dr. Wilsons opinion, and rejected the claimants contention that Dr. Godlewskis opinion should not be given any weight because Dr. Godlewskis opinion was not framed in the form of a medical certainty that the claimant had returned to her

pre-injury baseline. As to the latter point, the Court of Appeals noted that medical certainty is not required and that medical probability is the applicable standard with regard to such an issue. It therefore concluded that the Board had properly relied upon Dr. Godlewskis opinion as evidence in finding that the claimants work-related injury had resolved [*Bibb County Bd. of Edu. v. Bembry, Ga. App No. A07A1525 (7-30-07), 2007 Ga. App. LEXIS 862*].

Board Rule Changes

Effective July 1, 2007, the State Board of Workers' Compensation has made a number of changes with regard to its Rules & Regulations. Some of the more significant changes are discussed below.

Limitation on a Medical Providers Right to Recover Payment. The Board has created a new, 120 day, time limit on the period of time within which a medical provider may challenge the amount of the payment which it has received from the employer-insurer. In that regard, it provides, Any challenge by a medical provider to the amount of payment for goods, services, or expenses shall be submitted to the payor within 120 days of payment. Failure by a medical provider to challenge the amount of payment of such goods, services, or expenses within 120 days shall result in the waiver of additional payment. [Board Rule 203(b)(2)].

Medical Bills. The Georgia Workers' Compensation Act has long provided, No physician, hospital, or other provider of services shall be entitled to collect any fee unless reports required by the board have been made. [O.C.G.A. § 34-9-205(a)]. Board Rule 205 had specified, Reports required by the Board include State Board of Workers' Compensation Form WC-20(a), or HCFA 1500, HCFC 1450, or UB 92 . . . Effective July 1, 2007, the Board has added to the aforementioned list of acceptable forms the Form UB-04 [Board Rule 205(a)].

Settlements. The Board has revised its Rules to provide, if the stipulated settlement agreement provides for a Medicare Set-Aside Arrangement (MSA), the stipulated settlement agreement shall contain a provision as to the actual cost of the MSA. [Board Rule 15(d)].

The Board has also added a provision to its Rules requiring that where a case is being settled with a claimant who is represented by an attorney, and where that attorney is seeking payment for his or her expenses out of the settlement, the attorney shall certify that the expenses comply with Rule 1.8(e) of the Georgia Rules of Professional Responsibility and Board Rule 108. [Board Rule 15(e)].

The Board had been requiring that a Form WC-4 marked final be filed with any liability settlement or no-liability settlement as a prerequisite for Board approval of the settlement. However, the Board has revised its Rules & Regulations so that, effective July 1, 2007, one no longer needs to submit a Form WC-4 with a liability settlement or even a no-liability settlement but must instead submit such a Form WC-4 Within 30 days of final payment made pursuant to an approved stipulated settlement . . . [Board Rule 61(b)(5)(F)].

Challenge to Expert Witness Testimony. Effective July 1, 2007, Any challenge to the testimony of an expert under O.C.G.A. § 24-9-67.1 shall be made no later than 15 days prior to the hearing. Failure to raise a timely challenge shall result in a waiver of the challenge unless otherwise agreed to by the parties and the Administrative Law Judge. [Board Rule 102(E)(3)(e)].

O.C.G.A. § 24-9-67.1 establishes a methodology for determining what expert testimony will be accepted in Georgia civil cases. It essentially is a *Daubert* standard designed to avoid so-called junk science testimony from expert witnesses [*Daubert v. Merrell Dow Pharmaceuticals, Inc., 509 U.S. 579 (1993)*].

Costs for Appeal to Superior Court. Where a party is dissatisfied with a decision by the Appellate Division of the State Board of Workers' Compensation and appeals same, that party must file his appeal with the Board, which thereafter copies the record and transmits it to the clerk of the superior court. However, effective July 1, 2007, the Board has revised its Rules so that, Any party filing with the Board an appeal to Superior Court shall pay the reasonable copying and transmittal costs of the Board. Upon good cause shown, the Board may waive the copying and transmittal

costs. [Board Rule 105(f)].

Ten Days Advance Notice of Suspension of Benefits. It may often be difficult to determine exactly when a claimant has received the ten days advance notification of suspension of disability benefits which O.C.G.A. § 34-9-221(i) requires. The Board rule to that effect had been somewhat poorly worded. It had provided, The date of filing with the Board, in the absence of compelling evidence to the contrary, shall be considered the date of filing. However, effective July 1, 2007, the Board has revised the aforementioned rule to read: The date of filing with the Board in the absence of compelling evidence to the contrary, shall be considered the date of *notice* [emphasis added], so as to make it clear [Board Rule 221(i)(2)]. Similarly, the Rules were revised to provide that the date affixed by the Board to Forms WC-2 or WC-2A is going to be considered the date of notice to the employee or dependent in the absence of compelling evidence to the contrary. . . . [Board Rule 221(i)(3)].

The Board has further clarified that where a claimants benefits are being suspended based upon a release to unrestricted work by the authorized treating physician, the physician must have examined the employee within sixty days of the effective date of the release and a copy of the report to that effect must be attached to the Form WC-2 notice [Board Rule 221(i)(4)].

Form Filing. The Board is going to reject any document or form filed with it unless there is a file set up at the Board. Further, there is not going to be a file set up by the Board unless the Board has first received either a Form WC-1 or a Form WC-14 [Board Rule 60(h)].

The Board has further revised its Rules to provide that the instructions on the back of any Board form must be sent to the employee but are *not* to be filed with the Board itself [Board Rule 61(b)].

Cancellations and Postponements. If a case is set for a mediation, or a hearing before an ALJ or the Appellate Division, or if a Request for Change of Physicians or a motion is pending, then, if the issues are resolved or the case settles, the parties or their attorneys are required to immediately notify the ADR Division (in the event of a mediation), the Board or assigned ALJ (in the event of a hearing, request or motion), or the Court Clerk of the Appellate Division (in the event of an Appellate Division hearing) first by telephone call and then, if so instructed, by subsequent written or electronic confirmation. Where a party or attorney fails to follow this procedure and is unable to show good cause for that failure, that party or attorney may be subject to assessment of civil penalties payable to the Board and/or assessed attorney fees and/or costs and, in the event of a hearing, to liability for the court reporter charges [Board Rules 100(h)(3), 102(C)(1), 102(D)(4), 103(b)(8), 200(b)(1)].

Fee Schedule

The State Board of Workers' Compensation has authority to annually publish a schedule of maximum allowable charges with regard to the fees of physicians, surgeons and other healthcare providers. The Board has revised the Fee Schedule effective April 1, 2007. It includes a new provision requiring the use of generic drugs when they are available unless the physician prescribing the drugs handwrites either Brand Medically Necessary, or Brand Necessary.

The Board also added a provision, Prescription drugs will be reimbursed at the current average wholesale price (AWP) as published by Medispan, plus a dispensing fee of **\$6.00 for generic medications and \$4.00 for single-source brand medications. All bills submitted for reimbursement must include the National Drug Code (NDC) of the product provided. When the authorized treating physician prescribes pharmaceuticals, the prescription will indicate by stamp or other means that it is for a workers' compensation claim.**

Also effective July 1, 2007, the Board has created its first Non-Emergency Transportation Fee Schedule. It recognizes two types of non-emergency medical transportation: ambulatory transportation (which can include the transportation of wheelchair-bound individuals) and transportation by lift vans (which would include an individual who needs to be transported to and from the van by stretcher). It establishes maximum mileage rates for each of the two types of non-emergency transportation, as well as caps on surcharges for waiting time,

weekends, wheelchair movement, and no-call/no-show charges [<http://sbwc.georgia.gov> at Fee Schedule Medical].

For Further Discussion on Workers Compensation in Georgia, see statute of limitations for change in condition 1-9 Georgia Workers' Compensation Law § 9.06 (LexisNexis Matthew Bender), farm laborers 1-3 Georgia Workers' Compensation Law § 3.07 (LexisNexis Matthew Bender), medical evaluations 1-18 Georgia Workers' Compensation Law §§ 18.10--18.11 (LexisNexis Matthew Bender), payment penalties 1-22 Georgia Workers' Compensation Law § 22.09 (LexisNexis Matthew Bender).

For Further Discussion on Workers Compensation Law, see subsequent injury trust funds 5-91 *Larson's Workers' Compensation Law* § 91.01 (LexisNexis Matthew Bender), successive insurers 9-153 *Larson's Workers' Compensation Law* § 153.01 (LexisNexis Matthew Bender), concept of average weekly wage 5-93 *Larson's Workers' Compensation Law* § 93.01 (LexisNexis Matthew Bender), continuous employment of resident employees 2-24 *Larson's Workers' Compensation Law* § 24.03D (LexisNexis Matthew Bender).

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Rassp and Ponzio on Noteworthy California WCAB Decisions Denied Judicial Review

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Rassp and Ponzio on Noteworthy California WCAB Decisions Denied Judicial Review

By Robert G. Rassp and James Ponzio

October 3, 2007

SUMMARY: Each month important "writ denied" cases (California Workers' Compensation Appeals Board decisions denied judicial review) are reported in California Compensation Cases. This commentary by Robert G. Rassp and James Ponzio examines four recent writ denied cases dealing with medical treatment in the form of two-level arthroplasty disc surgery, attorney's fees in a situation where a compromise and release was entered into with an unrepresented applicant, an applicant's blood-borne methicillin-resistant staphylococcus aureus (MRSA), which was found to be a compensable consequence of his left shoulder injury, and a recent review of case law that covers the criteria for eligibility for Subsequent Injuries Benefits Trust Fund benefits. Robert G. Rassp was the Chair for the State Bar Workers' Compensation Law Section Executive Committee in 2000-2001 and is currently active as a member of that committee, and James Ponzio is a Certified Specialist in Workers' Compensation who exclusively represents employers and insurance carriers before the California Workers' Compensation Appeals Board and appellate courts.

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ARTICLE: Each month important "writ denied" cases (California Workers' Compensation Appeals Board decisions denied judicial review) are reported in *California Compensation Cases*. This article examines four recent writ denied cases dealing with medical treatment in the form of two-level arthroplasty disc surgery, attorney's fees in a situation where a compromise and release was entered into with an unrepresented applicant, an applicant's blood-borne methicillin-resistant staphylococcus aureus (MRSA), which was found to be a compensable consequence of his left shoulder injury, and a recent review of case law that covers the criteria for eligibility for Subsequent Injuries Benefits Trust Fund benefits. To read the full summary for each case as reported in *California Compensation Cases*, click on the case citation. The headnote for each case is reprinted below, followed by commentary from the applicant's perspective and, for the first two cases, the defense perspective as well.

Medical Treatment; ACOEM Guidelines

Glagola Construction Company v. W.C.A.B. (Larios) (2007) 72 Cal. Comp. Cas 1016 (writ denied)

Headnote

Medical Treatment--American College of Occupational and Environmental Medicine Guidelines--WCAB awarded

applicant construction carpenter/laborer further medical treatment to cure or relieve effects of his 12/18/2004 injury AOE/COE to low back and spine, including, but not limited to, two-level arthroplasty disc surgery recommended by applicant's treating physician and supported by agreed medical examiner, based on opinions from treating surgeon and agreed medical examiner and applicant's offer of proof, when applicant previously underwent failed lumbar laminectomy and hemilaminectomy for his injury, his treating surgeon recommended either two-level arthroplasty disc surgery (using artificial discs) or arthrodesis/fusion, applicant chose arthroplasty disc surgery, agreed medical examiner indicated he would prefer fusion but found arthroplasty disc surgery was also reasonable and supported choice of type of surgery made by applicant and treating surgeon, agreed medical examiner stated that treating surgeon was excellent surgeon, WCAB found that suggested surgery was outside ACOEM Guidelines, or, alternatively, that it was within Chapter 6 of Guidelines, which stated that treatment to increase function in chronic pain patients was appropriate, and there was no authority for defendant's contentions that requested surgery should be denied because it was experimental or not approved by Federal Drug Administration [See generally 1-5 CA Law of Employee Injuries & Workers' Comp §§ 5.01, 5.02[(3), 5.03(4), 22.01(1)].

Commentary

Applicant's Perspective. This is a very interesting case for the fact that the decision about whether to perform a two level inter-vertebral disc replacement surgery as opposed to a two level fusion was turned into a medical-legal issue. Here, the AME was leery of a two level disc replacement surgery in the lumbar spine but deferred to the judgment of the treating physician based upon that physicians expertise and reputation in spinal procedures.

This decision is significant for the difficulty in having a judge decide what is in the best interest of the applicant from a medical standpoint. All legal practitioners in workers compensation cases are faced with new medical procedures and technologies and the determination about whether an applicant in a workers compensation case should be subjected to those procedures. This problem can be called the Be careful what you wish for issue for what if the medical procedure fails and the procedure does not result in functional restoration of the applicants personal, social, and occupational activities?

The problem here is that many medications and medical procedures have unknown long term effects. For example, research may eventually show that disc replacement surgeries only work at one level and not two within the same sub-region of the spine, or that the disc replacement surgery only works in the cervical spine and not in the lumbar spine because of the weight of the torso on the lumbar spine is 100 times greater than the stress and weight of the head on the cervical spine. These issues have to be determined in a research setting over a long period of time, at least 5-10 years post surgically, and the disc replacement components and procedures were only recently approved by the FDA in the United States, i.e., in August 2005. So there is very little data on the long term effects of these procedures.

The defendants were too late in raising the issue of whether the surgeon in this case had a financial interest in the outcome of the surgery or in the sale and use of the disc replacement component. The WCJ was probably made aware of the fact that researchers in new and/or experimental medical procedures including investigational new drugs, biologics or devices including disc replacement surgical procedures encourage injured workers to be allowed in the inclusion criteria for medical research. The ethics of including injured workers in these research studies permit such participation because of the necessity to determine side effects, short and long terms risks, and benefits of those procedures and products since injured workers are part of the general population of potential patients [See 45 C.F.R. 46, 21 C.F.R. 50, 21 C.F.R. 56].

Disc replacement surgery is currently intended to delay a traditional fusion because of the knowledge that fusions cause adjacent segmental vertebral degeneration. The FDA and manufacturers of these devices are interested in long term safety and efficacy profiles of them after FDA approval (called a Phase 4 or post approval marketing study). If an injured worker enrolls in any medical research study involving the disc replacement procedure, the sponsor of the study,

not the workers compensation claims administrator, pays for the device or the surgical implant procedure. In all medical research studies involving the disc replacement procedure, the patients who enroll in the studies do not know if they actually receive the disc replacement rather than a traditional fusion until after they wake up from the surgical procedure because the surgeons do not know for sure whether any patient is within the inclusion criteria for the disc replacement device until the surgical site is under direct observation by the surgeon, which is why the patients consent to either the disc replacement or a traditional fusion prior to the surgery and as part of the informed consent process. In a non-research study setting, the best medical practice is for the surgeon to do the same thing, i.e., to obtain consent from the patient to do one or the other procedure. This is now becoming the standard of care in a clinical medical practice involving spinal surgery.

For the purpose of determining the need for treatment in workers compensation cases, the WCAB emphasized that the ACOEM Guidelines are limited in scope and application and Chapter 6 allows treatment in chronic pain cases to include anything that restores function. The Board decision also reminds us that just because a medical protocol is not listed in ACOEM does not mean that it cannot be authorized. A medical procedure that is outside ACOEM must cure or relieve the effects of an industrial injury. In addition, the WCAB decision is significant as the panel indicates two ways to rebut denials of treatment based upon the ACOEM Guidelines:

- . Use of Chapter 6 of ACOEM if the medical condition has become chronic or lasting more than 90 days and the medical procedure not listed in ACOEM will probably improve or restore personal (ADL), social and/or occupational functioning; or

- . Another nationally accepted treatment protocol from other accepted peer reviewed guidelines, such as the Official Disability Guidelines (ODG).

What is also interesting about this case is that the Court of Appeal granted attorney's fees to the applicants attorney due to the contention by the court that the defendant's petition for writ of review had no reasonable basis.

Defense Perspective. This case involves the interesting issue of how much control defendant can have over the question of what type of spinal surgery an applicant should undergo, rather than whether spinal surgery is appropriate at all. All parties conceded that spinal surgery was appropriate, and so the question was whether the somewhat experimental surgery proposed by the treating physician was appropriate. The result is not surprising as the AME indicated that he supported the procedure, although he would prefer fusion. What is surprising is that defendants attempted to mandate a particular type of surgery. The treating physician and patient would be in quite a quandary if the WCJ had mandated a procedure that neither the treating physician nor the patient were comfortable with. It is not surprising that the defendant's petition for writ of review was found unreasonable by the Court of Appeal.

Attorney's Fees; Compromise And Release

Monument Car Parts v. W.C.A.B. (Teach) (2007) 72 Cal. Comp. Cas 1021

Headnote

Attorney's Fees--WCAB ordered defendant to pay applicant's attorney's fees under Cal. Labor Code § 4064(c), when applicant claimed injury AOE/COE on 4/3/2004, parties filed compromise and release while applicant was unrepresented, compromise and release contained provision that "filing of this document is the filing of an application on behalf of the employee," WCAB did not approve compromise and release but instead suspended action on

compromise and release pending receipt of further information, WCAB later allowed applicant to withdraw from compromise and release, applicant obtained counsel, both parties obtained qualified medical evaluators, WCAB found that defendant did not advise applicant of his right to panel qualified medical evaluation, did not offer adequate settlement, did not respond to WCJ's request for documents, and did not appear at scheduled mandatory settlement conference, and that applicant's attorney provided valuable services, and WCAB construed filing compromise and release here to be filing application for adjudication of claim, based on terms of compromise and release itself, 8 Cal. Code Reg. § 10878, and WCAB panel decision, *Robinson v. Hawthorne Machinery Corp.* (2002) 30 CWCR 76 [2002 Cal. Wrk. Comp. P.D. LEXIS 107] (panel decision) [See generally 2-20 CA Law of Employee Injuries & Workers' Comp §§ 20.01(1), (4), 20.02(2), 22.11].

Commentary

Applicant's Perspective. This is an interesting case where the defendant cajoled the unrepresented applicant into accepting an inadequate compromise and release. To make matters worse for itself, the defendant failed to comply with the WCJ's orders prior to an adequacy hearing to produce documents, to give applicant his rights to a panel QME, and then to appear at a hearing. This set the stage for two things to happen: (1) for the applicant to retain legal counsel; and (2) for the WCJ to award attorney's fees under Cal. Labor Code § 4604(c).

We have not seen a case like this since just after Cal. Labor Code § 4604(c) was enacted as part of the workers compensation law reforms during the early 1990's. That enactment resulted in at least two cases that limited the award of attorney's fees if the defendant failed to pay benefits after a panel QME report was issued that was favorable to the applicant and the defendant had to pay benefits or file an Application. During what was referred to as the window period, which was for dates of injury from 1/1/91-12/31/93, the Application for Adjudication of Claim and the Declaration of Readiness to Proceed were incorporated into the same document and the claim form was a jurisdictional document.

This issue is now being addressed in a similar way as a decision known as *Ferguson v. Kemper Insurance Co.*, WCK 10961, (1994) 22 CWCR 83, which was later reversed in a decision called *Peterson v. State of California* (1995) 60 Cal. Comp. Cas 1206 (Appeals Board en banc opinion), which refers to attorney's fees under Cal. Labor Code § 4066 and disapproves the panel decision in *Ferguson*, which was a Cal. Labor Code § 4064 case. Those cases eventually resulted in limiting the application of Cal. Labor Code § 4064(c) to a very narrow set of cases involving unrepresented applicants where the defendant refuses to pay benefits based upon a panel QME's findings and files an Application for Adjudication of Claim.

This case reminds us of *Dwight Smith v. Workers' Comp. Appeals Board* (S150528) 2007 Cal. LEXIS 6780, which is now before the California Supreme Court on the issue of an award of attorney's fees pursuant to Cal. Labor Code § 4607 when a defendant fails to authorize medical treatment in a post award case.

The WCAB statement that the filing of a C&R is equivalent to the filing of an Application is well reasoned and consistent with the language embedded within the C&R form and by 8 Cal. Code Reg. § 10878. This case is a warning to the defense community to seriously take what a WCJ says about the adequacy or inadequacy of a settlement. This issue may recur as cases under the AMA Guides are presented for approval and the WCJ feels that there is something intrinsically wrong with a settlement and wants further documentation or other evidence from a defendant who may be uncooperative. A defendant cannot be dilatory in its obligation to respond to inquiries by a judge if a settlement is submitted on behalf of an unrepresented applicant.

Defense Perspective. This case is an example of the adage bad cases make bad law. 8 Cal. Code Reg. § 10878 has long held that the filing of either a compromise and release, or stipulations with request for award, shall constitute the filing of an application. Cal. Labor Code § 4064(c) holds that when the employer files an application at a point in time when the applicant is unrepresented, the employer shall be liable for applicants attorney's fees incurred by the employee in connection with the application. Once the WCAB gets over the hurdle of whether the C&R was filed by the employer, the imposition of attorney's fees became pretty much automatic. The combination of the filing of the settlement documents and the applicant later hiring an attorney would seem to mandate the payment of the attorney's fee, whether or not the settlement was reasonable. The WCAB has been loathe to award such fees, however, as to do so does in fact discourage settlements with pro per applicants. It is only in terrible factual situations such as this one are the rights under Cal. Labor Code § 4064(c) pursued, thereby making rather bad precedent from the employers perspective.

The WCAB has not yet reached the question of how the applicants attorney's fee will be calculated. Will it be calculated as a percentage of the recovery as in the WCAB panel decisions of *Telson v. Disneyland Hotel* (2000) 28 CWCR 177, and *Ferguson v. Kemper Insurance Co.*, WCK 10961, (1994) 22 CWCR 83 (reversed on the question whether it was a Cal. Labor Code § 4064 case at all) (both awarded under Cal. Labor Code § 4064 or Cal. Labor Code § 4066), or at an hourly rate as in *Town of Hillsborough v. W.C.A.B. (Sommer)* (2003) 68 Cal. Comp. Cas 304 (writ denied), and *Meek v John Muir Hospital*, 2006 Cal. Wrk. Comp. P.D. LEXIS 10 (Appeals Board panel decision) (both Cal. Labor Code § 5814.5 cases)? If the attorney's fee to be awarded is a percentage of the recovery, will it be strictly the difference in recovery between what defendants had originally agreed to settle for versus what was ultimately received, or the whole recovery? We would expect the WCAB to use its discretion in this regard to avoid encouraging applicants attorneys from requesting a fee where no valuable service was provided.

Injury AOE/COE; Compensable Consequence Injuries

***Ralphs Grocery Company v. W.C.A.B. (Romano)* (2007) 72 Cal. Comp. Cas 1028 (writ denied)**

Headnote

Injury AOE/COE--Compensable Consequence Injuries--WCAB held that reports of applicant's qualified medical evaluator, coupled with medical records, constituted substantial evidence to support finding that applicant's blood-borne methicillin-resistant *Staphylococcus aureus* (MRSA) was compensable consequence of his 12/20/2003 left shoulder injury and caused injury to his cardiovascular and cardiopulmonary systems, neck, and cervical and thoracic spine, with resulting paralysis, when applicant underwent left shoulder surgery on 8/29/2005, applicant began to have shoulder pain and stiffness as well as flu-like symptoms after surgery, applicant was hospitalized on 11/7/2005 and diagnosed with blood-borne MRSA that affected various internal and orthopedic systems, applicant's qualified medical evaluator and treating physicians opined that MRSA was most likely due to shoulder surgery, and WCAB did not find opinion of defense qualified medical evaluator to be persuasive [See generally 1-4 CA Law of Employee Injuries & Workers' Comp §§ 4.94, 34.16(3)].

Commentary

Applicant's Perspective. This case demonstrates how important it is for counsel to develop the record in a case that involves unique medical issues. The case shows how to develop the record in such matters by having one physician review all relevant records and then having him or her rebut the conclusions of any other physician that are contrary to that physicians own medical conclusions. The case shows how the evaluating physicians report constituted substantial medical evidence because that physician focused on the most significant medical records and stated how and why the

defense evaluator was wrong in his conclusions. [Note: This commentator is taking over the case from applicants counsel due to his retirement.]

Subsequent Injuries Benefits Trust Fund; Labor Disabling Injury

Rea v. W.C.A.B. (Rasmussen) (2007) 72 Cal. Comp. Cas 1035 (writ denied)

Headnote

Subsequent Injuries Benefits Trust Fund--Labor Disabling Injury--WCAB reversed WCJ's decision and found that applicant, who suffered industrial injuries to his right upper extremity and right thumb on 6/10/2003 and during period 6/8/2003 through 6/8/2004, and had at age nine suffered non-industrial amputation to his left arm two inches below shoulder, was entitled to Subsequent Injuries Benefits Trust Fund benefits pursuant to Cal. Labor Code § 4751, when applicant's amputation rated at 70 percent under 1997 Schedule for Rating Permanent Disabilities, rating was not rebutted by showing that applicant had long career as pharmacist since this did not establish that applicant had rehabilitated from amputation, WCAB found that amputation was not susceptible to rehabilitation, applicant testified that he performed his job as pharmacist with great effort and some difficulty, and applicant's vocational rehabilitation expert testified that applicant was excluded from 68 percent of jobs in labor market due to his amputation and was precluded from 97.5 percent of all jobs when amputation disability combined with his industrially-related disability [See generally 1-8 CA Law of Employee Injuries & Workers' Comp § 8.09].

Commentary

Applicant's Perspective. This case is a review of the relevant case law and covers the criteria for eligibility for Subsequent Injuries Benefits Trust Fund (SIBTF) benefits. The case is a modern reiteration of the law that there are two prongs of eligibility for SIF benefits--first, that there is a prior industrial or non-industrial permanent disability that rates greater than or equal to 70%, and, second, that the subsequent injury results in permanent disability that is greater than 5%. The decision also reaffirms the notion that the costs and expenses of a vocational expert witness are recoverable as a cost pursuant to Cal. Labor Code § 5811.

The WCAB is allowing reimbursement to applicants attorneys for expert witnesses in recent cases involving the use of vocational experts to rebut the 2005 Permanent Disability Rating Schedule (2005 PDRS), to provide direct testimony of diminished future earning capacity, and like in this case, to provide evidence that a persons prior medical condition was disabling in the open labor market, despite the individuals ability to work and his or her disability.

The question this case does not answer is, what if the subsequent injury is on or after 1/1/2005 and the 2005 PDRS applies with the *AMA Guides*? It appears from this decision that the WCAB relied on the 1997 Schedule for Rating Permanent Disabilities (2007 Schedule) to indicate the amputated left arm condition from age 9 rated 81% permanent disability and the 2004 subsequent industrial injury rated 14% permanent disability under the 1997 Schedule. The amputation of the arm under the *AMA Guides* would rate a 60% Whole Person Impairment (WPI) [see *AMA Guides*, Chapter 16], which would also adjust to over 70% permanent disability. But we do not know whether the 2004 subsequent injury would rate greater than 5% permanent disability under the *AMA Guides* and 2005 PDRS. The WCAB does not indicate whether it would accept a rating for the prior disability under the 1997 Schedule and the subsequent injury under the *AMA Guides* and 2005 PDRS and apply the same analysis it did in this case.

The WCAB also indicated that it would not bail out neither the defendant nor the SIBTF for their failure to depose

the AME about apportionment of the subsequent injury in accordance with the decision in *Escobedo v. Marshalls* (2005) 70 Cal. Comp. Cas 604 (Appeals Board en banc opinion). In other cases, the WCAB does not hesitate to reverse and remand a case for further development of the record on the issue of apportionment when the defendant also fails to conduct adequate discovery on that issue prior to trial. There appears to be significant inconsistencies between WCAB panels on the issue of when to remand for further development of the record on apportionment and when not to because a defendant failed to conduct adequate discovery prior to trial.

For further discussion on medical treatment, see generally 1-5 CA Law of Employee Injuries & Workers' Comp §§ 5.01, 5.02[(3), 5.03(4), 22.01(1).

For further discussion on attorney's fees, see generally 2-20 CA Law of Employee Injuries & Workers' Comp §§ 20.01(1), (4), 20.02(2), 22.11.

For further discussion on compensable consequence injuries, see generally 1-4 CA Law of Employee Injuries & Workers' Comp §§ 4.94, 34.16(3).

For further discussion on the Subsequent Injuries Benefits Trust Fund, see generally 1-8 CA Law of Employee Injuries & Workers' Comp § 8.09.

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Vernon Sumwalt on Proving Causation of Work-Related Medical Conditions

2008 Emerging Issues 575

Vernon Sumwalt on Proving Causation of Work-Related Medical Conditions

By Vernon Sumwalt

October 2, 2007

SUMMARY: A significant percentage of North Carolina appellate decisions have addressed the issue of causation in workers compensation cases over the past several years. In *Legette v. Scotland Memorial Hospital*, 640 S.E.2d 744 (2007), the Court of Appeals affirmed the Commissions finding that lifting a patient had caused or aggravated a nurses lymphedema in her arm, even though conflicting medical testimony indicated that her history of breast cancer placed her at an increased chance of contracting lymphedema as well. This commentary, written by Vernon Sumwalt, a Board Certified Specialist in North Carolina workers' compensation law, places the issues in *Legette* in their broader contexts and then breaks them down in a practical guide on how to avoid reversal on appeal.

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ARTICLE: A significant percentage of North Carolina appellate decisions have addressed the issue of causation in workers compensation cases over the past several years. In *Legette v. Scotland Memorial Hospital*, ___ N.C. App. ___, 640 S.E.2d 744 (2007), the Court of Appeals affirmed the Commissions finding that lifting a patient had caused or aggravated a nurses lymphedema in her arm, even though conflicting medical testimony indicated that her history of breast cancer placed her at an increased chance of contracting lymphedema as well. This commentary places the issues in *Legette* in their broader contexts and then breaks them down in a practical guide on how to avoid reversal on appeal.

The big picture of causation. *Legette* focuses on the issue of causation. Generally speaking, injured employees in workers compensation cases have the burden of proving each and every element of compensability, including causation. [*Watts v. Borg Warner Automotive, Inc.*, 171 N.C. App. 1, 8, 613 S.E.2d 715, 719 (2005), affd, 360 N.C. 169, 622 S.E.2d 492 (2005) (per curiam)]. For injuries under N.C. Gen. Stat. § 97-2(6), the arising out of element incorporates the causation between an accident and its medical consequences. This element is satisfied if (1) the work conditions placed the employee at an increased risk of injury, [see *Goodwin v. Bright*, 202 N.C. 481, 163 S.E.2d 576 (1932)], or the employees activities at the time of the injury provided an appreciable benefit to the employer, [see *Fortner v. J.K. Holding Co.*, 319 N.C. 640, 357 S.E.2d 167 (1987)]. For occupational diseases under N.C. Gen. Stat. § 97-53, there is causation if the work-related exposure significantly contributed to the development of the disease [see *Rutledge v. Tultex Corp.*, 308 N.C. 85, 101-102, 301 S.E.2d 359, 369-370 (1983)]. At one time, the Supreme Court of North Carolina required medical evidence to establish causation to a requisite degree in all cases involving complex medical issues, thus suggesting that cases involving uncomplicated issues do not need expert testimony [see *Click v. Pilot Freight Carriers, Inc.*, 300 N.C. 164, 167, 265 S.E.2d 389, 391 (1980)]. However, it is now clear that non-expert

testimony suggesting a causal relationship is not a sufficient basis upon which to find causality. [*Cummings v. Burroughs Wellcome Co.*, 130 N.C. App. 88, 91, 502 S.E.2d 26, 28 (1998)].

In *Legette*, for example, defendants expert, Dr. George Paschal, testified that causation between the employees accident and development of lymphedema was not likely. Plaintiffs counsel then deposed the employees family doctor, Dr. James Currin, who testified that causation between the two probably existed. The Commission gave more weight to Dr. Currins opinion and, thus, awarded the employees claim [see 640 S.E.2d at 747-748]. The late designation and deposition of Dr. Currin not only satisfied the employees burden of proving causation before the Commission, but it also provided a competent foundation for the Commissions Opinion and Award on appeal.

Practice Tip--Get an Expert! In every workers compensation case where the compensability of a medical condition is in dispute, failure to have an expert to address causation is fatal to the claim and may even constitute legal malpractice.

Reliability of expert opinions. In *Legette*, defendants attacked Dr. Currins causation opinion on several grounds. First, defendants alleged that the opinion was not sufficiently reliable under *State v. Goode*, 341 N.C. 513, 461 S.E.2d 631 (1995), and *Howerton v. Arai Helmet, Ltd.*, 358 N.C. 440, 597 S.E.2d 674 (2004). These two cases set forth a three-part test for the evaluation of expert testimony:

- (1) Is the experts proffered method of proof sufficiently reliable as an area for expert testimony?
- (2) Is the witness testifying at trial qualified as an expert in that area of testimony?
- (3) Is the experts testimony relevant?

[*Legette*, 640 S.E.2d at 755]. Although the *Legette* court fell short of explicitly holding that this standard applies to workers compensation cases, it nevertheless proceeded to follow the three-step analysis in resolving *Legette*.

Practice Tip--Dont Forget the Formal Evidentiary Rules. Workers compensation proceedings have always enjoyed a relaxed procedural environment, including the introduction and admission of evidence [see, e.g., *Tucker v. City of Clinton*, 120 N.C. App. 776, 780, 463 S.E.2d 806, 810 (1995)]. Even so, most significant appellate decisions on the issue of causation in North Carolina over the last decade have resorted to traditional principles of evidence that apply to non-administrative settings in determining whether evidence is competent for purposes of the appellate standard of review in workers compensation cases [see, e.g., *Holley v. ACTS, Inc.*, 357 N.C. 228, 581 S.E.2d 750 (2003)]. The lesson to be learned is to not get so comfortable with the relaxed evidentiary atmosphere that you forget to lay the appropriate foundation for your proof of causation through expert testimony.

Support in published medical literature not necessary. Second, Defendants attacked the reliability of Dr. Currins medical opinion because he did not cite any established medical techniques or review any studies establishing that a single incident can aggravate pre-existing lymphedema. [See *Legette*, 640 S.E.2d at 755]. On several previous occasions, North Carolina appellate courts had rejected similar arguments requiring corroboration through medical literature, [e.g., *Matthews v. City of Raleigh*, 160 N.C. App. 597, 607, 586 S.E.2d 829, 837-838 (2003)], and the Court of Appeals took the opportunity to reject it again in *Legette*.

Practice Tip--Do Your Research. Although several cases have now held that medical literature does not need to substantiate an expert opinion on causation, it certainly helps if research supports your theory of the case [cf. *Buck v. Proctor & Gamble Mfg. Co.*, 52 N.C. App. 88, 94, 278 S.E.2d 268, 272 (1981) (opinion should address reasonable probabilities according to scientific knowledge and experience)]. The practitioner should always conduct medical research to corroborate expert opinions in the clients favor. As a practical matter, most medical professionals are more concerned with treating patients than with substantiating their opinions through scholarly articles for purposes of litigation. Doing this work for them will make doctors more comfortable during examination and more confident in their opinions on causation.

No most advanced specialty doctrine. Although it did not address the issue explicitly, the court in *Legette* implicitly carried out its earlier decisions refusing to endorse the most advanced specialty doctrine in North Carolina. Under this doctrine, testimony by a doctor with more specialized credentials or experience is given controlling weight over non-specialists [e.g., *Perkins v. U.S. Airways, Inc.*, 177 N.C. App. 205, 211, 628 S.E.2d 402, 407 (2006); *Armstrong v. W.R. Grace & Co.*, 175 N.C. App. 528, 532, 623 S.E.2d 820, 823 (2006)]. In *Legette*, for example, defendants pitted the testimony of Dr. Paschal, a board-certified expert in surgery, against that of Dr. Currin, a board certified family practitioner who had treated approximately one hundred patients with numerous appointments each. The Court of Appeals affirmed the Commissions endorsement of Dr. Currin's testimony [see 640 S.E.2d at 756].

This endorsement reflects the standard of review that appellate courts have over the Commissions evaluation of witness credibility. The decision concerning what weight to give expert evidence is a duty for the Commission and not [appellate courts]. [*Adams v. Metals USA*, 168 N.C. App. 469, 483, 608 S.E.2d 357, 365 (2005), *affd*, 360 N.C. 54, 619 S.E.2d 495 (2005) (per curiam)]. Furthermore, [t]he degree to which an expert testifies as to causation, be it probable or most likely or words of similar import, goes to the weight to the testimony rather than to its admissibility. [*Martin v. Martin Bros. Grading*, 158 N.C. App. 503, 507-508, 581 S.E.2d 85, 88 (2003)].

Practice Tip--Stick with the Specialists Whenever Possible. Because doctors are already treating injured employees in most cases by the time employees seek legal representation, it is often beyond the practitioners control as to who the medical experts will be in a given case. In day-to-day practice, however, it normally takes compelling clinical experience for a non-specialist to override the credibility of a specialist. The practitioner should consider directing the employees medical care to a qualified specialist for proper treatment and investigation into causation.

Probability, not possibility. The Court of Appeals also looked at the competency of the evidence in terms of the degree to which the two experts testified on causation [see 640 S.E.2d at 756-757]. Generally speaking, expert opinions expressed in terms of *probability* are competent [see *Peeler v. Piedmont Elastic, Inc.*, 132 N.C. App. 713, 718-718, 514 S.E.2d 108, 112 (1999)], while expert opinions based on *possibility* are not, [see *Holley*, 357 N.C. at 234, 581 S.E.2d at 754]. This distinction reiterates the standard of proving causal factor[s] by a preponderance of the evidence in workers compensation cases before the Commission [*Gutierrez v. GDX Automotive*, 169 N.C. App. 173, 177, 609 S.E.2d 445, 448 (2005)].

In *Legette*, the court noted that Dr. Currin repeatedly testified to a *medical certainty* that Plaintiffs accident at work *probably* aggravated her pre-existing lymphedema and that we are not faced with a situation where Dr. Currin only presented could or might testimony. [See 640 S.E.2d at 756 (emphasis added)]. Thus, the plaintiff satisfied the requisite degree of proof before the Commission, and competent evidence supported the Commissions finding of causation on appeal.

Practice Tip--Memorize the Magic Language of Probability. In light of *Legette* and the remaining workers compensation appellate cases addressing the issue of causation over the past several years, the practitioner should avoid restricting the examination to only possible causes and should instead make sure to elicit testimony of probable causation.

This is most easily done through word choice in hypothetical questions. The following words often denote possibility and should be avoided: *assume, capable, chance, conceivably, conjecture, could, doubt, guess, hypothesize, imagine, may, maybe, might, perhaps, possible, postulate, potential, skeptical, speculate, suppose, surmise, take for granted, and unlikely*. In contrast, the following words are associated with probability and should be incorporated while questioning experts: *absolutely sure, best candidate, certainly (or reasonable certainty), greater chance, likely, more likely than not, more/most common, not unlikely, probably, and usually*.

The possible-probable distinction has its foundation in logic, which recognizes that an event must be possible

before it is probable. For example, if it is probable that the Court of Appeals will issue a published decision in the *Legette* case, it must first be possible for this to happen. However, there are two corollaries to this principle. First, an event that is impossible can never be probable. And, second, something may be possible even though it is not probable. Most workers compensation cases in which the proof of medical causation is insufficient to withstand appellate scrutiny fall into this latter category.

Practice Tip--List the Possible Causes, and Then Rule Them Out to Reach the Most Probable One. To get around witnesses who are reluctant to commit their opinions in terms of probability, the practitioner can ask the witnesses to list all possible causes of the medical condition, only to then use extrinsic evidence to have the witness eliminate these in order to reach the most probable one in the list by default. For example, if the possible causes of RSD are previous trauma, illicit drug use, previous stroke with hemiplegia, and cervical spondylosis, the expert can look to the patients medical history in ruling out the ones that are not supported by the history and in deriving the most probable cause through process of elimination.

Getting around the fallacy of *post hoc ergo propter hoc*. Finally, the *Legette* court held that Dr. Currins testimony was competent even though defendants characterized it under the *post hoc, ergo propter hoc* fallacy [see 640 S.E.2d at 756-757]. In *Young v. Hickory Business Furniture*, the Supreme Court of North Carolina held that [i]n a case where the threshold question is the cause of a controversial medical condition, the maxim of *post hoc, ergo propter hoc*, is not competent evidence of causation. [353 N.C. 227, 232, 538 S.E.2d 912, 916 (2000)]. But *Legette* was different in two ways.

First, *Legette* recognized that the rule in *Young* only renders expert opinions on causation incompetent when *post hoc* reasoning takes place with respect to controversial diagnoses [see 353 N.C. at 232, 538 S.E.2d at 916]. Unlike the controversial diagnosis of fibromyalgia in *Young*, the diagnosis of lymphedema in *Legette* was a differential diagnosis well-known to all medical experts who testified [see 640 S.E.2d at 756-757]. This distinction acknowledges the common-sense observation that the consequences of an injury do not surface until after the injury occurs, which falls under the classic *post hoc* pattern and also validates the importance that this temporal sequence can lend to the causation analysis, notwithstanding the fallacy.

Second, the court distinguished *Young* by pointing out that Dr. Currin, unlike the doctors in *Young*, had made an effort to rule out other possible causes of lymphedema in reaching the conclusion that Plaintiffs accident was the probable cause [see 640 S.E.2d at 757]. Although the decision did not say so explicitly, *Legettes* reasoning implicitly validated the methodology behind differential diagnosis, which is sometimes referred to as differential etiology.

This is a clinical process whereby a doctor determines which of several potential diseases or injuries is causing the patients symptoms to symptoms associated with known diseases, conducting physical examinations, collecting data on the patients history and illness, and analyzing that data--until a final diagnosis for proper treatment is reached. . . . *Differential diagnosis is the basic method of internal medicine and enjoys widespread acceptance in the medical community. . . . Generally speaking, when properly conducted the technique has important non-judicial uses, is generally accepted as valid by the medical community, and has been subjected to use, peer review, and testing. . . .*

Even with all the advances of medical science, the practice of medicine remains an art. *A properly conducted and explained differential diagnosis is not junk science.* If a differential diagnosis provides a sufficient basis on which to prescribe medical treatment with potential life-or-death consequences, *it should be considered reliable enough to assist a fact-finder in understanding certain evidence or determining certain fact issues.* [*Coastal Tankships, U.S.A., Inc. v. Anderson*, 87 S.W.3d 591 (Tex. App. 2003) (emphasis supplied)].

This validation fits well within the informal evidentiary environment of workers compensation cases, since even the formal rules of evidence recognize that technical theoretical arguments should not trump facts that are statistically

reliable on the issue of causation. [Cf., e.g., *Fed. R. Evid.* 703 advisory committee notes (Thus, a physician in his own practice bases his diagnoses on information from numerous sources and of considerable variety, including statements by patients and relatives, reports and opinions from nurses, technicians and other doctors, hospital records and x-rays. . . . The physician makes life-and-death decisions in reliance upon them. His validation, expertly performed and subject to cross-examination, ought to suffice for judicial purposes.)].

For discussion of general principles of occupational disease, see 3-52 *Larson's Workers' Compensation Law* § 52.01 et seq.

For discussion of lymphedema and breast cancer, see 18-312 *Attorneys' Textbook of Medicine* (Third Edition) P 312.130.

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Rassp on Affirming Fuentes Rule for Permanent Disability Indemnity Calculation

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Rassp on Affirming Fuentes Rule for Permanent Disability Indemnity Calculation

By Robert G. Rassp

October 2, 2007

SUMMARY: The California Supreme Court resolved in *Brodie v. Workers' Comp. Appeals Bd.*, 40 Cal. 4th 1313, 72 Cal. Comp. Cas 565, 2007 Cal. LEXIS 4334 (May 3, 2007), the conflict among the state appellate courts as to the correct Formula to be applied for determining the apportionment of subsequent permanent disability ratings. This commentary, written by Robert G. Rassp, the author of The Lawyer's Guide to the AMA Guides and California Workers' Compensation, examines from the perspective of an applicants attorney the ramifications of the interpretation in *Brodie* of Cal. Labor Code § 4663 and Cal. Labor Code § 4664 and Formula A.

PDF LINK: [Click Here for Enhanced PDF of Commentary](#)

ARTICLE: The entire workers compensation community has been anxiously awaiting the California Supreme Court's final decision in the conflicting courts of appeal cases in *Brodie*, *Welcher* and the companion cases since oral argument took place in Southern California on April 3, 2007. Under new Cal. Labor Code § 4663 and Cal. Labor Code § 4664, the debate has raged on as to which formulas, "A," "B," "C" or "modified C" apply in cases involving legal apportionment and whether the adoption of Formula A in *Fuentes v. Workers' Comp. Appeals Bd.* (1976) 16 Cal. 3d 1, 547 P.2d 449, 128 Cal. Rptr. 673, 41 Cal. Comp. Cas 42, is still applicable despite the repeal of former Cal. Labor Code § 4750. Formula A, which has been the law for the past 30 years, provides that the percentage of apportionment to prior injuries or illnesses that resulted in a permanent disability had to be subtracted from the overall percentage of permanent disability to determine liability for a current employer [See 1-8 CA Law of Employee Injuries & Workers' Comp § 8.07(2)(d)(i); 1-7 Herlick, California Workers' Compensation Law § 7.44(1)].

The legal conclusion as to whether percentages or dollars are subtracted when there is legal apportionment was thrown into a major debate and became one of the first issues under SB 899 that resulted in conflicting courts of appeal decisions and that needed speedy resolution by the Supreme Court for uniformity of decisions throughout California. This commentary analyzes the Court's decision in *Brodie v. Workers' Comp. Appeals Bd.* (2007) 40 Cal. 4th 1313, 72 Cal. Comp. Cas 565, 2007 Cal. LEXIS 4334, (*Brodie/Welcher*) on an issue-by-issue basis, followed by a discussion of the ramifications of the decision.

Key Provisions of Court's Decision. The following are key provisions extracted from the Court's decision in *Brodie/Welcher*:

. Formula A in *Fuentes* was originally determined applicable on statutory construction under former Cal. *Labor Code* § 4750. The philosophy was based upon Section 4750 that the current industrial portion of the overall disability needs to be considered in isolation, wholly independent of any nonindustrial or previous industrial disability [See *Fuentes*, 16 Cal. 3d at 5-6].

. The Court in *Brodie/Welcher* reaffirmed the policy that had existed behind former Cal. *Labor Code* § 4750 to encourage employers to hire the handicapped. Remember, the permanent disability payment schedule went from a linear increase by percentages to a progressive increase by percentages as of 1972. The notion in adopting Formula A in *Fuentes* was because an employer who hired an employee with a prior disability (whether work related or not) would not have to fear greater compensation costs if that worker with a prior disability were to be injured [See *Fuentes*, 16 Cal.3d at 5].

. When the legislative intent in enacting a particular statute is clear, the Cal. Labor Code § 3202 general rule of liberal construction will not compel a contrary result. The legislative intent with respect to how benefits were to be calculated after apportionment was never articulated in SB 899 except to change the law of apportionment to apply to causation of permanent disability and a conclusive presumption that a prior permanent disability award is still permanent.

. The Court in *Brodie/Welcher* states: Certainly nothing in current section 4663 or section 4664 expressly requires formula A, B, C, modified C, or any other approach to calculating compensation [under section 4658].

. The Court answered the following question in the negative: Did the Legislature intend to adopt a new and different formula when it adopted new and different language governing apportionment? Of course, under prior Cal. Labor Code § 4750, the Legislature never adopted any formula for calculating benefits after apportionment, which led to the *Fuentes* decision.

. SB 899 did not indicate the Legislature intended "to overthrow long-established principles of law [i.e., using Formula A per *Fuentes*] unless such intention is clearly expressed or necessarily implied."

. The Court compared old apportionment law with the new and stated with respect to the old law: In short, so long as the industrial cause was a but-for proximate cause of the disability, the employer would be liable for the entire disability, without apportionment.

. The Court goes on to say about rehabilitation from prior disabilities: The plain language of new sections 4663 and 4664 demonstrates they were intended to reverse these [full or partial rehabilitation between a first and second injury resulting in permanent disability] features of former sections 4663 and 4750. The Court then cites *Kopping v. Workers' Comp. Appeals Bd.* (2006) 142 Cal. App. 4th 1099, 1115, 48 Cal. Rptr. 3d 618, 71 Cal. Comp. Cas 1229, and *Sanchez v. County of Los Angeles* (2005) 70 Cal. Comp. Cas 1440, 1452 (Appeals Board en banc opinion).

. Former Cal. *Labor Code* §§ 4663 and 4750 were "inconsistent with the new regime of apportionment based on causation, as well as the conclusive presumption [of section 4664(b)] that previous permanent disability still existed for apportionment purposes." Former Cal. *Labor Code* § 4750 allowed trial judges to disregard a prior permanent disability if the applicant proved rehabilitation that is squarely at odds with new Cal. Labor Code § 4664(b). Repeal of Cal. Labor Code § 4750 was necessary to adopt an apportionment by causation regime.

. The legislative history for SB 899 is silent on a possible change from Formula A to any other formula.

. Citing the legislative history of SB 899, the Court seems to agree that there is a perceived crisis in skyrocketing workers compensation costs.

. There was no intent to raise workers compensation benefits other than those mentioned in SB 899, such as raising from 6 weeks to 16 weeks of payments of permanent disability for each percentage of PD over 70%.

. The Court chose Formula A and in Footnote 14 of its opinion indicates that Formula A creates equality from an employer-based perspective, whereas Formula C creates equality from an employee-based perspective.

. The Court gives deference to the WCABs holding in *Nabors v. Piedmont Lumber & Mill Company* (2005) 70 Cal. Comp. Cas 856 (Appeals Board en banc opinion) that incorporated Formula A because the Legislature did not intend to get rid of it. The Legislature did not intend to amend settled law and alter the status quo concerning the appropriate formula.

. The tables in section 4658 are for compensating the current injury only, not the totality of an injured workers disabilities. . . .

Impact of Current Political Climate. Although the Court's decision is disappointing to applicants' attorneys and labor advocates, the decision to adopt Formula A was a foregone conclusion and is not unexpected from an academic standpoint. The Legislature did not expressly reverse *Fuentes* in SB 899 by adopting a different method of calculating permanent disability after apportionment even though it could have done so. Reduced permanent disability awards in certain cases along with medical control have been on the business and insurance communities wish list for years. The political climate for change was not in the direction of increasing benefits to injured workers who had a prior award or previous injury or illness that resulted in permanent disability. The struggle to adopt a new formula in this political environment was noble but poorly timed.

Doctrine of *Stare Decisis*. The absence of legislative intent to change the method of calculating permanent disability after apportionment set the stage for the Court to rely on the doctrine of *stare decisis* from 30 years of the application of *Fuentes* without any compelling reason to change it. Going from what has been a less restrictive apportionment regime to a more restrictive one based upon causation of permanent disability with reductions in awards for pathology, asymptomatic conditions, prior awards and retroactive prophylactic restrictions is anathema to the idea that *Fuentes* should be reversed simply on the basis that the statute it was based on was repealed under SB 899.

Court's Public Policy Argument. That being said, there is virtually no evidence supporting the Courts assertion that the public policy in favor of hiring the handicapped is the main reason for adopting Formula A, thereby saving employers liability and money for new injuries. The Courts reliance on this notion is not based on any empirical data in 1977, or 30 years later, in 2007. This was a political fiction that is not based on any actual studies, research, or evidence-based facts presented to the Court leading up to both *Fuentes* in 1977 and now *Brodie/Welcher* in 2007.

This is especially true in light of current privacy and anti-discrimination laws that prohibit disclosure of protected health information and the existence of a disability or handicap, and whether a prospective employee must disclose if he or she has ever filed a workers compensation claim or suffered a work related injury as part of an employment application. The protections under the Americans with Disabilities Act [See 42 U.S.C.S. § 12101 et seq.], Family Medical Leave Act [See 29 U.S.C.S. § 2601 et seq.] and Californias Fair Employment and Housing Act [See Cal. Government Code § 12900 et seq.] did not exist in 1977 when *Fuentes* was decided by the Court, and those protections are probably more effective in promoting the public policy of hiring the handicapped than the use of Formula A in workers compensation cases.

The fact that the Court rejected the notion that Formula C (dollars minus dollars) should apply in cases in which subsequent industrial injuries occurred while the employee was employed by the same employer is troubling since the logic propounded by the trial judge in *E & J Gallo Winery v. Workers' Comp. Appeals Bd. (Dykes)* (2005) 134 Cal. App. 4th 1536, 37 Cal. Rptr. 3d 208, 70 Cal. Comp. Cas 1644, made legal and moral sense. Since successive permanent disabilities to the same parts of body result in progressive amounts of permanent disability indemnity, an employees ability to compete in the open labor market was greatly affected. If the employee is working for the same employer with successive injuries, there is no issue involving the public policy in favor of hiring the handicapped to protect the employer from being liable for a progressive permanent disability. A successively injured worker with the same employer should enjoy the progressive permanent disability payment schedule since the hire the handicapped public policy would not apply in those situations.

However, perhaps the Court did not want to invite litigation over equal protection for cases involving the same progressive disabilities but with injuries with separate employers or claims administrators.

Court's Discussion of Rehabilitation. The Courts discussion about rehabilitation from a prior disability is also troubling. It is clear in the regime of the new apportionment law that the Legislature intended to require prior awards of permanent disability to be subtracted from current ones involving the same parts of body pursuant to new Cal. Labor Code § 4664(b). However, in *dicta*, the Court seems to hint that injured employees may have a difficult, if not impossible, burden of proving rehabilitation from a prior injury that did not result in an award or any prior nonindustrial injury or condition. The Court has cast some doubt about whether rehabilitation can be claimed under apportionment under new Cal. Labor Code § 4663 by saying that the Legislature intended to reverse partial or total rehabilitation features of former Cal. Labor Code § 4663 and Cal. Labor Code § 4750.

The Court then cites the WCAB's en banc opinion in *Sanchez*, which held that an employee *can* prove a form of rehabilitation i.e., that a current permanent disability is caused by a different factor than the one that caused the prior disability to the same body part [See 1-8 CA Law of Employee Injuries & Workers' Comp § 8.07(2)(c); 1-7 Herlick, California Workers' Compensation Law § 7.46(3)]. So, on the one hand, the Court is saying that the Legislature intended to disallow claims of partial or total rehabilitation from a prior award, yet on the other hand it is saying that you can prove rehabilitation from a prior award if the new permanent disability is caused by a different factor than the one that caused the prior disability to the same body part. It is no wonder why the Court itself said they like to give great deference to the WCAB because of that agency's expertise in workers compensation matters. So now that the Court has spoken, indirectly, on the issue of rehabilitation from a prior disability, can we still claim that an employee has totally or partially recovered from a prior disability that did or did not result in an award?

The *dicta* in *Brodie/Welcher* implies the answer is "no," but in citing the *Sanchez* and *Kopping* cases, the Court seems to defer to the WCAB on that issue when the facts are similar to those that occurred in *Sanchez* or *Kopping*, i.e.,

the employees current disability was independent from the prior one even though both disabilities involve the same part of body, for example in the *Sanchez* case, the lower extremity. Perhaps from an applicants attorney standpoint, the conclusive presumption in Cal. Labor Code § 4664 is not always conclusive after all.

Effect of Court's Decision on Successive Injuries. We also have the burning question about whether the Courts decision in *Brodie/Welcher* affects established law for successive injuries under *Wilkinson v. Workers' Comp. Appeals Bd.* (1977) 19 Cal. 3d 491, 564 P.2d 848, 138 Cal. Rptr. 696, 42 Cal. Comp. Cas 406. Remember, *Wilkinson* also involved successive injuries and was decided after *Fuentes* by the same Court in 1977. The Court in *Wilkinson* extensively cited *Fuentes* by saying that the decision in *Fuentes*, adopting Formula A, does not overrule the *Bauer* Doctrine [See *Bauer v. County of Los Angeles* (1969) 34 Cal. Comp. Cas 594 (Appeals Board en banc opinion)], [See 1-8 CA Law of Employee Injuries & Workers' Comp § 8.07(2)(d)(ii)-(iii); 1-7 Herlick, California Workers' Compensation Law § 7.46(2)].

The *Bauer* Doctrine established the rule that if an employee suffers successive industrial injuries and becomes permanent and stationary at the same time for all injuries, then there is one overall permanent disability rating rather than separate ones for each industrial injury. This doctrine became even more important after 1972 when the permanent disability payment schedule went from linear increases to progressive increases for permanent disabilities in higher percentage ratings.

The Court in *Brodie/Welcher* is silent on the issue of how successive industrial injuries that become permanent and stationary at the same time are to be rated. The Court in *Wilkinson* simply stated that its decision in *Fuentes* did not overrule the *Bauer* Doctrine so there can be one overall rating for successive injuries that become permanent and stationary at the same time if the injuries involve the same employer and the same parts of body. We will probably see more litigation on this issue alone in cases involving the *AMA Guides* and the 2005 Permanent Disability Rating Schedule (2005 Schedule) in which the concept of separate body regions are applicable for rating purposes and apportionment under Cal. Labor Code § 4664(c).

Using the same logic the Court used in *Brodie/Welcher*, it is fair to say that the *Wilkinson* decision remains the law until the Court says otherwise, because there is nothing in SB 899 or in the legislative history of SB 899 that indicates the intent of the Legislature to overrule *Wilkinson*.

Practical Effects of Court's Decision. So what are the practical effects of the Court's decision in *Brodie/Welcher* on our law practices? It is obvious that in the current political climate in workers compensation law, the Court has saved employers and their claims administrators millions, if not billions, of dollars by, in effect, avoiding life pension cases in successive injury cases in which the employee is permanent and stationary at different times, either from prior industrial or nonindustrial injuries. Individuals with successive serious permanent disabilities will have to rely on public assistance programs, Social Security disability, and other means besides the private welfare program of workers compensation. Does the Court's decision violate the compensation bargain? This is a question left to the politicians, and with the Court essentially applying *stare decisis* in upholding the use of Formula A, there is no doubt that the compensation bargain remains the same, albeit in a weakened state.

Much of this issue will fade into the twilight, and more significant battles will be fought in litigation over how the Courts decision affects cases in which a prior industrial injury is rated under the 1997 Schedule for Rating Permanent Disabilities (1997 Schedule) and new injuries are rated under the *AMA Guides* and the 2005 Schedule involving the same body parts. You cannot subtract percentages based upon work restrictions under the 1997 Schedule from impairment and permanent disability ratings based upon the *AMA Guides* and the 2005 Schedule. This is because the 1997 Schedule is based upon reduced ability to compete in the open labor market, while the 2005 Schedule is based upon impairments under the *AMA Guides* adjusted by a diminished future earning capacity [See 1-2 Lawyer's Guide to *AMA Guides* and CA Workers' Comp § 2.02(2)-(3)].

For example, a no heavy work restriction for a 39-year-old nurse with a lumbar spine injury under the 1997

Schedule rates 30% permanent disability. The same nurse in a post 1/1/05 lumbar spine injury case would be rated using Chapter 15 of the *AMA Guides*, The Spine, and her rating under the 2005 Schedule would probably be less than 30% permanent disability. If you use the subtraction of percentages Formula A method mandated under *Brodie/Welcher*, the result would be inequitable and in some cases result in a negative percentage rating. This would be like subtracting apples from oranges. Formula A cannot apply in cross-over cases involving a prior award under the 1997 or earlier schedules and the 2005 Schedule.

By example, a hypothetical case arises when there are successive injuries to a lumbar spine for the 39-year-old nurse who suffers a specific lumbar spine injury in 1997 resulting in a 30% permanent disability award. She returns to work in 1998, has a second specific injury to her lumbar spine in 2004, returns to work in 2004, and has a continuous trauma injury to her lumbar spine from the beginning of her employment in 1990 through 2007. How would her permanent disability be evaluated assuming liability for all injuries have been accepted?

Under the *Brodie/Welcher* decision, the prior award under the 1997 Schedule is 30% and would be presumed to exist at the time of the new injuries pursuant to Cal. Labor Code § 4664(b). Since the employee returned to work after her 2004 specific injury and before 1/1/05, the 1997 Schedule would apply for that case if the employee's lumbar condition became permanent and stationary prior to 1/1/05. For the continuous trauma injury through 2007, the *AMA Guides* would apply.

If the employee's lumbar spine condition became permanent and stationary after each separate injury occurred, then there would be three separate ratings of permanent disability: the 1997 and 2004 specific injuries under the 1997 Schedule, and the 2007 injury rated under the 2005 Schedule. To arrive at the rating for the 2004 specific injury, the permanent disability from the prior 1997 specific injury (30%) would be subtracted from the percentage of permanent disability based on the 1997 Schedule for the 2004 injury. For example, if the 2004 injury resulted in a restriction to light work, which takes a 50% permanent disability rating standard under the 1997 PDRS, the prior award of 30% would be subtracted, leaving a 20% rating standard for the 2004 injury. This would be consistent with applying Formula A, as affirmed by the Court in *Brodie/Welcher*, which will now apply in all pending cases.

The employee would argue that she could present evidence under the *Sanchez* case that her prior award of 30% for the 1997 specific injury was due to a lumbar spinal condition that is different from the lumbar spinal condition that is a result of the 2004 injury and continuous trauma injury, and that the percentage of permanent disability from the prior award should not be subtracted from the 2004 rating from the 1997 Schedule because she was able to rebut the presumption that the prior 30% award should be subtracted from the award for the 2004 specific injury.

The evaluating or treating physician would then have to indicate the impairment rating for the continuous trauma injury of 2007 under the *AMA Guides* and he or she would have to apply apportionment under Cal. Labor Code § 4663 to indicate approximately what percentage of the employee's overall permanent disability to her lumbar spine is directly the result of continuous trauma and what percentage of her permanent disability is caused by the prior two specific industrial injuries and any other nonindustrial factors. It is impossible for a judge or the parties to be able to use Formula A to take the 2005 Schedule rating for the 2007 continuous trauma injury and subtract the prior 30% award from that rating applying Cal. Labor Code § 4664, because ratings under the 1997 Schedule cannot be subtracted from ratings under the 2005 Schedule since that would be unreasonable to subtract a permanent disability rating based upon work restrictions from one that is based on whole person impairment ratings.

The issue of how to calculate permanent disability payments with prior awards or prior injuries will require application of Formula A only in cases in which the same permanent disability rating schedule is used for all injuries. Otherwise an inequitable result will occur. But what happens if the nurse's lumbar spine condition as a result of her 2004 specific injury and 2007 continuous trauma injury became permanent and stationary at the same time? Under *Wilkinson*, how do you calculate her permanent disability, and how does Formula A apply?

The treating or evaluating physician would first have to indicate what the overall permanent impairment rating is

for the nurses lumbar spine condition. The physician would have to indicate in his or her apportionment discussion approximately what percentage of the permanent impairment to the lumbar spine is due to the continuous trauma injury and the specific injury of 2004, and how much of the impairment is due to the prior 1997 specific injury and any other factor. Cal. Labor Code § 4664(b) and the use of Formula A could not be used in this case at all since the prior award was for permanent disability under the 1997 Schedule and the current permanent disability is based on the 2005 Schedule. The award in this case would be determined by taking the overall permanent disability rating percentage from the 2005 Schedule and subtracting from it the percentage of apportionment for the prior industrial injury and any other factor that is causing permanent disability.

Thus, Formula A from *Brodie/Welcher* will not apply in cross-over cases, and its application will occur only when a prior award is based upon the same rating schedule as the current injury. Even if the prior 1997 lumbar spine injury was nonindustrial, Formula A would apply only to the extent of the judge subtracting from the overall percentage of permanent disability under the 2005 Schedule the percentage of impairment caused by other factors, including any prior industrial or nonindustrial injuries to the same part of body.

Effect of Court's Decision on Injured Workers' Permanent Disability Benefits. The Court in *Brodie/Welcher* in footnote 10 states that the principle of Occams razor that the simplest of competing theories should be preferred over more complex and subtle ones applies judicially as well as scientifically. The citation by the Court is ironic since this is a case in which the Court has saved millions of dollars for the employer/claims administrator community by adopting Formula A under SB 899 in a new workers compensation system that seems to sharply cut, with a razors edge, injured workers benefits for permanent disability. The Court accomplished this by two swipes of the razor by adopting Formula A instead of Formula C and by implying in *dicta* that rehabilitation from a prior injury that resulted in a disability may no longer be legally possible.

For insight and discussion on apportionment, see 1-8 CA Law of Employee Injuries & Workers' Comp §§ 8.05--8.07, 1-7 Herlick, California Workers' Compensation Law §§ 7.44--7.47, and 1-6 Lawyer's Guide to AMA Guides and CA Workers' Comp § 6.02.

For information on the lumbar spine, see 4-13A Attorneys' Textbook of Medicine (Third Edition) §§ 13A.00--13A.90; 1-5D Proving Medical Diagnosis and Prognosis §§ 5D.01-- 5D.08, 6.01--6.07; Common Diagnostic Procedures §§ 9.02, 19.02, 7.02[9], 27.08; and 1-15 Occupational Injuries and Illnesses §§ 15.01--15.17.

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Rabine on Audiss and Dover, Recent California WCAB Panel Decisions

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Rabine on Audiss and Dover, Recent California WCAB Panel Decisions

By Merle C. Rabine

October 2, 2007

SUMMARY: Recent interest in California Workers' Compensation Appeals Board panel decisions has been fueled by continuing uncertainty of interpretation of parts of Senate Bill 899 and by discussion and debate on the Internet. This commentary, written by Merle C. Rabine, the past Chairman of the Workers Compensation Appeals Board, examines two recent panel decisions: one involving "the bump" in permanent disability payments set forth in Labor Code § 4658(d)(2), (3), which is supposed to encourage return to work, and the other involving "contemporaneous" notices of termination and injury, which do not bar compensation pursuant to Labor Code § 3600(a)(10).

PDF LINK: Click Here for Enhanced PDF of Commentary

ARTICLE: Despite recent interest in California Workers' Compensation Appeals Board panel decisions, fueled by continuing uncertainty of interpretation of parts of Senate Bill 899 and by discussion and debate on the Internet, most panel decisions are of little interest to anyone other than the parties whose case is being decided. When the Appeals Board wants to announce a position on a substantive or procedural issue, it does so by issuing an en banc decision or significant panel decision [see http://www.dir.ca.gov/WCAB/wcab_dars.htm]. Panel decisions, however, tend to be case-specific with the result determined by the facts of the case. Moreover, while panel decisions are citeable authority, particularly on issues of contemporaneous administrative construction of statutory language [see *Griffin v. WCAB* (1989) 209 Cal. App. 3d 1260, 1264, fn 2, 54 Cal. Comp. Cas 145], they are not binding precedent, as are en banc decisions, on all Appeals Board panels and workers' compensation judges [see *Gee v. Workers' Comp. Appeals Bd.* (2002) 96 Cal. App. 4th 1418, 1425 fn. 6, 67 Cal. Comp. Cas 236].

This commentary examines two recent panel decisions, one involving "the bump" in permanent disability payments set forth in Cal. Labor Code § 4658(d)(2), (3), which is supposed to encourage return to work, and the other involving "contemporaneous" notices of termination and injury, which did not bar compensation pursuant to Cal. Labor Code § 3600(a)(10).

Employers substantial compliance with requirement of offer of regular work in Labor Code § 4656(d)(3)(A) results in 15% reduction in PD payments under Labor Code § 4658(d)(2), (3): *Audiss v. City of Rohnert Park*, 2007 Cal. Wrk. Comp. P.D. 9 (Appeals Board panel decision). Cal. Labor Code § 4658(d)(2) and (3) provide that an employer must notify an injured employee within 60 days of a disability becoming permanent and stationary whether or not the employer offers the employee regular work, modified work, or alternative work. If not, each permanent

disability (PD) payment from the date of the end of the 60-day period is increased by 15%. If employment is offered on a form prescribed by the administrative director, each PD payment from the date of the offer is decreased by 15%, whether or not the employee accepts the offer. If the employer terminates the offered work before PD payments have been completed, the amount of each remaining PD payment is increased by 15%.

These sections, known as the bump, reflect a public policy of encouraging employers to continue to employ their disabled employees. It is based on RAND data that demonstrate that employees who return to work after an industrial injury with their at-injury employers sustain lower wage losses than employees who do not. The 15% increase of PD for employees who are not offered work, and the 15% decrease for employees who are offered work, are intended to incentivize employers and employees to maintain their employment relationship.

I know of no evidence as to whether these sections make any difference in the real world. I expect that studies are going on now, and at some point we will know whether these sections have any effect. They have been operative for more than two years, and they seem to have produced remarkably little litigation to date. *Audiss v. City of Rohnert Park*, 2007 Cal. Wrk. Comp. P.D. LEXIS 9, (Appeals Board panel decision), which was decided on April. 2, 2007, is the first WCAB panel decision that I have seen on the subject.

Applicant, while employed as a recreation supervisor for the period ending October 26, 2005, sustained an industrial injury to her right wrist. She lost no time from work. Her treating physician found her condition to be permanent and stationary (P&S) on April 2, 2006. He issued a permanent and stationary report dated March 31, 2006, but faxed it to the claims administrator on July 5, 2006. The report rates 3%. He noted that applicant was capable of returning to her usual and customary job (which she had never left) with use of a wrist brace.

On July 21, 2006 (more than 60 days after applicant was P&S), the claims administrator sent applicant a form DWC-AD 10003 Notice of Offer of Regular Work. She accepted the offer on July 25, 2006. The claims administrator also sent applicant, who has never been represented by an attorney, Stipulations with Request for Award, providing that her permanent disability was 3% at \$187 per week, a 15% reduction pursuant to Cal. Labor Code § 4658(d)(3)(A).

The WCJ refused to accept the stipulation. Not only did he reject the 15% reduction, but he apparently awarded a 15% increase on the ground that the employer had not complied with the statute. (*Note*: It is not clear from the WCAB opinion exactly what the WCJ did or why.)

The WCAB panel reversed. First, they held that it was not unreasonable for the employer to wait for the P&S report before offering regular work, as defendants receipt of the physicians final opinion on the extent of applicants ability to engage in her usual and customary occupation was a necessary prerequisite to its determination that the job offer was appropriate, particularly where the applicant continued to work during the period.

Of course, the statute says nothing about necessary prerequisites. Furthermore, if the employer had offered employment on the day applicant was P&S and terminated the employment after receipt of the P&S report, it would have incurred no penalty under Cal. Labor Code § 4658(d)(3)(B), since all of the PD indemnity would already have been paid out.

Second, the panel held that [t]he continuation of applicants regular work throughout the period after her injury and her permanent and stationary date is sufficiently equivalent to the notice of regular work. We see no reason to deprive an employer of the benefits of Section 4658(d)(3)(A) where the employee has not been temporarily disabled through the permanent and stationary date.

If you were sufficiently nave, you might have thought that the plain language of the statute and the employers failure to comply with it was sufficient reason. The statute makes no exception for injured employees who continue to work at their regular employment. It provides for a decrease in PD only when the employer has made the formal offer within the prescribed time limit, and then the decrease only applies to PD payments after the offer is made. Here, the offer was untimely, and if it had been timely, there would have been no reduction because of the timing of the

payments.

But it appears that plain language is a disfavored mode of statutory interpretation, at least as it involves Senate Bill 899. For example, see *Vera v. Workers Comp. Appeals Bd.* (filed 8/2/07, certified for publication 8/30/07) *Cal. App. 4th* [72 *Cal. Comp. Cas.* 1115], in which the Court of Appeal blithely concluded that indicating the existence of permanent disability in Cal. Labor Code § 4660(d) means permanent and stationary. (Note: I was the dissenting commissioner in the underlying panel decision, *Vera v. Sapper Construction Company*, 2005 *Cal. Wrk. Comp. P.D. LEXIS* 50 (Appeals Board panel decision).)

On the other hand, I would not rely heavily on the *Audiss* panel decision in a future case in which applicant is represented by an attorney and the stakes are higher. Here, the benefits of Section 4658(d)(3)(A) to this employer were \$297.00. If the PD rating is higher and the potential increase or decrease is more significant, I anticipate that future parties and WCAB panels will look more carefully at the statute.

Contemporaneous notices of termination and injury do not bar compensation pursuant to Labor Code § 3600(a)(10): *Dover v. Fresh Start Bakeries*, 2006 *Cal. Wrk. Comp. P.D. LEXIS* 53 (Appeals Board panel decision). Cal. Labor Code § 3600(a)(10) provides that no compensation shall be paid when a claim for compensation is filed after notice of termination or layoff, unless the employee demonstrates, among other things, that the employer had notice of the injury prior to the notice of termination or layoff. It seems straightforward either the employer did or did not have notice of the injury prior to notice of termination. But nothing is simple.

In *Dover v. Fresh Start Bakeries*, 2006 *Cal. Wrk. Comp. P.D. LEXIS* 53 (Appeals Board panel decision), applicant was a probationary employee working as an industrial machinery engineer. He claimed to have sustained an industrial injury to his back on January 1, 2005. He said that he tried to report the injury but that his supervisor had already left for the day. When he arrived at work the next day, he was contacted by his supervisor and told to report to the front office. While walking together to the front office, the supervisor told applicant that he was to be terminated, and applicant told the supervisor about the industrial injury.

The WCJ, while finding that applicant was scrupulously honest in his testimony, held that the injury was barred by Cal. Labor Code § 3600(a)(10) because the employer did not have notice of the injury prior to the notice of termination.

The WCAB panel reversed. (Note: I was the lead Commissioner on this panel decision.) The panel determined that [s]ection 3600(a)(10) is not intended to bar compensation to an injured worker merely because the employer intends to terminate the employee. Instead, the statute is intended to bar claims made in retaliation for a personnel action involving termination or lay off.

As to the facts of the case, the panel reviewed the transcripts of the testimony of applicant and his supervisor. There was no contradiction between them as to the content and timing of their conversation on the way to the front office. The panel concluded that both applicant and [the supervisor] testified that notice of injury was *contemporaneous* with notice of termination. Indeed, the record shows the injury claim was discussed during the exit interview and that applicant was referred for medical treatment before he was terminated (emphasis added). The fact that one statement followed another during a conversation was not enough to conclude that the injury was barred because notice of injury to the employer occurred after notice to the employee of termination, especially when there was no reason to believe that applicants report of injury was made in retaliation for the notice of termination. This is as close as it gets.

For further discussion of "the bump" in permanent disability payments, see 2-32 Hanna, CA Law of Employee Injuries & Workers' Comp § 32.04[3][a], and 1-7 Herlick, California Workers' Compensation Law § 7.51.

For further discussion of post-termination notice of injury, see 1-4 Hanna, CA Law of Employee Injuries & Workers' Comp § 4.65, and 1-10 Herlick, California *Workers' Compensation Law* § 10.02.

ABOUT THE AUTHOR(S):

Merle C. Rabine was a Commissioner of the California Workers' Compensation Appeals Board from April 2000 to January 2007. He was Chairman of the Appeals Board from April 2000 to June 2005. Mr. Rabine is presently a member of the LexisNexis National Workers' Compensation Advisory Board. The opinions expressed herein are those of the author and do not reflect opinions of the Appeals Board or any of its Commissioners.

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McCoy on Elimination of Second Injury Funds and Impact on Iraqi War Veterans

2008 Emerging Issues 532

McCoy on Elimination of Second Injury Funds and Impact on Iraqi War Veterans

By Doug McCoy

October 1, 2007

SUMMARY: Second Injury Funds began in America in 1916 and were then modified following World War II to encourage the hiring of disabled war veterans. Beginning in 1992, however, states began to close their Second Injury Funds. This commentary by Doug McCoy of McCoy Consulting, examines the policies behind the closure of Funds and the potential impact on Iraqi War Veterans and others.

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ARTICLE: Second Injury Funds began in America in 1916 and were then modified following World War II to encourage the hiring of disabled war veterans. The first state to enact legislation to form a fund was New York [see N.Y. Work. Comp. Law § 15(8)]. Over the next 30 years, most states created some form of Second Injury Fund. The final state to enact legislation to form a Fund was Georgia on July 1, 1977 [see O.C.G.A. § 34-9-352].

Beginning in 1992, however, states began to close their Second Injury Fund. This commentary examines the policies behind the closure of Funds and the potential impact on Iraqi War Veterans and others.

How Second Injury Funds Worked

Second Injury Funds took two forms: (1) The Fund took over the handling of the claim and paid the injured worker for the disability and or medical cost above the amount of the workers compensation injury; or (2) the Fund reimbursed the employer/carrier after specified threshold amounts were met. For example, in the case of New York, reimbursement was made after 208 weeks of indemnity were paid [see N.Y. Work. Comp. Law § 15(8)(e)]. In Georgia reimbursement was made after the first \$5,000 was paid in medical and after 104 weeks of indemnity were paid [see O.C.G.A. § 34-9-360(a), (b)].

The effect of both types of Funds was to eliminate the additional costs as a consequence of a prior impairment combining with a subsequent injury to create a greater disability and medical costs.

Reasons for Eliminating Second Injury Funds

Funds were built up by a charge against carriers in cases of death without dependents. Sometimes there were special appropriations; and sometimes a small percentage assessment was made against carriers (or employers) [see 5-90 *Larson's Workers' Compensation Law* § 90.01(2)].

Businesses and insurers lobbied their state legislatures to eliminate the Funds, because in their opinion only a small group of employers or insurance carriers benefited, while all employers paid for the cost to administer the Funds and pay claims that qualified. In effect they felt there were more losers than winners.

On September 6, 2000, Edward Reinfurt, Vice President of The Business Council for the State of New York, testified before the Governor's Study Commission on Workers' Compensation Special Funds. Mr. Reinfurt stated that business was recommending elimination of New York's Fund even though, in the short term, it could mean higher workers compensation costs for some employers.

Acknowledging its purpose to encourage the hiring of disabled World War II veterans, he commented, "That seems reasonable. For what these veterans did for our country and for future generations, it was little to ask."

Mr. Reinfurt went on to testify that the New York Fund had outlived its original intent, citing that most World War II veterans were beyond retirement age, and New York's workplace accident rate was 38 percent below the national average.

9/11 and Its Aftermath

New York did not eliminate its Fund in 2000. Almost one year later, though, New York and the rest of America experienced the unthinkable. On September 11, 2001, terrorists successfully brought the World Trade Center twin towers crashing down, killing or injuring the largest number of civilian American workers in a single accident. On March 19, 2003, America sent troops to war in Iraq.

During his testimony Mr. Reinfurt argued that the Americans with Disabilities Act of 1992 eliminated the discrimination in employment for disabled Americans that existed in the post-war era of World War II.

As of September 11, 2007 we are still in Iraq, and New York has finally eliminated their Second Injury Fund earlier this year. New York is not alone in this respect, however. Many states have repealed their Second Injury Fund statutes, bringing the Fund in each of those states to closure.

States Where Second Injury Fund Eliminated or Reopened in a Different Form

Alabama. Fund repealed on 5/19/92.

Colorado. Fund does not apply to injuries occurring on or after 7/1/93 and for occupational diseases occurring on or after 4/1/94 [C.R.S. § 8-46-104].

Connecticut. Fund abolished in 1995.

District of Columbia. Fund repealed for injuries occurring on or before 4/16/99 [D.C. Code § 32-1508(6)(c)].

Florida. Fund eliminated; no claims allowed after 12/30/97 [see Fla. Stat. § 440.49].

Georgia. Fund eliminated; no claims allowed for injury dates on or after July 1, 2006 [O.C.G.A. § 34-9-368].

Kansas. Fund abolished for accidents after 7/1/94.

Kentucky. Fund eliminated for injuries occurring after 12/12/96.

Maine. Fund eliminated in 1992.

Minnesota. Fund abolished for claims arising after 6/30/92.

Nebraska. Fund eliminated for injuries sustained after 12/1/97.

New Mexico. Fund eliminated in 1996.

New York. Fund eliminated for all cases with a date of disablement after 7/1/2007 [N.Y. Work. Comp. Law § 15(8)(h)]. [Note: N.Y. Work. Comp. Law § 125 was amended in 2007 to prohibit discrimination against injured veterans in hiring. N.Y. Work. Comp. Law § 125-a, effective 4/12/2007, provides that any employer or insurance carrier that discriminates against an injured veteran shall be guilty of a Class A misdemeanor].

Oklahoma. Fund eliminated in 2000.

Oregon. Fund closed and reopened in a different form in 1987 [see Preferred Worker Program in ORS § 656.622].

Rhode Island. Fund repealed in 1998.

South Carolina. Fund abolished on 7/1/2013.

South Dakota. Fund eliminated in 1999.

Utah. Fund eliminated for all injuries occurring after 7/1/94 [Utah Code Ann. § 34A-2-702].

Vermont. Fund eliminated in 1999.

West Virginia. Fund eliminated in 2003.

The Human Cost of War: Both Military and American Contractors

Just like during and following World War II, we have hundreds and thousands of disabled veterans returning from war. It is estimated that there are approximately 100,000 injured soldiers as of September 11, 2007, with anticipation of an estimated five more years of hostilities. These estimates included minor injuries as well as amputations, loss of sight, and traumatic brain injuries.

In addition to the soldiers, there are a large number of civilian contractors working in Iraq. Nearly 300 American companies supply workers in the war zone. They comprise the largest civilian force in American military history. During the first quarter of this year alone, 3,430 civilian contractors have filed claims for wounds suffered in Iraq. For every four American soldiers killed in Iraq, there is also one American civilian employee killed.

Post-Traumatic Stress Disorder

There are many more returning soldiers that suffer from a less obvious disability, post traumatic stress disorder (PTSD).

PTSD is a disabling condition that can occur after exposure to a terrifying event in which grave physical harm occurred or was threatened. One of the traumatic events that can trigger PTSD is military combat. One traumatic event most often associated with PTSD for men is combat exposure. This also applies to women exposed to combat [see National Institute of Mental Health, 2001].

Americans with Disabilities Act

The Americans with Disabilities Act (ADA) does not contain a list of medical conditions that constitute disabilities. Instead, the ADA has a general definition of disability that each person must meet [see EEOC Technical Assistance Manual, Title I of the ADA 2.2]. Some people with PTSD will have a disability under the ADA, while others will not.

A person has a disability if he/she has a physical or mental impairment that substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment [see EEOC Technical Assistance Manual, Title I of the ADA 2.2].

While it is true the ADA protects disabled workers from discrimination, it only applies to employers with 15 or more employees [see 9-152 Larson on *Employment Discrimination* § 152.02]. According to the U.S. Census Bureau, approximately 18% of all employees in the United States work for firms with less than 15 employees.

The ADA is designed to protect employees, not employers, while the Second Injury Funds became a solution to the dilemma of an employer bearing the full cost of disability for an employee that already had a permanent impairment. Second Injury Funds usually made the employer ultimately liable only for the amount of disability attributable to the particular injury occurring in its employment, while the Fund paid the difference between that amount and the total amounts to which the employee is entitled for the combined effects of the prior and present injury [see 5-91 *Larson's Workers' Compensation Law* § 91.01].

Only time will tell if there is a substantial impact on returning service men and women and others without Second Injury Funds.

For further discussion of Second Injury Funds, see 5-91 *Larson's Workers' Compensation Law* § 91.01 et seq.

For further discussion of the New York Special Fund for Second Injuries, see 1-2 New York Workers' Compensation Handbook § 2.16, 5.59.

For further discussion on the Georgia Subsequent Injury Trust Fund, see Kissiah's *Georgia Workers' Compensation Law*, §§ 32.01-32.08.

For further discussion of the Florida Special Disability Trust Fund, see 1-20 Florida Workers' Compensation Handbook § 20.01 et seq.

For further discussion of the California Subsequent Injuries Benefits Trust Fund, see 1-8 Hanna, CA Law of Employee Injuries & Workers' Comp §§ 8.09, 31.20(4); 1-8 Herlick, *California Workers' Compensation Law* § 8.01 et seq.

For further discussion of the Americans with Disabilities Act, see 9-151 Larson on *Employment Discrimination* § 151.01 et seq., 152.01 et seq., 153.01 et seq., 154.01 et seq., 155.01 et seq., 156.01 et seq., 157.01 et seq., 158.01 et seq., see also 1-1 ADA: Employee Rights and Employment Obligations § 1.01 et seq.

For further discussion of post-traumatic stress disorder, see 12-101A Attorneys' Textbook of Medicine (Third Edition) P 101A.00 et seq.

ABOUT THE AUTHOR(S):

Doug McCoy is Principal of McCoy Consulting, an independent firm that provides consulting services to stakeholders in the property casualty insurance industry. He began his career as a multi-line claim adjuster in the property casualty claim operation of a major insurer. In 1992 he became the Divisional Vice President of Commercial Lines. In 1994 he became the Chief Operating Officer of a large workers' compensation managed care organization. Mr. McCoy's extensive industry experience includes representation on the National Council on Compensation Insurance Fraud Study Committee, Governor's Study Committee on Workers' Compensation, Warm Springs Institute for Rehabilitation Advisory Committee, Learning Services Head Injury Center Advisory Committee, and Pharmacy Management Services, Inc., Advisory Committee. He currently serves as a member of the Licensure and Self-Insurance Sub-Committee of the Chairman's Advisory Committee for the Georgia State Board of Workers' Compensation and of the Georgia CompScope Multi-state Advisory Committee for the Workers' Compensation Research Institute. He has been appointed by the Governor of Georgia, Roy Barnes, to serve on his Workers' Compensation Review Commission. Mr. McCoy has spoken on numerous topics concerning claims management throughout the country and has written articles for Business Insurance, Risk and Insurance Management, Rough Notes, and the Wall Street Journal. He is the author of Workers' Compensation: The Survival Guide for Business (LexisNexis Matthew Bender) and a member of the LexisNexis National Workers' Compensation Advisory Board.



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Levy on War Hazards Compensation Act for Overseas Injured Civilian Employees

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Levy on War Hazards Compensation Act for Overseas Injured Civilian Employees

By Roger A. Levy

October 1, 2007

SUMMARY: Hostilities in Eastern Europe, Afghanistan, and most recently Iraq and other countries in the Middle East have caused many employers concern and uncertainty over workers compensation exposures to employees working in those parts of the world. This Emerging Issues Analysis examines the War Hazards Compensation Act, one of the primary federal statutes that addresses these matters.

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ARTICLE: Hostilities in Eastern Europe, Afghanistan, and most recently Iraq and other countries in the Middle East have caused many employers concern and uncertainty over workers' compensation exposures to employees working in those parts of the world. Many consultants, technical representatives, advisors and all variety of workers have been sent overseas to assist directly or indirectly with the war effort. Many construction workers have already been sent to assist in the rebuilding of war-torn Iraq. Those whose memories do not date back to the Vietnam era may not be familiar with the two primary federal statutes which address these matters -- the Defense Base Act ("DBA") and the War Hazards Compensation Act ("WHCA") -- although all one has to do is pick up a newspaper, magazine or turn on the nightly news to read or hear the latest. A brief synopsis of the WHCA may be useful both as to events that may have happened or that may happen, as our military involvement hopefully winds down and the rebuilding effort gears up.

For expert commentary on the DBA, see *Roger A. Levy on the Challenges of Applying the Defense Base Act to Civilian Employees Injured Overseas*.

Purpose of WHCA. The general purpose of the WHCA is to shift to the United States government the costs of compensating certain civilian employees (domestic and foreign) of private companies who are working overseas in furtherance of American foreign policy and are injured or killed by a war risk hazard.

Coverage Under the WHCA. The WHCA can be found at 42 U.S.C.S. §§ 1701--1717. Because the Act does not provide for any appeal of an agency ruling, there are no reported appellate court or Benefits Review Board decisions. This Act imposes liability upon the United States for the prescribed benefits. It is not an act which imposes liability on an employer other than when the United States is the employer.

Section 101(a) of the Act provides for payment by the Division of Federal Employees' Compensation ("DFEC") when injury or death is the result of the hostile act of an enemy force to certain employees or contractors to the government [See 42 U.S.C.S. § 1701(a)]. These benefits are identical to those provided in the Federal Employees' Compensation Act ("FECA") [See 5 U.S.C.S. §§ 8101-- 8193].

Section 101(b)-(d) of the Act provides for certain payments by DFEC to the account of a detained person as discussed below who has been taken captive by a "hostile force". No injury is required and in fact proof of the lack of such is required as a prerequisite. These benefits may exceed weekly compensation prescribed in the LHWCA or DBA for an injury [See 42 U.S.C.S. § 1701(b)-(d)].

This provision of the WHCA applies where such a person is detained by hostile forces, is missing under circumstances supporting an inference that such absence is due to belligerent action of a hostile force, or is marooned by virtue of failure of the United States or its contractors to repatriate.

It is upon Section 104(a)-(c) of the Act that the vast majority of claims are made. It is the section that provides for reimbursement to an employer or carrier when benefits have been paid because of an injury or death to an employee as a result of a "war-risk hazard" [See 42 U.S.C.S. § 1704(a)-(c)].

DFEC's liability is triggered when there is an injury that occurs to a qualifying employee which "arose from a war-risk hazard." [See 42 U.S.C.S. § 1704(a)(1)]. The employees are generally those covered by the DBA, those covered by the Non-Appropriated Fund Instrumentalities Act, those employed directly by the United States, and those providing welfare or similar services for the Armed Forces of the United States. The injury must occur outside of the United States.

What Is a War Risk Hazard? All injuries occurring in a war zone are not covered under the WHCA. Injuries independent of the surrounding conflict are not covered.

The Act contains a lengthy, complicated definition which goes on for a number of paragraphs. In summary, it requires an armed conflict, but not necessarily a declared war. The injury may arise out of any of the following: discharge of a missile; use of any weapon, explosive or other noxious thing by hostile forces; combating an attack or imagined attack; action of a hostile force or person without use of specified weapons; discharge or explosion of munitions stored for use in a conflict; collisions of vessels or aircraft operating under conditions which would not be considered safe in normal times but are dictated due to the contingencies of the conflict (such as operating without running lights).

What About Terrorist Activity? Not specifically set forth in the WHCA definition is whether terrorist activity qualifies as a war-risk hazard. The Act was written in 1942. The world has changed dramatically since then. As a result, the Department of Labor has shown flexibility and an ability to adapt by including injuries and death as a result of terrorist activity within the definition.

Benefits and Administration of the WHCA. If a person is not entitled to receive benefits under any other workers' compensation statute, that person receives benefits as if he were covered under the FECA. Claims are administered by the U.S. Department of Labor, Office of Workers' Compensation Programs (OWCP). For those detained or marooned, there is a presumption of total disability.

Where there is coverage for injury under any other workers' compensation law, benefits must be paid pursuant to such law. The United States will then reimburse the insurer or self-insured employer for injuries proximately caused by a war-risk hazard occurring outside of the United States. Such reimbursement is administered by the Department of Labor, and is paid out of the fund established for payment of benefits under FECA. Reimbursement is also available for allocated claims expenses according to proof, and for unallocated claims expenses deemed 15% of the benefits paid.

To obtain reimbursement, a request should be filed, along with supporting documents, with the Employment

Standards Administration, U.S. Department of Labor/Office of Workers' Compensation Programs, 1240 E. 9th Street, Room 851, Cleveland, Ohio 44199. The documentation required includes proof of liability (such as an insurance policy or self-insurance certificate), any compensation orders, medical reports, statements of the employee or employer, claim forms, bills and proof of payments. Especially significant is evidence that the injury arose out of a war-risk hazard. Reimbursements are commonly annual. The Department of Labor may take over payment directly, but will only do so after the extent of liability has been determined.

A key provision in WHCA is that *no* reimbursement is allowed if the insurance carrier charges additional premium for the war risk hazard.

Detention Claims. Sadly, this provision has become more prominent given the way in which war is being conducted at present in the Middle East, Afghanistan and South America. Twenty-first century warfare involves the utilization of civilian contractors to perform certain parts of the military's work which, in the past, was done by enlisted men and women.

Necessary Elements for "Detention". The WHCA is implemented by 20 C.F.R. §§ 61.1--61.404 (2002). Subpart D contains the provisions relating to claims for detention benefits arising under Section 101(b) of the WHCA [20 C.F.R. §§ 61.300--61.307]. These provisions contain the basic framework for filing a claim for detention benefits [20 C.F.R. § 61.3 (2002)].

One of the preliminary matters to be resolved is whether the injured worker is a "specified" employee [42 U.S.C.S. § 1701(a)(1) (2003)]. A person is a specified employee if one of the following applies:

1. He is covered under the Defense Base Act;
2. He is engaged by the United States under a personal service contract;
3. He is covered under the Nonappropriated Fund Instrumentalities Act;
4. He is engaged for personal services by the United States under the Mutual Security Act; or

5. He is engaged by an American employer to provide welfare or similar services to the Armed Forces and the injury or death is casually related to a war-risk hazard. [*Federal Employees' Compensation Act Procedural Manual*, Trans. No. 94-39. 4-0300-7 (U.S. Dept. Lab. 1994)]

There is no requirement that the person actually be engaged in the course of his employment at the time of his disappearance or death [20 C.F.R. § 61.300(a) (2002)].

If the person is shown to be a specified employee, it must then be demonstrated that he has been "detained by a hostile force or person" in order to receive detention benefits [20 C.F.R. § 61.300 (2002)]. This determination is made on a case-by-case basis and is fact sensitive. The standard of proof for showing that the person has been detained by a hostile force is not clear, but in any event, it is not a high threshold [See 20 C.F.R. § 61.303 (2002)]. The showing "may be made on the basis that the employee has disappeared under circumstances that make detention *appear probable*." [See 20 C.F.R. § 61.303 (2002) (emphasis added)]. However, in making the determination that an employee has been detained, considerable weight will be given to the information from the department or agency having knowledge of the circumstances surrounding the employee's absence [See 20 C.F.R. § 61.303 (2002) (noting that conclusion of agency will be prima facie evidence of employee's status)].

Even if an employee is otherwise eligible for benefits, he can still be denied disabilities benefits for several reasons. For example, an otherwise eligible employee will not receive detention benefits when he resides in the place of employment, does not live there solely due to his employment, and he is detained under circumstances outside the course of his employment. That is, if the employee lives in proximity to where he works, for non-work purposes, *and* he

is detained outside the course of employment, he cannot receive detention benefits [See 20 C.F.R. § 61.303(d) (2002)]. Other events that may disqualify a specified employee include: the employee being detained by the United States as a prisoner of war; the individual receives workers' compensation benefits paid from any other source for the same period of detention; the person is a foreign national and is entitled to compensation benefits from a foreign country on account of the same detention; or the person has been convicted of any subversive act against the United States or its allies [See 20 C.F.R. § 61.303(d)(2)-(5) (2002)].

Time for Filing. The time limitations for filing for detention benefits are the same as those under the Federal Employees' Compensation Act (FECA) [See 20 C.F.R. § 61.302 (2002)]. Generally, written notice of injury must be provided by the employee, or someone on his behalf, within 30 days [5 U.S.C.S. § 8119 (2003)]. An original claim for compensation is to be filed within three years after the occurrence of detention/injury/death [5 U.S.C.S. § 8122 (2003)]. However, failure to comply with the above specified time periods will not preclude the employee from receiving benefits where notice could not have been given due to "exceptional circumstances." [See 5 U.S.C.S. § 8122(d)(3) (2003) (indicating that Secretary may excuse failure to comply due to exceptional circumstances)].

Duration of Detention Benefits. Once an employee has started to receive detention benefits, there are several grounds for which they may be terminated [See 20 C.F.R. §§ 61.303--61.305 (2002)]. Detention benefits cease upon the employee being returned to his home or place of employment [20 CFR § 61.305 (2002)]. If death is "in fact established," detention benefits are also terminated. A more problematic issue is that detention benefits also cease when death "can be legally presumed to have occurred." [20 C.F.R. § 61.303 (2002)]. The OWCP has authority to make a finding of death based on evidence that the employee disappeared under circumstances that make death appear probable or when the employee has been detained for a prolonged period of time. In making this presumption, the OWCP should consider not only the circumstances of the disappearance, but also the wishes of the employee's survivors. In order to invoke this presumption, an OWCP Senior Claims Examiner must prepare a memorandum to the Director and a compensation order for the Deputy Director for Federal Employees' Compensation to sign. A copy of the compensation order must be sent to the employee's survivors and should be accompanied by a letter telling the survivors of the procedure for filing a claim for death benefits [42 U.S.C.S. § 1716 (2003); *Federal Employees' Compensation Act Procedural Manual*, Trans. No. 94-39. 4-0300-17 (U.S. Dept. Lab. 1994)].

The employee's dependents are frequently the first to learn about any changes in the employee's status. That is, they are frequently the first to know if the employee has passed away or if he/she has been released from detention, thus triggering the termination of detention benefits. Therefore, the OWCP claims examiner should maintain contact with the employee's dependents by sending them a "yearly inquiry" where the claims examiner can ask for any new information concerning the employee's status [42 U.S.C.S. § 1716 (2003); *Federal Employees' Compensation Act Procedural Manual*, Trans. No. 94-39. 4-0300-17 (U.S. Dept. Lab. 1994)].

Consequences of Receiving Detention Benefits. An employee meeting the definition of "specified employee" is due certain benefits [See 20 C.F.R. §§ 61.300, 61.304, 61.306 (2002)]. As soon as the employee is "detained" [see "Necessary Elements", above], he is considered totally disabled until the point he is returned to his home, his place of employment, or to the "jurisdiction of the United States." [20 C.F.R. § 61.300(b) (2002); see "Duration of Benefits", above]. Detention benefits also cease when the employee is determined to be dead [20 C.F.R. § 61.300(b) (2002)]. When an employee is released from detainment, the OWCP "may pay" the cost of transporting the employee from the point of release to his home, the place of employment, or another place within the United States. While this language seems to suggest that the OWCP has discretion in determining whether to pay the costs, it appears the only time the OWCP would not pay the cost of transportation for a released employee is in the event that the employee is to be furnished transportation under any agreement with his employer [20 C.F.R. § 61.306(a) (2002)]. In the event that the employee should die during his detention, the OWCP may provide the cost of transporting the body to the deceased's home or any place the employee's next of kin designates [20 C.F.R. § 61.307 (2002)].

Prior to the time of release or death the employee is considered totally disabled and is entitled to compensation at 100% of his Average Weekly Wage (AWW) [20 C.F.R. § 61.300(c) (2002)]. The compensation is to be paid by the

OWCP from the Employees' Compensation Fund [*Federal Employees' Compensation Act Procedural Manual*, Trans. No. 94-39. 4-0300-17 (U.S. Dept. Lab. 1994)]. The only limitation is that the employee's AWW used to compute the detention benefits cannot exceed the AWW paid to civilian employees of the United States in the "same or most similar occupation" in the area nearest to the place of employment. This compensation is to be credited to the employee's account. In the event that the detained employee has dependents that reside in the United States, its territories, or possessions, the OWCP may pay the dependents 70% of the credited benefits. Although the regulations are not explicit, they seem to imply that the remaining 30% shall continue to be credited to the employee's account [20 C.F.R. § 61.300(c) (2002)].

An employee's detention benefits are not subject to the monetary limits that are found in Sections 6(b) and 9(e) of the LHWCA [20 C.F.R. § 61.304(a) (2002)]. Section 6(b) limits compensation for disability or death to 200% of national AWW [33 U.S.C.S. § 906(b)(1) (2003)]. However, one limitation on the amount of compensation to be paid to a detained employee and/or his dependents is that if either the dependents or the employee receives any other federal benefit in lieu of wages during the time of detention, and the United States paid for those, the OWCP is entitled to credit for such payments [20 C.F.R. § 61.304(b) (2002)]. A second limitation on detention benefits is that, generally, disability compensation may not be paid at the same time detention benefits are paid. The one exception to that general rule is that payment for scheduled losses may be made at the same time the employee receives detention benefits [*Federal Employees' Compensation Act Procedural Manual*, Trans. No. 94-39. 4-0300-17 (U.S. Dept. Lab. 1994)].

Process. In most instances the provisions of FECA apply with respect to the administration of claims made under the WHCA because payment is made from the fund established by FECA [James Michael Zimmerman, *Extraterritorial Employment Standards of the United States: The Regulation of the Overseas Workplace* 1027 (Quorum Books 1992)]. However, as noted above, the computation of disability and death benefits and the determination of pay rate and beneficiaries are made in accordance with the LHWCA [*Federal Employees' Compensation Act Procedural Manual*, Trans. No. 94-39. 4-0300-6 (U.S. Dept. Lab. 1994)]. Because both acts govern claims under the WHCA, either regular FECA or LHWCA forms may be used to claim benefits under the WHCA [*Federal Employees' Compensation Act Procedural Manual*, Trans. No. 94-39. 4-0300-5 (U.S. Dept. Lab. 1994)].

Prior to receiving compensation from the fund governed by FECA, the employee or dependent must obtain a determination from the Longshore District Director that no compensation is payable under the DBA [*Federal Employees' Compensation Act Procedural Manual*, Trans. No. 94-39. 4-0300-10 (U.S. Dept. Lab. 1994)]. This claim should be filed in the proper office for the filing of a DBA claim of injury. The employee, dependent, employer, or its attorney can accomplish this by submitting a DBA claim to the District Director [See e-mail from Richard Robilotti, Dist. Dir., *FECA Procedure Manual on WHA Claims* (Mar. 7, 2003)]. The goal here would not be to receive an award for DBA benefits but rather to obtain a ruling that, while the employment may fall under the DBA, there is no evidence to support a claim for such benefits. Section 61.301 governs what must be included for filing a claim for detention benefits [20 C.F.R. § 61.301 (2002)]. The following information should be provided [20 C.F.R. § 61.301 (2002)]:

1. Name of employee;
2. Address of employee;
3. Occupation of missing employee;
4. Name of dependent (if making the claim);
5. Address of dependent;
6. Relation of dependent to employee;
7. Name of employer;

8. Address of employer;
9. Contract number under which employee was employed;
10. Date of capture or detention;
11. Place of capture or detention;
12. Circumstances of capture or detention;
13. Date of release (if applicable);
14. Place of release (if applicable);
15. Circumstances of release (if applicable).

The claim must be supported by proof of employment, evidence of disability (if any), and evidence of death and/or detention. The showing of death and/or detention can be made through the use of investigative reports, newspaper clippings, etc. [See 20 C.F.R. § 61.301 (2002)]. While the claimant has the burden of establishing entitlement [*Federal Employees' Compensation Act Procedural Manual*, Trans. No. 94-39. 4-0300-10 (U.S. Dept. Lab. 1994)], the employer must provide information about the circumstances of the detention and the employee's pay rate at the time of capture [20 C.F.R. § 61.301(a) (2002)]. The OWCP claims examiner has the responsibility of developing the factual and medical evidence that is submitted to the District Director. Additionally, after development of case, the claims examiner is to draft a memorandum on whether the injury, detention, or death was the result of a war hazard [*Federal Employees' Compensation Act Procedural Manual*, Trans. No. 94-39. 4-0300-10 (U.S. Dept. Lab. 1994) (indicating that claims examiner is to undertake any necessary development of factual and medical evidence submitted)].

The District Director then reviews the claim and determines whether there is a claim under the DBA [*Federal Employees' Compensation Act Procedural Manual*, Trans. No. 94-39. 4-0300-10 (U.S. Dept. Lab. 1994) (indicating that claims examiner is to undertake any necessary development of factual and medical evidence submitted)]. If the DBA claim is denied, the District Director shall issue an order establishing the facts of the case. This order, along with a WHCA application and all above-referenced supporting evidence and information must then be submitted to the Branch of Regulations and Procedures, OWCP-DFEC, 200 Constitution Ave. NW, Washington D.C., 20210, Room S 3229; Attention to: Vinicia McNeil, Chief of Branch of Regulations & Procedures [See 20 C.F.R. § 61.301 (2002)].

The procedure to be followed when the employee is presumed dead is slightly different from the process above, when it can be shown that the employee has been released or has passed away. When the employee has been detained or missing for a "prolonged period of time," the OWCP claims examiner must prepare a memorandum, indicating that death is probable. The claims examiner is to send this memorandum to the Director and a compensation order for the signature of the Deputy Director Federal Employees' Compensation. A copy of the signed compensation order must be sent to the employee's survivors, accompanied by a cover letter advising the survivors of the procedure for filing a claim for death benefits [See *Federal Employees' Compensation Act Procedural Manual*, Trans No. 94-39. 4-0300-10 (U.S. Dept. Lab. 1994)].

Following one of the two processes above, benefits can then be credited to the detained employee or his dependents. At that point, the only task of the OWCP claims examiner is to make yearly inquiries of the dependent(s) to ensure there has been no release from detention or death. [See *Federal Employees' Compensation Act Procedural Manual*, Trans No. 94-39. 4-0300-10 (U.S. Dept. Lab. 1994)] Similarly, the dependent has an affirmative duty to notify the OWCP of any changes in the status of the missing employee [20 C.F.R. § 61.305 (2002)]

Conclusion. The handling of detention benefits under the WHCA could certainly be considered "arcane." [John M. Vittone & Augustus A. Simpson, Jr., *Judges' Benchbook*, § 60.5 (2002)]. However, as arcane as they may be, the

WHCA's provisions governing detention benefits provide needed compensation for loss of earnings of employees held captive by a hostile force [See James Michael Zimmerman, *Extraterritorial Employment Standards of the United States: The Regulation of the Overseas Workplace* 1025 (Quorum Books 1992)]. The detention benefits allow for the detained employee to receive 100% of his AWW, or his dependents to receive 70% of that amount, and are not subject to limitations found under the LHWCA [20 C.F.R. § 61.300(c), 61.304(a) (2002)]. Because the detention benefits are more generous than other compensation schemes, several conditions are placed on the payment of the benefits. Besides being a specified employee detained by a hostile force, the employee must not fall within one of the other exclusionary grounds [See "Necessary Elements for 'Detention'", above]. Death and a finding of presumed death further limit the right to receive detention benefits.

No less arcane is the process for filing a claim for detention benefits under the WHCA. The process unintuitively involves first seeking a denial of claim under the DBA and then submitting the claim to the Branch of Regulations and Procedures [See "Process", above]. The employer's/carrier's primary role involves supplying information to the OWCP to facilitate the OWCP's handling of the case. While the carrier may assist in submitting claims, the OWCP has the primary responsibility of developing the factual and medical evidence and determining if the individual is a specified employee detained as a result of a war hazard [*Federal Employees' Compensation Act Procedural Manual*, Trans. No. 94-39. 4-0300-10 (U.S. Dept Lab. 1994)].

For Further Discussion on the Longshore Act, see *Larson's Workers' Compensation Law*, § 145.01 et seq.

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Levy on Applying Defense Base Act to Civilian Employees Injured Overseas

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Levy on Applying Defense Base Act to Civilian Employees Injured Overseas

By Roger A. Levy

September 28, 2007

SUMMARY: Hostilities in Eastern Europe, Afghanistan, and most recently Iraq and other countries in the Middle East have caused many employers concern and uncertainty over workers compensation exposures to employees working in those parts of the world. This commentary, written by Roger A. Levy, who is Of Counsel to Laughlin, Falbo, Levy & Moresi, San Francisco, and specializes in the defense of cases brought under the Longshore and Harbor Workers' Compensation Act, examines the Defense Base Act, one of the primary federal statutes that addresses these matters.

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ARTICLE: Hostilities in Eastern Europe, Afghanistan, and most recently Iraq and other countries in the Middle East have caused many employers concern and uncertainty over workers compensation exposures to employees working in those parts of the world. Many consultants, technical representatives, advisors and all variety of workers have been sent overseas to assist directly or indirectly with the war effort. Many construction workers have already been sent to assist in the rebuilding of war-torn Iraq. Those whose memories do not date back to the Vietnam era may not be familiar with the two primary federal statutes which address these matters the Defense Base Act (DBA) [42 U.S.C.S. § 1651 et seq.] and the War Hazards Compensation Act (WHCA) [42 U.S.C.S. § 1701 et seq.] although all one has to do is pick up a newspaper, magazine or turn on the nightly news to read or hear the latest. A brief synopsis of the DBA may be useful both as to events that may have happened or that may happen, as our military involvement hopefully winds down and the rebuilding effort gears up.

For expert commentary on the WHCA, see *Roger A. Levy on the War Hazards Compensation Act for Overseas Civilian Employees Injured by a War Risk Hazard or Detained by a Hostile Force*.

Purposes of DBA. The general purpose of the DBA is to provide uniform and generous compensation benefits to certain civilian employees (domestic and foreign) of private companies doing work overseas in furtherance of American foreign policy.

Benefits and Administration of the DBA. The DBA is a relatively brief piece of legislation which basically sets forth the coverage requirements and provides that once those coverage requirements are met, the Longshore and Harbor Workers Compensation Act (LHWCA) applies [See 33 U.S.C.S. § 901 et seq.]. This coverage is situs intensive. That is, the work must occur over-seas at a location specified in Section 1(a)(1)-(6) of the DBA [See 42 U.S.C.S. § 1651(a)(1)]

-(6)]. In addition, such work must be pursuant to a contract for employment services outlined more particularly in Section 1(a)(4)-(6) [See 42 U.S.C.S. § 1651(a)(4)-(6)]. The same forms are used, proceedings are before the same agencies, and the benefits are, with some exception, the same as provided by the LHWCA.

There are some differences, however. The minimum compensation rates for the LHWCA do not apply to DBA claims. This acknowledges the reality that many local nationals are hired and paid at salaries commensurate with local custom. Dependency for aliens and non-nationals of the United States who are not residents of the United States or Canada is limited to spouse, child or parent. Compensation payable to such aliens or non-nationals may be discharged by payment of one-half the commuted value of future installments. Unlike the LHWCA, the DBA does not share concurrent jurisdiction with state compensation laws. The DBA supersedes application of state law, and is an exclusive remedy.

DBA Overview. The DBA was enacted in 1941, at least partially in anticipation of the United States' imminent involvement in World War II. Its purpose was to protect American citizens who travel abroad to work on foreign U.S. military bases by affording them a uniform scheme of workers' compensation benefits delivered in an expeditious manner. Today, many of those covered are non-citizens or resident aliens in the United States because they fall into coverage as employees of U.S. contractors or their sub-contractors unless specifically waived pursuant to the DBA.

Coverage under the Act was later amended to extend coverage to employees who are employed in public work as defined by the Act. Overall, the DBA has served its purposes well by affording a workers' compensation remedy based on the benefits afforded under the LHWCA to non-military and non-government civilian employees when they are injured at work under one or more of the six circumstances outlined in Sec.1(a)(1)-(6) of the Act [See 42 U.S.C.S. § 1651(a)(1)-(6)].

Over the past 66 years, though, the playing field has changed. American activity overseas has escalated and has taken on a more pervasive persona. In response to this change, the DBA is being applied under circumstances which were probably never contemplated by its authors.

The most significant change has been the result of outsourcing much of the work traditionally done by the armed-services of the United States. Particularly, the military has outsourced a great deal of its traditional non-combat work to private contractors, causing these employees to come under the protection of the DBA. Today, there are DBA employees in every imaginable field from security and logistics to information technology consulting. Overall, military outsourcing has been the driving force behind the sharp increase in employees covered by the DBA in the 21st century.

There are workers covered by the DBA in a vast number of nations throughout the world. However, they are predominantly involved in work relating to the present military actions in Iraq and Afghanistan. Although the total number of DBA covered employees today is uncertain, as of December 5, 2006, the Washington Post estimated that there were over 100,000 employees of private contractors in Iraq. Not surprisingly, these private contractors have made up the majority of DBA claims over the past three years.

Claims by these private contractors do not fit the mold of the traditional LHWCA/DBA claim. This broad shift in the makeup of DBA claims has raised legal and procedural issues of first impression in the courts. There are the following difficulties to the establishment of traditional defenses to these cases: (1) the Office of Administrative Law Judges's (OALJ) fast-track policy for war-zone cases, (2) the discovery quagmire, (3) employer inexperience/resistance, (4) the DBAs applicability to foreign national claimants, and (5) the earnings spike and labor market study problem.

OALJs Fast-track Policy. In 2004, the OALJ issued a memo directing that all DBA claims originating out of Iraq and Afghanistan to be fast-tracked. This means that a subject claim must be set for trial within 45 days of its referral. Ideally, the goal of this decision is to assist civilian contractors to obtain a quick resolution of their claims, recognizing that these employees have placed themselves in a work environment that little resembles the work place of a traditional LHWCA/DBA worker. However, as discussed below, the costs to both sides can be high, and it is questionable whether

the goal is really achieved. Given the regulations which apply to pre-trial discovery, 45 days is precious little time to properly prepare for trial. This is especially true in light of the special problems encountered in claims brought by foreign nationals.

The Discovery Quagmire. Hand in hand with the fast-track policy is the discovery quagmire. The fast-track policy magnifies the discovery constraints set forth in 20 C.F.R. § 702.331 et seq., which essentially start the discovery race from the moment the Office of Workers' Compensation Programs (OWCP) refers the case to the OALJ. Anyone who has dealt with the frustration of delays in obtaining answers to interrogatories and requests for admissions, arranging depositions, and obtaining subpoenaed records knows that 45 days is a blink of an eye in such processes.

Moreover, independent medical examinations and labor market studies are all but out of the question as a pre-trial exercise, not to mention the round of depositions they usually spawn. Most ALJs are sympathetic to the parties plight in this regard and are usually generous in allowing post-trial proceedings to address this dilemma. Nonetheless, routinely conducting discovery post-trial leads to a host of other problems.

Foreign National Claimants. These concerns are more pronounced when dealing with claims from foreign-nationals who, as mentioned above, find themselves under the coverage of the DBA by virtue of direct employment by U.S. companies or as employees of foreign companies who have sub-contracted with U.S. contractors or who have contracted directly with agencies of the U.S. government. As time passes, many of these people have found themselves in legitimate disputes with their employers and carriers, have retained counsel, and have entered into the dispute resolution process leading ultimately to ALJ trials. In these cases, the fast-track policy and discovery quagmire become even more problematic for obvious reasons.

Employer Inexperience. Many employers are familiar with their obligations both to the Department of Labor (DOL), their carrier and defense counsel. However, many are not, and, as a consequence, many of the DOL required reports are filed late or, in some instances, not at all. Information and evidence such as employer reports of incidents, the names and availability of witnesses, initial medical treatment records, and official reports to aid the carrier and its counsel in DBA claims are often difficult or impossible to obtain. This is not to suggest that these employers, usually foreign, are prone to ignore these obligations but are, rather, simply uninformed.

The Earnings Spike and Labor Market Study Problem. Many individuals who accept work under defense contracts to provide services in war-zones do so because they are attracted by the promise of high wages for their efforts. This reality has spawned a number of issues related to the calculation of average weekly wage (AWW), retained wage earning capacity, and securing labor market studies.

For example, an issue arises regarding the calculation of AWW when a worker leaves a relatively low-paying job at home for one paying often as much as five times more overseas. The Benefits Review Board has addressed the issue twice, coming up with essentially the same result in each case. In one opinion, *Zimmerman v. Service Employees International, Inc.*, BRB No. 05-0580 (February 22, 2006), the Board rejected the use of Sec. 10(a) on two grounds [see 33 U.S.C.S. § 910(a)]. First, it said that since the employee was a 7-day-a-week worker, Sec. 10(a) did not apply as it only applied to 5- and 6-day workers. Second, it said that Mr. Zimmerman's work as a truck driver in the U.S. was not the same as the truck driving he did in Kuwait, and, therefore, he did not satisfy the "shall have worked in the employment in which he was working . . . the whole of the year . . ." requirement. It accepted a Sec. 10(c) approach based on the number of days worked in Kuwait (44) divided by 44 to arrive at an acceptable daily wage for the purpose of calculating AWW.

In the second case, *Proffitt v. Service Employees International, Inc.*, 40 BRBS 41 (2006), the Board came to a similar result after saying the ALJ improperly but harmlessly relied on Sec. 10(b) to determine AWW [see 33 U.S.C.S. § 910(b)]. It said that Sec. 10(c) should have been utilized by relying on the value of the contract and dividing by 52. The same result was reached with this method as the one used by the ALJ.

There are a number of ALJ decisions and stipulations by parties in individual cases that creatively address the issue under Sec. 10(c). When there is less than 52 weeks of work under the DBA, some judges are "blending" the high pay earned with the actual earnings at home to make up the 52-week difference and dividing by 52. There are also cases where the parties have taken the value of the 52-week contract and added it to the earnings in the 52 weeks prior to the contract, then dividing by 104 for a fair AWW.

Further, now that many injured workers are reaching maximum medical improvement, problems arise as to the proper locale for labor market surveys. For example, when the worker is living in Chicago when hired, then travels to Iraq to work under a defense base contract and is injured, then returns to the United States and goes to the family home in upper Michigan, what is the proper labor market? Securing any labor market surveys at all is impossible when the injured worker is living in far-flung places such as the Philippines or Pakistan. Even when a labor market survey can be accomplished, is it fair to force the employer to pay TTD at a high rate based on the claimants overseas wages and compare that AWW to the post-injury domestic labor market? Even the higher paying jobs in the domestic labor market will likely be paying a much lower weekly wage than the claimant earned under the DBA contract with hazard pay, differential pay and bonus add-ons.

Zone of Special Danger. Much has been said about this concept and the mistaken notion of "24-hour coverage". While there is no mention of it in the Act itself, the courts have created a doctrine of coverage which extends beyond the traditional requirement that the injury arise out of and occur within the employment (AOE-COE). It recognizes that the circumstances of the assignment overseas may present a special risk not encountered by similar employment at home, and as such the employee should be covered when facing these risks even though not technically in service to the employer at the time of injury. Before such an unorthodox analysis takes place, it is best to determine first, if there is coverage under one of the more traditional extensions to coverage such as the "bunk-house", "employer furnished recreation" or "commercial traveler" rules.

There are precious few cases dealing with this issue. They start with a U.S. Supreme Court decision in *OLeary v. Brown-Pacific-Maxon*, 340 U.S. 504, 71 S. Ct. 470; 95 L. Ed. 483 (1951) and extend most recently to a Ninth Circuit court decision in *Kalama Services, Inc. v. Director, Office of Workers' Compensation Programs*, 354 F.3d 1085 (9th Cir. 2004), cert. denied, 543 U.S. 809 (2004). These decisions seem to recognize that an employer should be held to a higher or broader level of responsibility when the obligations or conditions of employment create the zone of special danger out of which the injury arose. [See *OLeary v. Brown-Pacific-Maxon*, 340 U.S. 504, 507, 71 S. Ct. 470; 95 L. Ed. 483 (1951)]. It is unfortunate that the court uses this language because it has led to confusion over the concept and its application. For example, some have mistakenly misinterpreted the language to require that the geographical area itself must be dangerous in order for the doctrine to apply.

In *OLeary* the employee drowned while trying to rescue fellow employees in a canal located in Guam during off-duty recreation. Unfortunately, the zone of special danger language was used but in fact, one could ask if the Court was really establishing a situational risk approach as arguably in that case, there was nothing especially dangerous in the activity that might not have been encountered at home in the United States. In fact, in many of the cases, it is hard to see a traditional special danger in the facts. But when viewed in terms of a situational risk, the results make more sense.

There are just a few reported cases that find that coverage should not be extended on the basis of the zone of special danger. In one, *Gillespie v. General Electric Company*, 21 BRBS 56 (1988), it was determined that a worker who died as a result of asphyxiation while engaged in an off-duty act of auto-eroticism was not covered. In another, *Kirkland v. Air America, Incorporated*, 23 BRBS 348 (1990), a widow was denied death benefits for her complicity in the killing of her husband during a burglary in their home while assigned overseas in DBA covered employment.

For Further Discussion on the Longshore Act, see *Larson's Workers' Compensation Law*, § 145.01 et seq.

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Denis Paul Juge on Status of PPO Litigation in Louisiana: Whats The Problem?

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Denis Paul Juge on Status of PPO Litigation in Louisiana: Whats The Problem?

By Denis Paul Juge

September 27, 2007

SUMMARY: Litigation has been filed in both federal and state courts in Louisiana concerning the discounting of payments by silent PPOs to healthcare providers for medical services that are provided to patients for treatment under the Louisiana workers compensation act. This commentary, written by Denis Paul Juge, the author of Louisiana Workers' Compensation, examines the impact of the PPO statute, La. Rev. Stat. §§ 40:2201-2210, on workers compensation patients and their healthcare providers and analyzes the status of this litigation.

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ARTICLE: Physicians, chiropractors, physical therapists, diagnostic facilities, and hospitals who have executed contracts with preferred provider organizations (PPOs) have had their bills for medical services reduced in accordance with the terms of their contract. This practice has been in operation for many years and has been applied (where the contract provides) to medical services provided to patients who are injured at work and entitled to medical treatment under the Louisiana workers compensation act. The PPO creates a network of providers who have agreed to these discounts and then contract with insurers, third party administrators (TPAs), and employers to provide the discounts to the employers.

Several years ago an attorney in the Lake Charles area, Tom Filo, was asked by one of his medical provider clients to determine if these PPO contracts were enforceable in workers compensation cases because they noticed that the employee did not have a PPO card (as they do in health insurance cases). According to the providers, the first notice that they had that these patients were covered under a PPO contract was when the provider received an Explanation of Review (EOR) which would show the discount taken and the reference to the PPO.

From this initial complaint Mr. Filo researched the Louisiana laws regulating PPO contracts and the workers compensation act. The attorney for the medical provider came to the conclusion that they could challenge the discounts taken under two theories:

1. That the PPO discounts were improper under the PPO statute [La. Rev. Stat. §§ 40:2201-2210] because the employee did not have a PPO card (or other form of notice to be discussed latter) and;
2. That even if the PPO discounts were not in violation of the PPO statute, they violated the workers compensation

act [La. Rev. Stat. 23:1021, et seq.] in that no provider payments can be lower than the reimbursement schedule.

The PPO Statute: La. Rev. Stat. §§ 40:2201-2210.

- . Created by Acts 1984, No. 374 The Any Willing Provider Act;
- . Purpose Control the rising costs of health care;
- . Original act did not have requirement for notice to provider (such as a PPO card) nor did it provide any penalties;
- . Any willing provider provision was struck down by federal court as preempted by ERISA. [*CIGNA Healthplan vs. State of Louisiana*, 82 F.3d 642 (U.S. 5th Cir. 1996)]

The 1999 Amendments to the PPO Statute.

- . Notice is to be given to the Provider that an entity will access the PPO discount [La. Rev. Stat. § 40:2203.1]:
- . by patient presenting PPO card or
- . written notice that entity is accessing the PPO
- . Violation of above:
- . provider not bound by PPO agreement and
- . penalties and attorney fees
- . group purchasers subject to penalties and fees
- . However, notice provisions are not required when providing health benefits through its own network or direct provider agreements or to such agreements of a group purchaser.

What Was The Reason For The Law Change in 1999?

- . According to some legislative observers the amendments were designed to address the issue of silent PPOs.

The Silent PPO. The best example of the silent PPO is the leasing of a PPO network by one PPO (PPO#1) to another PPO (PPO#2) so that the party paying for the lease (PPO#2) can gain access to discounts that PPO #1 has negotiated with a provider. When the patient covered by that insurance plan goes to the provider, the employer (either directly or through its TPA or insurer) pays the provider the discounted rate. Some PPO contracts permit such arrangements. The exhibits at the end of this article show the traditional PPO arrangement [exhibit B] and the leasing of a PPO [exhibit C].

Objections to Silent PPO. Providers contend that the patient is not aware of this silent agreement and, thus, is not selecting the provider because of the PPO contract thus there is no steerage of the patient to the provider.

Provider Suits Involving PPO Discounts in Workers Compensation. Medical providers have opened up two theaters of battle on the PPO issue:

1. Class action suit [*Gunderson et al. v. F.A. Richard & Associates, Inc., et al.*, #2004-2417, 14th JDC Judge

Wyatt]. Suit alleges PPO contracts violate provisions of the PPO Statute that regulate PPO agreements. Damages are twice the value of services but in no event less than the greater of **\$50 per day during period of non-compliance or \$2,000 plus attorney fees [La. Rev. Stat. 40:2203.1]**.

2. Over 4,000 suits in the Office of Workers Compensation seeking payment of discounted fees plus penalties and attorney fees.

Class Action Suit. Plaintiffs Class action suit seeks to have all providers included in class who have had their fees for services rendered to workers compensation claimants reduced under a PPO contract.

Defendants Suit names several parties including a TPA, an insurer, and a PPO. The suit seeks to have all group purchasers as defined in La. Rev. Stat. § 40:2202 named as a class of defendants and, thus, subject to the penalties and attorney fees provisions. The trial court has held that TPAs are included in definition of group purchasers.

Class Certification -- The district court judge has certified the plaintiffs class. This ruling has been appealed to the Third Circuit (one issue raised on appeal is whether Lake Charles Memorial Hospital should be included in the plaintiffs class since it operates a PPO (Physician Hospital Organization). The defendants have also filed an exception to the courts subject matter jurisdiction contending that the OWC is the proper court to adjudicate these issues. The district judge denied the exception and this issue has also been appealed to the Third Circuit Court of Appeals.

Settlements in the Class Action Suit. Two of the PPOs have entered into settlements with the providers. FOCUS (Concentra) agreed to pay 12 Million Dollars and FARA (a TPA that owned a PPO network) has agreed to pay 10 Million Dollars. These settlements will not relieve the employers, insurers, or TPAs who relied upon these PPO contracts unless they are able to establish that they are entitled to indemnification.

Suits Filed in the Office of Workers Compensation

Allegations:

1. PPO contracts unenforceable because of notice defects under the PPO Statute;
2. The workers compensation law [La. Rev. Stat. § 23:1033] prohibits employer contracts that pay less than fee schedule [La. Rev. Stat. § 23:1203].

Demand:

1. Payment of the discounted fees;
2. Penalties and attorney fees [La. Rev. Stat. § 23:1201.F].

Employers Response:

1. Reimbursement Schedule is a ceiling and not the floor; Louisiana fee schedule is one of highest in nation;
2. Utilization Review Regulations [LAC 40:I.4733] recognize the right to a lower than fee schedule rate based on a pre-negotiated amount;
3. The PPO Statute was not intended to regulate PPO contracts involving workers compensation but was, rather, intended to apply only to the health and accident claims.

The defendants in these suits have filed exceptions of prematurity, prescription, various affirmative defenses, and

reconventional demands against the plaintiffs for breach of the PPO contracts.

New Judge Appointed for PPO Cases in District 3. A retired district court judge, Frank McGee, has been appointed by the Director of the OWC to take charge of the over 4,000 PPO suits filed in District 3 (Lake Charles). Judge McGee spoke to the attorneys representing the plaintiffs (medical providers) and the defendants (employers, TPAs and insurers). Judge McGee urged the attorneys to consolidate as many issues as possible to streamline the litigation process. Although most of the suits have been filed in District 3, similar suits have been filed in the other districts and there appears to be a new waive of these suits being filed in all of the OWC districts.

Federal Court Litigation. Suits for Declaratory Judgment Several of insurers and TPAs have filed complaints in federal court to challenge the claims of the medical providers. The first of such suits was *Liberty Mutual Insurance Company v. Dr. Clark Gunderson and Lake Charles Memorial Hospital*, No. 04-2405, 2006 U.S. Dist. LEXIS 10278 (D. La. 2006). Liberty Mutual filed this suit seeking a declaratory judgment from the court that the Louisiana workers compensation law did not prohibit discounts below the fee schedule and that its PPO contract (First Health) was not in violation of the PPO Statute. Judge Trimble granted Liberty's motion for summary judgment. In his memorandum ruling Judge Trimble noted:

The PPO Contract between Liberty Mutual and First Health is an agreement of [a] group purchaser [i.e. First Health]. Accordingly, the language of the statute is clear that the notice requirements do not apply to group purchasers when providing health benefits through their own network or to such agreements of group purchaser. This is the logical and reasonable interpretation of the statute and is in line with the Legislatures intent to contain escalating health care costs. Furthermore, and more significantly, this was the expectation of the parties when they entered into the PPO Contract and Provider Agreements

Declaratory Judgment Suits in District Courts. Self-Insured groups and local third party administrators who do not have diversity of jurisdiction needed for suit in federal court have filed suit in the state district courts to have the courts declare that the workers compensation law permits discounts below the fee schedule and that the PPO relied upon by them is either not regulated by the PPO Statute or is not in violation of that regulation. No decisions have been rendered as yet on these suits.

Providers have also a filed declaratory judgment suit. However, the suit was ultimately dismissed by the Third Circuit Court of Appeals. In *Lake Charles Memorial Hospital v. Superior Carriers, Inc.*, No. 06-807, 942 So. 2d 754 (La. Ct. App. 3d Cir. 11/2/06), the provider filed a declaratory judgment action in the 14th JDC (Judge Carter), seeking a finding by the district court that the PPO discounts taken by the employer were invalid due to failure to give notice under the PPO statute and because no reduction can be taken below the Louisiana reimbursement schedule. The district court judge granted the providers summary judgment and held the discounts totaling **\$4,144.50 to be invalid for both reasons urged by the plaintiff. An appeal was taken to the Third Circuit Court of Appeals. The Third Circuit reversed the trial court, finding the district court lacked subject matter jurisdiction for adjudicating provider disputes with employers as these disputes are within the jurisdiction of the OWC. The court also stated that the PPO statute claims of the providers should be adjudicated in the OWC. This would suggest that the class action suit pending in the 14th JDC should be dismissed on the basis that the district court does not have subject matter jurisdiction.**

Putting the Pieces Together. While the statutory basis for the provider claims may differ, the legal issues in the provider class action suit and the claims filed in the OWC are identical. The providers allege that the contracts in which they agreed to be paid less than the fee schedule should not be enforced because the schedule is the minimum and not the maximum they can charge. Alternatively they argue that the PPO contract (whether it was Focus, First Health, FARA, Metracomp, Medcomp, or Corcare) violated the notice requirements of the PPO statute and thus any discounts under that contract are underpayments entitling them to the penalties and attorney fees established in the PPO statute (against the group purchasers) as well as penalties and attorney fees under the workers compensation act (against the employers and insurers).

The various courts that will consider these claims will need to rule on several issues before granting relief to the providers:

1. Does the workers compensation act permit a provider to contract with a payor to receive less than the fee established in the reimbursement schedule? If the court finds that no discount below the fee schedule is permitted by law, then there is no need for any further inquiry and the amount discounted would be owed to the provider and the court would then need to consider whether penalties and attorney fees are owed for the underpayment of the fee.

2. However, if the court finds that there is no statutory prohibition against such contracts, then the court will need to consider the remaining issues. One such issue is whether the legislature intended to include PPO contracts involving workers compensation claims when it created and amended the Any Willing Provider Act of La. Rev. Stat. Tit. 40. A finding that it did not would end all claims of the providers in both the class action litigation and the thousands of claims in the OWC.

3. If the regulations of the PPO statute do apply to PPO contracts involving workers compensation, then the question for the court is whether the particular PPO contract requires any special notice to the provider that a particular insurer, TPA, or other entity was accessing the contract, or does the contract fall within the exception to the notice provision. This legal issue has been reviewed by a federal judge in the *Liberty Mutual* (Judge Trimble) case and a state district court judge (Judge Wyatt) in the class action suit. The state district court judge gave a very narrow interpretation of the statutory exception to the notice requirements of the PPO statute, while the federal district court judge rendered a broader interpretation of the statute. Judge Wyatt of the state district court concluded that the only situation in which a PPO is not required to give prior notice to a provider that an entity is accessing the PPO contract is if it owns the PPO (such as FARA a TPA that owns its PPO [See exhibit A]. Judge Trimble of the federal district court, on the other hand, considered all PPO contracts that did not involve leasing to another PPO to be within the notice exception. Thus, under Judge Trimble's interpretation, the PPO arrangement in exhibit B would not require the PPO statute notice to the provider, but the arrangement in exhibit C would involve a silent PPO and the PPO that had contracted with the provider would be required to meet the notice provisions of the PPO Statute.

4. Should the court that is reviewing these issues conclude that the PPO utilized by the defendant (employer or insurer) did not violate the notice provisions of the PPO statute, then the claim of the provider would be dismissed. A contrary finding, however, would result in an award in favor of the provider for the amount discounted.

5. The final issue for the court, assuming that it has determined that the PPO discount was improper either because no discounts are permitted under the workers compensation act or the PPO contract at issue did not comply with the notice provisions of the PPO statute, is whether penalties and attorney fees should be awarded. The defendants have raised the exception of prescription (one year from the date of the failure to pay the full amount owed under the fee schedule) and have also argued that no penalty or attorney fees are warranted when the legal issues are novel and not clearly established in the statute or jurisprudence. The providers contend that the law is clear in establishing the fee schedule as the minimum fee owed to a provider despite the contractual agreement signed by the provider.

Legislative Efforts The Governors Advisory Committee. In the 2006 legislative session, bills were introduced at the urging of the providers and the business community. The Director of the Office of Workers Compensation, Karen Winfrey, called upon the members of the Governors Workers Compensation Advisory Committee to meet with other interested parties to work towards an agreement on a legislative bill that would address the PPO issues. Despite the efforts of all involved to hammer out a compromise bill, no agreement could be reached and the session ended with no legislative action taken on this issue. More recently, the representatives of the providers and employers met on several occasions but were again unable to agree on a legislative resolution of the PPO dispute.

Exhibit A.

PROVIDER

?

PPO

?

TPA

Owns the PPO

? ?

Payor # 1 Payor # 2

Accesses accesses

PPO PPO

Exhibit B.

PROVIDER

?

PPO

?

Claims Adjusting

Entity

? ?

Employer Ins. Co.

accessing accessing

PPO PPO

Exhibit C.

(Silent PPO)

PROVIDER

?

PPO

#1

?

PPO

#2

?

TPA, Insurer or

Self-Insured Employer

accesses

PPO #1 thru PPO #2

For Further Discussion on Louisiana Workers Compensation Medical Cost Containment, see 1-13 Louisiana Workers' Compensation § 13:5 (LexisNexis Matthew Bender).

For Further Discussion on Payment of Workers Compensation Medical Expenses, see 5-94 *Larson's Workers' Compensation Law* § 94.02 (LexisNexis Matthew Bender).

For Further Discussion on Preferred Provider Organizations, see 2-8A Treatise on Health Care Law § 8A.04 (LexisNexis Matthew Bender).

For Legal News, see Louisiana Judge Holds Provider Agreements Valid, Providers Not Owed Money 10-7 Mealey's Man. Care Liab. Rep. 13 (2006).

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Embry on Crossing the Jensen Line and Coppola v. Logistec Connecticut, Inc.

2008 Emerging Issues 526

Embry on Crossing the Jensen Line and Coppola v. Logistec Connecticut, Inc.

By Stephen C. Embry

September 26, 2007

SUMMARY: In *Coppola v. Logistec Connecticut, Inc.* (2007) 283 Conn. 1, 925 A.2d 257, the Connecticut Supreme Court reversed the Connecticut Workers' Compensation Commission and ruled that the state has concurrent jurisdiction with the federal government over certain claims involving injuries incurred on navigable waters. This commentary, written by Stephen C. Embry, a past chairman of the American Trial Lawyers Section on Workers' Compensation, examines the Court's ruling and the status of the Jensen line of cases.

PDF LINK: [Click Here for Enhanced PDF of Commentary](#)

ARTICLE: In *Coppola v. Logistec Connecticut, Inc.* (2007) 283 Conn. 1, 925 A.2d 257, the Connecticut Supreme Court reversed the Connecticut Workers' Compensation Commission and ruled that the state has concurrent jurisdiction with the federal government over certain claims involving injuries incurred on navigable waters.

Michael Coppola was working as a longshoreman in the hold of a ship in New Haven Harbor when the steps on which he was descending broke, resulting in a broken hip and wrist. He filed claims under the Connecticut Workers Compensation Act [see Conn. Gen. Stat. § 31-275 et seq.] and the Longshore and Harbor Workers Compensation Act [see 33 U.S.C.S. § 901 et seq.]. He was eventually awarded compensation under the Longshore Act and the next day the respondent moved to dismiss the state workers' compensation claim for lack of jurisdiction. Logistec Connecticut, Inc. claimed that since Coppola was involved in maritime employment on a vessel floating in the navigable waters of the United States, his state claim was barred by *Southern Pacific Company v. Jensen* (1917) 244 U.S. 205, 37 S. Ct. 524; 61 L. Ed. 1086.

The Connecticut Workers Compensation Commission reasoned that since *Jensen* held that admiralty interests could not be hindered or burdened by state workers compensation systems, the Commission therefore lacked jurisdiction in this case. Its decision was appealed to the Connecticut Supreme Court, which concluded that the respondent and commissioners were in error and held instead that Connecticut had jurisdiction over this claim. The Court remanded the case to the Connecticut Workers Compensation Commission.

Southern Pacific Company v. Jensen. The genesis of the journey begins with *Southern Pacific Company v. Jensen* (1917) 244 U.S. 205, 37 S. Ct. 524; 61 L. Ed. 1086 (*Jensen*) in which Justice McReynolds held for a divided court, under remarkably similar circumstances, that an award of **\$5.87 per week to the widow of Christen Jensen, a**

deceased longshoreman who was killed during the course of his employment, ran afoul of U.S. Const. Art. III, § 2, which confers admiralty jurisdiction upon the courts of the United States. Justice McReynolds stated that the Congress could not have intended to place the rules and limits of maritime law under the disposal and regulation of the several states. He noted that it was certainly true that in fact Congress had done this regularly by allowing states to enact statutes relating to commercial liens for repair of vessels [see *The Lottawanna*, 21 Wall. 558], and acknowledged that it would be difficult, if not impossible, to define with exactness, just how far the general maritime law may be changed, modified, or affected by state legislation. That this may be done to some extent cannot be denied. [See *Jensen* at p. 215]. However the extension of the State Workers Compensation Act seaward was found to be offensive, the remedy barred, and Mrs. Jensen left to fend for herself and her two children.

Perhaps the reason for this can be gleaned from Justice McReynolds' suggestion that Congress had a policy of encouraging investments in shipping while limiting the liability of the owner. In any case, the *Jensen* line was born and state jurisdiction was generally held at the end of the waters edge.

The Impact of the *Jensen* Line. Unfortunately *Jensen* left workers with no remedy and Congress was required to take steps to fill the gap. It took several efforts to do this, although the first attempt was rejected by Justice McReynolds in *Knickerbocker Ice Company v. Stewart* (1920) 253 U.S. 149, 40 S. Ct. 438, 64 L. Ed. 834, where he struck down a federal statute affirming that Congress did in fact intend to extend the rules of work related accidents and compensation acts seaward [See also *State of Washington v. W.C. Dawson & Company* (1924) 264 U.S. 219; 44 S. Ct. 302; 68 L. Ed. 646]. After several attempts, the Congress enacted the Longshore Act in 1927, providing a remedy for injuries occurring upon navigable waters of the United States.

However, as is so often the case, accidents and injuries paid little attention to Justice McReynolds or the *Jensen* line, and the courts had to deal with increasingly arcane rules to examine where the injury had occurred in order to determine whether Longshore Act jurisdiction attached.

In *Davis v. Department of Labor & Industries* (1942) 317 U.S. 249; 63 S. Ct. 225; 87 L. Ed. 246, Washington State law was found applicable after Mr. Davis fell from a drawbridge he was dismantling and his body was found floating in the Snohomish River. In *Davis*, the court was not asked to reconsider *Jensen* and the confusion resulting from the uncertainty injected into the law by that case. However, Justice Black simply noted that a presumption of constitutionality attached to the State Act and that therefore U.S. Const. art. III, § 2 was no obstacle to the claimants recovery. This created a Twilight Zone, the extent of which was left undefined.

Other excursions followed as in *Calbeck v. Travelers Ins. Co.* (1962) 370 U.S. 114, 82 S. Ct. 1196, 8 L. Ed. 2d 368, where injuries on new vessels under construction upon the navigable waters of the United States were found to be "maritime, but local," and it was held that the State Workers Compensation Act could validly be applied to such injuries.

Extension of the Longshore Act. In light of the confusion created by the Twilight Zone, the maritime but local rule, and other semantic imponderables, Congress acted in 1972 to extend the Longshore Act landward to include injuries occurring upon the adjoining land areas customarily used in maritime employment. The move to dual and concurrent jurisdiction was strengthened in *Sun Ship, Inc. v. Pennsylvania* (1980) 447 U.S. 715, 100 S. Ct. 2432, 65 L. Ed. 2d 458, which held that concurrent jurisdiction was not offensive.

The *Coppola* Decision. In *Coppola* the respondent sought to resurrect the confusion and complexities injected into the law by *Jensen* and *Knickerbocker*. The Connecticut Supreme Court in a 40-page decision reviewed the twisting course of the law and declined to add to the confusion. Instead the Court made clear that the thrust of events, culture, and the law in the near century since *Jensen* had been toward simplicity and uniformity.

The *Coppola* Court noted that other state and federal courts had expressed increasing reservations regarding *Jensen* in the last 90 years. They cited *Mooress Case* (1948) 323 Mass. 162, 80 N.E.2d 478, a quintessential maritime case in

which a worker was injured on a floating drydock. In *Mooress Case* it was found that *Davis* had so weakened *Jensen* that Massachusetts law was held applicable [See *Bethlehem Steel Co. v. Moores* (1948) 335 U.S. 874].

The *Coppola* Court further noted that the momentum to dual and concurrent jurisdiction had been recognized by a variety of states. In *Lane v. Universal Stevedoring Co.* (1973) 63 N.J. 20, 304 A.2d 537, for example, the New Jersey Supreme Court held that the state had jurisdiction over a longshoreman's injury that occurred in a hold of a ship floating in the navigable waters of the United States.

The *Coppola* Court concluded that the *Jensen* concern with uniformity had been addressed by the Longshore Act and that the existence of the state remedy did not act to lessen the reach of the Federal Act.

The *Coppola* Court was not persuaded that the extensions of the state acts seaward had the effect of undermining administrative efficiency. *Davis* was intended to reduce uncertainty and confusion arising from *Jensen*. Thus, the presumption of constitutionality of the state acts flowing from *Davis* and *Baskin v. Industrial Accident Comm'n* (1949) 338 U.S. 854, 70 S. Ct. 99, 94 L. Ed. 523, was to be expanded.

The *Coppola* Court cited *Larson's Workers' Compensation Law* § 145.02(6) for the proposition that the courts have better things to do than spend their time tracing ghostly definitional boundaries between the repair of a ship and the reconversion of a ship, and that the courts have too much self-respect to say with a straight face that awarding state workers compensation benefits would shatter the uniformity of maritime law.

Is *Jensen* Dead? The question arises then, is *Jensen* dead, and, if so, what caused the illness?

The answer to the first question is "not quite." *Jensen* remains good law if the proposition is reversed. U.S. Const. Art. III, § 2 grants Congress the power to pass laws in admiralty, and the Longshore Act arises under that section. Thus, Congress clearly had the power to enact the federal law, that is, the Longshore Act is constitutional.

Jensen as originally presented, however, stood this proposition on its head, suggesting that extensions of state workers compensation laws to the territorial waters of the state was impermissible. In *Jensen* itself the Court acknowledged that it was difficult to understand why this should be the case, since it was black letter law that state laws protecting commercial liens and business interests were constitutional even though they affected admiralty rights [See *The Lottawanna*, 21 Wall. 558]. Apparently the Court felt that the Constitution was not offended by state action designed to protect commercial interests but viewed state action designed to protect workers as unacceptable.

It appears that the driving force that compelled the introduction of confusion and uncertainty in *Jensen* was cultural rather than legal.

Justice McReynolds elucidated and expanded his *Jensen* reasoning in the *Knickerbocker* decision, which followed his musings in *Jensen* by three years. Speaking about workers compensation law that had only recently made its way to the American shores, he said, if the new and revolutionary principle of compensation, involving the creation of a liability without fault, hitherto unknown in any system of law, is to be extended to maritime employments, this must be done by a law enacted by Congress establishing a uniform system throughout the country." [See *Knickerbocker Ice Company v. Stewart* (1920) 253 U.S. 149, 40 S. Ct. 438, 64 L. Ed. 834].

Nearly a century later, workers compensation does not seem to be so new and revolutionary; but rather much more conservative and designed to limit and protect commercial interests from the full effects of work related injuries. Commercial activity has increased exponentially as the humanitarian remedy took the edge of the economic impact of industrial injuries. The finger of the law has moved on, and it is clear that *Jensen* made little sense and has caused much harm, particularly to Mrs. Jensen who had become widowed at age 29 when her husband was taken from her and her two children. The *Jensen* decision took from her the **\$5.87 per week, but protected the Southern Pacific Company from the revolutionary principle of liability without fault.**

For Further Discussion on the Longshore Act, see *Larson's Workers' Compensation Law* § 145.01 et seq.

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Stephen C. Embry is a 1971 graduate of American University, School of International Service and received his Juris Doctor degree from the University of Connecticut in 1975. He practices in Groton, Connecticut with the law firm of Embry and Neusner, where he focuses on personal injury, workers' compensation, and employee rights litigation. He is past chairman of the American Trial Lawyers Section on Workers' Compensation, a sustaining member of the National Organization of Social Security Claimants' Representatives, and a Past President and board member of the Work Place Law and Advocacy Group of AAJ. Mr. Embry also serves on the LexisNexis Benefits Review Board Service--Longshore Reporter Advisory Board and the LexisNexis National Workers' Compensation Advisory Board.



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CA Supreme Court Affirming the Fuentes Rule for the Calculation of Permanent D

2008 Emerging Issues 489

Ponzio on the California Supreme Court Affirming the Fuentes Rule for the Calculation of Permanent D

By James Ponzio

September 11, 2007

SUMMARY: The California Supreme Court resolved in *Brodie v. Workers' Comp. Appeals Bd.*, 40 Cal. 4th 1313 (2007), the conflict among the appellate courts as to the correct formula for calculating the permanent disability indemnity when there is apportionment to either a previous industrial disability, to non-industrial causes, or both. James Ponzio asserts that the determination of apportionment has thus taken on increased importance for permanent disability awards. Ponzio concludes that because for some body parts, the ratings under the 2005 Schedule are significantly lower than under the 1997 Schedule, the practical effect of *Brodie* will be that in subtracting out the old percentage of disability under the 1997 Schedule, there will frequently be claims under the 2005 Schedule in which there will be no indemnity due, despite an obviously worsened condition. This commentary, written by James Ponzio, a Certified Specialist in Workers' Compensation and partner with Mullen & Filippi who exclusively represents employers and insurance carriers, examines from the perspective of a defense attorney the major implications and unanswered questions of the *Brodie* interpretation of Cal. Labor Code §§ 4663, 4664 and Formula A.

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ARTICLE: On 5/3/07 the California Supreme Court issued its unanimous decision in five consolidated cases [See *Brodie v. Workers' Comp. Appeals Bd.* (2007) 40 Cal. 4th 1313, 72 Cal. Comp. Cas 565, 2007 Cal. LEXIS 4334 (May 3, 2007)]. Although the factual scenarios differed, all of these cases dealt with the question of how to calculate the permanent disability indemnity due under the recently revised Cal. Labor Code § 4663 and the newly enacted Cal. Labor Code § 4664, when there is apportionment to either previous industrial disability, or to non-industrial causes, or both. The Court upheld the calculation method defined by *Fuentes v. Workers' Comp. Appeals Bd.* (1976) 16 Cal. 3d 1, 547 P.2d 449, 128 Cal. Rptr. 673, 41 Cal. Comp. Cas 42. That calculation method provides for subtraction of the percentages of disability, rather than providing for merely subtracting the dollars that would be attributable to the non-industrial or prior industrial causes [See 1-8 CA Law of Employee Injuries & Workers' Comp § 8.07(2)(d)(i); 1-7 Herlick, California Workers' Compensation Law § 7.44(1)]. This decision favored the defendants in these matters, and rejected any claim that the recent enactment of Cal. Labor Code § 4663 and Cal. Labor Code § 4664 was designed in part, to benefit injured workers. This commentary will discuss some of the major implications of this important decision as well as the questions left unanswered by the Court.

Background. Permanent disability indemnity is one of the benefits provided for by the California workers compensation system. It is the only benefit that is apportionable to non-industrial, or prior industrial causes. Once one is

assigned a permanent disability rating, reference is made to a table promulgated pursuant to Cal. Labor Code § 4658 in order to determine the dollar value of that rating. The permanent disability rating schedule provides for graduated benefits, whereby the more serious the injury, the more money each percent of disability is worth. For example, an injury in 2003 that caused 30% disability is worth \$23,310, while a 60% rating for that same date of injury is worth \$64,056.25, almost three times as much. The graduated schedule is made more so for injuries of 70% or more, because of the addition of a life pension. A 100% rating is payable at the temporary disability rate (usually higher than the permanent disability rate) for life.

The 1976 *Fuentes* decision dealt with the question of how to calculate permanent disability indemnity, after apportionment. The *Fuentes* court determined that the proper way to calculate permanent disability indemnity after apportionment was simply to determine the percentage of industrial permanent disability after apportionment, and assign the appropriate dollar amount to that percentage. The Court rejected other approaches, including one suggesting that the overall permanent disability before apportionment be calculated, and then the only subtraction would be for the dollars that would be assigned to the *apportioned out* disability. The *Fuentes* rule was followed from 1976 until it came under attack based on the 2004 reform legislation [See 1-8 CA Law of Employee Injuries & Workers' Comp § 8.07(2)(d)(i); 1-7 Herlick, California Workers' Compensation Law § 7.44(1)].

In 2004, SB 899 was enacted. This piece of legislation caused major changes throughout the California workers compensation system, many of which are still not fully understood. As part of this legislation, the statutes governing apportionment of permanent disability were changed. Instead of allowing apportionment solely to the extent of disability that would be present absent the industrial injury, the standard was changed to apportionment of causation of the permanent disability. The new Cal. Labor Code § 4664(b) also provided for almost automatic apportionment for a prior permanent disability award, disallowing evidence regarding medical rehabilitation. In changing the standards for apportionment, the legislature repealed or amended the statutes that the *Fuentes* court relied on, and substituted an amended Cal. Labor Code § 4663 and a new Cal. Labor Code § 4664 in their place.

With the repeal of former Cal. Labor Code § 4750 and the amendment of Cal. Labor Code § 4663, a question arose as to whether the *Fuentes* method of calculation was still valid in light of the fact that it was based on the now repealed Cal. Labor Code § 4750. A number of cases wound their way through the California workers compensation system on this issue, with various permutations, involving prior industrial permanent disability, non-industrial disability, as well as disability to overlapping body parts. The California Workers' Compensation Appeals Board addressed this issue in *Nabors v. Piedmont Lumber & Mill Company* (2005) 70 Cal. Comp. Cas 856 (Appeals Board en banc opinion). That divided en banc decision upheld the *Fuentes* calculation method. Thereafter a number of Courts of Appeals entertained the issue and reached widely divergent decisions. The First District Court of Appeals reversed the WCAB en banc in *Nabors* and found that the dollars only attributed to apportionable causes should be subtracted. *Nabors v. Workers' Comp. Appeals Bd.* (2006) 140 Cal. App. 4th 217, 44 Cal. Rptr. 3d 312, 71 Cal. Comp. Cas 704. The Fifth District, with its finding in *E&J Gallo Winery v. Workers' Comp. Appeals Bd. (Dykes)* (2006) 134 Cal. App. 4th 1536, 37 Cal. Rptr. 3d 208, 70 Cal. Comp. Cas 1644, agreed with the First District. Another Division of the First District basically agreed with the *Nabors* court and the *Dykes* court, but calculated the dollars to be subtracted in a different method. *Brodie v. Workers' Comp. Appeals Bd.* (2006) 142 Cal. App. 4th 685, 47 Cal. Rptr. 3d 825, 71 Cal. Comp. Cas 1007. Meanwhile the Third District upheld the *Fuentes* calculation in the *Welcher* cases consisting of matters involving *Welcher*, *Strong*, *Williams*, and *Lopez* [See *Welcher v. Workers' Comp. Appeals Bd.* (2006) 142 Cal. App. 4th 818, 47 Cal. Rptr. 3d 888, 71 Cal. Comp. Cas 1087]. Because of this conflict the Supreme Court accepted the *Brodie* case and the *Welcher* cases for review and advanced them on the Courts schedule.

The Brodie/Welcher Decision. The Supreme Court affirmed the *Welcher* decisions, reversed *Brodie* and affirmed the calculation method previously utilized under *Fuentes*. This decision applies to situations in which the apportionment is to prior awards (*Brodie*, *Welcher*, *Strong* and *Williams*), where the present disability is total (*Lopez*), where the

apportionable disability is due to non-industrial causes (*Lopez*), and where the prior disability is to other, overlapping body parts (*Strong*). The Courts discussion makes it clear that it makes no distinction for calculation purposes between the apportionment under Cal. Labor Code § 4663 or Cal. Labor Code § 4664.

Remaining Issues and Problems. Although the Court clarified this individual issue, there are still major apportionment issues under Cal. Labor Code § 4663 or Cal. Labor Code § 4664 winding their way through the WCAB and the courts. A sample of these issues is as follows:

1. Does it apply to total permanent disability? One of the cases affirmed as part of the Supreme Courts decision was *Lopez*, one of the cases consolidated with *Welcher* at the Court of Appeals level. *Lopez* involved a person who was totally permanently disabled after the industrial injury, in conjunction with the non-industrial apportionment. Although the Supreme Courts decision dealt solely with the calculation aspects, the affirmation of the lower court allows for apportionment of a total disability award. This is contra to several lower court decisions, including *Webster v. Workers' Comp. Appeals Bd.* (1989) 54 Cal. Comp. Cas 228 (court of appeal opinion not published in official reports), which previously held that when an old orthopedic disability overlapped the new orthopedic disability, there was no apportionment towards a 100% award that was a compensable consequence of the new injury.

2. How can Cal. Labor Code § 4664(b) be applied when there is an obvious worsening, but also prior awards. Cal. Labor Code § 4664(b) provides that when an applicant has received a prior award of permanent disability, that disability is presumed to still exist at the time of the subsequent industrial injury. Assume there was a prior award of 60% to the spine. At the pre-reform trial on the subsequent injury, applicant showed total medical rehabilitation and was awarded another 50% for the spine. There is now a Petition to Reopen on the subsequent injury, and assume further that applicants present disability is 100%, of which 80% is attributable to the subsequent industrial injury. Does this applicant receive any additional indemnity or is he barred from increasing his 50% rating by virtue of the prior award in the prior case of 60%? The problem exists as well with overlapping body parts per *Strong*.

3. How can the apportionment be calculated under Cal. Labor Code § 4664(b) when comparing ratings under the 1997 Schedule vs. the 2005 Schedule? At the present time it seems fairly clear that for some body parts, the ratings under the 2005 Schedule are significantly lower than under the 1997 Schedule. The practical effect of the *Brodie/Welcher* decision will be that in subtracting out the old percentage of disability under the 1997 Schedule, there will frequently be claims under the 2005 Schedule in which there will be no indemnity due, despite an obviously worsened condition [See generally 1-2 Lawyer's Guide to AMA Guides and CA Workers' Comp § 2.02(2)-(3)].

4. When there is apportionment under both Cal. Labor Code § 4663 and Cal. Labor Code § 4664(b), how is the calculation done? Cal. Labor Code § 4663 provides for apportionment based on causation. Cal. Labor Code § 4664(b) provides that prior awards are to be considered still in effect, and basically to be subtracted out. Does the proper method of calculation involve first subtracting out the prior award, and then dividing the remainder based on causation, or vice versa? For example, if applicant had a previous award of 30%, and now has a disability of 80%, one-fourth of which is due to non-industrial causes, do you subtract out the 30% prior award first, and then the one-fourth of the remaining 50%, leaving 37%. Or do you first apportion out one-fourth of 80%, leaving 50%, and then subtract out the prior award, netting 20%? This question becomes further complicated if the *Wilkinson* doctrine is still alive and several injuries are combined under the *Wilkinson* doctrine and different apportionment calculations apply to each of the injuries. [See *Wilkinson v. Workers' Comp. Appeals Bd.* (1977) 19 Cal. 3d 491, 564 P.2d 848, 138 Cal. Rptr. 696, 42 Cal. Comp. Cas 406], [See 1-8 CA Law of Employee Injuries & Workers' Comp § 8.07(2)(d)(ii)-(iii); 1-7 Herlick, California Workers' Compensation Law § 7.46(2)].

5. What does apportionment to causation mean and what is substantial evidence to support it? In *Escobedo v. Workers' Comp. Appeals Bd.* (2005) 70 Cal. Comp. Cas 604 (Appeals Board en banc opinion), the WCAB attempted to establish the standards for apportionment and laid out the burdens of proof regarding such. The Supreme Court in *Brodie/Welcher* seems to support, in dicta, the *Escobedo* decision allowing for apportionment to pathology and asymptomatic causes, citing *E. L. Yeager Construction v. Workers' Comp. Appeals Bd.* (2006) 145 Cal. App. 4th 922, 52

Cal. Rptr. 3d 133, 71 Cal. Comp. Cas 1687 [See 1-8 CA Law of Employee Injuries & Workers' Comp § 8.06(1); 1-7 Herlick, California Workers' Compensation Law § 7.44(1)].

6. How do we deal with different occupational variants and ages? Cal. *Labor Code* § 4664 provides that a previously awarded permanent disability is presumed to still exist at the time of the subsequent industrial injury. It does not state that the prior rating is to be subtracted, although that is the common practice. How is this to be dealt with when the applicant changes occupations and as is usually the case, moves from one to another age bracket? Is the standard rating to be subtracted using the new occupation and age, or is the prior final rating to be subtracted?

7. How do we deal with the situation where the prior rating was after apportionment? If the prior permanent disability is presumed to still exist, and if the prior permanent disability included both apportionable disability and reimbursable disability, which is conclusively presumed to still exist? Is it the industrial portion only or the entire prior disability?

The practical effect of the *Brodie/Welcher* decision is to increase the importance of the apportionment decision. The determination of apportionment of permanent disability will have a greater impact on the parties than a contrary decision in *Brodie/Welcher* would have had. In light of that increased importance, it is expected that the WCAB and the courts will more carefully scrutinize apportionment opinions by physicians to ensure that they constitute substantial evidence.

For insight and discussion on apportionment, see 1-8 CA Law of Employee Injuries & Workers' Comp §§ 8.05--8.07, 1-7 Herlick, California Workers' Compensation Law §§ 7.44--7.47, and 1-6 Lawyer's Guide to AMA Guides and CA Workers' Comp § 6.02.

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Rabine on Recent California Workers' Compensation Appeals Board Panel Decisions

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Rabine on Recent California Workers' Compensation Appeals Board Panel Decisions

By Merle C. Rabine

September 5, 2007

SUMMARY: Recent interest in California Workers' Compensation Appeals Board panel decisions have been fueled by continuing uncertainty of interpretation of parts of Senate Bill 899 and by discussion and debate on the Internet. This commentary, written by Merle C. Rabine, examines recent panel decisions on expert DFEC testimony and outpatient surgery centers' burden of proof regarding the reasonableness of their charges.

PDF LINK: Click Here for Enhanced PDF of Commentary

ARTICLE: Despite recent interest in California Workers' Compensation Appeals Board panel decisions, fueled by continuing uncertainty of interpretation of parts of Senate Bill 899 and by discussion and debate on the Internet, most panel decisions are of little interest to anyone other than the parties whose case is being decided. When the Appeals Board wants to announce a position on a substantive or procedural issue, it does so by issuing an en banc decision or significant panel decision [see http://www.dir.ca.gov/WCAB/wcab_dars.htm]. Panel decisions, however, tend to be case-specific with the result determined by the facts of the case. Moreover, while panel decisions are citeable authority, particularly on issues of contemporaneous administrative construction of statutory language [see *Griffin v. WCAB* (1989) 209 Cal. App. 3d 1260, 1264, fn 2, 54 Cal. Comp. Cas 145], they are not binding precedent, as are en banc decisions, on all Appeals Board panels and workers' compensation judges [see *Gee v. Workers' Comp. Appeals Bd.* (2002) 96 Cal. App. 4th 1418, 1425 fn. 6, 67 Cal. Comp. Cas 236].

Expert Diminished Future Earning Capacity (DFEC) Testimony Fails to Rebut Rating: *Magana v. Essey International, Inc.*, AHM 127643, 2007 Cal. Wrk. Comp. P.D. LEXIS 26 (Appeals Board panel decision). In *Costa v. Hardy Diagnostic* (2006) 71 Cal. Comp. Cas 1797 (Appeals Board en banc opinion), the Appeals Board held that the 2005 Permanent Disability Rating Schedule (PDRS) was prima facie evidence of the permanent disability attributed to an injury, pursuant to Cal. Labor Code § 4660(c). While the Appeals Board held that Cal. Labor Code § 4660(c) continues to allow the parties to present rebuttal evidence to ratings under the 2005 PDRS, it did not address what kind of evidence would be relevant and/or persuasive. That would be determined on a case-by-case basis.

Magana v. Essey International, Inc. is one of those cases. Applicant sustained industrial injury to his left ankle and left foot on February 5, 2005. Medical evaluation by a physician (status unspecified in the opinion) rated 12%. Applicant presented a witness who concluded that he had sustained a 27% diminished future earning capacity loss.

Defendants expert concluded that applicant would not sustain any wage loss in the future. The WCJ awarded 12% permanent disability, based on the rating of the medical evaluation.

The Appeals Board panel noted that Cal. Labor Code § 4660(a) demonstrates that the DFEC modifier is not the sole determining factor of permanent disability. The panel implies, but does not hold, that rebuttal evidence must rebut the DFEC modifier that is included in the 2005 PDRS. The panel stated in relevant part: To simply convert a DFEC percentage to the overall percentage of PD, as suggested in applicants petition herein, is invalid under *Labor Code section 4660(d)* . . . and is insufficient to rebut a rating thereunder.

Furthermore, the rating under the PDRS falls within the range of evidence of DFEC loss. The panel stated in relevant part: [T]he range of DFEC loss was 0 to 27%, according to expert testimony. Therefore, the PD rating herein, which is based upon the DFEC modifier in the 2005 PDRS, essentially is in accord with the range of expert evidence on DFEC and as such is inherently reasonable and probable.

The opinion does not describe the expert testimony offered by either party. So we do not know how they tried to rebut the rating. All we know is that they failed. They did not convince the WCJ or the three commissioners who decided this case. The fact that a rating falls within the range of evidence on DFEC loss may not be determinative if a future panel is convinced that one or the other of the experts succeeds in rebutting the rating.

The most interesting aspect of this opinion is the language stating that DFEC evidence may be offered only to rebut the DFEC modifier, not the overall rating. The implication is that even if Applicants expert had successfully rebutted the DFEC modifier, the rating would not be 27%. The panel does not say what the rating would be. This issue will most likely be addressed by future panels. Ultimately, this is an issue that will be resolved by the Appeals Board in an en banc decision or by the appellate courts.

Outpatient Surgery Centers Have Burden of Proving That Their Charges Are Reasonable Expenses Under Cal. Labor Code § 4600: *Pfeffer v. Fisher Construction*, POM 0252332, 2007 Cal. Wrk. Comp. P.D. LEXIS 10 (Appeals Board panel decision), *Jimenez v. Galaxy Shade Systems*, ANA 0377538, 2007 Cal. Wrk. Comp. P.D. LEXIS 11 (Appeals Board panel decision). In the mid 1990s, outpatient surgery centers became a new cottage (or mansion) industry in workers compensation. They were not regulated by a fee schedule under Cal. Labor Code § 5307.1. They were not covered by the restrictions on self-referral in Cal. Labor Code § 139.3. So they started charging whatever they wanted, which was a lot. Claims administrators initially responded by paying whatever was billed, apparently on the mistaken belief that they could not challenge the charges because of the presumption of correctness of the treating physician under former Cal. *Labor Code* § 4062.9 (now repealed). After a while, they started complaining about the fees. Attempts to address the problem legislatively were blocked by the surgery centers.

After the Legislature failed to address the issue of outpatient surgery facility fees in 2002, the Appeals Board issued its en banc decision in *Kunz v. Patterson Floor Coverings, Inc.* (2002) 67 Cal. Comp. Cas 1588. The Appeals Board held that although the Official Medical Fee Schedule did not apply to outpatient surgery facility fees, those fees must be reasonable. The Appeals Board outlined the kind of evidence that would be useful in determining reasonableness and also set out the burdens of going forward of the parties.

After *Kunz*, I had thought that the major claims administrators and outpatient surgery centers would develop comprehensive data to determine reasonableness of facility charges for various common procedures, especially epidural injections. Indeed, one carrier (Zenith) negotiated a fee schedule with some of the outpatient surgery centers. But based on my review of many of these cases while I was a commissioner, I found that litigation over outpatient surgery center liens was extremely haphazard. In some cases the outpatient surgery center introduced evidence of what it accepted, the defendant introduced no evidence, and the surgery center won. In other cases the surgery center introduced no evidence beyond its lien, the defendant introduced evidence of payments to other outpatient surgery centers and to inpatient facilities, and defendant won. None of the parties seemed to be paying much attention to the guidance in *Kunz*, and the results were all over the map.

In *Pfeffer* and *Jimenez*, the panels seem to have caused a little bit of a stir by reminding the parties that the outpatient surgery centers have the burden of proving that their charges are reasonable expenses. In *Pfeffer* the surgery center billed \$65,000 for services (unspecified in the opinion). Apparently, the sur

gery center did not introduce any evidence on reasonableness, either in its case in chief or in rebuttal. Instead, it contended that defendant had the burden of proving that the fees were unreasonable. Defendant produced a witness. The parties stipulated to defendant's offer of proof that the witness was an expert and that she would testify that the average fee for an inpatient facility was \$6,593.12. The WCJ awarded \$6,593.12. The panel denied lien claimant's petition for reconsideration. It held that it was proper for the WCJ to rely on inpatient charges. It also held that an outpatient surgery center facility fee that is nearly ten times as great as the fee that inpatient facilities could legally receive for the same services shocks the conscience and is manifestly unreasonable.

In *Jimenez* the outpatient surgery center filed a lien for \$31,007. The WCJ awarded the entire amount. The WCJ stated that defendant had not raised the issue of reasonableness and that therefore she was required to award the entire amount. The panel reversed. After reviewing the requirements of *Kunz*, the panel emphasized that the medical provider always has the burden of proof as to reasonableness, whether it is raised at trial or not [See also *Gee v. Workers' Comp. Appeals Bd.* (2002) 96 Cal. App. 4th 1418, 67 Cal. Comp. Cas 236 (WCAB must take judicial notice of all federal and state decisional, constitutional, and statutory laws)]. The panel emphasized: [E]ven in the complete absence of contrary evidence from a defendant, a WCJ need not accept a billing statement which is on its face unreasonable. The panel remanded the case to develop the record.

There is really nothing new here. The outpatient surgery centers have the burden of proof as to reasonableness, and some of the kinds of proof that may be convincing are outlined in *Kunz*. The Appeals Board will not accept a billing statement which is on its face unreasonable, but even that is susceptible of proof. It appears that the parties to the ongoing lien litigation have decided that it is not worth the effort to put on a serious case. As long as that happens, the results will continue to be all over the map, and, in my opinion, a serious waste of judicial resources.

For Further Discussion on California Workers Compensation Diminished Future Earning Capacity, see 2-32 CA Law of Employee Injuries & Workers' Comp § 32.03A (LexisNexis Matthew Bender), 1-2 Lawyer's Guide to AMA Guides and CA Workers' Comp § 2.02(4) (LexisNexis Matthew Bender), 1-7 Herlick, California Workers' Compensation Law § 7.03A (LexisNexis Matthew Bender).

For Further Discussion on California Workers Compensation Reasonableness of Medical Treatment Charges, see 2-22 CA Law of Employee Injuries & Workers' Comp § 22.05 (LexisNexis Matthew Bender), 1-4 Herlick, California Workers' Compensation Law § 4.26.

ABOUT THE AUTHOR(S):

Merle C. Rabine was a Commissioner of the California Workers' Compensation Appeals Board from April 2000 to January 2007. He was Chairman of the Appeals Board from April 2000 to June 2005. Mr. Rabine is presently a member of the LexisNexis National Workers' Compensation Advisory Board. The opinions expressed herein are those of the author and do not reflect opinions of the Appeals Board or any of its Commissioners.

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McCoy on the Closing of the Georgia Subsequent Injury Trust Fund

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McCoy on the Closing of the Georgia Subsequent Injury Trust Fund

By Doug McCoy

September 4, 2007

SUMMARY: On July 1, 2006 the Georgia legislature closed the Subsequent Injury Trust Fund to new claims with injury dates on or after that date. This commentary, written by Doug McCoy, examines the impact of this legislation, the steps claims handlers should take to preserve claims, and the strategies that recovery specialists should take as soon as possible to recover payments from the Fund on inactive claims.

PDF LINK: [Click Here for Enhanced PDF of Commentary](#)

ARTICLE: It all began 30 years ago on July 1, 1977, when Georgia opened a new agency, the Subsequent Injury Trust Fund [See O.C.G.A. § 34-9-352]. Georgia was the last state in the nation to enact legislation to create a Fund to encourage the hiring and retention of disabled workers by protecting employers from large workers' compensation claims.

On July 1, 2006 the Georgia legislature [see HB 1405] closed the Subsequent Injury Trust Fund to new claims [See O.C.G.A. § 34-9-368]. Not so fast! Even though the legislation stopped new claims from being submitted to the Fund with injury dates on or after July 1, 2006, the Fund is still operating, paying claims, and assessing insurers and self-insured employers in the state. Payments will continue to be made by the Fund on accepted claims indefinitely [See O.C.G.A. § 34-9-368(a), (c)].

In fact, in the year following July 1, 2006, the Fund paid more claims and assessed more money than ever before! The assessment for insurers and self-insured employers in 2007 was 10.15 percent for **\$204.5M. Those assessments are projected to continue indefinitely into the future to pay claims accepted by the Fund with injury dates prior to July 1, 2006. That means assessments will be made based on claims paid at a time when there will be no opportunity to make a claim with the Fund [See O.C.G.A. § 34-9-368(b)].**

The worst case scenario for a new insurance company to the state after July 1, 2006 or a large self-insured employer that provides jobs in the state and that starts business in the state after July 1, 2006, would be that they will be assessed to pay claims and never have the opportunity to make a claim themselves.

Acceptance; Automatic Denial. Now that the legislature has taken steps to eliminate the Fund, many do not understand that the Fund will be around for many years to come. All claims filed with the Fund since July 1, 1977 to the

present that have not been accepted by the Fund, now must be perfected for acceptance or they are automatically denied by the Fund on July 1, 2009 [See O.C.G.A. § 34-9-362(d)].

Statute of Limitations; Request for Hearing. Once that automatic denial occurs, the only way to toll the statute will be to request a hearing before the State Board of Workers Compensation [See O.C.G.A. § 34-9-362(g)]. All claims not perfected by July 1, 2009, and have no hearing requested, will be forever barred by a statute of limitations created by HB 1405.

Placing Fund on Notice. The Fund is still taking new claims and will continue to take new claims after July 1, 2009. If claims handlers have not placed the Fund on notice of any claim that occurred from July 1, 1977 to July 1, 2006, and not more than 78 weeks of benefits have been paid, they may place the Fund on notice of their claims at any time in the future [See O.C.G.A. § 34-9-362(a)]. Other than the 78 weeks of benefits paid, there is no time limit for such claims. Once claims handlers have placed the Fund on notice, however, they will have three years from that date to perfect their claim [See O.C.G.A. § 34-9-362(e)].

Many claim handlers or recovery consultants advise putting the Fund on notice when a claim is established. I suggest waiting until the very last minute, which provides more time since the three years begins to run from the date the Fund is placed on notice [See O.C.G.A. § 34-9-362(e)].

Prior Impairment. There are many other things about the Fund that folks, even recovery specialists, overlook. For instance, the employer is not required to have prior knowledge in all cases. One of the more effective mergers for reimbursement involves an individual who has a prior impairment of mental retardation. The statute states that it shall not be necessary for the employer to know the employees actual intelligence quotient or actual ranking in relation to the intelligence quotient of the general population. [See O.C.G.A. § 34-9-361(12)].

The statute deals with conditions that are presumed hindrances to employment. If it can be shown that an employee has mental retardation that does not meet the definition in the statute of a presumed hindrance to employment, then a claim can still be pursued. The list found in O.C.G.A. § 34-9-361 is not all inclusive for prior impairments; rather, these are only conditions that are considered presumed hindrances.

The statute defines mental retardation as the employees intelligence quotient such that he or she falls within the lower two percent of the general population. This is what I call the Forrest Gump statute for slight mental retardation. Many workers in laboring jobs have an IQ of 70 or below and would fall within this category. In such cases the employer does not have to know what the IQ is or the ranking in relation to the IQ of the general population.

Case Study of Prior Impairment: Mental Retardation. Not long ago, an associate was handling a claim involving an injured employee who placed a propane tank in a washer with an open flame. Due to his slight mental retardation, the employee placed the container with 15 pounds of propane in the washer, which resulted in an explosion and burns to the employee.

The employer had no knowledge of the employees IQ and only considered him a little slow. That was sufficient to recover not only the indemnity but also the medical since the merger was defined in O.C.G.A. § 34-9-351(1)(A), i.e., had the preexisting permanent impairment not been present, the subsequent injury would not have occurred. This was missed by the prior recovery specialist.

Inactive Claims. There are 138,823 inactive claims filed with the Fund now by 1,122 difference insurers and self-insured employers in Georgia. Some of these claims are below the threshold for recovery and some have no potential, but there are hundreds of millions of un-recovered dollars that have been abandoned. These claims will be forever closed by statute if not perfected by July 1, 2009.

Strategies for Fund Recovery on Inactive Claims. Many recovery specialists pursue the low hanging fruit, i.e., those claims that are obvious that the Fund will accept. If they are willing to climb up in the tree, though, there is plenty

more fruit that can be picked.

In another recent claim accepted by the Fund, 11 years after the injury, the recovery specialist and defense attorney had both ruled out any possibility of Fund recovery. The initial notes the adjuster made was that the employee had a history of anxiety and depression. Even though the subsequent injury was a neck injury, the catastrophic designation and pain treatment arose from the psychoneurotic impairment.

Psychoneurotic disability with confinement for more than six months is a presumed hindrance to employment [See O.C.G.A. § 34-9-361(13)]. In this case, even though the requirement for a presumed hindrance to employment was not met, the anxiety and depression was proven a hindrance to employment and the Fund accepted the claim.

Claims for other impairments other than mental retardation and psychoneurotic disability are being overlooked and recoveries abandoned. Now is the time to take a subsequent look at all claims for Fund recovery. The prior permanent impairment need not be caused by an injury, but it must be known by the employer, considered a hindrance to employment, and merge with the subsequent injury by (1) causing the injury, or (2) creating a greater disability. A third merger is created when death would not have been accelerated had the preexisting permanent impairment not been present [See O.C.G.A. § 34-9-351].

Insurance carriers and TPAs should not be confused by the list of impairments found in O.C.G.A. § 34-9-361. These are only permanent impairments that are presumed hindrances to employment. There are many other impairments not found on this list that can merge with the subsequent injury to qualify for acceptance by the Fund.

If insurance carriers and TPAs examine claims already submitted to the Fund that are inactive, the worst case scenario is to insure they have no claims that recovery can be made, and the best case scenario is they make recovery from the Fund. It is found money.

In many instances for an insurance carrier or TPA, it is insurance to confirm they have done all they can to recover their policyholder's or client's money. Not taking the steps to insure that they have made a full recovery from all claims with potential could be considered an error or omission and create a liability for which there is no remedy from the Georgia Subsequent Injury Trust Fund.

The Fund was created to make recovery payments. Insurance companies and TPAs should make sure they are making the maximum recovery possible under the statute before it is too late.

For Further Discussion on the Georgia Subsequent Injury Trust Fund, see *Kissiah's Georgia Workers' Compensation Law*, §§ 32.01-32.08.

ABOUT THE AUTHOR(S):

Doug McCoy is Principal of McCoy Consulting, an independent firm that provides consulting services to stakeholders in the property casualty insurance industry. He began his career as a multi-line claim adjuster in the property casualty claim operation of a major insurer. In 1992 he became the Divisional Vice President of Commercial Lines. In 1994 he became the Chief Operating Officer of a large workers' compensation managed care organization. Mr. McCoy's extensive industry experience includes representation on the National Council on Compensation Insurance Fraud Study Committee, Governor's Study Committee on Workers' Compensation, Warm Springs Institute for Rehabilitation Advisory Committee, Learning Services Head Injury Center Advisory Committee, and Pharmacy Management Services, Inc., Advisory Committee. He currently serves as a member of the Licensure and Self-Insurance Sub-Committee of the Chairman's Advisory Committee for the Georgia State Board of Workers' Compensation and of the Georgia CompScope Multi-state Advisory Committee for the Workers' Compensation Research Institute. He has

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Aylward on "Occurrence" and "Occurrences" in Mass Shooting Claims

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Aylward on "Occurrence" and "Occurrences" in Mass Shooting Claims

By Michael F. Aylward

February 7, 2007

SUMMARY: Michael F. Aylward, Chair of Morison Mahoney LLP's Complex Insurance Claims Resolution Group, explores cases addressing the intersection of these themes. It highlights the December 27, 2007 opinion of the Pennsylvania Supreme Court in *Donegal Mut. Ins. Co. v. Baumhammers* in which the court found coverage but limited the insureds' recovery to a single policy limit.

PDF LINK: Premium Emerging Issues Commentary (\$)

ARTICLE: Columbine, Virginia Tech, the Amish Shootings . . . Behind the sensational headlines and human tragedy that accompany mass shooting incidents, an often unseen drama is played out to determine who will compensate the victims of these crimes. More specifically, will liability insurers provide coverage and, if so, in what amount? In the following article we will analyze these "spree" claims with a particular emphasis on the Pennsylvania Supreme Court's opinion in *Donegal Mut. Ins. Co. v. Baumhammers*, n1 the most recent case to address these questions.

Whether presented in the context of sexual assaults, mass shootings or other "spree" crimes, cases in which a single individual's criminal acts cause injury to multiple individuals present two distinct insurance coverage issues: First, do such claims arise out of an accidental "occurrence" arising as they do out of the intentional acts of a criminal? However, because the policyholder seeking coverage is not the perpetrator but rather a parent, employer or entity with responsibility for the conduct of the perpetrator, plaintiffs have argued with some success that the insured's negligent hiring, training or supervision of the perpetrator is a basis for liability independent of the perpetrator's crimes. Where coverage has been found to apply, a second question is how many indemnity limits the insurer must pay to satisfy its insured's liabilities: one, reflecting the overall negligence of the insured, or several, in light of the specific cause and circumstances of each victim's injuries?

The incidents giving rise to *Baumhammers v. Donegal Mutual* began on April 28, 2000, when 34 year-old Richard Baumhammers went on a shooting spree that, over the course of two hours, killed five people and wounded another. Baumhammers began by shooting and killing his neighbor, Anita Gordon, whose home he then set on fire. Richard next got in his car and drove to Scott Township where he shot and killed Anil Thakur and seriously wounded Sandip Patel. He then drove to Robinson Township where he shot and killed Ji-Ye Sun and Thao Pak Pan. Finally, Baumhammers

drove to Center Township where he shot and killed Gary Lee.

Richard Baumhammers was tried and convicted of first degree murder with respect to the five killings and aggravated assault and attempted homicide for the shooting of Patel. Thereafter, Patel and the estates of his deceased victims filed suit against Baumhammers and his parents in the Court of Common Pleas. Their Complaint alleged that the parents had failed to procure adequate mental health treatment for Baumhammers, had failed to take his hand gun away from him and had failed to notify law enforcement authorities of the fact that he possessed a hand gun.

Richard Baumhammers and his parents sought a defense to these claims under a homeowner's policy issued to the parents by Donegal Mutual. n2 Donegal Mutual agreed to provide a defense to the underlying lawsuits under a reservation of rights and filed an action for declaratory relief, seeking a declaration that there was no "occurrence" and that the most that it possibly owed was the policy's \$300,000 per occurrence limit as all the claims arose out of "continuous or repeated exposure to substantially the same general harmful condition." n3

In 2001, the Court of Common Pleas ruled that Donegal Mutual had no duty to defend or indemnify Richard Baumhammers. However, the court ruled that Donegal Mutual owed coverage for the claims against the parents and declared that each of the victims constituted a separate "occurrence" for purposes of determining the insurer's indemnity obligations. On appeal, the Superior Court (Pennsylvania's intermediate appellate court) initially issued an opinion reversing the holding of the Court of Common Pleas. That decision was withdrawn, however, and following re-argument *en banc*, the Superior Court ruled 5-3 in *Donegal Mut. Ins. Co. v. Baumhammers*, n4 that the trial court had correctly found that the underlying claims involved six separate "occurrences." Donegal Mutual appealed.

Nearly ten months after hearing oral argument, a sharply divided Pennsylvania Supreme Court ruled a few days before the end of 2007 that the Superior Court had been correct in finding coverage but had erred in its determination of the number of "occurrences." The majority declared that innocent insureds whose negligence enables the intentional acts of a co-insured to cause injury are entitled to coverage despite the intentional and criminal acts of the perpetrator. The court distinguished its holding in *Gene's Restaurant, Inc. v. Nationwide Ins. Co.*, n5 in which it had ruled that an intentional willful assault was not an "occurrence." Rather, in keeping with its earlier opinion in *Mohn v. American Casualty Co.*, n6 the Supreme Court observed that the fact that the event causing the injury may be traced to an intentional act of a third party does not preclude the occurrence from being an accident insofar as negligence is claimed with respect to the policyholder. Likewise, the court cited the Third Circuit's opinion in *Nationwide Mut. Fire Ins. Co. v. Pipher*, n7 in which coverage had been found for claims against a landlord who failed to install doors on a second-floor apartment where a tenant was subsequently murdered by a burglar. In keeping with these earlier opinions, the Pennsylvania Supreme Court refused to find that the extraordinary shooting spree embarked upon by Baumhammers was the natural and expected result of the negligence of the parents. As a result, considering these claims from the standpoint of the parents, the Supreme Court held that they exhibited the degree of fortuity necessary to constitute an "accident." n8

While the *Baumhammers* court's declaration of coverage is hardly unique, numerous courts have adopted an analysis similar to the one undertaken by the Pennsylvania Supreme Court, n9 other leading courts have held that theories of negligent hiring, training or supervision and the like do not trigger coverage since those theories of negligence did not result in any injury to the plaintiff and in view of the fact that the plaintiff's injuries would not have occurred but for the intentional or criminal acts of the third party. Thus, in *Farmers Alliance Mut. Ins. Co. v. Salazar*, n10 the U.S. Court of Appeals for the Tenth Circuit ruled in an Oklahoma case that allegations of negligent supervision against the mother of a murderer could not be an "occurrence" as an "occurrence" is the event that causes the plaintiff's injury, not the remote cause of that injury. n11

Having found that the underlying theories of negligence against the Baumhammers constituted an "occurrence," the Pennsylvania Supreme Court turned to the issue of whether the Superior Court had correctly determined that each individual victim was a separate "occurrence." Here, the Supreme Court fragmented into three different camps. The majority opinion, which reflected the views of Justices Baldwin, Castille, Saylor and Eakin, concluded that only a single

"occurrence" limit should be triggered by the various wrongful death and personal injury actions. Chief Justice Cappy dissented, arguing that the Superior Court had correctly found six "occurrences." Justice Baer likewise dissented but proposed an intermediate approach wherein separate claimants might be aggregated together insofar as their injuries occurred in close proximity to each other.

Writing for the majority, Justice Baldwin held that, just as the determination of whether there was an "occurrence" reflected the conduct of the insureds without regard to the intentional or criminal acts of their son, the number of "occurrences" must reflect the acts for which the insureds were held to be liable and not the actions of their son. While the Supreme Court agreed with the Superior Court that a "cause" test was appropriate, it held that the "cause" in question was the cause of the insureds' liability, not the immediate injury-producing act that caused the death and injuries of the underlying claimants.

The Pennsylvania Supreme Court took issue with *Koikos v. Travelers Ins. Co.*, n12 the 2003 Florida Supreme Court opinion that the Pennsylvania Superior Court had focused on in adopting a "six occurrences" finding. *Koikos* arose out a case in which gang members, having been "dissed" by a rival gang at the insured's restaurant, returned with guns, with fatal results to several patrons. On a certified question from the federal court, the Florida Supreme Court held that each injured victim was a new "occurrence." The court rejected Travelers' contention that the relevant consideration was the single omission of its policyholder in failing to provide proper security. Further, the Florida Supreme Court refused to find that the "continuous and repeated exposure to conditions" language was relevant in considering the acts or omissions of the policyholder for which it was deemed to be legally responsible, ruling instead that this language was intended to broaden the scope of earlier coverage so as to clearly afford coverage for incidents in which injuries resulted from environmental exposures or other conditions that occurred over an extended period of time:

We conclude that the inclusion of the "continuous or repeated exposure" language does not restrict the definition of "occurrence" but rather expands it by including ongoing and slowly developing injuries, such as those in the field of toxic torts. Therefore, we reject Travelers' reliance on the "continuous or repeated exposure" language as a basis for concluding that *Koikos*' negligent failure to provide security constitutes a single occurrence under the terms of the policy. The victims were not "exposed" to the negligent failure to provide security. If the victims were "exposed" to anything, it was the bullets fired from the intruder's gun.

As a result, the *Koikos* court had declared that "it is the act that causes the damage, which is neither expected nor intended from the standpoint of the insured, that constitutes the 'occurrence.'" The court found that "focusing on the immediate cause -- that is the act that causes the damage, rather than the underlying tort-that is the insured's negligence, is also consistent with the interpretation of other forms of insurance policies." n13

In *Baumhammers*, however, the Pennsylvania Supreme Court declared that *Koikos* had been wrong to base the number of "occurrences" on the actions of third parties rather than the negligent conduct of the insured. Instead, the *Baumhammers* court looked to the Nevada Supreme Court's opinion in *Washoe County v. Transcontinental Ins. Co.*, n14 in which the County had been sued for negligently licensing a day care center at which an employee had sexually abused children over a three-year period. The Nevada Supreme Court held that despite the number of incidents and children abused, the appropriate application of the "cause test" resulted in only a single "occurrence" reflecting the insured's overall negligence in failing to properly certify or license the day care facility. The court explained that where the insured is not itself directly responsible for the injuries, "[t]he focus of the inquiry should not be on the number, magnitude or time of the injury but rather on the cause or causes of the injury." Because each of the separate incidents of molestation arose from the same proximate cause, that is to say the County's negligent failure to license the facility, that negligence constituted a single "occurrence."

The *Baumhammers* majority also took note of other cases in which courts around the country have found only one "occurrence" for shooting spree cases. Thus, in *Travelers Indem. Co. v. Olive's Sporting Goods, Inc.*, n15 a sporting goods store was sued by several individuals who were injured after a person to whom the store had sold a gun went on a shooting spree. In these circumstances, the

Arkansas Supreme Court held that all of the claims against the insured arose out of the same "occurrence," which is to say the insured's sale of the gun.

The court also cited *RLI Ins. Co. v. Simon's Rock Early College*,ⁿ¹⁶ a case in which the Massachusetts Appeals Court ruled in 2002 that claims against a college for failing to prevent a shooting spree by a deranged student all arose out of a single "occurrence." In 1992, Wayne Lo, a student at Simon's Rock, went on a shooting spree killing two students and injuring four other individuals. Simon's Rock was sued by the injured students and their families alleging that it had been negligent in allowing the incident to occur. The College's primary insurer (American Alliance) argued that these claims all arose out of the same "occurrence" and that its maximum indemnity obligation was therefore \$1 million. The excess insurer (RLI) contended that the injuries had occurred over a span of time in different places, resulting in different injuries to different individuals and therefore involved multiple "occurrences" such that the primary policy's \$3 million aggregate limit must therefore be paid before it had any obligation to provide coverage for the underlying losses. The Superior Court and, on appeal, the Appeals Court ruled that these claims involved a single "occurrence."

RLI argued that the "cause" test required that the number of occurrences be measured by "the immediate cause of the victims' injuries, i.e., Low's shooting."ⁿ¹⁷ The Appeals Court disagreed:

We conclude that when the issue is the number of occurrences, we must look to the "cause" of the injury by reference to the conduct of the insured for which insurance is afforded.

.....

Where the underlying claims against the school and its employees are for negligence, it is their alleged negligent acts or omissions in failing to prevent Low from using his gun that constitute the occurrence for purposes of determining general liability coverage."

The court observed that the unambiguous language of the policy at issue "clearly contemplates the possibility that multiple acts taking place over a space of time may contribute to a single occurrence for purposes of coverage." Despite the fact that the underlying claims alleged several discrete acts of negligence on the part of the College (its failure to search Low's room, to confiscate his weapons parts, to call his parents or to call the police), the court held that these were not separate "occurrences" but rather evidence of an arguably inadequate policy of security and student supervision that contributed to Low's ultimate access to a murder weapon. As a result, the court concluded that the "occurrence" giving rise to the College's liability was the alleged failure or inadequacy of its security policy.

In keeping with cases such as *Olive's Sporting Goods* and *Simon's Rock*ⁿ¹⁸ the *Baumhammers* majority declared that:

Determining the number of occurrences by looking to the underlying negligence of the insured recognizes that the question of the extent of coverage rests upon the contractual obligation of the insurer to the insured. Since the policy was intended to insure parents for their liabilities, the occurrence should be an event over which parents had some control Although this is a disturbing case with tragic consequences, we are compelled to conclude that parents' alleged negligence constituted but a single occurrence for purposes of coverage under the Donegal insurance policy.

Writing in dissent, Justice Cappy argued that the Supreme Court should have followed the Superior Court in finding six separate "occurrences" based on *Koikos*. He also contended that it was premature to determine the limits of coverage available for indemnity since there had not yet been a finding of liability on the part of the parents.

Finally, Justice Baer argued in his dissent that there should have been four "occurrences." In contrast to the majority's approach, which focused on the negligent conduct of the insured or Chief Justice Cappy's analysis, which looked solely to the acts that had caused the plaintiffs' injuries, Justice Baer argued that the better question was to look to whether there was "one proximate uninterrupted and continuing cause" that resulted in separate injuries or damage. In

this case, he observed that although six individuals had been shot, those injuries arose out of four separate shooting incidents as Richard Baumhammers traveled from location to location. As a result, he concluded that both of the individuals shot at Scott Township and the two individuals shot at Robinson Township could both be grouped as two "occurrences."

Determining the number of "occurrences" is generally not difficult in cases where the insured is the direct cause of the plaintiffs' injuries. In recent years, most of the controversy concerning the number of "occurrences" has reflected cases where the insured is a remote actor, either where the insured manufactures a product that subsequently results in injury to numerous individuals or where, as in *Baumhammers*, the insured is sued for failing to prevent losses caused by a third party.

While courts across the country have accepted the notion that a "cause" test should apply, there is little uniformity with respect to whether the application of a "cause" test should consider direct or remote causes. As may be seen in the asbestos cases, a "cause" test that looks to the specific circumstances concerning each plaintiff's specific disease or injury is little different from the "effect" analysis that was abandoned years ago. Nevertheless, as with Justice Baer's dissenting opinion in *Baumhammers*, courts have been uncomfortable in applying a "cause" test that groups together events that are not proximate in time and space and that have often occurred decades apart throughout the United States under widely differing circumstances.

Ultimately, for all of its twists and turns, the majority in *Baumhammers* got it right. The appropriate focus of the "occurrence" analysis is on the conduct of the insured. If a court is to hold that an insured is entitled to coverage due to independent acts of negligence and notwithstanding the fact that the direct cause of the plaintiffs' injuries are actions for which coverage would not be allowed under a policy (i.e., criminal or intentional assaults), then the same analysis should be applied with respect to determining the number of "occurrences."

Oddly, Justice Cappy also got it right. A court should not consider the actions of a third party in determining whether there is an "occurrence" and then apply an inconsistent analysis in adopting the number of occurrences analysis. Since casualty policies are intended to provide coverage for an insured's claimed liability, the appropriate focus should be on the insured's liability, not the facts or circumstances giving rise to each claimant's injuries.

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n1 1 938 A.2d 286 (Pa. 2007).

n2 2 Both the parents and Richard Baumhammers were "insureds" under the policy as Richard Baumhammers, although no longer a minor at the time of these incidents, was a member of his parents' household.

n3 3 The "Limits of Liability" section of the Donegal Mutual policy stated that, "all bodily injury and property damage resulting from any one accident or from continuous or repeated exposure to substantially the same general harmful condition shall be considered to be the result of one occurrence."

n4 4 2006 PA Super 32 (Pa. Super. Ct. 2006).

n5 5 519 Pa. 306 (1988).

n6 6 458 Pa. 576 (1974).

n7 7 140 F.3d 222 (3d Cir. 1998).

n8 8 The issues that consumed the *Baumhammers* court might have been avoided under more recent editions of the HO-3 form, which contain an "intentional acts" exclusion barring coverage for "bodily injury or property damage which may reasonably be expected to result from the criminal or intentional acts of an insured person or which in fact are intended by an insured person."

n9 9 See *Silverball Amusement v. Utah Home Fire Ins. Co.*, 842 F. Supp. 1151 (W.D. Ark. 1994), *aff'd per curiam*, 33 F.3d 1476 (8th Cir. 1994) (allegations that the insured failed to properly supervise an employee who sexually abused children were held to constitute an "occurrence"); *United States Fidelity & Guar. Co. v. Open Sesame Child Care Ctr.*, 819 F. Supp. 756 (N.D. Ill. 1993) (insurer must provide coverage for allegation that day care operator negligently hired employees who committed sexual assaults); *Westfield Cos. v. Kette*, 77 Ohio St. 3d 154 (Ohio 1996) (negligent supervision claims against the wife of a child molester were covered under their homeowner's policy); *United Fire & Cas. Co. v. Shelly Funeral Home, Inc.*, 642 N.W.2d 648 (Iowa 2002) (corporate insured was entitled to coverage, despite the intentional acts of one of its directors, since the plaintiffs' injuries were unexpected or unintended from its standpoint).

n10 10 77 F.3d 1291 (10th Cir. 1996).

n11 11 Similarly, other courts have pointed out that independent theories of liability, while not based on the actual criminal conduct, would not have given rise to injury but for the fact that they allowed the intentional acts to occur. See, e.g., *Erie Ins. Exch. v. Claypoole*, 449 Pa. Super. 142 (Pa. Super. Ct. 1996) (claimed negligence of bus company in hiring and supervising rapist would not have given rise to injury but for employee's intentional acts); *Sweet Home Cent. Sch. Dist. v. Aetna Commercial Ins. Co.*, 263 A.D.2d 949 (4th Dept. 1999) (allegations that school district was negligent in hiring teacher who sexually assaulted pupils did not allege a covered "occurrence" as it is "the nature of the underlying acts, not the theory of liability, that governs."

See also *Commercial Union Ins. Co. v. Roberts*, 7 F.3d 86 (5th Cir. 1993) (Texas law); *Farmers Union Mut. Ins. v. Kienenberger*, 257 Mont. 107 (1993).

n12 12 849 So. 2d 263 (Fla. 2003).

n13 13 *Koikos* is in keeping with two earlier opinions of the *Florida District Courts of Appeal In Am. Indem. Co. v. McQuaig*, 435 So. 2d 414 (Fla. 5th DCA 1983), a homeowner engaged in a shoot-out with the police, injuring three officers with successive shotgun blasts. The District Court of Appeals held that each shotgun blast was a separate "occurrence." Likewise, in *N.H. Ins. Co. v. RLI Ins. Co.*, 807 So. 2d 171 (Fla. 3rd DCA 2002), a tenant in the insured's apartment building fired three separate shots at different times and places inside the apartment complex, injuring three individuals and killing two. The families of the victims sued the apartment building owner alleging that he had been negligent in failing to provide proper security that might have precluded such events from occurring. The Third District of the Florida District Court of Appeal concluded that each separate incident was a different "occurrence." The court ruled that "the act which causes the damage constitutes the occurrence." The Third District concluded that "there were three separate acts of shooting, causing three separate injuries to three separate persons in three separate instances. This is not a case with one proximate, uninterrupted continuing cause resulting in the deaths and injuries but rather three separate causes. New Hampshire did not incur any liability because of the aggressor's residence, but rather liability attached when the aggressor fired three shots which resulted in injury to the three victims."

n14 14 110 Nev. 798 (1994).

n15 15 297 Ark. 516 (1989).

n16 16 54 Mass. App. Ct. 286 (2002).

n17 17 54 Mass. Ct. at 290.

n18 18 To similar effect is *Bomba v. State Farm Fire and Cas. Co.*, 379 N.J. Super. 589 (App. Div. 2005), in which the Appellate Division of the New Jersey Superior Court ruled that claims against a homeowner for injuries suffered in an incident where the insured's adult son shot at various police officers on three occasions,

injuring several officers, constitute a single "occurrence." The court rejected the insured's contention that each separate gunshot was a new "occurrence," holding instead that inasmuch as the claims against the insured were based upon their negligence in allowing their son access to gun, the underlying injuries all shared the same "cause."

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