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ACCEC
American College of Coverage and Extracontractual Counsel
Fifth Anniversary
Meeting and Program
May 10-12, 2017 • Chicago, IL
2017 Annual Meeting
Palmer House Hilton
Chicago, IL | May 10-12, 2017

AGENDA

ACCEC
American College of Coverage and Extracontractual Counsel

ACCEC 2017 Annual Meeting Agenda
May 10-12, 2017
Palmer House - Chicago, IL

Wednesday, May 10, 2017	
10:00 am – 5:00 pm	Strategic Planning Session/Board of Regents Meeting (offsite)
5:30 pm – 6:30 pm *Salon 2*	**Committee Meetings**
6:30 pm – 7:30 pm *Crystal Room*	**Welcome Reception**

Thursday, May 11, 2017	
8:00 am – 8:50 am *Empire Room*	Continental Breakfast
8:50 am – 9:00 am *Honore Room*	**Welcome Remarks** • Mary Craig Calkins, Kilpatrick Townsend & Stockton LLP; ACCEC President • Stephen Pate, Cozen O'Connor, 2017 Annual Meeting Co-chair • Robert Thavis, Stinson Leonard Street, LLP; 2017 Annual Meeting Co-chair
9:00 am - 9:50 am *Honore Room*	**The Cobbler's Children Have No Shoes: Professional Liability Insurance** **Speakers:** Laura Hanson, Meagher & Geer; Ron Kammer, Hinshaw & Culbertson LLP; R. Hugh Lumpkin, Ver Ploeg & Lumpkin; Sheri Pastor, McCarter & English; *Professional liability insurance policies share several common characteristics. How well do you understand this product, which covers both insurer and policyholder attorneys? What's a Claim? What constitutes Professional Services? Does the Profit and Advantage exclusion apply when a grievant seek return of the legal fees they paid you? We've got these issues covered so that you will better understand your client's, and your own, professional liability insurance programs.*

9:50 am – 10:30 am *Honore Room*	**Subrogation, Equitable Contribution, and Other Insurance: Untangling The Gordian Knot Without Prolonged Litigation** **Speakers:** Barry Fleishman, Kilpatrick Townsend; Tarron Gartner-Ilai, Cooper & Scully, P.C.; Ellen Van Meir, Thompson Coe *Policyholders often are required to shoulder the costs of covered claims as insurance companies battle among themselves on how to allocate liabilities. Policyholders complain that it seems the more coverage they have, the less likely it is that they actually get covered. the panel will explore creative ways to resolve these situations short of prolonged and expensive litigation.*
10:30 am – 10:40 am *Honore Room*	BREAK
10:40 am – 11:25 am *Honore Room*	**War and Peace (The Abridged Version): Application of the War and Terrorism Exclusions** **Speakers:** Bruce Celebrezze, Sedgwick LLP, Elizabeth Stewart, Murtha Cullina *The war exclusion has existed in many types of insurance policies for over 100 years. Yet it is not often litigated. This presentation would be an exploration of the genesis of the exclusion, its many amendments over the years, where it applies and where it does not apply. In addition, the presentation would discuss the pertinence of the exclusion in today's world of terrorism.*
11:25 am – 12:00 pm *Honore Room*	**Building Product Class Actions - Coverage Under the Roof?** **Speaker**: Timothy Burns, Perkins Coie; Janet Davis, Cozen O'Connor; Lee Ogburn, Kramon & Graham, P.A. *How are building product class actions weathering? If the future is liability-only classes, what are the defense obligations of an insurer that covers only consequential property damage? Speaking of the defense obligation, how do insurers over 20-30 years share the defense, should they select counsel? Hourly rates: how much is enough? The end is in sight, but what happens to the defense obligation when the certified class is limited to non-covered damages?*
12:00 pm – 1:00 pm *Empire Room*	Lunch **Keynote Remarks:** Alexander Hamilton and James Donavan: Coverage Lawyers in the Spotlight **Speaker:** Randy Maniloff, White and Williams LLP *Coverage lawyers are not often household names nor part of pop culture. That has changed recently. Randy Maniloff, noted author of* Coverage Opinions*, will present a presentation on two in this category. Alexander Hamilton handled many insurance coverage cases as a lawyer. James Donovan, of "Bridge of Spies" fame, was a coverage lawyer when not representing a Soviet spy and negotiating for the release of a U.S. spy.*

	Annual Business Meeting, featuring Recognition of New Members
1:00 pm – 1:40 pm *Honore Room*	**Keeping Your Food "Recall Insurance" Fresh** **Speakers**: Art Garrett, Keller and Heckman LLP; Suzan Charlton, Covington & Burling LLP *Food companies need to prepare for the inevitable food recall. In order to support the in-house prevention programs, all food companies should strive for a "food recall insurance" program with little or no gaps. The insurance program not only provides for the defense and indemnity when the policies are triggered, but can also provide the necessary outside experts to manage the crisis and to assist in handling numerous potential illness and injury claims, legal support, and recall support through catastrophe centers designed and ready to go in a moment's notice. Insurance policies to be explored are the CGL (primary/ excess), property, marine cargo, D&O, PCI and Supplier's CGL (as additional insured).*
1:40 pm – 2:40 pm *Honore Room*	**Master Class: Bad Faith Trial Tactics From the Best, For the Best** **Speakers:** Joyce Wang, Carlson, Calladine & Peterson LLP; Chris Martin, Martin, Disiere, Jefferson & Wisdom LLP; Mike Huddleston, Munsch Hardt Kopf & Harr, PC; Barbara O'Donnell, Zelle McDonough & Cohen LLP *A group of the country's preeminent Bad Faith trial attorneys discuss and demonstrate the latest trends in extra contractual litigation. The panel will cover institutional discovery from both sides, the use and striking of experts, dispositive motions, pre-trial considerations, and trial itself.*
2:40 pm – 2:50 pm	Break
2:50 pm – 3:30 pm *Honore Room*	**Show Me the Money: Latest Developments in the Recovery of Attorneys Fees in Coverage and Bad Faith Litigation** **Speakers:** Robert D. Allen, The Allen Law Group; Nicholas Nierengarten Gray Plant Mooty; Sara Thorpe, Nicolaides Fink Thorpe Michaelides Sullivan LLP *The ability of parties in coverage and bad faith litigation to recover attorneys fees often adds an extra issue into a dispute that can have significant consequences in terms of cost and exposure. The speakers will discuss various ways attorneys fees can be recovered and options available in prosecuting and defending claims for attorneys fees.*

3:30 pm – 4:10 pm *Honore Room*	**Louisiana Hayride—Arceneaux and Pro-rata Defense Allocation—the New Trend** **Speakers:** Laura Foggan, Crowell & Moring; Marty Pentz, Foley Hoag; Jay Sever, Phelps Dunbar LLP *The topic concerns the question whether Arcenaux and other recent rulings in which courts have divided responsibility for defense costs represent a new order, in which there will be greater recognition of limitations on defense obligations, or a flash in the pan with narrow applicability to the facts of individual cases.* Committee champion: Steve Pate
4:10 pm – 4:50 pm *Honore Room*	**Reflections on a Paradigm Shift for Extra-Contractual Liability in the Restatement of the Law, Liability Insurance** **Speakers:** Michael Aylward, Morrison Mahoney LLP; Lorelie Masters, Hunton & Williams; Jeffrey E. Thomas, University of Missouri - Kansas City School of Law *An assessment of the Restatement's approach to extra contractual liability, which is a new paradigm (building on case law) that treats the duty to settle as non-bad faith but requires subjective bad faith for damages beyond excess of limits payments.* Committee champion: Robert Thavis
6:30 pm – 7:30 pm *Empire Room*	Reception
7:30 pm – 9:30 pm *Empire Room*	Dinner

Friday, May 12, 2017	
8:00 am – 9:00 am *Empire Room*	Continental Breakfast
9:00 am – 9:40 am *Honore Room*	**Chances Are … A Fortuity Case Study** **Speakers:** Bernard Bell, Miller Friel, PLLC; Myles Parker, Carroll Warren & Parker PLLC; Susan Harwood, Boehm Brown Harwood PA (moderator) *The advocates and moderator will present one or more hypothetical fact scenarios and, from the perspective of insurer and policyholder, analyze whether the loss(es) are fortuitous. The panelists will discuss their experiences in a large matter that was arbitrated in London over the issue of whether the loss was fortuitous.*

9:40 am – 11:00 am *Honore Room*	**You Screwed Up: You Trusted Us!: Conflicts Among Insurers, Independent Counsel, and Insureds** **Speakers:** Marion B Adler Rachlis Duff Adler Peel & Kaplan, LLC; William Barker, Dentons; Doug McIntosh, McIntosh Sawran & Cartaya, P.A.; Neil Posner, Much Shelist PC *What are the rights and responsibilities of insurers with respect to defense by independent counsel; what duties to the insurer does independent counsel have in its dealings with the insurer?*
11:00 am – 11:10 am	Break
11:10 am – 12:05 pm *Honore Room*	**Fifteen Cases in Forty-Five Minutes: The Most Important Coverage and Extracontractual Decisions of the Past Year** **Speakers:** Robert Chesler, Anderson Kill; Suzanne Midlige, Coughlin Duffy LLP**;** Anthony Leuin, Shartsis Friese LLP *A distinguished panel will lead an interactive audience conversation about these recent important cases. This is not a "talking heads" speech-- it is a group discussion about the impact of these cases on the country's leading practitioners-- Us.*
12:05 pm – 12:10 pm *Honore Room*	Closing Remarks

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PRESENTATIONS

The Cobbler's Children Have No Shoes:

What Insurance Coverage Attorneys Need to Know About their Professional Liability Insurance Policies

2017 Annual Meeting
May 11-12, 2017
Chicago, IL

Laura Hanson (Meagher & Geer)
R. Hugh Lumpkin (Ver Ploeg & Lumpkin)
Ron Kammer (Hinshaw & Culbertson LLP)
Sherilyn Pastor (McCarter & English, LLP)

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This is an academic discussion, not legal advice. Because this presentation was authored by several people, the views expressed are not necessarily those of an individual author, or of any author's clients or firm. The opinions and comments in this presentation are intended to spur debate and should not be taken as an expression of opinion by any writers' firm or any client of an author's firm.

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What Constitutes a Claim?

- Is the term "claim" defined in the policy? If not, how do you determine whether a claim has been made?
- If the term "claim" is defined in the policy as a demand for money or services, how do you determine if the letter you receive from a potential claimant qualifies as a demand for money or services?
- Is a request for your insurance information or records without more a claim?
- To report or not. What happens if you conclude that a claim has not been made and the insurer concludes otherwise?

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What are "Professional Services"?

Courts' descriptions:

- Arises from "a vocation, calling, occupation, or employment involving specialized knowledge, labor, or skill"
- "Predominantly mental or intellectual"
- "Evidenced by the need for specialized learning or training" and distinguishable from "the ordinary activities of life and business"

Frequently debated issues:

- Fee disputes
- Business pursuits with clients

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The Related Acts Exclusion

Badges of relatedness:

- Same or different parties
- Same or different time periods involved
- Similar or different alleged wrongful acts
- Same or different duties, and if the same, are the people or entities to whom the duties were owed the same or different
- Same or different causes of action, and if different, do the causes of action arise out of the same core of operative facts
- Same or different damages or remedies sought

Recent application of test: *National Union Fire Ins. Co. v. Zillow, Inc.,* No: C16-1461JLR (W.D. Wash. April 13, 2017) (finding in trademark dispute that demand letter requesting removal of photographs from Zillow website before policy incepted to be related to later lawsuit)

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Prior Knowledge Provisions and Related Acts Provision

Each wrongful act, in a series of wrongful acts, will be deemed to have occurred on the date of the first wrongful act.

- *OneBeacon Ins. Co. v. T. Wade Welch & Assocs*., 2012 WL 6608264 (S.D. Tex. Dec. 18, 2012) *aff'd* 841 F. 3d 669 (5th Cir. 2014)

  Court held that a related acts provision together with prior knowledge provision is ambiguous as applied to facts of that claim.

- Litigating prior knowledge and related acts can be difficult – developing a complete record is critical

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What Is The Prior Knowledge Provision?

The policy only provides coverage when **no insured** had a basis to believe that any such act or omission or interrelated act or omission might reasonably be expected to give rise to a claim

If any insured had a basis to believe an act or omission might lead to a claim, there is no coverage.

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Prior Knowledge – Sample Policy Provision

This Policy does not apply to and We shall have no obligation to pay any Damages, Claim Expenses or Supplemental Payments for any Claim:

D. based upon or arising out of any actual or alleged Wrongful Act that:

***

3. You had knowledge of prior to the Policy Period and had a reasonable basis to believe that such Wrongful Act could give rise to a Claim; provided, however, that if this Policy is a renewal or replacement of a previous policy issued by Us providing materially identical coverage, the Policy Period referred to in this paragraph will be deemed to refer to the inception date of the first such policy issued by Us.

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Prior Knowledge Provisions

- *Truck Ins. Exch. v. Ashland Oil, Inc.*, 951 F.2d 787 (7th Cir. 1992); *Bryan Bros., Inc. v. Cont'l Cas. Co.*, 660 F.3d 827 (4th Cir. 2011).
- *Foster v. Winchester Fire Ins. Co.*, No. 09-1459, 2012 U.S. Dist. LEXIS 88274 (W.D. Pa. June 26, 2012)

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Knowledge - Objective or Subjective?

- Courts have held that a mixed subjective/objective analysis applies. There must be actual subjective knowledge of the facts related to the act or omission. And the objective component must be met – a reasonable professional in the insured's position would expect it to give rise to a claim. *Cohen-Esrey Real Estate Services, Inc. v. Twin City Fire Ins. Co. and Hartford Fire Ins. Co.,* 636 F.3d 1300 (10th Cir. 2011)
- A subjective test applies only to the "knowledge" aspect of the application question, while an objective test applies to the "might reasonably be expected to give rise to a claim" component. *Perkins v. Am. Int'l Specialty Lines Ins. Co.*, No. 1:12-cv-3001-TWT, 2012 U.S. Dist. LEXIS 175592 (N.D. Ga. Dec. 11, 2012)

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Evaluating the Insured's Knowledge - Extrinsic Evidence Considered

- *Westport Ins. Co. v. Albert*, 208 F. App'x 222 (4th Cir. 2006) (prior pleadings in a related matter established knowledge)
- *American Guarantee & Liability Ins. Co. v. Fojanini*, 90 F. Supp. 2d 615 (E.D. Pa. 2000) (correspondence predating lawsuit established knowledge)
- *Eisenhandler v. Twin City Fire Ins. Co.*, 2011 WL 5458180 (Conn. 2011) (extrinsic evidence relevant to whether insured knew his client would sue him considered)

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Evaluating the Insured's Knowledge - Extrinsic Evidence Not Considered

- *M.D. Sass Investors Servs., Inc. v. Reliance Ins. Co.,* 810 F. Supp. 1082 (N.D. Cal. 1992) (court refused to consider extrinsic evidence because prior knowledge provision was an exclusion)
- *Am. Guar. & Liab. Ins. Co. v. Hoeffner*, 2009 WL 130221 (S.D. Tex. 2009) (court held duty to defend applied because underlying suit did not allege prior knowledge of facts)
- *Home Mut. Ins. Co. v. Lapi*, 596 N.Y. F.2d 885 (N.Y. App. Div. 1993) *Or. Ins. Guar. Assn. v. Thompson*, 760 P.2d 890 (Or. Ct. App. 1988) (court considered extrinsic evidence where insured admitted intentional conduct but the underlying suit alleges negligence)

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Failure to Disclose/Misrepresentation in Application for Insurance

A standard application provision reads:

It is understood and agreed that failure to provide true and complete response to any of the questions, statements or request for information in this Application or to provide any other information material to this Application may, at the sole option of the insurer, result in the voiding of the insurance policy issued in reliance on this Application and /or denial of coverage for specific claims asserted against us (the Applicant) or any other insured under the policy. The undersigned on behalf of the Applicant and all other insureds under this policy issued by the insurer, hereby waives any defense to an action by the insurer for voiding or revoking of the policy based upon misrepresentation of fact or failure to disclose material information in connection with this Application. The Applicant agrees to hold the insurer harmless from all loss as a result of any such misrepresentation or failure to disclose, including, without limitation, all costs and attorney fees incurred by the insurer in connection with said action for voiding or revoking the policy.

I HEREBY DECLARE that the above statements and particulars are true to the best of my knowledge, that I have not suppressed or misstated any facts and I agree that this application shall form part of the insurance policy. I also acknowledge that I am obligated to report any changes that could affect the disclosures in this application that occur after the date of signature, but prior to the effective date of coverage.

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Failure to Disclose/Misrepresentation in Application

- *Perkins v. Am. Int'l Specialty Lines Ins. Co.,* No. 1:12-cv-3001-TWT, 2012 U.S. Dist. LEXIS 175592 (N.D. Ga. Dec. 11, 2012)

  Failure to disclose circumstances of a claim is material information.

- *Goodman v. Medmarc Ins*., 977 N.E.2d 128 (Ohio Ct. App. 2012)

  Misrepresentation was a representation, not a warranty, and does not void the policy.

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Failure to Disclose/Misrepresentation in Application

- Rescission actions vary by state law
- Standard is typically more onerous than prior knowledge coverage defense
- Fully developed record is important

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Personal Profit Exclusion

Limits coverage for "any Claim based on, or arising out of, or in any way involving any Insured having gained any personal profit or advantage to which he or she was not legally entitled." Berkley Ins. Co. Lawyers Professional Liability Policy, LPL 39450 (10-14) at IV.K.

Application of exclusions requiring:

- Wrongful profit or advantage
- Profit "in fact"

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WAR AND PEACE (THE ABRIDGED VERSION): APPLICATION OF THE WAR AND TERRORISM EXCLUSIONS

2017 Annual Meeting
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Bruce D. Celebrezze and Elizabeth J. Stewart

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The Beginning of War Exclusions

Civil War: extra premiums charged based on proximity to war zone

Civil War: 1861-1865

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The Beginning of War Exclusions

WWI: Brought into existence the modern types of war exclusions.

World War I: 1914 - 1918

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ISO Coverage Form: War Exclusion

2. Exclusions

This insurance does not apply to:

* * *

i. War

"Bodily injury" or "property damage," however caused, arising, directly or indirectly, out of:

1. war, including undeclared or civil war;
2. warlike action by a military force, including action in hindering or defending against an actual or expected attack, by any government, sovereign or other authority using military personnel or other agents; or
3. insurrection, rebellion, revolution, usurped power, or action taken by governmental authority in hindering or defending against any of these.

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What Constitutes a "War"?

- U.S. Const. art. I, § 8, cl. 11: Congress has the sole power to declare war.
- U.S. Const. art. II, § 2: names the President Commander-in-Chief of the armed forces; bestows the President with the power to direct the military after a Congressional declaration of war.

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Congressional Declarations of War

- Congress has only declared war on 5 occasions against 11 countries
  - War of 1812: Great Britain
  - Mexican-American War: Mexico
  - Spanish-American War: Spain
  - WWI: Germany, Austria-Hungary
  - WWII: Japan, Germany, Italy, Bulgaria, Hungary, Romania

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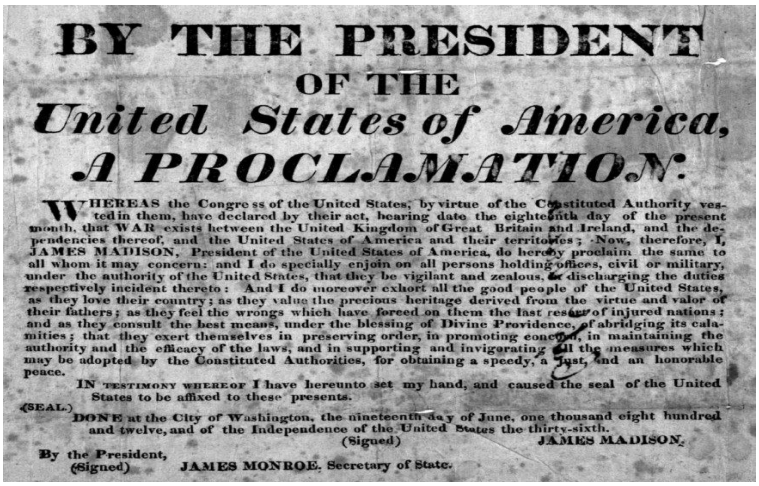
Congressional Declarations of War



BY THE PRESIDENT
OF THE
United States of America,
A PROCLAMATION.

WHEREAS the Congress of the United States, by virtue of the Constituted Authority vested in them, have declared by their act, bearing date the eighteenth day of the present month, that WAR exists between the United Kingdom of Great Britain and Ireland, and the dependencies thereof, and the United States of America and their territories; Now, therefore, I, JAMES MADISON, President of the United States of America, do hereby proclaim the same to all whom it may concern: and I do specially enjoin on all persons holding offices, civil or military, under the authority of the United States, that they be vigilant and zealous, in discharging the duties respectively incident thereto: And I do moreover exhort all the good people of the United States, as they love their country; as they value the precious heritage derived from the virtue and valor of their fathers; as they feel the wrongs which have forced on them the last resort of injured nations; and as they consult the best means, under the blessing of Divine Providence, of abridging its calamities; that they exert themselves in preserving order, in promoting concord, in maintaining the authority and the efficacy of the laws, and in supporting and invigorating all the measures which may be adopted by the Constituted Authorities, for obtaining a speedy, a just, and an honorable peace.

IN TESTIMONY WHEREOF I have hereunto set my hand, and caused the seal of the United States to be affixed to these presents.

(SEAL.)

DONE at the City of Washington, the nineteenth day of June, one thousand eight hundred and twelve, and of the Independence of the United States the thirty-sixth.

(Signed) JAMES MADISON.

By the President,
(Signed) JAMES MONROE, Secretary of State.

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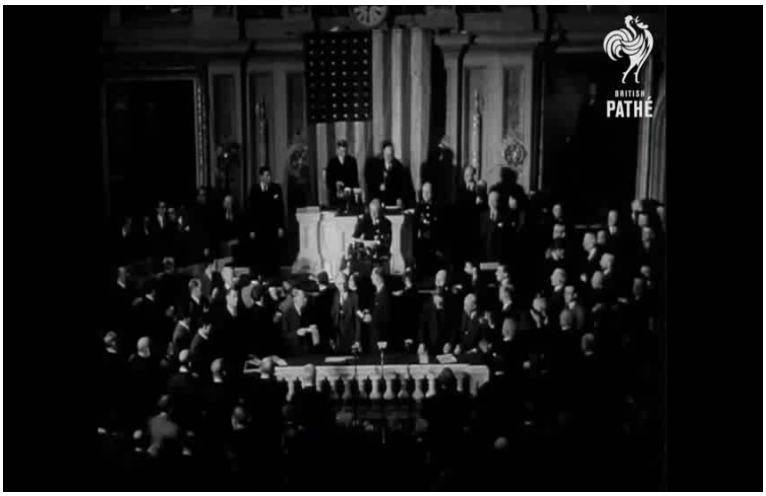
FDR Declares War on Japan



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Bas v. Tingy, 4 U.S. 37 (1800)

- One of the earliest cases to address what constitutes a "war."
- Held the naval conflict with France from 1798 to 1800 constituted a "war."
- Conflict was an "external contention by force, between some of the members of the two nations, authorized by the legitimate powers."

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Expansion of What Constitutes a War

Courts have found the following to constitute a war:

- **Blockade**: *The Amy Warwick,* 67 U.S. 635, 670 (1862)
- **Rebellion**: *Dole v. Merchants' Mut. Marine Ins. Co.,* 51 Me. 465 (1863)
- **Conflict between US and Native American tribe**: *Montoya v. United States,* 180 U.S. 261, 270 (1901)
- **Offensive Entry** (i.e., Kuwait, Afghanistan, Iraq): *Dellums v. Bush*, 752 F.Supp. 1141, 1146 (D.D.C. 1990)

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Interpreting the Meaning of "War"

Three Doctrines: Developed during WWII

1. Technical Meaning
2. Common Meaning
3. Inherently Ambiguous

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Is the Loss Covered?

Ambiguous Scenarios:

1. Loss occurs prior to the formal declaration of war;
2. Loss occurs after the cessation of hostilities, but prior to the official termination of the war;
3. Loss occurs in hostilities that are never formalized by a declaration of war; and
4. Loss occurs after the cessation of hostilities that were never formalized by a declaration of war.

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Korean War / Suez War

- After the Korean War, courts began adopting common meaning doctrine as chosen method of interpretation.
- *Shneiderman v. Metro. Cas. Co. of N.Y.,* 14 A.D.2d 284 (N.Y. 1961) (Suez War conflict constituted a war under the exclusionary clause, but held that the beneficiary was entitled to benefits because the journalist died four days after the warring nations had agreed to a cease fire).

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Vietnam War

Expansion of the Definition of "War" in the Policy

- Undeclared war
- Warlike Conditions
- Warlike Operations

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ISO Coverage Form: War Exclusion

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Earlier Case Law on Terrorism Incidents

- *Pan American World Airways v. Aetna Casualty and Surety Co.,* 505 F.2d 989 (2d Cir. 1974).
- PFLP hijacks aircrafts over London; destroyed in Egypt in 1970.
- Pan American sought coverage from its various underwriters under its all-risk policies.

Pan American Aircraft Hijacked and Bombed

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Pan American World Airways v. Aetna Casualty and Surety Co., 505 F.2d 989 (2d Cir. 1974)

- Second Circuit rejects insurers' reliance upon the war exclusion. Rationale:
  - PFLP not recognized by any nation state.
  - PFLP were agents of a radical political group, not a sovereign government.
  - PFLP receiving financial support from several states does not give it the status of "quasi-sovereign."
  - PFLP's own rhetoric ("at war with the entire Western World") does not change the practical realities of the group.

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Holiday Inns Inc. v. Aetna Ins. Co., 571 F.Supp. 1460 (S.D.N.Y. 1983)

- Beirut hotel damaged by bombings in 1975-1976.
- Insurer: damage precluded because caused by "insurrection, civil war, and war."
- S.D.N.Y. rejects argument; finds that damage was caused by a series of factional "civil commotions," of increasing violence.

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Application of the War Exclusion in an Age of Terrorism

September 11, 2001

- President George W. Bush: Declares 9/11 was an "act of war."
- Would the insurance industry invoke the war exclusion to preclude coverage?
- US House Financial Services Committee issues opinion letter to NAIC.

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Application of the War Exclusion in an Age of Terrorism

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September 11th Litigation

- No reported cases of an insurer asserting war exclusion to preclude coverage.

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In re Sept. 11 Litig., 931 F.Supp.2d 496 (S.D.N.Y. 2013), aff'd, 751 F.3d 86 (2d Cir. 2014)

- One case addressed the analogous act-of-war defense in CERCLA.
- Owner of building near the World Trade Center Towers brought an action under CERCLA for cleanup and abatement expenses for removing pulverized dust after the collapse of the World Trade Center Towers.
- American Airlines, United Airlines and their insurers asserted the CERCLA act-of-war defense in arguing that they did not owe the building owner cleanup and abatement expenses under CERCLA.

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In re Sept. 11 Litig., 931 F.Supp.2d 496 (S.D.N.Y. 2013), aff'd, 751 F.3d 86 (2d Cir. 2014)

- Court found that the airlines and their insurers did not qualify as an "owner or operator" of the hazardous substances or any "other responsible person[s]" for the release of a hazardous substance, and therefore, could not be sued under CERCLA.
- However, the court did find that, even if these entities could be sued under CERCLA, the act of war defense would be applicable in precluding liability and/or coverage.

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After September 11th

- Insured losses totaled $32.4 billion
- Reinsurers begin to exclude terrorism from coverage in January 2002
- ISO drafts and NAIC approves terrorism standard exclusion for liability and property insurance
- 45 states and D.C. approve

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Federal Terrorism Risk Insurance Program

- Congress enacts Terrorism Risk Insurance Act of 2002
- Series of reauthorizations in 2005, 2007 and 2015
- Backstop for Insurers

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Federal Terrorism Risk Insurance Program

- Certain lines of property and casualty insurance must participate and cannot exclude terrorism
- ISO forms track statute
- Government reimburses insurers after they pay a certain amount of claims
- 2017: Government share of losses = 83%

  Aggregate insurance industry losses needed to trigger government reimbursement = $140M
- $100B cap on government contribution

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Federal Terrorism Risk Insurance Program

- Requires certified act of terrorism
  - Violent act that is dangerous to U.S. life, property or infrastructure
  - Part of an effort to coerce U.S. population or policy
  - Aggregate property and casualty losses > $5M
  - Not part of a war declared by Congress

Boston Marathon Bombing - 2013

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Standalone Terrorism Insurance

- Typically does not require certified act of terrorism
- Broader coverage terms, wider geographic area, high limits
- Terms up to 3 years

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Nuclear, Biological, Chemical and Radiological Terrorism

- Not covered by Federal Terrorism Risk Insurance Program
- Nuclear Exclusions and Pollution Exclusions are ubiquitous
- Some standalone NBCR coverage is available

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Cyberterrorism

- Federal Terrorism Risk Insurance Program is silent
- It is possible that a cyberterrorism event could be certified, but
  - Property policies require damage to tangible property
  - General liability policies have not consistently been held to apply to cyber events
  - Professional liability policies are not part of the Program

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Judicial Interpretation

- Jerez v. Republic of Cuba:
  - Acts of torture in Cuba did not result in damage in U.S. or attempt to coerce U.S.
- Miscellaneous cases on 2002 exclusions and whether tenants or borrowers had to buy terrorism insurance

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Judicial Interpretation – Pending Case

- Universal Cable Productions LLC v. Atlantic Specialty Ins. Co.
  - Entertainment companies sued production carrier after they moved TV production from Israel when rockets were fired from Gaza Strip
  - May interpret war exclusion and terrorism coverage

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Questions?

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How Are Building Product Class Actions Weathering?

2017 Annual Meeting
May 11-12, 2017
Chicago, IL

Janet R. Davis
Lee H. Ogburn
Timothy W. Burns

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Building Product Class Actions

- Historical Overview of Predominance Requirement
- Current State of Building Product Class Actions
- Duty to Defend Considerations
  - When is the duty to defend triggered?
  - Allocation of defense costs
  - Impact of covered and uncovered claims

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Class Actions' Predominance Requirement

- Rule 23(b)(3) permits class certification if questions of law or fact common to class members predominate over questions affecting only individual class members.
- *Amchem Prod., Inc. v.* Windsor (1997)
  - Supreme Court holds certified class settlement did not meet Rule 23(b)(3) predominance requirement due to individual nature of class members' asbestos bodily injury damages.

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Class Action Predominance Trilogy

- Supreme Court, led by Justice Scalia, followed *Amchem* in rejecting proposed settlement classes finding individual damages determinations and proposed damages model could not be applied on class-wide basis.
- *Wal-Mart Stores, Inc. v. Duke* (2011)
- *Comcast Corp. v. Behrend* (2013)

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Current State of Building Product Class Actions

- In spite of *Amchem*, increase in building product class actions since 2000.
- Cause is use of mass-produced products—often untested—in residential housing leading to construction defect class actions.
- Why do class counsel continue to file in spite of Predominance Trilogy?
  - Non-trivial number of classes have been certified.
  - Rewards are great for class counsel if they prevail on certification.

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The 7th Circuit Knows Best?

- 7th Circuit does not find Class Action Predominance Trilogy impediment to class cert in building product class actions
- *In re IKO Roofing Shingle Products Liability Litigation* (Easterbrook, 2014)
  - District court mistaken that "commonality of damages" is legally indispensable.
- *Butler v. Sears* (Posner, 2013, *cert denied* 2014)
  - "It would drive a stake through the heart of the class action device…that every member of the class have identical damages."

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Not So Fast, 7th Circuit…

- D.S.C. rules against certification in two Pella MDL cases
  - *Romig v. Pella* and *Naparala v. Pella* (June 3, 2016)
  - Proposed classes met Rule 23(a) requirements of ascertainability, numerosity, commonality, typicality, and adequacy of class representation.
  - But class cert denied based on finding that individual issues re causation and damages predominated over common liability issues.

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Not So Fast, 7th Circuit…

- D. N.J. denies class certification in "shingle" case
  - *Stern v. Maibec, Inc.* (March 2017)
  - Maibec opposition to class cert cites numerous cases denying class cert and finding that multiple individualized issues defeat predominance.
  - Maibec cites authority for the proposition that the trend is against certification of building product classes.

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Class Certified? Settlement Imminent…

- Bifurcation of class action trial where common question of liability but individual damages.
- But few cases make it to Phase 2—most cases settle after certification so not much of a roadmap for trials of building product class actions.

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Duty To Defend Considerations

1. Does the duty exist?
    a. The alleged conduct of the insured.
    b. The relief sought.
2. Allocation of defense costs.
3. Who defends these cases?
4. Who selects counsel?

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The Conduct of the Insured

- Class counsel will (almost) always allege non-intentional conduct
  - But you never know, early *Pella* complaint
- If unintentional wrongful conduct alleged: the defective workmanship rationale applies:
  - If consequential damage is alleged, unintentional conduct is almost always an "occurrence"
  - If no consequential damage is alleged, the "occurrence" rule applies, but it doesn't matter – "your product" exclusion
- In a minority of states, even consequential damage may not be caused by an "occurrence":
  - Pennsylvania
  - Wisconsin
  - Anywhere else?

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The Relief Sought

- Two categories of relief for insurance purposes:
  - Just replacement of the allegedly defective product
  - Replacement of the product *plus* damages for consequential damage

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Replacement of Product

- Typically, no potential for coverage
  - The "your product" exclusion
  - No "property damage"
    - *Pozzi*
    - *Moore & Associates*

- But, what about damage caused by replacement?
  - Typically "rip and tear" and not covered

- But better check
  - *Buckhorn v. Lumbermens,* 1988 WL 106624 (Ohio App.)

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Replacement Plus Consequential

- Typically, allegations of consequential damage create the potential for coverage, but
  - *Kvaerner* and *Gambone* in Pennsylvania
  - *Kolbe & Kolbe* in Wisconsin – the "integrated systems" doctrine

- Indemnity issue:

  If consequential damage is alleged, is "rip and tear" to replace product covered?
  - *Pavarini* and *Carithers* under Florida law
  - *Pella* April 2017 decision

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Allocation of Defense Costs

- Building product class actions concern extended periods of time and multiple triggered policies
- Majority Rule — Time On The Risk
- Equal Shares — Georgia and Minnesota

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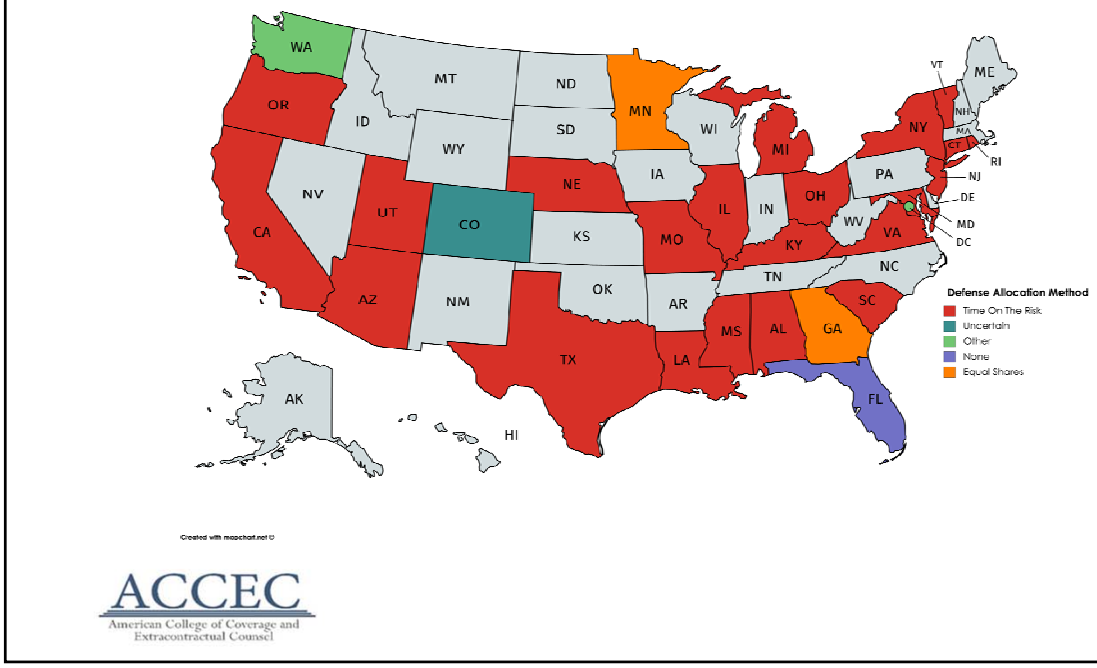

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Defense Counsel

Building Product Class Actions Are Defended By National Firms

- Tamko — Skadden
- Kolbe & Kolbe — Foley & Lardner
- Pella — Faegre Baker Daniels, LLP
- GAF Timberline Defective Roof Shingles — Sullivan & Cromwell LLP
- Goodyear — Ballard Spahr, LLP
- Louisiana-Pacific Corporation — Bingham McCutchen
- Trex Company — K&L Gates LLP
- Barrette Outdoor Living, Inc. — King & Spalding LLP
- Weyerhaeuser Company — Perkins Coie
- Atlas Roofing — Womble Carlyle

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Who Selects Counsel?

- Restatement of the Law of Liability Insurance §16:

  "When an insurer with the duty to defend provides the insured notice of a ground for contesting coverage . . . And there are facts at issue that are common to the legal action for which the defense is due and to the coverage dispute, such that the action could be defended in a manner that would benefit the insurer at the expense of the insured, the insurer must provide an independent defense of the action."

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Certification of Only Uncovered Claims

- Does the certification order terminate the duty to defend?
  - *Del Web Coventry Homes, Inc. v. National Union Fire Ins. Co., 2014 WL 7639486 (C.D. Cal. Nov. 19, 2014)*
- What if covered individual claims remain in the lawsuit?
  - *Universal Underwriters Ins. Co. v. CARSDIRECT.COM*, 2003 WL 22669016 (C.D. Cal. Oct. 28, 2003)
  - *Restatement of Law of Liability Insurance § 13(1)*

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Certification of Only Uncovered Claims

- Terminating events and certification orders
  - *Restatement of Law of Liability Insurance § 18(1)-(8)*
  - *Del Web Coventry Homes, Inc. v. National Union Fire Ins. Co., 2014 WL 7639486 (C.D. Cal. Nov. 19, 2014)*
- Does the potential for liability still exist?
  - What will the release in the settlement agreement include?

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"FOOD RECALL INSURANCE"
KEEPING IT FRESH

2017 Annual Meeting

May 11-12, 2017

Chicago, IL

Suzan F. Charlton, Covington & Burling LLP

Julia Molander, Cozen O'Connor

Arthur S. Garrett III, Keller and Heckman LLP

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OLIVER IN 21ST CENTURY AMERICA

- "Food Poisonous Food" or "Is Gruel the better option?"

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Food poisonous food

You don't want to try it

Three recalls a day

The FDA diet

Listeria, e coli

What next is the question?

Could it be food poisoning,

Or indigestion?

Food poisonous food

Your client's big downfall

Try not to get sued

Maybe just a recall

One undeclared allergen

Or campylobacter

Ingredient suppliers

Could be a factor!

Food poisonous food

Could there be insurance?

Insurers are screwed

If there's an occurrence

Don’t be a mere processor

“Your work” is exclu-ded

Food!

Dangerous food!

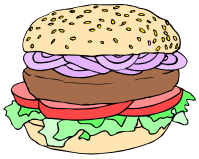
Hazardous food!

Poisonous food!

RECENT FOOD CONTAMINATION SITUATIONS

- Spinach
- Pomegranates
- Peanuts
- Chicken
- Pistachios
- Cumin
- Ice Cream

- **Soft Cheese**
- **Peanut Butter**
- **Ground Beef**
- **Parsley**



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FOOD RECALL INSURANCE

- What is "Food Recall Insurance?"
  - A Comprehensive Insurance Program Tailored for a Food Company
    - Manufacturer
    - Supplier
    - Retailer
    - Co-Packer
  - The Program includes: GL Insurance, Property, D&O, Product Contamination (Recall) Insurance

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CGL, Property and D&O Coverage

Traditional Insurance

- CGL
- Property Coverage
- D&O

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CGL, Property and D&O Coverage

CGL

- "Bodily Injury"
  - Sickness due to Contamination
- "Property Damage"
  - Incorporation of a tainted ingredient into an otherwise unadulterated food could be enough to cause "property damage"
- Exclusions
  - Contamination
  - "Business risks" (your work/product, impaired property, *recall)*

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CGL, Property and D&O Coverage

Commercial (First-Party) Property

- If the company can show "physical injury to tangible personal property" then it could be entitled to recover via different valuation approaches
- What if the recalled product has not yet suffered "physical injury"? Are costs associated with the recall or decontamination efforts covered?

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CGL, Property and D&O Coverage

D&O

- Follow-up by FDA/DOJ

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PRODUCT CONTAMINATION INSURANCE

PCI - Basic Coverage for Accidental Contamination

- Business Interruption
- Lost Gross Profit
- Rehabilitation Expenses
- Crisis Management/Consultants
- Recall Expenses
  - Transportation/disposal of product, replacement product, additional personnel/overtime, expenses for rental of warehouse space for storage, notification to third parties, combing supermarket shelves to remove contaminated product, cleaning equipment, laboratory analysis

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PRODUCT CONTAMINATION INSURANCE

What Triggers Coverage?

- ~~voluntary recall of product~~
- ~~mandatory, government-ordered recall of product~~
- ~~recall due to possibility that product might cause serious adverse health consequences or death~~
- recall because of known or suspected defect … which has caused or is reasonably expected to cause bodily injury or physical injury to tangible property other than your product.

Costs

- Business Interruption
- Lost Gross Profit
- Rehabilitation Expenses
- Crisis Management/Consultants
- Recall Expenses
  - Transportation/disposal of product, replacement product, additional personnel/overtime, expenses for rental of warehouse space for storage, notification to third parties, combing supermarket shelves to remove contaminated product, cleaning equipment, laboratory analysis

PRODUCT CONTAMINATION INSURANCE

- Trigger is the key
  - Policies only apply to recalls necessary when the policyholder's contaminated food "has resulted in or would result in bodily injury" or property damage. . .
  - Or as at least one policy puts it, "may likely result in bodily injury" or property damage . . .

Endorsements

- Government Recall Endorsement
- Adverse Publicity Endorsement
- 3rd-Party Recall Liability Provision
- Product Refusal Provision

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THE PURCHASE/SALE OF A PCI POLICY

- What is the recall policy's conceptual framework?
- Part of a business package policy?
- "Liability" coverage for first-party losses?
- "Bare bones" coverage with added coverage by endorsement?
- Types of insured events covered?
- Types of damages covered?

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THE PURCHASE/SALE OF A PCI POLICY

- What claims services does the insurer provide?
- Crisis Management/PR/Customer Contact?
- Accounting and Legal?
- Warehousing/Product Destruction/Reclamation?
- Food Safety Specialists for Identifying Root Causes of Contamination?

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THE PURCHASE/SALE OF A PCI POLICY

- What are the co-insurance arrangements?
- Is there an SIR or a deductible?
- What part of the loss satisfies the deductible?

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THE PURCHASE/SALE OF A PCI POLICY

- What must be disclosed in the application?
- Prior contamination?
- Failure to take corrective measures?
- Knowledge (objective/subjective) of executives?

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THE RECALL/FOOD CONTAMINATION CLAIM

- How does the insured present the loss?
- Notice to the insurer before the actual recall?
- Are there crisis management consultants as part of coverage? Sublimits? Outside the SIR?
- Are there forensic accountants as part of coverage? Sublimits? Outside the SIR?

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THE RECALL/FOOD CONTAMINATION CLAIM

- What should be the insurer response to a covered loss?
- Does the policy have limits on the range of loss categories?
- Are there some losses cannot immediately be calculated, like loss of market share?
- How does the policy evaluate the monetary loss of returned product?
- Does the policy compensate for loss of goodwill, bad publicity?
- How are gross and net profits defined in the policy?

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THE RECALL/FOOD CONTAMINATION CLAIM

- Are there subrogation opportunities?
  - Pomegranate Case Discussion (*TFI v. Goknur*, 2017 Fed. Dist. Ct., California)
- Should the insurer pay first and subrogate?
- If there are losses outside of coverage should the insured pursue and then seek to collect the covered losses from the insurer?
- How do the insurer and the insured work together to keep from trampling on each other's recovery rights as against third parties?

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THE RECALL/FOOD CONTAMINATION CLAIM

- How does the insurer respond to uncovered/questionably covered losses?
- Were there prior incidents of contamination?
- Would it be appropriate to hire an expert early?
- Was the claim timely made and reported?
- Was a voluntary recall reasonable if not compelled by a governmental agency?

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DISCUSSION

- Should insurers attempt to standardize their specialty recall offerings? Advantages and disadvantages?
- Inconsistency in coverage triggers, particularly re actual contamination requirement and actual (or likely? or possible?) bodily injury requirement.
- To the extent that coverage is not standardized and may be negotiable, what would be your top tips for policyholders at application/renewal time when negotiating coverage for recall incidents?
- Advice for claims: Issues with adjustment and documentation requirements?
- "Additional insured" and Subrogation issues when multiple parties in the food chain are involved?

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PRACTICAL TIPS WHEN PURCHASING RECALL/CONTAMINATION INSURANCE

- Negotiating with the PCI insurer to soften the government recall coverage trigger from "mandate" to "recommendation"
- Negotiating the "other insurance" provision with the primary CGL carrier so that the insured's carrier responds on behalf of the insured in the event of an outbreak and not the supplier's carrier on which policy the insured is an additional insured
- Disclosures during application/renewal process
- Consistency between primary and umbrella/excess terms

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Master Class: Bad Faith Trial Tactics

Christopher W. Martin
Martin, Disiere, Jefferson & Wisdom
Houston, Texas

Michael Huddleston
Munsch, Hardt, Kopf & Harr
Dallas, Texas

Joyce C. Wang
Carlson, Calladine & Peterson
San Francisco, CA

Barbara A. O'Donnell
Zelle, McDonough & Cohen
Boston, MA

Deposition Issues

- Company Witnesses
- Policyholders

Written Discovery

- E-Discovery Issues
- Shotguns vs. Rifles
- Attorney Fee Discovery

"Institutional" Discovery

- Bonus Plans
- Training Programs
- Post-Claims Underwriting
- Staffing
- CAT Operations
- IA Compensation
- Claims Experts: frequency & compensation
- Document Retention Program
- "Discovery on Discovery"

"Institutional" Discovery

- General Contractor Overhead & Profit
- Depreciation Standards
- Coinsurance Penalty Calculations
- Sales Tax Calculations
- UM/UIM Waivers
- Pricing Guides
- Customer/DOI Complaints (or Logs)
- Other Bad Faith Lawsuits
- Carrier Computer Data

"Institutional" Discovery

- Strategic Considerations
- "Framing" the Issues
- Trial Implications

Witness Prep Issues

- Depo "School"
- Trial Prep Differences

Bifurcation?

- Strategic Considerations
- Trial Implications

Multiple Defendant Cases

- Co-Counsel Issues
- Adjusters/Agents as Trial Defendants

Technical Experts

- Designation & Depo Issues
- Trial Uses & Abuses

Bad Faith Experts

- Do They Ever Make a Difference?
- Proper Strategic Uses

Mock Jury Considerations

- Limited Issue Inquiries
- "Filter" Identification
- Witness & Damage Assessments

Jury Questionnaires

- ALWAYS ask.
- Brevity is Key.
- Content Issues: Don't Ask Panel What You Now Know

Witness Prep Issues For Trial

- Differences with Depo Prep
- The Order of Testimony -- Prepping to be Crossed First
- The Structure of Testimony: Think "Rebuttal"

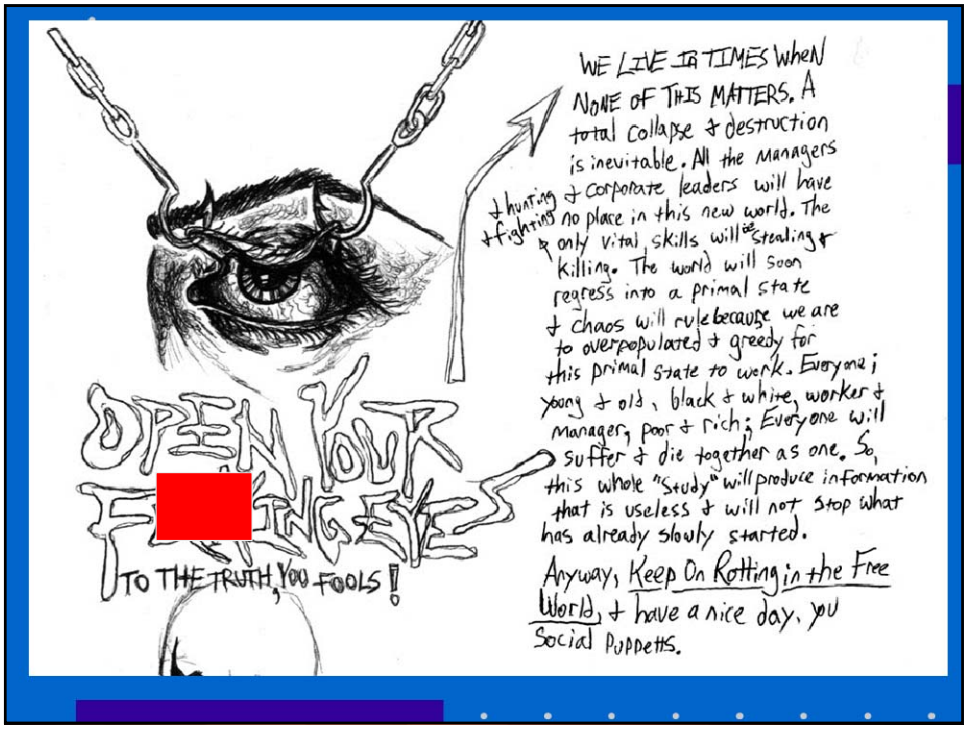
Bad Faith Case Themes

- You Need One.
- Proper Use of Case Themes

The Danger of Biased Stereotypes

"The Baptists are more hopeless than the Presbyterians. They too are apt to think the real home of all "outsiders" is Sheol, and you do not want them on the jury, and the sooner they leave the better… If chance sets you down between a Methodist and a Baptist, you will move toward the Methodist to keep warm."

- Clarence Darrow, *Esquire Magazine*, May 1936, p.48



Frequent Voir Dire Mistakes

- Cross Examination, rather than "Therapy"
- No "Looping"
- Lack of "Range" Questions

Graphics & Trial Technology

- Electronic Exhibits
- Effective Use of Demonstratives
- The Abuse of Video Depositions?

Dealing with "Bad Facts?"

- Own them & Integrate
- Cover early – voir dire, opening statement
- Address on direct examination
- Create true context for processing "bad facts" or "bad" documents

Swaying Unsympathetic Jurors

- Take the offensive
- Direct your experts to answer the unasked questions of the skeptics.
- Reframing the "Justice" Issue

Trying The Institutional Bad Faith Case

- Turning the Tables: "Go Big"
- Re-Focusing the Jury: What's Really at Issue
- Re-Focusing the Jury: Don't Forget the Plaintiff
- Unique Witness Issues

ATTORNEYS FEES RECOVERY

ACCEC Annual Meeting
May 11, 2017

Robert D. Allen, The Allen Law Group
Nicholas Nierengarten, Gray Plant Mooty
Sara M. Thorpe, Nicolaides Fink Thorpe Michaelides Sullivan LLP

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Introductions

- Robert D. Allen, The Allen Law Group
- Nicholas Nierengarten, Gray Plant Mooty
- Sara M. Thorpe, Nicolaides Fink Thorpe Michaelides Sullivan LLP

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Attorneys Fees Recovery
- Overview of Presentation

- Coverage for attorneys fees awarded against insured
  - Damage
  - Cost and the Supplementary payment provision
- Defense costs recovery where disputed
  - Reasonable and necessary
- Coverage for attorneys' fees incurred seeking insurance coverage
  - By contract, statute, case law
  - When there is "bad faith"

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Hypothetical

- Insured, a real estate developer, sued for construction project where siding selected for the homes is graying and peeling because it was not the correct siding for the area and conditions.
- Contract between developer and owners of the homes has attorneys fee provision – fees to be paid to prevailing party.
- Insured loses the case. Found to have used wrong siding for the conditions so homes are unsightly and have to be completely re-sided.
- Homeowners awarded their attorneys fees of $1.5 million.
- Insured has general liability insurance. Insurer refused to defend. Insured selects defense counsel.
- Insurer refused to pay judgment claiming no property damage.
- Insured sued insurer for coverage for defense and judgment.

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Right to Attorneys Fees

- American Rule: each party bears its own attorneys' fees in litigation
- Only exceptions are a contract, statute, rule, or case law authorizing the shifting of legal fees from the prevailing party to the losing party

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Right to Attorneys Fees

- Contract – parties agree that, if there is a dispute, prevailing party can recover attorneys fees, e.g.,
  - Landlord – tenant
  - Construction project
  - Real estate

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Right to Attorneys Fees

- Statutory (statutes and rules), for example, in Texas:
  - Tex. Civ. Prac. & Rem. Code §37.001 (breach of contract)
  - Tex. Civ. Prac. & Rem. Code §38.009 (state court declaratory judgment actions)
  - Tex. Ins. Code §541.152 (unfair claims handling practices)
  - Tex. Ins. Code §542.541 (breach of prompt payment of claims)
  - Tex. R. Civ. P. 91a (actions not based in law or in fact)
  - Fed. R. Civ. P. 37(b)(2)(C) (federal court discovery sanctions)

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Right to Attorneys Fees

- Case law
  - Recovery of attorneys fees to insured seeking coverage if insurer acted in bad faith, *Brandt v. Superior Court,* 37 Cal. 3d 813, 817 (1985)

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Coverage for Attorneys Fees Awarded Against Insured

- Damages or Costs
  - Damages
    - Amounts to compensate party (to put person in place would have been if had not been a breach)
    - Contract provides that in contract dispute, prevailing party entitled to attorneys fees
  - Costs
    - Amounts awarded to prevailing party by statute, e.g., Cal. Civ. § 1033.5(b)(5) (if statute refers to award of "costs and attorney's fees," then attorney's fees are an item of costs)
    - For costs of litigating, rather than item of damage, e.g. *Cutler-Orsi Unified School Dist. v. Tulare Co.,* 31 Cal. App. 4th 622 (1994) (attorney fees awarded under Voting Rights Act "does not compensate the plaintiff for the injury that first brought him into court[;] [i]nstead, the award reimburses him for a portion of the expenses he incurred in seeking ... Relief")

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Coverage for Attorneys Fees Awarded Against Insured

- Damage – hypothetical
  - Construction case
    - Insured lost case and HOA awarded attorneys fees ($1.5 million)
  - Whether what contractor has to pay is covered by his insurance policy depends on whether considered damages or cost, and then whether policy covers this type of damages or these costs

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Coverage for Attorneys Fees Awarded Against Insured

- If Attorneys Fees are Damages
  - Depends on whether covered damages, e.g.
    - Under general liability policy, damages for property damage or bodily injury or advertising or personal injury
    - Under professional liability policy, fall within "damages" definition (which does not include, for instance, return of fees, contractually owed amounts)

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Coverage for Attorneys Fees Awarded Against Insured

- If Attorneys Fees are Costs
  - "Supplementary Payments" provision of policy: "costs taxed against insured"
    - If duty to defend, then duty to pay these costs
  - However, policies may limit this to costs associated with covered claims, e.g., definition in Supplementary Payments provision or by endorsement only pays for costs associated with covered claims

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Defense Costs Recovery

- Hypothetical
  - Insurer refused to defend contractor
  - Issues
    - Rates
    - Billing practices (e.g., “block billing”)
    - “Overhead” (e.g., clerical, bate stamping, in-house conference)
  - Tension-producing: deductions, audits

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Defense Costs Recovery

- Standard
  - Reasonable
  - Necessary to insured’s defense
- Documentation
  - Explanation as to reasonableness
- Use of expert

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Coverage for Attorneys Fees Incurred Seeking Insurance Coverage

- Again, American rule, so only when allowed by contract, statute, rule, case law
- Contract versus extra-contractual obligation
  - Remedy for insurer's breach of contract
    versus
  - Remedy only if insurer acted in "bad faith"

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Coverage for Attorneys Fees Incurred Seeking Insurance Coverage

- Hypothetical – construction case
  - Suit to obtain coverage (attorneys fee award, damages awarded to HOA, defense costs)
  - Also right to attorneys fees incurred in pursuing coverage?

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Coverage for Attorneys Fees Incurred Seeking Insurance Coverage

- Contract – rarely (never?) are attorneys fees provided for in the insurance policy

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Coverage for Attorneys Fees Incurred Seeking Insurance Coverage

- Breach of contract, e.g., (hypothetical) – by statute, rule, case law, e.g.:
  - Texas statutes
  - Washington – *Olympic Steamship Co. v. Centennial Ins. Co.*, 811 P.2d 673 (Wash. 1991)

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Coverage for Attorneys Fees Incurred Seeking Insurance Coverage

- Requires bad faith (breach is not enough)
  - California – *Brandt v. Superior Court,* 37 Cal. 3d 813, 817 (1985)

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Coverage for Attorneys Fees Incurred Seeking Insurance Coverage

- Procedural issues
  - During trial (by jury)
  - Post-trial (by Judge)
- Burden of proof
- Standard
  - "Lodestar"
  - Reasonable and necessary
  - Not to prove "bad faith"

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Coverage for Attorneys Fees Incurred Seeking Insurance Coverage

- Insurer arguments
  - Rates
  - Failure to segregate between covered/non-covered
  - Duplicative, block billing, vague
- Policyholder arguments
  - Estoppel to contest due to breach of duty to defend

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Thank you

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Allocating the Defense: Two Perspectives on *Arceneaux* and Beyond

2017 Annual Meeting

May 11-12, 2017

Chicago, IL

Laura A. Foggan, Crowell & Moring LLP

Jay Russell Sever, Phelps Dunbar LLP

Martin C. Pentz, Foley Hoag LLP

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The *Arceneaux* Decision

- In 2016, in *Arceneaux v. Amstar Corp.*, the Supreme Court of Louisiana addressed whether and how the cost of defense ought to be allocated among multiple insurers in a long-tail exposure claim covered by commercial general liability ("CGL") insurance.
- The insured, American Sugar Refining, Inc., was sued by approximately 100 former employees. The former employees alleged that they were exposed to loud noise while working for American Sugar and suffered resulting hearing loss. The exposures allegedly occurred during various years from 1941 until 2006.
- The insurer, Continental Casualty Company insured American Sugar from 1963 to 1978, although bodily injury to employees was excluded for most of this period, excepting only some 26 months during the period 1975 to 1978. Continental thus was on the risk for about 26 months out of more than 60 years of exposure, and American Sugar evidently had no coverage for much of the remaining time.

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The *Arceneaux* Decision

- American Sugar sought full coverage of its past defense costs and asked Continental to provide a complete defense going forward.
- Continental agreed to pay only 25% of the defense (subject to a full reservation of rights) on a theory that responsibility for defense costs should be prorated across the full period of exposure.
- The Continental policy employed widely-used wording for the pertinent definitions:
  - "Bodily injury" was defined as "bodily injury, sickness or disease sustained by any person which occurs during the policy period, including death at any time resulting therefrom."
  - "Occurrence" was defined as "an accident, including continuous or repeated exposure to conditions, which results in bodily injury or property damage neither expected nor intended from the standpoint of the insured."

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The *Arceneaux* Decision

- The Supreme Court of Louisiana noted that "there appears to be no Louisiana precedent on the precise issue the court is presented with in this case, which is whether an insurer's duty to defend may be prorated among insurers and the insured during periods of self-insurance in long latency disease cases."
- The Court held that Continental would only be liable for its pro rata share of American Sugar's defense, based strictly on Continental's time on the risk, which was about 3.3% and 3.7% in the two cases addressed by the appeal.
- Among other reasons, it observed that the policy language limited coverage to bodily injury occurring during the policy period, that Louisiana tort law does not include the concept of joint and several liability, and that adopting joint and several liability for defense costs could inappropriately reduce incentives for policyholders to maintain continuous coverage.

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Significance of *Arceneaux:* Insurer Perspective (Foggan/Sever)

- Part of a trend by courts across the country toward a more equitable system of allocating defense costs in long latency injury claims.

- In reaching the conclusion that pro rata is more appropriate than the joint and several allocation method for defense, these courts tend to focus on the following factors:
  (1) policy language/contract interpretation;
  (2) reasonable expectations;
  (3) equity/public policy; and
  (4) judicial economy.

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Significance of *Arceneaux:* Insurer Perspective (Foggan/Sever)

Policy language/contract interpretation:

The *Arceneaux* court recognized that the policy language itself limited "coverage for bodily injury to that which occurs during the policy period."

Moreover, the courts have discounted the "all sums which the insured shall become legally obligated to pay as damages" language — *i.e.,* the language courts cite to support application of the joint and several allocation method. This language, according to the courts, does not bear the interpretation that the insurer should be liable for injuries that do not occur during the policy period and, consequently, that the insurer should be liable for all defense costs relating to such injuries

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Significance of *Arceneaux:* Insurer Perspective (Foggan/Sever)

Reasonable expectations:

Neither the insurers nor the insured could reasonably have expected that the insurers would be liable for losses occurring in periods outside of their respective policy coverage periods.

More specifically, "[n]o 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." *Boston Gas Co.,* 454 Mass. at 363.

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Significance of *Arceneaux:* Insurer Perspective (Foggan/Sever)

Equity/public policy

In *Arceneaux*, the court explained that a pro rata allocation is "reasonable" because the joint and several scheme "would treat an insured who had uninterrupted policies for twenty years the same as an insured who had a triggered policy for one year." To hold otherwise, would entitle an insured to receive coverage for a period in which it did not pay a premium.

The joint and several liability approach provides a disincentive to insureds to obtain uninterrupted insurance coverage and would result in a windfall to those companies that had broken chains of insurance.

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Significance of *Arceneaux:* Insurer Perspective (Foggan/Sever)

Judicial economy:

The joint and several allocation approach, according to the court, is inefficient in that it does not ultimately resolve the allocation issue. Instead, the issue is postponed and divided into two parts — the policyholder first chooses the triggered insurer to pursue and second, the triggered insurer then sues other insurers for contribution.

As a result, the joint and several approach increases litigation costs, which are then passed on to policyholders via higher premiums, whereas the pro rata approach resolves all coverage and allocation issues in a single proceeding.

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Paying A Pro Rata Share/Reimbursement (Foggan/Sever)

Based on the pro rata allocation method, an insurer is obligated to pay only its share of defense costs attributable to harm that took pace during its policy period.

An insurer that is providing a complete defense to an insured is entitled to reimbursement of defense costs for uncovered claims, including those claims that are not triggered for that policy period or those claims that otherwise are not covered under the terms and conditions of a policy. In support of reimbursement, courts similarly look to the policy language, as well as equity and public policy.

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The Pro Rata Allocation of Defense Costs and its Application to Other Case Types (Foggan/Sever)

Pro rata allocation of defense costs should not be limited to long-tail environmental cases, as the logic underlying it should be extended to apply to any claim involving multiple years of coverage, multiple policies, or gaps in coverage.

Examples of such case types include (but are not limited to):

- construction defect claims,
- products liability claims,
- the non-environmental aspect of oil and gas claims, and
- continuous bodily injury claims (sexual molestation or abuse).

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The Absence of Coverage Has No Impact on a Pro Rata Allocation (Foggan/Sever)

- Under the pro rata allocation approach, an insured's lack of coverage vis-à-vis a coverage denial, uninsured years or a self-insured retention has no bearing on the method of allocation for defense costs.

- To accurately formulate an insurer's pro rata share, the court must take into account **all** years of damage regardless of whether coverage is available to the insured. Such a formulation is the only fair and equitable means of applying this approach.

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Significance of *Arceneaux:* Policyholder Perspective (Pentz)

***Arceneaux* Fails to Address Unique Attributes of the Defense Duty and Offers No Compelling Rationale for "Defense Proration"**

- Ignores unitary nature of duty "to defend."
- Incorrectly assumes proportionality rationale underlying indemnity proration also applies to defense.
- Misapprehends equitable considerations.
- Relies on incentives analysis that does not reflect insurance-purchasing realities.
- Exaggerates supposed "judicial economy" advantage of proration.
- Reflects unique attributes of Louisiana law.

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Significance of *Arceneaux:* Policyholder Perspective (Pentz)

***Arceneaux* Ignores Unitary Nature of Insurer "Right and Duty" to Defend**

- CGL policies provide insurer with "right and duty" to "defend" – not just an obligation to pay or reimburse defense costs or some fractional portion thereof.
- To defend means to retain counsel, investigators and experts, to supervise their activity, to determine strategy, etc. Not something that can be divided into pieces.
- If the policies had contemplated sharing of defense, they would have provided a process and formula for same; how governance happens, how to resolve disagreements. Not addressed.
- Reservation of a "right" to defend, *i.e.*, to control the defense, is valuable to insurers, who sometimes waive reservations to keep it. Conceptually incompatible with proration.

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Significance of *Arceneaux:* Policyholder Perspective (Pentz)

Proportionality Theory Underlying *Pro Rata* Allocation Does Not Apply to Defense

- *Pro rata* theory said to be needed due to infeasibility of fact-based allocation to policy periods; some case law favors fact-based allocation where possible (*Boston Gas*, *PEM*).
- Underlying rationale posits that there is at least a direct relationship between length of exposure and degree of injury, if not a strictly proportional one.
- Same cannot be said of burden of defense undertaking, which is often entirely unrelated to exposure time. *Boston Gas*, 910 N.E.2d at 311 n.38.
- That claimant's exposure was five or ten or twenty years will rarely affect what must be done to defend or how much defense will cost.
- Also, nonsensical to say parties expected defense duty to be allocated when defense is needed at outset of suit – as facts needed for proration will be unknown at that time.

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Significance of *Arceneaux:* Policyholder Perspective (Pentz)

Equitable Considerations Do Not Support Proration Of Defense

- If insurer has "right" to "defend" a mixed claim, then it should not be heard to contend it can fractionalize and convert to partial reimbursement, when "duty" to "defend" arises
- Results of *pro rata* allocation bear no relation to impact of "extra years" on cost of defense
- If equitable principles trump policy language, then *Buss* approach better serves the purpose: Insurer would defend with right to recoup only those defense costs it can show to be *exclusively* attributable to out-of-policy-period injury
- Particularly inequitable to permit assignment of costs to post-exposure periods before manifestation. New injury or disease phenomenon comes to the fore and insurers exclude it; coverage becomes unavailable. Yet, under pro rata theory, if it takes another twenty years for harm to manifest, insurer's "share" shrinks to vanishing with the passage of time.

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Significance of *Arceneaux:* Policyholder Perspective (Pentz)

Reasonable Expectations: Manipulative Insurance Purchasing Scenarios Ring Hollow

- Policyholders should seek to persuade courts to steer clear of speculation about expectations.
- *Boston Gas* musing that no reasonable policyholder would expect a single-year policy to cover decades of exposure is mistaken. That's exactly what a claims-made policy would do, subject only to "retroactive date."
- Policyholders will not deliberately cease purchasing insurance, depending on old policies to cover years of continuing injury.
  - Would leave company with no coverage for accidents taking place, or exposures beginning, in later years.
  - Coverage gaps typically do not arise from purchasing manipulation, but from lost policies, insurer insolvency and unavailability of coverage based on industry-wide exclusions.

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Significance of *Arceneaux:* Policyholder Perspective (Pentz)

Proration of Defense Largely Neutral to Judicial Efficiency

- Assuming insurer contribution rights vis-à-vis defense, so-called re-allocation proceedings can be pursued by third-party complaint in same action.
- "Other Insurance" provisions of CGL policies contemplate methods of sharing. Litigation among insurers may not be necessary.
- *Pro rata* approach, on the other hand, virtually assures policyholder will need to join all insurers "on the risk" in litigation.

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Significance of *Arceneaux:* Policyholder Perspective (Pentz)

Louisiana Supreme Court Holding Expressly Limited in Several Ways:

- "Joint and several" concept not recognized in Louisiana law.
- One concurring opinion attributed the result to the unique context of Louisiana law regarding long latency occupational disease cases. Not clear whether would be extended to property damage or different disease etiologies.
- Expressly tied to wording considered (1973 ISO Standard Provisions); may not be controlling even in Louisiana under other wordings.

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Significance of *Arceneaux:* Policyholder Perspective (Pentz)

Declaration of "Trend" Premature

- Proration of defense costs also recently rejected in *Peabody Essex Museum v. U.S. Fire*, applying the law of a jurisdiction (Massachusetts) that has endorsed proration of indemnity.
- Likewise rejected in states adopting "all sums" extent-of-coverage theory, but expressly premising the ruling as to defense on defense duty "in for one, in for all" precedents *Plastics Eng'g*. (Supreme Court of Wisconsin).
- Neither *Arceneaux* nor *Peabody Essex Museum* grapples with the issue in the sort of depth that is likely to make either a seminal case – such a decision has yet to be rendered.

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Extra-Contractual Liability and the Restatement on Liability Insurance Law

2017 Annual Meeting

May 11-12, 2017

Chicago, IL

Michael F. Aylward, Lorelie S. Masters, Jeffrey E. Thomas

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§ 24 Uses an "Objective" Standard for Settlement Decisions

1) When [the insurer has control over the settlement and there is a potential for an excess verdict] the insurer has a duty to the insured to make reasonable settlement decisions.
2) A reasonable settlement decision is one that would be made by a reasonable insurer who bears the sole financial responsibility for the full amount of the potential judgment.

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Do Insurers have an Affirmative Duty to Initiate Settlement?

d. Applying the reasonableness standard. . . . The duty to make reasonable settlement decisions includes the duty to accept a settlement offer that a reasonable insurer would accept and to make an offer to settle when a reasonable insurer would do so. . . . [2 more paragraphs and 2 illustrations].

f. The insurer's failure to make settlement offers and counteroffers. There is no hard and fast rule regarding the insurer's obligation to make offers. It is a question of what a reasonable insurer would do in the circumstances. In the absence of a reasonable offer by the plaintiff, there are circumstances in which an insurer has a duty to make a settlement offer, such as, for example, a suit in which the policy limits are significantly less than the reasonable settlement value of the case. In such circumstances, the insurer is obligated to attempt to protect its insured . . . . It is important to emphasize, however, that an insurer has no obligation to make an offer unless a reasonable insurer that bore the sole financial responsibility . . . would do so, and there may be good reasons not to.

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§ 51 Adopts a Subjective Standard for Bad Faith

An insurer is subject to liability to the insured for insurance **bad faith** when it fails to perform its duties under a liability insurance policy:

(a) Without a reasonable basis for its conduct; and

(b) With knowledge of its obligation to perform or in reckless disregard of whether it had an obligation to perform.

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"Bad Faith" Examples (?)

- **Bad faith rejection of settlement** – defense counsel and adjuster agreed that settlement offer should be accepted, but supervisor overrules and declines
- **Inadequate or improper investigation** – Illustration includes a supervisor who "directed [the] investigator to change her report" to reflect that the accident was not the insured's fault.
- **Failure to communicate the settlement offer to the insured** – the insurer wants to fight the claim, or thinks the settlement offer is too high, and believes that insured is on-board (or just doesn't care about insured's view); had insured known, it would have demanded settlement

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§ 52 Bad Faith Damages vs. § 27 Damages for Failure to Settle

- **Bad faith damages**:

(1) The attorneys' fees and other costs incurred by the insured in the legal action establishing the insurer's breach;

(2) Any other loss to the insured proximately caused by the insurer's bad-faith conduct; and

(3) If the insurer's conduct meets the applicable state-law standard, punitive damages.

- **Failure to settle damages**:

An insurer that breaches the duty to make reasonable settlement decisions is subject to liability for the full amount of damages assessed against the insured in the underlying legal action, without regard to the policy limits, as well as any other foreseeable harm caused by the insurer's breach of the duty.

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Concluding Remarks

Discussion

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CHANCES ARE . . . A FORTUITY CASE STUDY

Acme Chemical Inc. v. Zenith Insurance Co.

2017 Annual Meeting
May 11-12, 2017
Chicago, IL

Moderator: Susan B. Harwood
Boehm Brown Harwood, PA

For Acme: Bernard P. Bell
Miller Friel, PLLC

For Zenith: Myles A. Parker
Carroll Warren & Parker PLLC

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Disclaimers

- These are hypothetical loss scenarios presented for purposes of continuing professional legal education, and may not be duplicated, shared or used for any purpose other than presentation at the 2017 Annual Conference of the American College of Coverage and Extracontractual Counsel
- The facts presented are composite scenarios based on reported cases and the authors' experiences across multiple property damage insurance claims involving catastrophic industrial losses. They are of "like kind and quality," but are not factually accurate replicas of specific individual claims

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Acme's Insurance Program and Loss

- Claimant Acme Chemical Inc. ("Acme") purchased a program of "all risks" property insurance
- Acme's coverage is governed by terms of policy issued by Respondent Zenith Insurance Company ("Zenith")
- On January 1, 2010, during policy period, a pressure vessel at an Acme facility ruptured, dispersing flammable process material that ignited, causing an explosion and fire that damaged or destroyed Acme's insured property, and caused an interruption of Acme's business
- Zenith Policy provides that New York law shall govern the interpretation and application of the Policy, and that all disputes shall be resolved through binding arbitration in Bermuda

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Cause and Origin of Acme's Loss

- Acme's loss was caused by rupture of a vessel that resulted from damage to vessel's shell caused by internal corrosion, capable of detection only by recognized internal inspection procedures
- The vessel that ruptured was part of a set of three cylindrical vessels through which process material flowed in sequence
- The vessels were part of a process chain that was designed to, and did, operate under both heat and pressure
- The temperature was highest as the process material entered Vessel A, and then decreased through Vessels B and C

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Cause and Origin of Acme's Loss

- The shell of Vessel A, subject to the highest temperatures, was made with an alloy steel and fully clad internally with stainless steel. These materials are less susceptible to corrosion than carbon steel
- The shell of Vessel B was made largely from carbon steel, except for a few feet at the hotter end where it received effluent from Vessel A and was lined internally with stainless steel
- The shell of Vessel C was made from carbon steel
- At equal temperature and pressure, carbon steel is more susceptible than alloy/stainless steel to the type of internal corrosion that caused Vessel B to fail

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Cause and Origin of Acme's Loss

- The particular form of corrosion that caused Acme's loss is a gradually occurring damage mechanism well-known in Acme's industry
- The two critical parameters on which corrosion attack depends are:
  - Temperature of the shell; and
  - Pressure inside the vessel
- Plotting the combination of these two variables results in curves
- Industry standards are developed from experience and published
- These standards set forth operating conditions under which corrosion damage is expected (or not expected) to occur in different kinds of steel

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Cause and Origin of Acme's Loss

- These curves are adjusted over time to reflect new reports of corrosion damage
- For a given type of steel, combinations of pressure and temperature "below" the curve are considered to be safe
- Similarly, combinations of pressure and temperature "above" the curve are not considered to be safe
- These standards constitute recognized and generally accepted good engineering practices (RAGAGEP)

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Acme's Mechanical Integrity Program

- At the time of loss, Vessel B was 40 years old
- A prior owner designed, constructed and installed the vessels in 1970
- Acme bought the facility in 2000
- Acme relied on third-party corrosion experts to evaluate its equipment
- In 2001, 2006 and 2009, these experts reviewed the metallurgy, operating conditions and process of Vessel B for susceptibility to the corrosion that occurred
- As part of the 2001 review, Acme took a temperature reading at the inlet (hot) end of Vessel B, and the reading was within the range thought to be safe. Acme did not regularly monitor the temperature at the inlet to Vessel B
- Between 2006 and 2009, Acme instituted certain process and operational changes that likely increased the temperature and pressure in Vessel B

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Scenario A:

- None of the three corrosion reviews found that Vessel B was susceptible to this form of corrosion
  - One review erroneously assumed that Vessel B was fully clad in stainless steel
  - This assumption was not corrected
  - Vessel B failed at or near the seam between the cladding and the carbon steel
- Each review recommended that Vessel A, but not B, be internally inspected
- Acme included Vessel A, but not B, in program for internal inspection for this form of corrosion damage
- Acme never internally inspected Vessel B for this form of corrosion damage
- Acme was not aware of damage to Vessel B until post-incident laboratory testing
- If Acme had included Vessel B in its inspection program, it is more likely than not that Acme would have discovered the damage

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Scenario B:

- Following the 2009 review, Acme inspected Vessel B and discovered the corrosion damage
- Acme solicited bids, from three international firms with extensive experience and qualifications in Acme's industry, to repair the damage
- Acme elected to perform the repair in 2009 with its own work force, at considerably less cost than the three bids, but without the same level of expertise
- Acme continued to operate the vessels after the repairs without directly measuring vessel shell temperatures or internal pressures
- Post-incident testing determined that
  - The repairs had failed either to address past damage to Vessel B or to prevent future damage; and
  - Vessel B operated at a combination of temperature and pressure above the curve

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Scenario C:

- Following the 2006 review, Acme inspected Vessel B and discovered the corrosion damage
- Acme conducted certain repairs as a temporary patch, and returned Vessel B to service until final repairs could be made
- Zenith was aware of Acme's 2006 decision to return Vessel B to service and wrote to Acme reserving the right to deny any subsequent claim resulting from the Vessel's return to service on the basis that such loss would not result from a fortuitous event
- Zenith renewed coverage and increased premium in 2007, and renewed coverage each year thereafter
- Vessel B failed in 2010 before final repairs were carried out
- Acme operators complained to management that continued operation with temporary repairs was not safe

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The Fortuity Defense

Policyholder's Perspective

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Fortuity – The Test is Substantial Certainty

- Under New York law, a loss is fortuitous unless the insured:
  - Intended the loss, or;
  - Acted, or failed to act, with knowledge that the loss was substantially certain to result
- Courts sometimes express this standard as acting with knowledge that the loss "would flow directly and immediately from the insured's intentional act"
  - *See National Union Fire Ins. Co. of Pittsburgh, PA v. Stroh Cos.*, 265 F.3d 97 (2d Cir. 2001) (citing *City of Johnstown v. Bankers Standard Ins. Co.*, 877 F.2d 1146, 1150 (2d Cir. 1989).
  - Second Circuit rejected insurer's argument that loss was not "fortuitous" because it was not "beyond the control of either party" within the meaning of N.Y. Ins. Law § 1101(a)(2).

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The Test is Certainty, Not Control

- Some courts applying New York law have relied on New York Insurance Law in determining whether losses are fortuitous.
- Section 1101(a) of that statute defines "fortuitous event" as "any occurrence or failure to occur which is, or is assumed by the parties to be, to a substantial extent beyond the control of either party."
  - Section 1101 properly applies to licensure, not coverage
- Test of fortuity is not properly centered around degree of "control" that an insured exercises over the risk, and reliance on Section 1101 to support such an argument is misplaced
- Non-fortuity requires certainty, and neither insured's control of risk, nor even courting of risk, is sufficient to show non-fortuity.

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The Test Is Certainty, Not Control

- Professor Edwin Patterson was an author of NY Insurance Law

"*The Designing Act of the Insured*.

> . . . But to say that the insurer is not liable if the happening of the insured event was within the control of the insured would be erroneous or at least likely to mislead. Unless control means only designedly causing the insured event, a meaning narrower than the ordinary sense of the word, it includes a great many situations in which the insurer is undoubtedly liable. Thus, a defective chimney is "within the control" of the insured, since it can be repaired; yet fires due to defective flues are covered by the ordinary fire policy. Even if control is narrowed to include only situations of which the insured has knowledge, it is still too broad, since an insured who carelessly put off repairing a known defect in his chimney would not thereby be barred from recovering on his fire-insurance policy.

- Patterson, ESSENTIALS OF INSURANCE LAW 257-58 (2d ed. 1957).

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Loss Resulting From Calculated Risk May Still Be Fortuitous

- "It is not enough that an insured was warned that damages might ensue from its actions, or that, once warned, an insured decided to take a calculated risk and proceed as before . . . Recovery will only be barred if the insured intended the damages . . . or if it can be said that the damages were, in a broader sense, 'intended' by the insured because the insured knew that the damages would flow directly and immediately from its intentional act . . . ."
  - *City of Johnston*, 877 F.2d at 1150 (emphasis added; citations omitted).
- Fortuity doctrine does not bar coverage for *likely* losses, i.e., known enhanced risks. "Even if the risk [of the loss that occurred] was known [by the insured], and known to be high," when the coverage at issue was added to the policy, that would not bar coverage. *Id.*
  - *National Union v. Stroh*, *265 F.3d* at 108 (citing *City of Johnstown)*.

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Loss Resulting From Calculated Risk May Still Be Fortuitous

- "A person may engage in behavior that involves a calculated risk without expecting that an accident will occur – in fact, people often seek insurance for just such circumstances . . . ."
  - *Continental Cas. Co. v. Rapid-American Corp.*, 609 N.E.2d 506, 510 (N.Y. 1993)(citing, *inter alia*, *City of Johnstown*)
- Rockslide example:
  - Rockslide, "while a known risk at the time the [all-risks] policies took effect, was not 'substantially certain to occur,'" and was therefore fortuitous, even though:
    - it involved a sixty-ton boulder falling from a hillside above the insured's store;
    - there had been rockslides before policies' inception, including another sixty-ton boulder falling on the store; and
    - the insured was aware of the geologic instability of the hillside
  - *Wal-Mart Stores, Inc. v. United States Fid. & Guar. Co.*, No. 06-4417/2002, 2005 BL 323, *aff'd in relevant part*, 816 N.Y.S.2d 17, 18 (N.Y. App. Div. 2006) (citing *National Union*, *supra*)

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Burden of Proof

- The insured under an all-risks policy has a "relatively light" burden of showing that its loss was fortuitous
  - *Petroterminal De Panama, S.A. v. QBE Marine & Specialty Syndicate 1036,* 2017 U.S. Dist. LEXIS 7638 (S.D.N.Y. Jan. 19, 2017) (quoting *Int'l Multifoods Corp. v. Commercial Union Ins. Co.*, 309 F.3d 76, 83 (2d Cir. 2002)); *see also Fleet Business Credit, L.L.C. v. Global Aerospace Underwriting*, 812 F. Supp. 2d 342, 354 (S.D.N.Y. 2011).
- Once insured meets that burden, burden shifts to insurer to prove otherwise
- In *National Union*, Second Circuit held that "[t]he initial burden of showing that the loss in question was fortuitous – here meaning that the inevitability of such loss was not known to the insured before coverage took effect – is on the insured party . . . Once that burden is met, the insurer must come forward with evidence showing that 'an exception to coverage applies,' including exceptions based on the non-fortuity or known loss doctrines." *National Union*, 265 F.3d at 109 (citations omitted).

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Applying the Certainty Standard To Hypothetical Scenarios

- Under any of the three scenarios:
  - Absurd to suggest that Acme would knowingly cause an explosion that destroys its property, interrupts its business, and threatens the lives of its employees, including the employees responsible for Acme's mechanical integrity program

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Applying the Certainty Standard To Hypothetical Scenarios

- The industry standards (curves) are developed from industry experience and adjusted over time to reflect new reports of corrosion
- At time of loss, Acme's mechanical integrity program in full compliance with recognized and generally accepted good engineering practices (RAGAGEP) in regard to the vessels
  - After incident, industry standards altered to be more protective
- Acme's mechanical integrity program also in compliance with Acme's own internal inspection practices, which exceeded the requirements of RAGAGEP
- Acme engaged third-party corrosion experts to evaluate the equipment
  - Acme personnel lacked expertise to evaluate all equipment for every potential damage mechanism
  - Acme retained and relied on third parties with superior expertise

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Applying the Certainty Standard To Hypothetical Scenarios

- Scenario A:
  - Acme did not know of the damage that caused the loss
  - That is enough to show that Acme did not know that an explosion would occur
  - Even accepting, in hindsight, that Acme could have discovered the damage does not mean that Acme knew that it was substantially certain that an explosion would occur
- Scenario B:
  - Acme knew of the damage, but thought it was repaired
  - Simply choosing least expensive, and in hindsight, inadequate repair alternative does not mean that Acme knew that it was substantially certain that an explosion would occur

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Applying the Certainty Standard To Hypothetical Scenarios

- Scenario C:
  - Warning letters mentioned "risk" of catastrophic failure or explosion, but did not opine on how likely or how soon
  - So long as failure was a mere risk, even if a heightened risk, it remained insurable
  - Insurer explicitly took into account the possibility of catastrophic failure, and increased premium to account for it, and renewed year after year
    - Letter "reserving the right" to deny claims is not a part of the policy
    - The policy governs the claim, and insurer cannot unilaterally modify policy

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The Fortuity Defense

Insurer's Perspective

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The Starting Point

Fortuity is a required element of policies based on an **"accident"** or **"occurrence"**.

Consol. Edison Co. of N.Y., Inc. v. Allstate Ins. Co., 98 N.Y.2d 208, 220 (N.Y.2002)

Under an all-risk policy, the insured's prima facie case must establish (i) policy existence; (ii) insurable interest; and (iii) **fortuitous loss, i.e., an event happening by chance or accident.**

40 Gardenville, LLC v. Travelers Prop. Cas. of Am., 387 F. Supp. 2d 205, 211 (W.D.N.Y. 2005)

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Why Have the Requirement

In an insurance contract, the parties are making a wager as to the likelihood that a specified loss will occur. If the loss has already occurred, or the insured knows it is certain to occur for undisclosed reasons, then the contract is not a fair bet.

CPH Int'l, Inc. v. Phoenix Assur. Co. of N.Y., No. 92 Civ. 2729 (SS)(NRB), 1994 WL 259810, at *6 (S.D.N.Y. June 9, 1994)

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The Building Blocks for the Defense

New York Ins. Law § 1101: Fortuitous event is an occurrence which is to a substantial extent beyond the **control** of the parties.

Key Component: Insured's Control

Newtown Creek Towing Co. v. Aetna Ins. Co., 57 N.E. 302 (N.Y. 1900): While the insured hoped the vessel would not strike the ice that was all around, he admittedly could not see the ice at night, but proceeded anyway heedless of the risk.

Key Component: Insured's Causative Conduct

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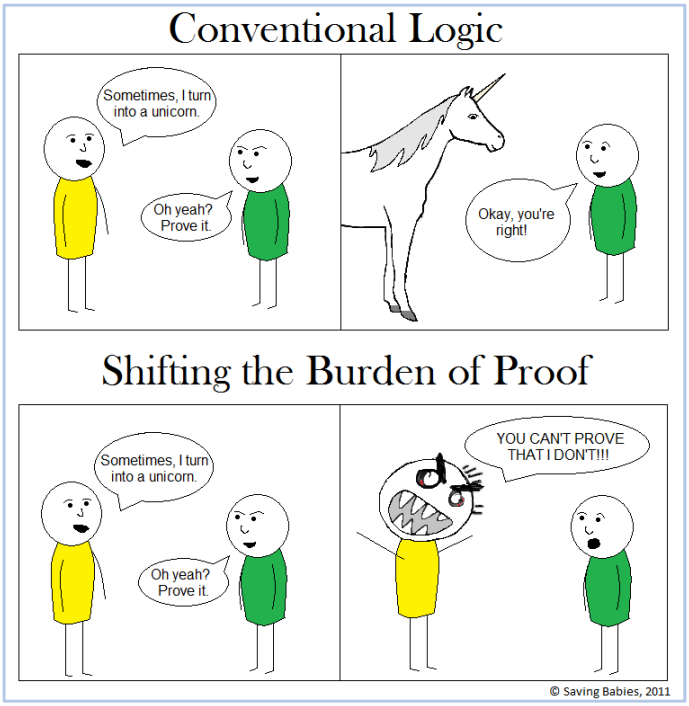
The Burden of Proof



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Catastrophic Loss – Burden of Proof Reality

- Legally – the insured must prove the loss was caused by a fortuitous event, meaning an event happening by chance or accident
- Practically – the insurer must present substantial evidence of the insured's control and causative misconduct
- The insurer must disprove the event was an accident or occurrence by showing the loss was known, planned, intended, or substantially certain to occur

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Meeting the Burden – Critical Fact Development

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Retained Experts Must Analyze

- The maintenance, inspection, and operational history of the equipment
- The cause(s) of the equipment failure
- The insured's non-compliance with controlling internal and industry standards
- The insured's heightened knowledge of the risks or dangers involved
- The insured's deliberate misconduct leading to the loss

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The Immediate Goal – Avoiding Summary Judgment

The denial of summary judgment interjects substantial financial risk for the insured.

The insurer must make the case that a jury could reasonably find that the insured's intentional acts prevent the loss from being attributable to mere chance.

Royal Indem. Co. v. Deep Sea Int'l, 619 F.Supp.2d 14, 22-23 (S.D.N.Y. 2014) (insured's summary judgment on fortuity defense denied where vessel repair was knowingly made in violation of applicable standards and caused ship to sink).

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Now, Turning to Acme . . .

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A Significant Hurdle

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Flying Blind = Intentional Misconduct

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Points to Consider

- Is the collision with the wall an accident
- Is the collision substantially within the insured's control
- Is the decision to fly blindfolded intentional misconduct of the type necessary to prove non-fortuity

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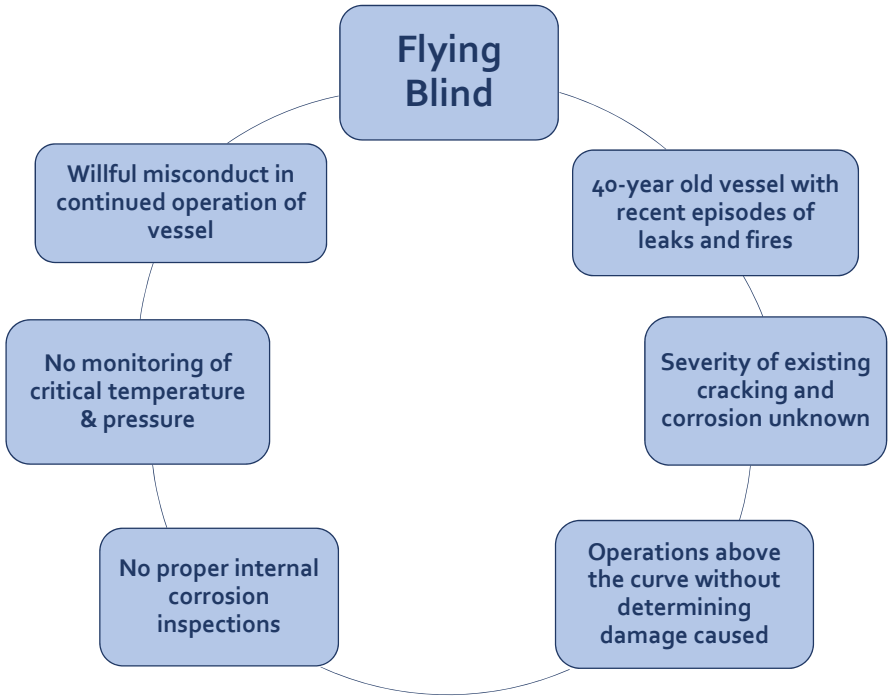
Acme's Decision to Fly Blind



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Deliberate Risk Taking with Known Danger

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Substantial Certainty

- Insurance is not available for loss the insured knows of, planned, intended or is aware is substantially certain to occur
- When the rope burns in half, and the fall occurs, is that fortuitous
- Does continuing the rope walk in the face of known danger with the expectation that a fall will not occur constitute intentional misconduct sufficient to render the fall non-fortuitous

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Applying the Example to Acme's Misconduct

- Deliberately courted known risks to property and personnel – **unacceptable**
- Continued vessel operation with history of fires and volatile leaks without repair – **unacceptable**
- Implemented "accelerated" start-up procedures from 12 hours to 2 hours to mitigate the fires and leaks – **unacceptable**
- Continued vessel operation above the curve in the known danger zone – **unacceptable**
- Failed to know vessel's operating temperatures and pressures; instead assuming these key parameters remained safe – **unacceptable**

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Case Recap

***In re Margulies*, No. 16 Civ. 2643 (KPF), 2017 WL 1049548 (S.D.N.Y. Mar. 20, 2017)**

No coverage for damages caused by insured driver who hit traffic director. "[T]he incident was not 'to a substantial extent beyond the control of either party.' [Insured] was in control of his car, had the capacity to use his brakes, and chose not to do so. The situation was well within his capacity to avoid."

***Nat'l Union Fire Ins. Co. of Pittsburgh, PA v. Turner Constr. Co.*, 986 N.Y.S.2d 74 (N.Y. App. Div. 2014)**

"[T]he requirement of a fortuitous loss is a necessary element of insurance policies based on either an 'accident' or 'occurrence.' . . . [A] claim for faulty workmanship, in and of itself, is not an occurrence . . . because a failure of workmanship does not involve the fortuity required to constitute an accident."

***Highland Capital Mgmt., L.P. v. Glob. Aerospace Managers Ltd.*, 488 Fed. App'x 473, 475-76 (2d Cir. 2012)**

All risk policy covering "direct and accidental physical loss" to aircraft did not cover any co-insureds' claims because "airframe and engine losses . . . were caused by the intentional misconduct of plaintiffs' coninsured" who removed airplane parts after company's bankruptcy and thus "the damage was not fortuitous."

***Royal Indem. Co. v. Deep Sea Int'l*, 619 F. Supp. 2d 14, 22-23 (S.D.N.Y. 2007)**

"[T]here is a factual issue as to whether Deep Sea properly repaired the vessel . . . . If the jury credited Royal's evidence, it could reasonably find that Deep Sea intentionally chose inadequate methods to repair the Aloha, despite being aware that those methods violated the standards required of Panamanian-flagged ships. The jury could then find Deep Sea's actions to be intentional misconduct even in the absence of outright fraud. Deep Sea is therefore not entitled to summary judgment with respect to the fortuitous nature of the loss of the scientific equipment."

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"You Screwed Up: You Trusted Us! Conflicts Among Insurers, Independent Counsel and Insureds."

ACCEC Annual Meeting
Chicago, May, 2017

Marion B. Adler – William T. Barker – Doug McIntosh – Neil Posner

Panel Discussion — "Friction Points"

Billing Rates: Insurer has agreed to accept insured's defense under a reservation of rights that, under applicable law, give the insured the right to be defended by independent counsel of insured's choosing. Insured wants to use one of its regular "Big Law" or "Sophisticated Litigation Boutique" firms to defend. This firm charges "premium" rates. Insurer, recognizing that applicable law requires it to relinquish control of the defense and discharge its defense obligations by reimbursing the insured for the reasonable costs of defense, wants to cap its reimbursement obligation at the highest rate the insurer pays panel counsel.

I. What Rules are at issue here?
II. Any other law?

"National vs. Local Counsel"

Insured has been sued in multiple jurisdictions for a substantially similar injury. Insured gave timely notice and tender to its insurer, which accepted the defense of these lawsuits without a reservation, and appointed defense counsel in each jurisdiction. This is the type of action, however, that the insured fears is the type of suit that gives rise to similar or "copycat" types of lawsuits. As a result of this concern, insured has retained "national coordinating counsel" to oversee the defense of these lawsuits, and wants insurer to pay for the cost of such national coordinating counsel. Insurer believes it has discharged its duties by providing local counsel in each jurisdiction. Insured feels that a coordinated defense could serve to reduce the risk of similar lawsuits in other jurisdictions, and might save money with respect to these current lawsuits.

I. What Rules are at issue here?
II. Any other law?

When "Independent" Counsel becomes "Panel" Counsel

I. Insured is covered under a CGL policy, which comes with the usual "form" exclusions and a few additional ones based on underwriting concerns. Insured is sued; gives timely notice and tender to insurer. Insurer disclaims coverage for defense and indemnity based on one of those endorsed exclusions and several of the form exclusions, and files a Declaratory Judgment action.
II. Insured hires its usual law firm, Stifle & Blote to handle the case, which is in a jurisdiction in which S&B does not have an office. S&B then hires Goode & Plenti as local counsel. Both firms charge rates that are approximately twice what the insurer's panel counsel charge in those jurisdictions. In those jurisdictions, the insurer's panel law firms have lawyers qualified to handle the insured's case.

When "Independent" Counsel becomes "Panel" Counsel

IV. One of the current firms that has been defending the underlying case for the last four years actually is an approved panel firm, and for files sent to the firm by the insurer, charges half the rate they charge for outside cases.

V. The insurer agrees to pay the higher rate both back to the date of notice and going forward, subject to a reservation of rights to recover the all costs and fees if it turns out coverage is denied to the insured on one of the reserved exclusions.

When "Independent" Counsel becomes "Panel" Counsel

Ethics Questions:

1. Does the panel firm have an obligation to reveal to its client its "preferred" rate it charges to the insurer? If so, did it have this obligation at the beginning of the engagement? Or only now that the court has ruled in the insured's favor?

When "Independent" Counsel becomes "Panel" Counsel

Ethics Questions:

2. Does the panel firm have an obligation to offer the insurer the lower rate on a going forward basis, given the risk that the insured-client may have to reimburse the insurer if the case results in liability based on excluded conduct?

When "Independent" Counsel becomes "Panel" Counsel

Ethics Questions:

3. What Rules, other law, are implicated here?

What Information is Insurer Entitled To?

I. Situation I: Reservation of Rights; Independent Counsel

1. Insurer issued reservation of rights that, under applicable law, give insured right to select independent counsel.
2. Insurer relinquishes control of the defense but, regardless, asserts right to be informed of defense strategy and defense counsel's assessment of liability. Insurer argues that, since it may eventually have to pay, it has a need to know what it may be in for, so it can appropriately set reserves, and because it ultimately may have to write out a big check.
3. Insured instructs defense counsel not to share any of this with insurer, given that insurer, by virtue of its ROR, already has indicated a desire to avoid payment.
4. What Rules, other law, are implicated here?

What Information is Insurer Entitled To?

II. Situation II: No Reservation of Rights; Insurer-Appointed Counsel

1. Even though insurer is providing a defense without a reservation of rights, through discovery and discussions with the insured client defense counsel learns of facts that, if provided to the insurer, may give the insurer grounds to deny coverage.
2. What Rules, other law, are implicated here?

Litigation Management & Billing Guidelines

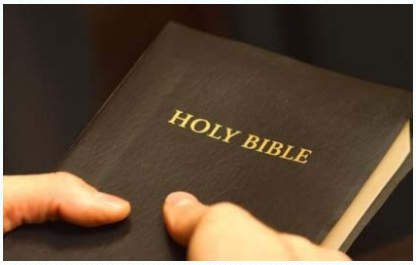
I. Insurer has accepted defense under a reservation of rights. Under applicable law, insured has the right to select independent counsel, and does. Insurer sends its standard Litigation Management & Billing Guidelines to independent counsel, with a cover letter explaining that insurer expects counsel to agree to these and to not deviate from them without insurer's written consent. The LM&BG document includes the following limitations:

Litigation Management & Billing Guidelines

1. Counsel must seek advance permission of insurer to conduct any legal research that will take more than 5 hours.
2. Time entries for interoffice conferences among lawyers and/or legal assistants will be disallowed.
3. No more than one lawyer may attend a court proceeding, deposition, or other meeting.
4. Counsel must seek advance permission of insurer to engage consultants and experts.
5. Counsel must seek advance permission of insurer for out-of-town travel.
6. Counsel must submit a detailed litigation budget within 60 days of being retained or 30 days of filing the Answer or first responsive pleading, whichever comes first.
7. Counsel must submit status reports no less frequently than every 90 days.
8. Dispositive pleadings (but not routine motions) are to be submitted to insurer 5 days prior to due date.
9. "Block billing" will be disallowed; every task must be entered in a separate billing entry, in 0.1 hour increments, and ABA task codes must be used. All bills to be submitted through insurer's electronic billing system. Bills must be submitted monthly; will be paid quarterly.
10. Bills for that which insurer regards as overhead will be disallowed, such as postage, copies, fax, messengers, local transportation, and Westlaw & Lexis.

Litigation Management & Billing Guidelines

II. What Rules, other law, are implicated here?



Defense Counsel or Coverage Counsel?

I. Insured is sued in an environmental case. Insured gives timely notice and tender to insurer, which accepts the defense under a reservation of rights, which, under applicable law, gives insured the right to independent counsel. Insured retains the law firm of Monte & Piethon to defend. After about a year, the insurer reaches the conclusion that there is no basis upon which liability can be found that would not be excluded by the policy, and files a Declaratory Judgment action against insured. Insured, which believes that the insurer is wrong, asks defense counsel to defend the DJ. The lead partner on the case, Bradley Straightarrow, runs the request through the firm's conflict-checking system, and gets "push back" from a partner in one of the firm's other offices; that partner does a lot of corporate work for that insurer, and doesn't want to rock the boat by asking for a conflict waiver. The firm declines the engagement.

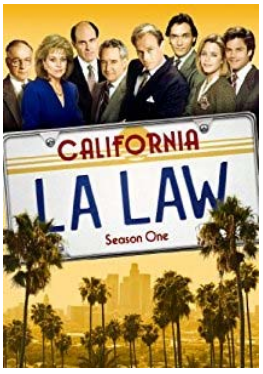
II. Bradley, at client's request, refers the DJ matter to another law firm, Mayke Mai & Day, LLP, which specializes in policyholder-side coverage. MM&D's partner, Ann-Marie Marianne, asks Bradley for assistance in preparing to defend the DJ. Bradley, believing that he owes his client a duty to provide coverage counsel with the requested assistance, complies.

Defense Counsel or Coverage Counsel?

III. Bradley's "other office" partner--the one who pushed back and refused to ask his insurer-client for a waiver--pitches a fit and threatens to report Bradley to the State Bar Disciplinary Commission. Freaked out, Bradley goes to his firm's in-house Ethics & Professional Responsibility counsel for advice.

IV. In this case, may defense counsel play a role in coverage? If not in this case, in any case?

V. What Rules, other law, are implicated here?



Fifteen Cases in Forty-Five Minutes: The Most Important Coverage and Extracontractual Decisions of the Past Year

2017 Annual Meeting
May 11-12, 2017
Chicago, IL
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1. Late Notice

Templo Fuente de Vida Corp. v. National Union Fire Insurance Co., 224 N.J. 189 (2016)

- Claims-Made D&O policy
- Policyholder gave notice within policy period
- Policy required notice 'as soon as practicable'
- Unexplained six month delay in providing notice
- No coverage

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2. What is a Claim?

S.M.Electric Company, Inc. v. Torcon, Inc., 2016 N.J. Super. Unpub. LEXIS 2289 (N.J. App. Div. 2016)

- Torcon – construction manager
- SME – contractor
- Claims-made policy
- SME sent letter to Torcon in 2008 entitled "A Request for Equitable Adjustment," seeking $15,337,068, "as compensation for the additional cost of performing the work." Torcon did not give notice to its insurance company.
- SME sued Torcon in 2010. Torcon provided notice to its insurance company.
- Court – 2008 letter was a claim. Late notice barred the claim.

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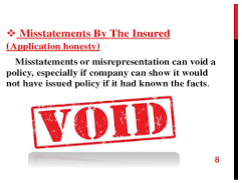
3. Misrepresentation on Application

H.J. Heinz Co. V. Starr Surplus Lines Ins. Co., 2017 U.S. App. Lexis 510 (3d Cir. 2017)

- Multi-million dollar claim for contaminated baby food in China
- Court found that Heinz' risk manager had deliberately failed to list prior losses in order to obtain lower SIR
- Policy rescinded
- No waiver by insurance company due to possible knowledge of unreported losses from extraneous sources.



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4. Construction Defects Insurance

Cypress Point Condominium Assn. v. Adria Towers, 226 N.J. 403 (2016)

National Surety Corp. v. Westlake Investments, LLC, 880 N.W. 2d (Iowa 2016)

- Both cases addressed insurance coverage under general liability policies for construction defects.
- Both found coverage
- Subcontractor errors were accidental and an occurrence
- Subcontractor exception to your work exclusion applies
- Cypress – "consequential damages caused by the subcontractors faulty workmanship – is an 'occurrence' under the plain language of the CGL policies at issue here"
- National Surety – "Whether an event amounts to an accident that constitutes an occurrence triggering coverage under a modern standard-form CGL policy turns on whether the event itself and the resulting harm were both 'expected or intended from the standpoint of the insured.'"

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5 Property Damage

Phibro v. National Union Fire Insurance Company, 446 N.J. Super. 419 (App. Div. 2016)

- Feed additive in chicken feed caused chickens not to gain weight – chickens were wrong size for processors
- Court – change in chickens' physical condition constituted property damage under general liability policy

Also, loss of use

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6. Data Breach

Travelers Indem. Co. v Portal Healthcare, 2016 U.S.App. LEXIS 6554 (4th Cir. 2016)

- Medical records on web – no evidence that anyone viewed them
- Insurance company – no publication
- Court – "Publication" does not hinge on third party access, but occurs when information is placed before the public
- Now – most liability policies have massive data breach exclusions

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7. Cyber-insurance

P.F. Chang's v. Federal Insurance Co., 2016 U.S. Dist. Lexis 70749 (D. Ariz. 2016).

- Data breach on cyber-insurance policy
- P.F. Chang's had contract with servicer to manage credit card transactions. That servicer had contract with bank.
- Because of data breach, bank incurred charges, which it passed on to servicer, servicer passed on to P.F. Chang's.
- No insurance coverage – contract exclusion
- Carefully draft cyber-insurance policies

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8. Cyber II

Apache Corp. v. Great American Ins. Co., No. 15-20499 (5th Cir. Oct. 18, 2016)

- Computer fraud provision of crime protection insurance policy – "We will pay for loss…resulting directly from the use of any computer to fraudulently cause a transfer…."
- "authorized payments of legitimate invoices from its vendor to the criminals' bank account…."
- Trial court found coverage – Fifth Circuit reversed
- Criminals sent email on vendor's letterhead with old and new bank account numbers.
- Apache called phone number on letterhead to confirm and then approved change and sent money to false bank account.
- Fifth Circuit found that use of computer was not direct cause of loss – use of email was "merely in- cidental" – every fraud that uses email is not a computer fraud

See also, Taylor & Lieberman v. Federal Insurance Company, no. 15-56102 (9th Cir. 2017)

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9. Number of Occurrences

Selective Ins. Co. of Am. v. County of Rensselaer, 26 N.Y.3d 649 (2016)

- Class action against County for strip searches of prisoners
- Policies had a per occurrence deductible
- Court – each individual class member is a separate occurrence to which a separate deductible applied
- When settlement was prorated among individual class members, each individual's share was within deductible
- Solutions – batch clauses, aggregating clauses, aggregate deductible

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10. Reservation of Rights

Harleysville Group Insurance v. Heritage Communities, No. 27698 (S. Car. 2017)

- "Harleysville's efforts to reserve its rights were generic statements of potential non-coverage coupled with…copies (through a cut-and-paste method) of the insurance policies."
- Insurance company defended under reservation of rights.
- Court found ROR letter to be ineffective: "It is axiomatic that an insured must be provided sufficient information to understand the reasons the insurer believes the policy may not provide coverage."

Reservations about Reservation of Rights

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11. Ambiguity

St. Paul Mercury Ins. Co. v. Federal Deposit Ins. Corp., No. 14-56830 (9th Cir. 2016)

1. If insurance company had intended exclusion to have broad application, should have used broader language, such as "based upon, arising out of, attributable."

If insurance company and policyholder both present reasonable interpretations, policyholder wins.

2. 'Insured v. Insured' exclusion ambiguous "as applied to FDIC as receiver."

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12. Settlement

J.PMorgan Securities Inc. v. Vigilant Ins. Co., No. 600979/09 (N.Y. Sup. 2016)

- Insurance policy – policyholder can't settle without insurance company's consent. Under NY law, policyholder could settle if insurance company denied coverage.
- Insurance companies sent numerous letters over many years giving reasons why coverage did not exist, but ended each letter by stating that it was dependent on further information.
- Policyholder settled without insurance company's consent
- Insurance companies: we never denied coverage, so settlement isn't covered
- Court – insurance companies effectively denied coverage.

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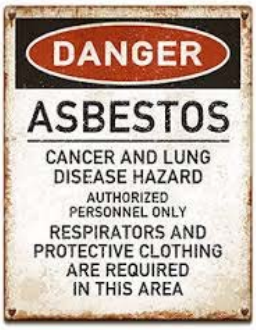
13. Continuous Trigger, not injury in fact

a. Trigger theory adopted as matter of law, without need for expert medical testimony
   i. Rejected insurer arguments that current medical understanding of asbestos diseases is not compatible with prevailing trigger theories.



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13. Pro-rata allocation

a. Adopts "unavailability of insurance rule"
   i. Leave door open for equitable exception
   ii. Claims made years coverage only to be included for claims that meet the policy's claim made trigger; otherwise, claims made coverage is not considered as "available"
   iii. Compare with Keyspan in NY, declining to apply Unavailability Rule and Honeywell in NJ, rejecting equitable exception
b. Default DOFE for claims without a known DOFE
   i. Rejected fixed 1962 or 1948 default DOFE; remanded for further proceedings to determine default DOFE method reflecting actual latency periods
c. Affirmed exhaustion of primary policies based on payments made under allocation agreement between primary insurers, even though agreement used shorter allocation block than court ultimately adopted.

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13. Duty to Defend

a. No duty to defend under excess coverage in umbrella/excess policies

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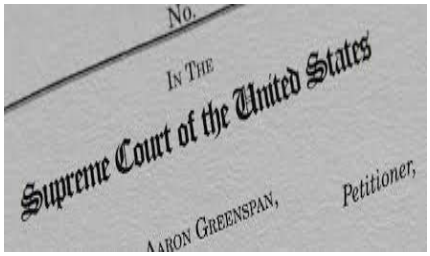
13. Petitions to CT Supreme Court Due April 26



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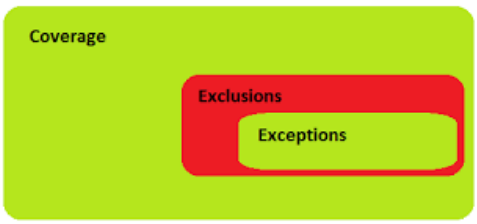
13. Exclusions

a. Absolute and qualified pollution exclusions apply only to "traditional environmental pollution" and not to indoor asbestos exposures.

b. Occupational disease exclusion not limited to insureds' employees



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14. Damages "Because of" Bodily Injury

Cincinnati Ins. Co. v. H.D. Smith, L.L.C., 829 F.3d 771 (7th Cir., 2016)

- "Pill Mill" Case
- West Virginia sues pharma distributors, alleging:
  - Pharmacies knowingly provide addictive drugs to fuel citizens' addictions;
  - Distributors should know from quantities supplied that drugs would be used for illicit, destructive purposes;
  - State spends hundreds of millions of dollars annually treating residents' drug-related injuries.
- CGL policy covers "damages **because** of bodily injury."

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14. Damages "Because of" Bodily Injury (cont'd)

- "**Bodily injury**" means "bodily injury, sickness or disease **sustained by a person**…"
- "**Damages because of bodily injury**" include "**damages claimed by any person or organization for care….resulting at any time from the bodily injury**."
- District court grants insurer's MSJ: Suit does not allege damages because of bodily injury.
- Insurer: State seeks own damages, not damages on behalf of its citizens.
- 7th Circuit: "[S]o what?" Insurer's argument "untethered to any language in the policy."
- Carrier must defend.

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15. ABSOLUTE POLLUTION EXCLUSION

Colony Insurance Co. v. Victory Construction, 3:16-cv-00457 (D. Or. 2017)

- Failure to install properly a swimming pool heater led to release of carbon monoxide; several people sickened
- No coverage – carbon monoxide is a pollutant

The Doe Run Resources Corporation v. American Guarantee & Liability Insurance Co., et al., 10SL-CC01716 (Mo. Ct. App. 2016)

- Lead pollutants arising from smelting operation- covered
- Exclusion is ambiguous, coverage for policyholder's operations

Castoro & Co. v. Hartford Acc. & Ind. Co., et al., Civil Action No. 14-1305 (MAS)(DEA) (D.N.J. 2016), on reconsideration, (D.N.J. 2017)

- Absolute Pollution Exclusion only applies to traditional, intentional pollution

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Thank You

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PAPERS

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The Cobbler's Children Have No Shoes: What Insurance Coverage Attorneys Need to Know About their Professional Liability Insurance Policies

American College of Coverage and Extracontractual Counsel 5th Annual Meeting

Chicago, IL
May 11-12, 2017

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The Cobbler's Children Have No Shoes: What Insurance Coverage Attorneys Need to Know About their Professional Liability Insurance Policies

Professional liability insurance policies, also known as errors and omissions (E&O) policies, share several common characteristics, discussed below.[1] These policies, generally speaking, cover amounts an insured becomes legally obligated to pay as a result of a claim resulting from a wrongful act. Wrongful act typically encompasses acts, errors, omissions or breaches of duty in rendering professional services. What constitutes a claim or professional services, as defined by a given policy, can give rise to disputes.

What Is A Claim?

Most insurance policies define the term "claim" and that definition determines whether there is a "claim" under the facts of a specific case. Typically the definition includes a "demand for money or services" or the "institution of legal proceedings." In policies that do not contain a definition of "claim," courts look to whether there has been an assertion as opposed to a mere recognition of a legal right. *San Pedro Properties Inc. v. Sayre & Toso, Inc.,* 203 Cal.App.2d 750, 21 Cal.Rept. 84 (1962), disapproved on other grounds *Gyler v. Mission Ins. Co.* 514 P.2d 1219 (Cal. 1973) and *American Center of Int'l Labor Solidarity v. Federal Ins. Co.,* 548 F.3d 1103 (D.C. Cir. 2008) (EEOC proceeding is a claim since it is a formal administrative proceeding and where the policy included in the definition of claim "a formal administrative or regulatory proceeding").

[1] This is an academic discussion, not legal advice. Because this paper was authored by several people, the views expressed are not necessarily those of an individual author, or of any author's clients or firm. The opinions and comments in this article are intended to spur debate and should not be taken as an expression of opinion by any writers' firm or any client of an author's firm.

A mere assertion of a "wrongful act," without more, typically is not a "claim." *MGIC Indem. Corp. v. Home State Sav. Ass'n.,* 797 F.2d 285, 288 (6th Cir. 1986) (a letter identifying individual officers as targets of a grand jury investigation is not a claim).

Cases Finding a Claim

A letter stating the intention to hold an insured responsible for losses is a claim. *Continental Casualty Co. v. Enco Assoc. Inc.,* 66 Mich. App 46, 238 N.W.2d 198 (1975) (finding a claim even though there was no demand for money noting that Continental's position was "splitting hairs"). In addition, a demand made by a client to his or her attorney to fix a defective legal document for free is also a claim. *Phoenix Ins. Co. v. Sukut Construction Co.* 136 Cal.App.3d 673, 186 Cal. Rept. 513 (2d Dist. 1982) (This was not a request for information as in *Hoyt.* It was a request to correct and complete work for which payment had already been made). Likewise an assertion against an architect stating that the architect is going to be held responsible for correcting its defective design is a claim. *Williamson & Voller Engineering, Inc. v. Sequoia Ins. Co.,* 64 Cal.App.3d 261, 134 Cal.Rept. 427 (1st Dist. 1976.), questioned on other grounds *National Steel Corp. v. Golden Eagle Ins. Co.,* 121 F.3d 496 (9th Cir. 1997) A suit is not required for there to be a claim so long as there is a letter or series of letters that constitute a demand for money. *Philadelphia Consolidated Holding Corp. v. LSI-Lowery Sys. Inc.* 2015 WL 127368 (8th Cir. 2015) (letters complaining about the insured's products and that include a demand for remediation and threat of legal recourse when taken together is a "demand for money" and therefore a claim).

Cases Not Finding a Claim

In contrast, a letter merely requesting records is not a claim. *Columbia Cas. C. v. Columbia Hosp. for Woman,* 633 F.Supp 697 (D.D.C 1986), (claim not defined in the policy). Nor is a letter

from a lawyer stating that he was hired to investigate a claim, *Baquero v. Lancet Indem. Risk Retention Group. Inc.*, No. 12–24105–CIV., 2013 WL 5237740 (S.D. Fla. Sept. 17, 2013), (letter from lawyer saying he was hired to investigate a medical malpractice claim against you). The *Baquero* court also found that a demand for insurance information was not a claim. *Id.* Even a letter complaining about an outcome of a surgical procedure is not a claim. *Hill v. Physicians & Surgeons Exchange,* 225 Cal.App.3d 1, 274 Cal.Rept. 702 (1990) (no claim where the term "claim" was not defined even though the doctor admitted that the outcome was not supposed to happen and did not bill for his services). Finally asking an attorney how he or she reached their decision that created a substantial additional estate tax is not a claim. *Hoyt v. St. Paul Fire & Marine Ins. Co.,* 607 F.2d 864 (9th Cir. 1979). Examination of some cases in greater detail further highlights what constitutes a claim and establishes that that what constitutes a claim is often not an easy question to answer.

Some Specific Examples

In *Innes v. St. Paul Fire and Marine Insurance Company*, 2015 WL 5334580 (D.N.J. Sept. 11, 2015), a legal malpractice claim asserted against a law firm of for providing a passport to their client's ex-wife in violation of an agreement between the parties. The ex-wife then fled the country with their child, which resulted in the plaintiff having to incur significant legal fees seeking his daughter's return. The St. Paul's policy defined a "Claim" as a "demand received by an insured for money or services alleging an error, omission, negligent act or 'personal injury' in the rendering of or failure to render 'professional legal services' for others by you or on your behalf.

The insured received a letter from the husband's lawyer on January 24, 2006, indicating the he represented the plaintiff "in an action against [the] Firm and instructed the Firm to put its insurance carrier "on notice." Two days later, the insured responded, indicating that it believed

the claim was "frivolous and would accept service if a lawsuit was filed, however it did not notify its insurer. In June 2006, the plaintiff filed an ethics claim against the insured and in October 2007 sued the firm. In November 2007, the insured finally notified St. Paul and informed St. Paul that it would defend itself and was not seeking coverage for the claim. The suit proceeded to trial and awarded the plaintiff in excess of $1.4 million.

The question before the court was whether the January 24, 2006 letter was a "claim" under the policy. The plaintiff argued that the letter did not constitute a claim because it did not contain a demand for the payment of money or services. Finding the language of the policy to be unambiguous, the court concluded that the letter qualified as a claim. The court observed that "[s]everal courts in this district and elsewhere have determined that similar letters constitute 'claims' under identical or nearly identical policy language despite the fact that they do not contain a verbatim demand for money or services." *Id.* at *7.

In *Paradigm Ins. Co. v. P & C Ins. Systems, Inc.*, 747 So. 2d 1040, 1041 (Fla. 3rd DCA 2000), a judgment holder's attorney sent a letter to the insurance company's agents stating a loss occurred because they had negligently failed to procure insurance coverage. The judgment holder later filed suit against the insurance agents, reiterating the same claim of negligence. When contacted, the insurance company contended there was no coverage under the insureds' claims-made policy because the relevant claim of negligence was not made until after the policy expired. The court rejected the policyholder's contention that a letter written by a judgment creditor's attorney to the insured did not meet the policy definition of a "claim," stating:

> [w]e think a statement of a claim of negligence and resulting loss (in this case, a claimed failure of an insurance agency to procure liability insurance), followed by a request "to turn this letter over to your errors and omissions insurance carrier for handling" amounts to a demand for money within the meaning of Paradigm's policy.

Id. at 1041 (citations omitted).

Other courts, however, disagree that a mere request for insurance information is a claim. For instance, in *Lancet Indem. Risk Retention Grp., Inc. v. Allied World Surplus Lines*, Case No. 8:15-cv-406-T-23JSS, 2016 WL 3906924 (M.D. Fla. July 19, 2016), Lancet insured Hollywood Diagnostics from December 6, 2011, to December 6, 2012, and Allied insured Hollywood Diagnostics from December 6, 2012, to December 6, 2013. On September 26, 2012, an attorney sent Hollywood Diagnostics a letter which stated:

> We represent Benjamin Shamay, surviving spouse of Zoya Shamay, deceased and we are investigating a claim for damages arising out of care provided to Mrs. Shamay in September, 2011.
>
> Florida Statute § 627.4137 requires that you disclose to us the names of all of your liability insurance companies (both primary and excess) which may provide you with coverage for this incident. This Statute also requires that you tell us the amount of coverage that you have with each insurance company. You are required by law to advise us within thirty (30) days of the receipt of this request.
>
> We are enclosing extra copies of this letter which you should forward to each of the insurance companies who provide you with coverage for this incident. Please be sure to send a copy of this letter to each company with the request that the company contact us. FAILURE TO NOTIFY YOUR INSURANCE COMPANY IMMEDIATELY MAY CAUSE THE COMPANY TO REFUSE TO PROTECT YOUR INTERESTS.
>
> We request you complete the enclosed forms and return them to our office in the envelope provided at your earliest convenience. In the event you do not have insurance, please contact this office as soon as possible.

Lancet Indem. Risk Retention Grp., Inc., 2016 WL 3906924 at *2 (emphasis in original).

According to the United States District Court for the Middle District of Florida, "[t]he letter's advising that an insured forward the request for information to insurers is based on Section 627.4137's requiring an insured to 'forward such request for information . . . to all affected insurers.' Allied cannot infer from the letter's iteration of this statutory language 'an intention to

hold the insured responsible.'" *Id.* at *3. The court consequently held that the letter did not constitute notice of a claim. Perhaps also important in this case is that the letter talked about investigating a claim, and nothing more.

In *Florida Dept. of Fin. Services v. Nat'l Union Fire Ins.*, 4:11CV242, 2012 WL 760606 (N.D. Fla. Mar. 7, 2012), the district court determined that a letter from a receiver was not a claim. In pertinent part, the letter provided notice of an "intention to assert claims" for errors "resulting in injury in excess of $5 million." *Id.* at *4. But, the letter did not go so far as demanding that the recipient pay any sum certain. That was enough for the court to conclude the letter was not a claim. The district court observed the "'intention to assert claims' is … a future action, not one that has or is currently occurring. Further, the letter is not a 'written demand ... for relief.' It makes no present demand for any action from Defendant, such as tendering the policy limit." *Id.*

In *Continental Cas. Co. v. Jewell, Moser, Fletcher & Holleman, P.A.*, 2005 WL 1925964, *1-2 (E.D. Ark. Aug. 11, 2005), a law firm was sued for malpractice. Under the policy a "claim" was defined as "a demand received by the Insured for money or services arising out of an act or omission … in the rendering of or failure to render legal services." The first complaint, which was filed about six months prior to the policy's inception, only sought injunctive relief – specifically for the production of certain of the firm's records. There was no demand for money damages. Nearly two months after the policy incepted, the complaint was amended to request compensatory and punitive money damages. In the coverage action, the insured argued that since there was no demand for damages until the complaint was amended, the first "claim" made against it fell within the policy period. The court rejected this argument, reasoning:

> While it is true that the March initial action only sought injunctive relief against [the insured], it also included (1) numerous allegations of legal malpractice and wrongdoing on the part of [the insured] who was alleged to be Michael Sims' attorney; (2) allegations that [the insured] had breached his duties to Michael Sims;

> and (3) a mandatory injunction requiring [the insured] to produce copies of documentation regarding a sale of certain property and a mandatory injunction requiring [the insured] to surrender all files and trust account funds.
>
> …The Court…holds that this language amounts to a demand for services which is included in the definition of claim.

Continental, 2005 WL 1925964 at *2.

In *Berry v. St. Paul Fire & Marine Ins. Co.*, 70 F.3d 981 (8th Cir. 1995), the court explained that a "claim" is first made where "the inference that [the claimant's] injuries … should be compensated in money is unmistakable," or when anyone receiving the subject correspondence "would know that [the claimant] was claiming that he was owed money." *Id.* at 982. In *Berry*, the policy defined a "claim" as a "demand in which damages are alleged." *Id.* at 982. At issue was whether the following letter) satisfied that definition:

> This office represents Ronald D. Berry for personal injuries and disability he sustained while using one of your products during a period of employment in Springfield, Missouri. The particular product in question is a "sandblasting" unit … As a result of his use of this product, Mr. Berry has sustained severe and permanent disability to his lungs and pulmonary body parts.
>
> Our representation is upon a contingency fee contract and our attorney's lien is hereby asserted. All communications and correspondence on this matter should be directed to this office.
>
> Please forward this letter to your products liability insurance carrier for proper handling so we may discuss this situation prior to the commencement of products liability litigation.

Id. The insured argued that this letter was not a "claim," but just a "communication of a present legal right." The court quickly dismissed this argument as "tortured" and "strained." *Id*. Instead, the court found that "this letter, fairly read, clearly qualifies as a 'claim,'" specifically noting that the letter directed the insured to put its carrier on notice. *Id.* But see *Colony Ins. Co. v. Chesapeake Energy Corp.* 2016 WL 6418517 (W.D. Ok. 2016) (distinguishing *Berry* where the

letter only asked for a litigation hold and did not accuse the insured of any wrong doing or ask for the insured to put its insurer on notice).

In *Simpson & Creasy, P.C. v. Cont'l Cas. Co.*, 453 Fed. App'x 868, 870-71 (11th Cir. 2011) (applying Georgia law) the 11th Circuit held that the insured's acknowledgement prior to the inception of his professional liability policy period that a former client was demanding money from him constituted a "claim" which preceded the inception of the policy. The court found that the definition of a claim does not require a formal lawsuit to be filed, and the insured's acknowledgement that the client was seeking money, combined with other correspondence evidencing dis-satisfaction with the legal services provided, was sufficient to establish a "claim" as a matter of law. *Id*. at 870-71 ("Because the August 18, 2008 letter and other correspondence establish that a claim was made before the policy period began on April 1, 2009, the district court properly granted summary judgment ….").

In contrast, in *Nat'l Fire Ins. Co. v. Bartolazo*, 27 F.3d 518, 519 (11th Cir. 1994) the court held, under Florida law, that a request for medical records that only alluded to a possible malpractice claim did not rise to the level of a "claim" because it contained no specific demand for money or services, and did not specify a "medical incident." The letter stated that the attorney represented the former patient "in her claim for medical malpractice and other relief against you." The letter requested copies of the patient's medical records and stated the doctor would be reimbursed for the copy charges. There was no demand for money or specification of the relief sought. The court found that the letter was not a "claim" even though the letter used the word "claim," holding that because the letter contained no demand for money it was not a "claim" pursuant to the terms of the insurer's policy which defined a claim to mean receipt by the insured of a demand for money or services, naming you and alleging a medical incident. The court

concluded that the insurer's contention that the letter constituted a claim was "meritless." The letter made no demand for money or services, nor did it allege a medical incident. The letter merely requested medical records and alluded to a claim for malpractice. *See also Myers v. Interstate Fire & Cas. Co.*, 2008 WL 276055 (M.D. Fla. 2008) (finding that a letter requesting medical records and insurance information without a demand that it be sent to the insurer did not constitute a claim – attorney's statement that he was retained to represent the client in a claim for damages was merely notice of a potential claim).

In *Rentmeester v. Wisconsin Lawyers Mut. Ins. Co.*, 473 N.W.2d 160 (Wis. Ct. App.), *rev. denied*, 477 N.W.2d 287 (Wis. 1991), the issue was whether a letter from the claimant's attorney to the insured constituted a claim, where the policy defined claim as a demand for money or services, naming the insured and alleging a wrongful act. The letter was sent during the policy period but never reported. The court found that the letter constituted a "claim" for purposes of the policy, and therefore there was coverage as there was no requirement that the claim be reported during the policy period. The letter stated in part:

> [The claimants] intend to appeal. . . . I am reluctant and embarrassed to address the next matter . . . However under the circumstances, the [claimants] have asked us to ask you to notify your professional insurance carrier of this matter. We would ask that a representative [contact the undersigned].

In construing the letter, the court stated that "the only reasonable construction of the [claimant's attorney's] letter was to notify [the insured] and his insurer that the [claimants] would hold [the insured] financially responsible in the event their appeal failed. In [the] letter, he stated that the [claimants] intended to appeal. He next noted his 'general distaste for professional malpractice claims,' but requested that [the insured] notify his insurance carrier of the situation and ask a representative to contact him. . . . [This] letter could only mean that the [claimants] planned to seek relief from [the insured] if they lost on appeal. Moreover, not only did [the

claimant's attorney] term his demand 'a claim,' this is the precise construction that [the insured] gave the letter. [The insured] responded to [the] letter stating that the 'potential claim' would be forwarded to his insurance carrier and that he hoped the appeal would 'work out.'" *Id.* at 163. The court looked at the context of the letter, finding it a demand for money for the financial loss suffered by the claimants as a result of their former attorney's error, and that the claim was no less a claim because it was contingent on the result of the appeal. *Id.* The court found that this type of contingent demand was a claim because the contingency in this case, the result of the appeal, was easily ascertainable and certain to occur.

In *Herron v. Schutz Foss Architects*, 935 P.2d 1104 (Mont. 1997), the court held that a letter to put a malpractice carrier on notice constituted a claim, despite the fact that no specific money demand was made. In October, 1991, the claimant slipped on ice and was injured. In January, 1992, the claimant wrote to the insured, indicating that an unsafe condition existed, but made no demand for money, that he would hold the insured liable, or requesting notification to the insured's carrier. In July, 1993, the claimant's attorney wrote to the insured requesting that his malpractice carrier contact him to discuss the "claim." The insured denied liability, and in October, 1994 the claimant filed suit against the insured. The claimant argued that the 1994-1995 policy (which had higher limits) was applicable, while the carrier argued that the 1993-1994 policy was applicable since the July 1993 letter constituted a claim. In analyzing the situation, the court noted that the policy language was unambiguous, and that only the claimant's letter was ambiguous, and that the rule that a policy is to be construed against the insurer does not carry over to construction of correspondence from a claimant. *Id.* at 1107. The court examined *Berry* and *Rentmeester*, and rejected the argument that the claim was not made until suit was filed. The court noted that the policy states that coverage exists during that period when a claim is *first* made against the

company. *Id*. at 1108. "Where the alleged tortfeasor has reasonably been put on notice by the injured party that he intends to hold the tortfeasor responsible for his damages, it would, indeed, be anomalous to hold that a claim is, nevertheless, not made until a suit is actually filed. To do so would encourage litigation as opposed to negotiation and settlement." The court reached this decision even though there was no specific monetary demand in the 1993 letter. The court observed the text on its face indicates that the claimant was seeking compensatory payment, otherwise there would be no reason for the insured to contact his insurance carrier. The court also looked to the fact that both the insured and insurer treated the 1993 letter as a claim since the insured completed a notice of claim form and forwarded this to the insurer.

Claim-Related Conclusions

As the above cases establish, what constitutes a claim is not always an easy determination. Moreover the consequences of not reporting what may be a claim can lead to a loss of coverage. Accordingly when faced with the choice whether to report a claim (which may result in a higher premium) or not (which may result in a loss of coverage) always requires careful consideration.

What are "Professional Services"?

There is a substantial body of case law interpreting the scope and meaning of professional services. At its most basic, professional liability policies cover claims relating to errors or issues arising from an attorney's professional advice and judgments. In the oft-cited decision, the Supreme Court of Nebraska described "professional services" as "arising out of a vocation, calling, occupation, or employment involving specialized knowledge, labor, or skill" which is "predominantly mental or intellectual," in nature, "rather than physical or manual." *Marx v. Hartford Accident & Indemnity Co.*, 157 N.W.2d 870, 872 (Neb. 1968); *see also Medical Records Assocs., Inc. v. Am. Empire Surplus Lines Ins. Co.,* 142 F.3d 512, 514-17 (1st Cir. 1998) ("[P]rofessional services" . . . embrace those activities that distinguish a particular occupation from

other occupations – as evidenced by the need for specialized learning or training – and from the ordinary activities of life and business."). Thus, what constitutes "professional services" cannot be determined solely from "the title or character of the party performing the act," *id.*, but requires a fact-sensitive inquiry into the "nature of the tortious act" itself. *Niedzielski v. St. Paul Fire & Marine Ins. Co.,* 589 A.2d 130, 131-32 (N.H. 1991); *see also Garland, Samuel & Loeb, P.C. v. American Safety Cas. Ins. Co.,* 651 S.E.2d 177, 179-80 (Ga. App. 2007).

Not all wrongful acts committed by an attorney are therefore covered. *See, e.g., Gregg & Valby, L.L.P. v. Great American Ins. Co.,* 316 F. Supp. 2d 505 (S.D. Tex. 2004) (fee dispute did not constitute "professional services"); *Roberts v. Fla. Lawyers Mut. Ins. Co.,* 839 S.2d 843, 846 (Fla. Ct. App. 2003) (billing dispute between former partners did not arise from law firm's rendering of professional services); *Cerrato v. American Home Ins. Co.*, No. 3:99-cv-2355, 2001 WL 1911768 (D.Ct. 2001) (lawyer's sexual assault of client deemed not to arise out of rendering or failure to render "professional services."

In considering the scope of coverage, some courts distinguish "professional services" (missing a statute of limitations or failing to obtain a client's consent to settle) from those acts they conclude to be commercial in nature. *See, e.g., Harrad v. Aetna Cas. & Sur. Co.,* 839 F.2d 979 (3d Cir. 1988). The latter, although they may grow out of the attorney-client relationship may not be covered if they do not involve the rendering of "professional services." *See, e.g.*, *Fanaras Enterprises, Inc. v. Roger Allen Doane,* 666 N.E.2d 1003, 1005-06 (Mass. 1996) (lawyer's failure to repay money loaned by client did not involve rendering or failing to render professional services as to the loan itself); *Krasner v. Professionals Prototype I Ins. Co. Ltd.,* 983 F.2d 1076 (9th Cir. 1992) (lawyer's participation in scheme to defraud insurers did not involve professional services

because lawyer was not acting in his capacity as a legal advisor and the claimant did not allege professional malpractice).

Whether a lawyer's unrelated business pursuits with a client constitute "professional services" remains a subject of debate. Many courts hold they do not; or that such business pursuits are professional services excluded from coverage under "business enterprise" or "ownership" exclusions. *See, e.g., General Acc. Ins. Co. v. Namesnik,* 790 F.2d 1397, 1399 (9th Cir. 1986) (tax lawyer who solicited clients to invest in his company was acting as a business agent, not a lawyer, and was therefore not rendering professional services); *Potomac Ins. Co. v. McIntosh,* 804 P.2d 759, 762-63 (Ariz. 1991) (exclusion barred coverage where clients' loss was not caused by lawyer's negligent failure to advise financial risks of investment, but by failure of the partnership in which the clients invested). Other courts find a lawyer's business pursuits to constitute "professional services" where a close nexus exists between the former and the latter. *Westport Ins. Corp. v. Bayer,* 284 F.3d 489, 497-98 (3d Cir. 2002) (lawyer's fraudulent misrepresentations and facilitation of "Ponzi" scheme held to be "professional services," even absent a formal attorney-client relationship between lawyer and defrauded investors); *Napoli, Kaiser Bern, LLP v. Westport Ins. Co.,* 295 F. Supp. 2d 335, 342-43 (S.D.N.Y. 2003) (suit filed by law firm against referring law firm based on allocation of settlement proceeds held to involve professional services).

The Related Acts Exclusion; Whose Ox Is Being Gored?

As a product, insurance depends on one fundamental ingredient – fortuity. The old saw that one cannot insure a burning building against loss by fire finds its expression, either expressly or by implication, in every form of insurance whether by inclusion in a policy's text, or by resort to common law doctrines designed to guard against the moral hazard of insuring known losses. This principle yields an obvious example in the "related acts" exclusion nestled in most insurance

protecting professionals from loss stemming from wrongful acts in the performance of professional services. What follows is intended as a guide – not an exhaustive collection of case law harvested from multiple jurisdictions. And, as this section's writer lives in and finds most of his practice roots in Florida, Florida law primarily furnishes the bones of this outline. Bear in mind, this writer represents policyholders, but as the title makes clear, the answer to what might prove to be a related act or series of acts depends greatly on the financial impact (much like trigger cases) of a particular result. To root this discussion in actual events, set forth below are facts to better inform the discussion.

The Facts

The names have been changed simply because they don't matter to the outcome of the case. (It is also my experience that, using actual identities where someone lost and the purpose of a discussion is to learn not dance on the ashes, is simply not productive). A well-known full service law firm represented both an individual and companies related to her investing business. The firm performed both traditional transactional work as well as defending litigation. In 2007, however, the wheels came off when it was learned the money raised from lenders and investors was not re-invested, but simply squandered to support a lavish lifestyle. The individual was indicted, and the related companies placed in bankruptcy. Shortly thereafter, the trustee wrote a letter to the firm and to one of the lenders, Smith Financial, claiming that the firm had breached duties owed to the companies, in part by allowing conflicts of interest between the individual and the companies to cause a massive loss, far in excess of available insurance coverage. No suit was filed, however, and the letter was short on specifics.

The firm placed its then-primary and excess cover on notice and began negotiating a settlement, funded in part by exhausting the available insurance and with a substantial contribution

by the firm. Eventually, a consent order was entered into memorializing the monetary and non-monetary aspects of the settlement. The consent order included a bar order, preventing the debtors, those affiliated with the debtors and lenders from bringing an action against the firm following approval of the consent order. Collateral litigation then erupted between the insurers, with one claiming that a predecessor insurer owed money in partial satisfaction of the settlement. That suit was pending when the following events transpired.

In 2009, a number of lawyers formerly with the firm broke off and formed a new firm (New Firm) limiting its practice to litigation. Two of the departing partners had done work for the indicted individual and debtors, but no work for Smith Financial. In 2010, New Firm applied for professional liability cover, seeking both primary and excess protection from the same insurer. The application was submitted after the settlement with the old firm was consummated, and asked the following question:

> 5. Please complete a "claim summary report" for any claim made against the applicant or any predecessor in business of the firm, as well as any **open circumstances** the applicant has reported to its insurer(s), during the past ten (10) years. *(Please use the attached Claim Summary Report).*

In response, New Firm stated: "A **written demand** was received from the Trustee of the Debtors both of which were formerly owned by the individual miscreant. The Trustee **asserts damages** in excess of a zillion dollars and has opened discussions about settlement.

Under the heading "Status for the 2009/2010 Application," the Claim Summary Report states that the firm and the Trustee reached a settlement agreement and provided the amount paid by the firm and its insurers in contemplation of settlement. In reliance on this application, and without conducting any further investigation, the insurer issued the policy. The policy provided prior acts coverage for members of New Firm who were also members of the firm. The policy also sported a definition and exclusion pertinent to these facts.

> All CLAIMS regardless of whether they involve one or more insureds arising from the same ACT or series of related ACTS shall constitute a single CLAIM irrespective of the number of claimants, and shall be deemed to have been made during the policy period in which the CLAIM arising from the ACT or series of related ACTS is first made against the insureds without regard to the policy periods.

During the effective dates of coverage of the policy, Smith Financial sued several defendants, including two members of New Firm who used to work for the firm. In connection with a single loan made by Smith to the ringleader of the investment fraud, Smith alleged under various theories of relief that, in connection with the loan, the lawyers omitted known facts and made misrepresentations to Smith inducing Smith to lend the money. Smith was damaged when the money could not be repaid. The Complaint was tendered to the insurer for defense and indemnity. The insurer denied coverage, claiming that the Trustee letter and ensuing settlement barred coverage, as a Claim arising from a series of related ACTS made prior to the inception of the policy.

Analysis And The Law

Any lawyer who has debated trigger theory, or attempted to ascertain the number of occurrences arising out of a multi-vehicle accident or the sale of infirm products knows what is afoot under these facts. The carrier on the risk when the claim is made, if different than the earlier insurer will argue that it owes nothing; or, having sold a series of annually renewed policies with the most recent having a new, large deductible will argue lack of relatedness in order to limit the loss. The insured will strive to shepherd the loss into the policy period which has the most robust limits and, perhaps, defense costs as a separate limit atop loss limits – whose ox is being gored remains the question. And, this question is not subject to easy rules of determination, because courts have given us, like badges of fraud, no clear rule to follow, but ideas to think about in order

to imbue relatedness with sufficient meaning to provoke a rule of decision in keeping with the Court's predilections. (The first thing we do in a case like this is to check the docket to see which judge will favor us with her wisdom).

First, bear in mind that every word in a policy provision of this ilk has specific meaning, even if undefined. An ACT is not a Claim. Arising from or out of is a phrase of broad meaning, inviting a cause analysis with big and little circles being drawn on legal pads. And then there is the word "related," imparting a degree of consanguinity requiring more than casual kinship. Each of these words or phrases must be invested with particular meaning by governing law (to the extent extant) whilst poring over legal and non-legal dictionaries on-line seeking refuge in the one interpretation which yields the desired result.

The milieu matters, because analysis arising from a denial would be different than one concerning indemnity for loss where defense costs are being advanced or defense being provided under a reservation of rights (or Coverage Position Letter as Liberty Mutual labels it). *Allstate Ins. Co. v. RJT Enters., Inc.*, 692 So. 2d 142, 144 (Fla. 1997). Why? Because where the duty to defend or to advance defense costs is at issue (and the test for both is the same in Florida),[2] a possibility of coverage is all that is required under, typically, the eight corners test. *Mid-Continent Cas. Co. v. Basdeo*, 742 F. Supp. 2d 1293, 1324 (S.D. Fla. 2010) ("Any doubts regarding the duty to defend must be resolved in favor of the insured."). If a comparison of the allegations of the complaint (4 corners) and the policy (the other four) yields a possibility of coverage, construing the policy in the fashion most courts do, then the insurer must defend. Bear in mind as well, that the comparison test in this context does not require comparing a prior complaint with the new

[2] *See Maplewood Partners, L.P. v. Indian Harbor Ins. Co.*, 295 F.R.D. 550, 601 (S.D. Fla. 2013) ("[a]n insurer's obligation to advance defense expenses is not materially different from a duty to defend.").

complaint to determine relatedness. Instead the court may consider a letter (as a species of Claim) to perform the analysis. *See Higgins v. State Harm and Cas. Co.*, 894 So. 2d 5, n. 2 (Fla. 2004) (noting some limited exceptions to the general rule); *Acosta, Inc. v. Nat'l Union Fire Ins. Co*., 39 So. 3d 565, 574-75 (Fla. 1st DCA 2010); *Composite Structures, Inc. v. Cont'l Ins. Co.*, 560 Fed. Appx. 861, 866-67 (11th Cir. 2014). There is a twist aborning in Florida, however; an exception to the eight corners rule which allows a court, sometimes, to consider documents other than the complaint and policy in discerning the duty to defend. *Id.*; *see, also*, Hugh Lumpkin & Alex Stern, *We Need a Hard Eight: Florida's Growing Exception to the Eight Corners Rule*, 89 FLA. BAR. JOURNAL NO. 3, 8 (March, 2015) (shameless plug). This exception may have bearing in a relatedness analysis, as, typically a lawsuit (or Claim) may not on its face refer to an earlier Claim or suit though known to the insured and its insurer. This does not mean, of course, that the entire prior proceeding need be examined to determine the duty to defend (or pay for the defense) – it should not as indemnity is not afoot, just a defense. Thus, if need arise, the pleading or claim letter from the previous matter may be relevant, and if the insurer or insured seeks to broaden the enquiry, then careful attention must be given to how much is too much.

The thoughtful lawyer must also give consideration to analogous law given the tests courts articulate to employ a relatedness analysis. For example, case law discussing what may be a compulsory or permissive counterclaim and cases analyzing bar or merger principles in the context of *res judicata* can also be mined for examples to either support or distinguish cases for or against the party's position.

We now turn to the applicable test in Florida. Determining whether two claims arise out of a series of related ACTS is fact-sensitive. *See Capital Growth Fin., LLC v. Quanta Specialty Lines Co.,* No. 07-80908-CIV-HURLEY, 2008 WL 2949492, at *4 (S.D. Fla. July 30, 2008)

("cases interpreting [relatedness] policy language have produced widely varying results according to the circumstances of each case.") Where the term "related" is not defined in the policy, the Eleventh Circuit has adopted the dictionary definition of the word, which is "to show or establish a logical or causal connection between." *Cont'l Cas. Co. v. Wendt,* 205 F.3d 1258, 1263 (11th Cir. 2000) (the assessment of relatedness "typically involves consideration of whether the acts in question are connected by time, place, opportunity, pattern, and perhaps most importantly, by method or modus operandi."); *Morden v. SL Specialty Ins.,* 177 F. Supp. 3d 1320, 1332 (D. Utah 2016).

The court in *Capital Growth* provided several factors to be considered, including whether the parties are the same, whether the claims all arise from the same transactions, whether the 'wrongful acts' are contemporaneous, and whether there is a common scheme or plan underlying the acts. No. 07-80908-CIV-HURLEY, 2008 WL 2949492, at *4. But the court cannot treat multiple claims as a single claim if they are so factually and legally distinct that the relationship between the two is "so attenuated or unusual that an objectively reasonable insured could not have expected that they would be treated as a single claim under the policy." *Bay Cities Paving & Grading, Inc. v. Lawyers' Mut. Ins. Co*., 855 P.2d 1263, 1275 (Cal. 1993).

Judge Atkins' decision in *Kopelowitz v. Home Ins. Co*., 977 F. Supp. 1179 (S.D. Fla. 1997) is accord. There, a lender hired an attorney to assist it in a secured loan transaction with a company. *Id.* at 1182. The company defaulted on the loan and went into bankruptcy, where it was discovered that the attorney failed to properly perfect the lender's interest in the collateral. *Id.* Based on this determination, the attorney advised the lender to allow entry of a default judgment, rendering its claims in the property unsecured debts. *Id.*

Following the bankruptcy, the lender sued the attorney for malpractice arising out of

his negligent failure to properly perfect the security interest ("Claim #1"). *Id.* The lender amended its complaint to include the law firm and various other partners, including attorney Robert Shapiro. *Id.* at 1182-83. The complaint was then amended a third time to seek damages for the firm's breach of fiduciary duty and lack of fair dealing in the handling of the bankruptcy case ("Claim #2"). *Id.* at 1183.

Between the filing of the second and third amended complaint, Shapiro obtained new insurance for himself individually. *Id.* When he submitted the third amended complaint to his new insurer, the insurer refused to defend him, arguing that the allegations in the third complaint arose out of those alleged in the first and second complaints, and thus related back to a prior policy. *Id.* Shapiro eventually settled and assigned his rights in the policy to the plaintiff who then brought an action against the insurer alleging, among others things, that it breached its duty to defend.

The court held the claims were not "related." *Id* at 1187-89. Specifically, the court focused on the allegations in the third complaint, which alleged that the firm (and hence Shapiro) breached its fiduciary duty to faithfully represent the plaintiff's interests in the bankruptcy, by amongst other things failing to inform plaintiff of a settlement offer. *Id.* at 1188. Because this was a separate cause of action from claims underlying the loan transaction (negligence) they were not related. *Id.* In other words, the breach of fiduciary claim could have existed independently of the negligence claim: if there was no negligence in the handling of the loan transaction there could still be a separate action against the firm for its failure to inform plaintiff of the settlement offer. *Id.* Further, if there *was* negligence in the loan transaction, the failure to inform plaintiff of the possible settlement offer would be a separate act of negligence, based on distinct facts, and possibly distinct damages resulting from the failure to perfect

security interest. *Id.*

> Accordingly, the court in *Kopelowitz* found that there was no nexus between the two acts because one cause of action could have existed independently of the other. That both claims had arisen out of the firm's representation of a single client was inconsequential. *See, also Morden,* 177 F. Supp. 3d at 1331 ("Not every wrongful act that shares some common facts, however, is necessarily interrelated . . . . the wrongful acts must be at least logically or causally connected.").

While the analysis in *Kopelowitz* was analogous to cases determining the issue of *res judicata*, other courts have focused on a variety of other factors in order to resolve the issue of relatedness. *See, e.g.*, *Vozzcom, Inc. v. Great Am. Ins. Co. of New York*, 666 F. Supp. 2d 1332, 1339 (S.D. Fla. 2009), *aff'd*, 374 F. App'x 906 (11th Cir. 2010) ("Acts are not considered 'related' if they . . . give rise to separate causes of action."); *Camico Mut. Ins. Co. v. Rogozinski,* No. 3:10-CV-762-J-32MCR, 2012 WL 4052090, at *8 (M.D. Fla. Sept. 13, 2012) *aff'd*, 530 F. App'x 910 (11th Cir. 2013) (focusing on the underlying wrongful act as opposed to the duties breached and finding a logical and causal connection between multiple acts where the same accountant made the same accounting error over a period of years which resulted in damages to three brothers pursuing a joint business venture); *Paradigm Ins. Co. v. P & C Ins. Sys., Inc.*, 747 So. 2d 1040, 1042 (Fla. 3d DCA 2000) ("the question appears to be whether each of the claimed negligent acts contributes to, or causes, the same monetary loss.").

The Law Applied To The Facts

The factual setting set forth above is a real case where one party lost and another won. Here, the insured won in the face of obdurate and canny opposition, in part because the insurer did not do what it should have done – defend under ROR thereby shifting the focus from a duty to

defend setting with all of the presumptions operating in favor of the insureds to one where a broader consideration of the true facts might have obtained.

Predictably, the insurer tried in vain to broaden the enquiry by stuffing the record with collateral facts mined from the litigation between the insurers who paid to fund the settlement with the trustee, as well as letters and affidavits from the underlying litigation between new firm and Smith. While patiently considered, this effort was stillborn as a traditional eight corners test modified to include consideration of the trustee's demand and the settlement agreement obtained.

There were several important considerations which drove the decision, though the bar order was curiously not one of them. We argued that, if a claim survived application of the bar order (and the underlying complaint was tested on motion to dismiss for this precise reason) it was necessarily unrelated. Yet, while facially appealing, the opinion made no mention of this fact or argument.

First, the duties allegedly breached by the firm were owed to the defunct entities in bankruptcy as well as to the now-felon. Smith bottomed its claim on duties owed to it. Second, and while the insurer attempted a gestalt view of "arising out of" nexus, the decider rejected such a broad view, instead focusing on the ACTS giving rise to liability. Since new firm and its counsel were involved in a single transaction of limited duration, and the damages claimed were distinct from those sought by the trustee, the case resonated with Kopelowitz. The insurer put great stock in Vozzcom, which was, frankly, a mistake. Vozzcom is a great example of a case imbued with relatedness, but there were other cases where the insured lost on facts more closely aligned with our fact setting. At bottom, simply representing someone is neither an ACT nor a circumstance sufficiently specific to imbue a relatedness argument with meaning. If it were, the existence of a single common feature would suffice to preclude coverage.

What Is The Prior Knowledge Provision?

Most errors and omissions policies issued to professionals are typically claims made policies that provide coverage for claims that were first made against the insured during the policy period. Insurers include "prior knowledge" provisions in such policies to ensure that no insured has knowledge – before the inception of the policy – of an act that is reasonably likely to become a claim. Courts have typically upheld such prior knowledge provisions as an integral part of errors and omissions professional liability coverage. *See, e.g., Truck Ins. Exch. v. Ashland Oil, Inc.*, 951 F.2d 787 (7th Cir. 1992); *Bryan Bros., Inc. v. Cont'l Cas. Co.*, 660 F.3d 827 (4th Cir. 2011).

While prior knowledge provisions vary, they typically provide that the policy provides coverage for a claim only if no insured "had a basis to believe that any such act or omission or interrelated act or omission might reasonably be expected to be the basis of a claim." These provisions can be contained in the insuring agreement, the conditions, and/or the exclusions sections of the policy.

A sample policy provision with this prior knowledge provision in the exclusion appears below:

> This Policy does not apply to and We shall have no obligation to pay any Damages, Claim Expenses or Supplemental Payments for any Claim:
>
> * * *
>
> D. based upon or arising out of any actual or alleged Wrongful Act that:
>
> 1. was committed prior to the Retroactive Date;
> 2. has been the subject of any notice given under any other policy of which this Policy is a renewal or replacement; or
> 3. You had knowledge of prior to the Policy Period and had a reasonable basis to believe that such Wrongful Act could give rise to a Claim; provided, however, that if this Policy is a renewal or replacement of a previous policy issued by Us providing materially identical coverage, the Policy Period referred to in this paragraph will be deemed to refer to the inception date of the first such policy issued by Us.

* * *

When the prior knowledge provision is an exclusion, the burden is on the insurer to establish that it applies. *Foster v. Winchester Fire Ins. Co.*, No. 09-1459, 2012 U.S. Dist. LEXIS 88274 (W.D. Pa. June 26, 2012)(court declined to follow case law in other jurisdictions and denied a motion to reconsider its holding that, under Pennsylvania law, the insurer had the burden of proving the applicability of a prior knowledge condition that appeared within an errors and omissions policy's insuring agreement). Prior knowledge provisions that are placed in the conditions section of the policy provide the insurer with an argument that the insured must establish that the claim is covered by showing it had no prior knowledge.

Evaluating the Insured's Prior Knowledge – Extrinsic Evidence and the Duty to Defend

When evaluating the insured's prior knowledge, and particularly when attempting to determine whether it precludes a duty to defend, courts often look at evidence beyond the allegations in the underlying complaint. In *Westport Ins. Co. v. Albert*, 208 F. App'x 222 (4th Cir. 2006), a previous court filing that sought to remove a personal representative contained allegations of mismanagement against the insured. The *Albert* court reviewed the allegations of an earlier related proceeding to conclude that such allegations put the insured on notice that there could be a claim for such conduct. Even though these additional allegations were not found in the underlying complaint against the insured, the court nevertheless considered them to conclude that the prior knowledge provision barred a duty to defend. *Id.* at 225-226. Another court considered correspondence that predated the underlying lawsuit which established the insured's knowledge of circumstances that might lead to a claim. *American Guarantee & Liability Ins. Co. v. Fojanini*, 90 F. Supp. 2d 615 (E.D. Pa. 2000). Similarly, another court relied on extrinsic evidence in determining whether the insured's prior knowledge precluded a duty to defend by considering

whether the insured knew that his client might sue him. *Eisenhandler v. Twin City Fire Ins. Co.*, 2011 WL 5458180 (Conn. 2011). The *Eisenhandler* court also stated that considering extrinsic evidence to analyze the insured's knowledge was critical and the failure to do so would undermine public policy. *Id.* at *6. *See also Nat'l Cas. Co. v. Franklin County*, 718 F. Supp. 2d 785 (S.D. Miss 2010); *Darwin Nat'l Assur. Co. v. Hellyer*, 2011 WL 2259801 (N.D. Ill. 2011).

There are courts that have refused to consider extrinsic evidence when determining the duty to defend. *M.D. Sass Investors Servs., Inc. v. Reliance Ins. Co.,* 810 F. Supp. 1082 (N.D. Cal. 1992) (extrinsic evidence may be considered when the prior knowledge provision is located in the policy's conditions section, but not if it is contained in the policy's exclusions section); *Am. Guar. & Liab. Ins. Co. v. Hoeffner*, 2009 WL 130221 (S.D. Tex. 2009) (the absence of allegations in the underlying complaint against the insured that the insured knew or could foresee that his conduct could result in a claim means that results in the insurer's duty."

Extrinsic evidence is typically necessary to determine whether the prior knowledge provision bars a duty to defend. Usually, the facts related to prior knowledge are unrelated to the underlying tort claimant's factual allegations and causes of action. The extrinsic facts related to the insured's prior knowledge may be completely unknown by the tort claimant. Moreover, the underlying tort lawsuit may well contain undeniably false allegations. Some courts have examined extrinsic evidence where the insured admitted intentional conduct, which is contrary to allegations made by the underlying tort claimant. *Home Mut. Ins. Co. v. Lapi*, 596 N.Y. F.2d 885 (N.Y. App. Div. 1993); *Or. Ins. Guar. Assn. v. Thompson*, 760 P.2d 890 (Or. Ct. App. 1988).

Most underlying tort claimants have no reason to allege a specific history of the relationship and the various communications between the claimant and the insured that predate the

lawsuit. As a result, it is critical for courts to examine extrinsic evidence to determine whether the prior knowledge provision is invoked.

Prior Knowledge Provisions and Related Acts Provisions

Another policy provision that limits coverage – the related acts provision – sometimes intersects with the prior knowledge provision. The related acts provision typically states that "[e]ach wrongful act, in a series of wrongful acts, will be deemed to have occurred on the date of the first wrongful act." When there are wrongful acts alleged both before and after the inception of the policy, the related acts provision together with the prior knowledge provision can result in no coverage for the insured. One court found the related acts provision together with the prior knowledge provision ambiguous as applied to the facts of the claim. In *OneBeacon Ins. Co. v. T. Wade Welch & Assocs*., 2012 WL 6608264 (S.D. Tex. Dec. 18, 2012) *aff'd* 841 F. 3d 669 (5th Cir. 2014), the district court held that the prior knowledge exclusion and related acts provision were ambiguous as applied, and held that the insurer had a duty to defend the insured for an underlying malpractice claim alleging wrongful acts occurring both before and after its policy incepted. The insurer denied a defense and coverage and started a declaratory judgment action. The policyholder argued that the policy was at least ambiguous as to whether the insurer could use the related wrongful acts provision to deny coverage under the prior knowledge exclusion. The court agreed, finding that the insured's interpretation of the policy was reasonable and thus the policy was ambiguous. In so holding, the court distinguished a series of cases cited by the insurer on the grounds that those cases all involved the issue of whether alleged wrongful acts were related for limits of liability purposes instead of for determining whether independent wrongful acts could be linked to determine whether they implicated a policy's prior knowledge exclusion. The Fifth

Circuit Court of Appeals affirmed, holding that the district court's analysis of the policy language was correct.

Litigating the prior knowledge provision and/or the related acts provision can be more nuanced than a standard insurance coverage legal dispute. The policy provisions as applied to the facts of the claim can raise other issues of contract interpretation. Policyholders and insurers should make sure that the record is established before presenting an issue to the court via dispositive motion, because it is difficult to anticipate all arguments the opposing party may make when the record is poorly developed.

Failure to Disclose/Misrepresentation in Application for Insurance

Applications for professional liability insurance typically require the applicant to disclose circumstances that may give rise to a claim and permit the insurer to rescind the policy when the insured fails to do so. A standard application provision reads:

> It is understood and agreed that failure to provide true and complete response to any of the questions, statements or request for information in this Application or to provide any other information material to this Application may, at the sole option of the insurer, result in the voiding of the insurance policy issued in reliance on this Application and /or denial of coverage for specific claims asserted against us (the Applicant) or any other insured under the policy. The undersigned on behalf of the Applicant and all other insureds under this policy issued by the insurer, hereby waives any defense to an action by the insurer for voiding or revoking of the policy based upon misrepresentation of fact or failure to disclose material information in connection with this Application. The Applicant agrees to hold the insurer harmless from all loss as a result of any such misrepresentation or failure to disclose, including, without limitation, all costs and attorney fees incurred by the insurer in connection with said action for voiding or revoking the policy.
>
> I HEREBY DECLARE that the above statements and particulars are true to the best of my knowledge, that I have not suppressed or misstated any facts and I agree that this application shall form part of the insurance policy. I also acknowledge that I am obligated to report any changes that could affect the disclosures in this application that occur after the date of signature, but prior to the effective date of coverage.
>
> Name (please print): _____ Signature _____

Some courts have found a failure to disclose circumstances of a claim as "material information" such that the policy may be rescinded. In many of those cases, the misrepresentation or failure to disclose is egregious. *See, e.g., Perkins v. Am. Int'l Specialty Lines Ins. Co.,* No. 1:12-cv-3001-TWT, 2012 U.S. Dist. LEXIS 175592 (N.D. Ga. Dec. 11, 2012) (insurer was entitled to summary judgment on the issue of rescission of an investment management insurance policy because insured had failed to disclose that it was operating a Ponzi scheme). Other courts find that rescission does not necessarily apply in situations of a failure to disclose. In *Goodman v. Medmarc Ins.*, 977 N.E.2d 128 (Ohio Ct. App. 2012), an insurer could not rescind a professional liability insurance policy after a malpractice lawsuit was filed against the insured even if the insured made misrepresentations in the policy application by answering "no" in response to questions about whether the insured was aware of any possible claims, errors, or omissions that might reasonably be expected to be the basis of any claims. Because the answers were representations, not warranties, even if misrepresentations were made, they did not void the policy and could not be used to avoid liability arising under the policy after such liability has been incurred.

Rescission actions can be governed by various procedural rules under state law. Parties litigating a potential rescission action based on a failure to disclose or misrepresentation should be familiar with potential defenses to such a claim and possible alternative theories that can or should be asserted.

The Personal Profit Exclusion

Professional liability policies often include a personal profit or advantage exclusion that bars coverage for claims where the insured gained a personal profit to which it was not legally entitled. The exclusion prevents the insured from recovering insurance proceeds for any personal gain the insured is later forced to return. The most basic version of the personal profit exclusion

bars coverage for "any Claim based on, or arising out of, or in any way involving any Insured having gained any personal profit or advantage to which he or she was not legally entitled." Berkley Ins. Co. Lawyers Professional Liability Policy, LPL 39450 (10-14) at IV.K. However, different versions of the exclusion raise varying critical issues depending on the factual context in which the exclusion is applied.

Some personal profit exclusions will raise questions as to who gained the profit and whether that same person is seeking coverage. Others will require an analysis into whether the insured gained the illegal profit "in fact." Where, for example, the insured is a law firm, but not all the lawyers at the firm personally profited, coverage may be excluded only as to the lawyer who personally profited.

Certain versions of the exclusion apply only where the insured against whom the claim is asserted is also the insured who gained the profit or advantage. *See TIG Specialty Ins. Co. v. Pinkmonkey.com Inc.*, 375 F.3d 365, 371 (5th Cir. 2004). This version would exclude coverage only for the insured who gained the profit or advantage and not the other insureds. Broader versions of the exclusion apply to claims arising from personal profit or advantage by "any insured." This version excludes coverage for all insureds, even where only one insured personally profited. *See Westport Ins. Co. v. Hanft & Knight, P.C.*, 523 F.Supp. 2d 444 (M.D. Pa. 2007).

In *Hanft*, the law firm to which the attorney who illegally profited belonged argued it was an "innocent co-insured" because the firm itself did not obtain any profit or advantage from its attorney's misconduct. 523 F.Supp. 2d at 460. The Pennsylvania District Court rejected the argument, noting the exclusion barred coverage for claims "resulting from **any Insured** having gained in fact any personal profit or advantage to which he or she was not legally entitled." *Id.* (emphasis in original). The court explained "Pennsylvania law is clear that the use of the term

'any insured' in these exclusions, rather than 'the insured,' bars coverage for innocent co-insureds." *Id.* at 461.

What About Exclusions?

Like other insurance policies, professional liability polices contain exclusions, including those for intentionally dishonest, fraudulent, criminal or malicious acts. They also may exclude claims between insured persons and the insured entity, so that they insurer need not cover conflicts within law firms, such as employment practices liability. They likewise may exclude coverage for claims arising from attorneys service as public officials or on the boards of non-profit or charitable organization.

The Personal Profit Exclusion

Professional liability policies often include a personal profit or advantage exclusion that bars coverage for claims where the insured gained a personal profit to which it was not legally entitled. The exclusion prevents the insured from recovering insurance proceeds for any personal gain the insured is later forced to return. The most basic version of the personal profit exclusion bars coverage for "any Claim based on, or arising out of, or in any way involving any Insured having gained any personal profit or advantage to which he or she was not legally entitled." *See* Berkley Ins. Co. Lawyers Professional Liability Policy, LPL 39450 (10-14) at IV.K. Differing versions exist, and depending on the factual context, can cause disputes between insurers and their policyholders.

Some personal profit exclusions will raise questions as to who gained the profit and whether that same person is seeking coverage. Others will require an analysis into whether the insured gained the illegal profit "in fact." Where, for example, the insured is a law firm, but not all the lawyers at the firm personally profited, coverage may be excluded only for the lawyer who

personally profited from the wrongdoing. *See, e.g., TIG Specialty Ins. Co. v. Pinkmonkey.com Inc.*, 375 F.3d 365, 371 (5th Cir. 2004). The scope of coverage may depend on whether applies only to the insured profiting, or to all insureds, even where only one insured personally profited. In *Westport Ins. Co. v. Hanft & Knight, P.C.*, 523 F.Supp. 2d 444 (M.D. Pa. 2007), for example, a law firm sought coverage despite one of its attorney's profit, arguing that the balance of the firm were innocent co-insureds. *Id*. at 460. The Pennsylvania District Court rejected the argument, noting the involved exclusion barred coverage for claims "resulting from *any Insured* having gained in fact any personal profit or advantage to which he or she was not legally entitled." *Id.* (emphasis in original). The court explained "Pennsylvania law is clear that the use of the term 'any insured' in these exclusions, rather than 'the insured,' bars coverage for innocent co-insureds." *Id.* at 461.

Illegal Profit or Advantage

Some policies exclude illegal profit, rather than any profit. Thus, courts often must analyze whether the allegations, established facts, and involved causes of action relate to receipt of profits that were, indeed, illegal. *E.g., Alstrin v. St. Paul Mercury Ins. Co.*, 179 F.Supp. 2d 376, 399-401 (D. Del. 2002); *Westport Ins. Co. v. Hanft & Knight, P.C.*, 523 F.Supp. 2d 444 (M.D. Pa. 2007). *Accord John M. Quinn, P.C. v. National Union Fire Ins. Co of Pittsburgh, PA*, 33 F.Supp. 3d 756 (S.D. Tex. 2014) (exclusion for return of profit or advantage to which firm was not legally entitled applied where firm was required to return general expenses improperly deducted from class members' settlement distributions).

The court in *Westport v. Hanft,* 523 F.Supp.2d at 454, also considered this issue. The clients, there, alleged that their attorney fraudulently induced them into loaning him money, which he used to gamble. They further claimed that they had received no legal services or other value

for their loans. Although the involved law firm argued that the illegal profit exclusion did not apply because a jury could conclude that the attorney was legally entitled to the loan money, but had commit malpractice by not properly securing the clients' funds. The court disagreed, noting that the clients had specifically alleged that the loans were procured by fraud, and that the attorney was not legally entitled to their money. *Id.*

Profit or Advantage "In Fact"

Many personal profit exclusions bar coverage for claims resulting from an insured "having gained *in fact* any personal profit or advantage." As in the context of other insurance policies, courts have grappled with the meaning of the words "in fact," and whether they require an insurer to defend unless and until there is a judicial determination of the facts needed to invoke the exclusion. *See, e.g., Brown & LaCounte, LLP v. Westport Ins. Corp.*, 307 F.3d 660, 662 (7th Cir. 2002). Some policies address this issue by exclusions making express that they apply only where the insured's illegal profit is established by: "(a) a plea of guilty or nolo contendere by any Insured; or (b) a final adjudication of the Claim, or final adjudication in any judicial, administrative or alternative dispute resolution proceeding." *See* OneBeacon Employed Lawyers Professional Liability Policy, NPF-30001-11-08, III.(A) (1) (b).

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SUBROGATION, EQUITABLE CONTRIBUTION AND OTHER INSURANCE – A SURVEY OF CURRENT CASE LAW

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This paper seeks to clarify (i) when "other insurance" provisions, and principles of subrogation, equitable subrogation and equitable contribution apply to the apportionment of insurance company obligations, (ii) whether a policyholder is entitled to a complete defense from any single insurance company when more than one insurer has a duty to defend, and (ii) whether a policyholder is entitled to complete indemnification from a single insurance company when more than one insurer has a duty to indemnify. The paper's focus is on situations when there are multiple policies on the risk for loss arising from a single identifiable event, such as when additional insured coverage applies to a single construction loss.[1]

In a nutshell,

- "Other insurance" clauses apply as tools to allocate responsibility for coverage when more than one policy applies to the same risk at the same level of coverage;
- Equitable contribution applies when one carrier has paid for a claim with respect to which another carrier also has responsibility, and it allows the paying carrier to seek recovery of a portion of the loss from the other carrier;
- Contractual subrogation or equitable subrogation applies when one carrier has paid for a claim with respect to which the policyholder has rights of recovery from a third-party, and it allows the paying carrier to stand in the shoes of the policyholder to recover its total payment from the third-party;
- In virtually all cases, any single carrier that has a duty to defend must pay for the entire defense of the case upon demand from the policyholder. The paying carrier in most states can recover from another carrier with a duty to defend as to the same risk under principles of equitable contribution.
- Courts generally agree that any individual insurance carrier that has a duty to indemnify must fund the entire amount of its indemnity obligations and cannot seek to use an "other insurance" clause as a limitation or exclusion with respect to those indemnity obligations. Other than applicable law in Texas and South Dakota, state law precedent acknowledges that carriers that have made indemnity payments can recover from other carriers that have coverage obligations with respect to the same loss either through subrogation or equitable contribution, and often in accordance with the allocation principles of the respective policies' other insurance clauses.

I. WHEN DO OTHER INSURANCE CLAUSES, SUBROGATION, EQUITABLE SUBROGATION, AND EQUITABLE CONTRIBUTION APPLY?

Other insurance clauses originated in property policies to prevent fraudulent claims in excess of property values. *Dart Industries, Inc. v Commercial Union Ins. Co.*, 28 Cal. 4th 1059, 1079-80 (2002) ("*Dart*"); *Hardware Dealers Mut. Fire Ins. Co. v Farmers Ins. Exch.*, 444 S.W.2d

[1] The paper does not address "other insurance" in the multi-year/latent injury context, and therefore does not attempt to address issues such as "all sums," horizontal versus vertical exhaustion or multiple deductibles of retentions. *See, e.g.*, 3-22 New Appleman on Insurance Law Library Edition §22.03, *Commonly Adopted Means of Allocation*. The paper also does not address how courts address conflicting "other insurance" clauses. *Id.* at § 22.02, *Purpose and Application of "Other Insurance" Clauses*; *see also* Baldwin, S., *Issues Involving "Other Insurance," Additional Insured coverage, Targeted Tenders, Equitable Contribution, and Equitable Subrogation Claims by and between Insurers*," posted by Shaun McParland Baldwin, Tressler LLP, Insurance Coverage and Practice Symposium, December 2012 at p. 283 ("*Baldwin/Other Insurance*").

583, 586 (Tex. 1969). The effect of the clauses was to reduce multiple recoveries for single losses, and use of the clauses ultimately made its way into automobile and other liability policies. Importantly, these clauses were not designed to limit the recovery of a policyholder for rightfully covered loss – they were designed to prevent double recovery.

Other insurance clauses are restrictive in their applicability. They apply only when "two or more insurance policies are on the same subject matter, risk and interest." *Am. Fire & Cas. Co. v. Marathon Aviation Marathon, Inc.*, 196 So. 2d 782, 783 (Fla. 2d Dist. Ct. App. 1967); *see* 3-22 New Appleman on Insurance Law Library Edition § 22.02, *Purpose and Application of "Other Insurance" Clauses* ("'[o]ther insurance' situations arise when two or more insurers provide concurrent coverage for the same risk at the same level"). Thus, other insurance clauses do not apply when different insurance coverages, e.g., CGL and professional liability coverages, are involved because those policies do not cover the same risks. *See Citizens Prop. Ins. Co. v. Ashe*, No. 1D09-1546, 2010 WL 4628915 (Fla. 1st Dist. Ct. App. Nov. 17, 2010) at 10 (other insurance clauses do not apply when one policy covered loss from wind and another policy covered loss from flood). Typically, other insurance clauses apply when an insured has both coverage under its own policies as well as under policies of others as an "additional insured." This often is the case in construction coverage cases involving owners, contractors, subcontractors, architects, and engineers.

Subrogation occurs when an action is brought by a paying insurance company against a third party whom the insurer alleges is responsible for causing the loss paid by the insurer. Courts distinguish "contractual/conventional subrogation" from "equitable subrogation" as follows: contractual subrogation takes place when there is an agreement that the injured party will transfer its rights to the indemnitor; equitable subrogation takes place when there is no formal agreement and the transfer of rights results from operation of law. *Nautilus Ins. Co. v. Lex. Ins. Co.*, Civil 09-00537DAE-LEK (D.C. Haw. November 17, 2010) at 15-16. Typical examples of contractual subrogation are when, pursuant to a provision of the insurance policy, an insurance company steps into the shoes of a policyholder after payment of a claim and brings an action against an alleged tortfeasor. *See State Farm General Ins. Co. v. Wells Fargo Bank, N.A.*, 143 Cal.App.4th 1098 (2006). Typical examples of equitable subrogation are when an excess carrier that has paid a claim steps into the shoes of the policyholder to assert a claim against a primary carrier that allegedly should have paid the claim. *New Amst. Cas. Co. v. Certain Underwriters at Lloyd's, London*, 34 Ill. 424 (1966). In all instances, subrogation is an attempt to shift the entirety of loss from the insurer who covered it to the third-party that bears responsibility for it.

By contrast, equitable contribution occurs when a paying insurance company seeks to get reimbursed for a portion of its payment from another insurance company that allegedly provided coverage for the same loss. *See, e.g.*, *Royal Globe Ins. v. Aetna Ins.*, 82 Ill. App. 3d 1003 (1st Dist. 1980) Courts generally only allow equitable contribution when there is "an identity between the policies as to the parties and insurable interests and risks." *Schal Bovis v. Cas. Ins. Co.*, 315 Ill.App.3d (1st Dist. 2000). Thus, an excess carrier ordinarily cannot seek contribution from a primary carrier "because excess carriers and primary carriers insure different risks." *Id*.

II. WHAT IS THE RESULT WHEN A POLICYHOLDER HAS DEFENSE COVERAGE UNDER MORE THAN ONE POLICY?

A. Can The Policyholder Recover All Of Its Defense Costs From Any Single Carrier That Has A Duty To Defend?

1. The Texas Rule

The majority of state and federal courts in Texas hold that the other insurance clauses of liability policies do not apply to the duty to defend, and that each carrier insuring the loss owes a 100% duty to defend the insured. *See Texas Property and Cas. Ins. Guaranty Association/Southwest Aggregates, Inc.*, 982 S.W.2d 600 (Tex. App. – Austin 1998, no pet); *Maryland Cas. Co. v. South Texas Medical Clinics, P.A.*, 2008 l 98375 (Tex. App. – Corpus Christi 2008, no pet.); *Mid-Continent Cas. Co. v. Academy Development, Inc.* 476 Fed. Appx. 316 (5th Cir. 2012). Thus, as a general rule, each insurer is jointly and severally liable for all costs of defense incurred. *Trinity Universal Ins. Co. v. Employers Mutual Cas. Co.*, 592 F.3d 607 (5th Cir. 2010).

The law is rooted in the Texas Supreme Court's decision in *Mid-Continent Ins. Co. v. Liberty Mut. Ins. Co.*, 236 S.W.3d 765 (2007) ("*Mid-Continent*"). In that case, the court held that when the insurance policies of primary co-insurers contain other insurance clauses, "a co-insurer paying more than its proportionate share cannot recover the excess from the other co-insurers" for their breach of the duty to indemnify through contribution because the insurers did not share a common obligation since the pro rata clauses made the contracts several and independent of each other. *Id.* at 772. The court in *Trinity Universal Ins. Co. v. Employers Mut. Cas. Co.*, 592 F.3d 687 (5th Cir. 2010) clarified *Mid-Continent*, holding that the other insurance clauses only apply to the duty to indemnify. *Id.* at 694.

The court in *Lexington Ins. Co. v. Ace American Ins. Co.*, 2014 WL 3406512 at *10 (S.D. Tex., July 7, 2014) further explained that "[w]here the court determines under the eight corners doctrine that the primary insurer has a duty to defend but breaches that duty and refuses to do so, a *subrogation clause* in a policy can entitle the insurer who took over the defense to recover defense costs from the primary insurer." *Id.* (citing *Continental Cas. Co. v. N. Am. Capacity Ins. Co.*, 683 F.3d 79, 87 (5th Cir.2012). In reaching this conclusion, the court relied on the other insurance clause of Lexington's policy, which provided: "[i]f no other insurer defends, we will undertake to do so, but we will be entitled to the insured's rights against all those other insurers." *Id.* Addressing an insurer's right to contribution, the *Lexington* court distinguished how equitable contribution applies to the duty to indemnify as opposed to the duty to defend:

> To prevail on a claim for contribution, a party must demonstrate that "several insurers share a common obligation or burden and the insurer seeking contribution has made a compulsory payment or other discharge of more than its fair share of the common obligation or burden." *Mid-Continent,* 236 S.W. 3d at 772. In *Trinity Universal Ins. Co. v. Employers Mutual Casualty Co.,* 592 F.3d 687, 694 (5th Cir. 2010), the Fifth Circuit clarified that ruling in *Mid-Continent and* opined that the "other insurance" clauses apply only to the duty to indemnify. In contrast, where the court finds that the allegations

> in a third-party suit against an insured fall within the scope of the insurance policy's coverage and a co-insurer breaches its duty to defend, which under Texas law is a separate and broader duty than its duty to indemnify, and because the insurer has a duty to provide a complete defense even if only one of several claims falls within the policy's coverage, a co-insurer who can satisfy the elements of a claim for contribution can sue to recover its defense costs.

Id. But see Truck Ins. Exch. v. Mid-Continent Cas. Co., 320 S.W.3d 613 (Tex. App. Austin, 2010, reh'g overruled)(holding that all contribution claims between primary co-insurers are barred under *Mid-Continent*).

While the cases cited involve breaching co-insurers, there is no indication that the law is any different in a case where the insured "selects" a single insurer, among several, to defend a lawsuit. Texas law is clear that this is the case where multiple consecutive policies covering a single indivisible injury are triggered. *American Phys. Ins. Exch. v. Garcia,* 876 S.W.2d 842, 855 (Tex. 1994)("Once the applicable limit is identified, all insurers whose policies are triggered must allocate funding of the indemnity limit among themselves according to their subrogation rights."); *see also Lennar Corp. v. Markel Am. Ins. Co.*, 413 S.W.3d 750 (Tex. 2013).

2. Court Outside of Texas

Virtually all states now agree that an insurance company cannot use an "other insurance" clause to escape full payment of defense costs when a duty to defend exists under its policy. As stated clearly by the New York Court of Appeals, "if *any* of the claims against an insured arguably arose from covered events, the insurer is required to defend the entire action," and "it is immaterial that the complaint against the insured asserts additional claims which fall outside the policy's general coverage." *Fieldston Prop. Owners Assn., Inc. v. Hermitage Ins. Co., Inc.*, 16 N.Y.3d 257, 264 (2011) ("*Fieldston*"), *quoting Town of Messina v. Healthcare Underwriters Mut. Ins. Co.*, 690 N.E.2d 866 (2002) (original emphasis).

In holding that an other insurance clause could not be used to restrict or limit a triggered carrier's duty to defend, the Supreme Court of Hawaii in *Nautilus Ins. Co., v. Lexington Ins. Co.*, 132 Haw. 283 (2014) ("*Nautilus*") made the following important and salient points about the duty to defend:

- By "requiring that a primary insurer have the duty to defend, regardless of the 'other insurance' clause, an insured will be ensured a defense where he or she may be entitled to one", *id*. at 293;
- "Where an insured has contracted for primary insurance, an insurer should not be able to refuse to defend and place the risk on the insured, of the insurer's erroneous understanding of another insurance policy that is not part of the original contract", *id*. at 294;
- "The insured chose a particular insurer as its primary insurer, and as such, the insured has the reasonable expectation that the insurer will come to the insured's defense when coverage is applicable", *id*.;

- "[R]elieving primary insurers of the duty to defend would provide a windfall to the carrier insofar as the costs of defense – litigation insurance – are contemplated by, and reflected in, the premiums charged for primary coverage", *id*. at 294-5.

Accord Preferred Mut. Ins. Co. v. Vermont Mut. Ins. Co., 32 N.E.3d 336, 343 (Mass. App. Ct. 2015), *quoting GMAC v. Nationwide Ins. Co.*, 4 N.Y.3d 451, 456 (2005)("When a primary policy is not a true excess policy, but merely 'is deemed "excess" by virtue of other collectible insurance, the limiting language is directed to its obligation to contribute to a settlement or judgment, not its duty to defend'").

B. Can The Paying Carrier Recover A Portion Of The Defense Costs It Has Paid From Another Carrier On The Risk?

In the majority of states, an insurance company that has paid defense costs under a duty to defend may seek to collect reimbursement for all or a portion of those costs through either subrogation or equitable contribution. As stated in *Nautilus*:

> [W]e simply reiterate that a primary insurer has the initial duty to defend regardless of any "other insurance" provision purporting to relieve that insurer of the duty to defend if it is deemed excess as to liability, but that an insurer may enforce such an "other insurance" clause when obtaining equitable contribution or reimbursement for defense costs where it believes that it has been made excess by operation of an "other insurance clause."

Nautilus at 296-96. *See, e.g., Med. Mut. Ins. Co. v. Am. Cas. Co.*, 721 F. Supp. 2d 447 (E.D.N.C 2010); *Potomac Ins. Co. of Ill. v. Pennsylvania Manuf. Assoc. Ins. Co.*, 215 N.J. 409 (2013); *see also Baldwin/Other Insurance* at 336. The minority of states that still do not allow contribution under these circumstances are Florida (*Continental Cas. v. United Pacific Ins. Co.*, 637 So.2d 270 ((Fla. Dist. Ct. App. 1994)), South Carolina (*Sloan Constr. Co. v. Central Nat'l Ins. Co.*, 269 S.C. 183 (1977)), and Mississippi (*Universal Underwriters Ins. Co. v. Amer. Motorists Ins. Co.*, 541 F. Supp. 755 (N.D.Miss. 1982)).

States differ as to whether the specific terms of other insurance clauses will apply to allocate defense costs where equitable contribution exists. In New York, for example, the Court of Appeals did not require contribution after determining that under the respective other insurance clauses of two carriers, one was deemed to be excess and the other was deemed to be primary. *Fieldston*, 16 N.Y. 3d at 265. In California, however, the courts have adopted the "modern trend" requiring pro rata apportionment irrespective of the language of the other insurance clauses. *Certain Underwriters at Lloyd's, London v. Arch Specialty Ins. Co.*, 246 Cal. App. 4th 418, 428-430 (2016).

III. WHAT IS THE RESULT WHEN A POLICYHOLDER HAS INDEMNITY COVERAGE UNDER MORE THAN ONE POLICY?

A. Can The Policyholder Recover All Of Its Indemnity Loss From Any Single Carrier That Has A Duty To Indemnify?

1. The Texas Rule

The Texas Supreme Court has taken an anomalous approach to allocation between carriers providing concurrent coverage to an insured. As mentioned above, *Mid-Continent,* 236 S.W.3d 765, profoundly affected the way carriers look at indemnity under Texas law because the Texas Supreme Court largely eliminated carriers' right to reallocate indemnity payments absent an express, explicit agreement between concurrent carriers. *Id.*

In *Mid-Continent*, the court considered whether a liability insurer could recover from a co-liability insurer a proportion of the amount it paid to settle an underlying lawsuit under theories of contribution and subrogation. 236 S.W.3d at 768. The underlying lawsuit in *Mid-Continent* involved an automobile accident in which a general contractor on a highway construction project was sued based on its alleged responsibility for the signs and dividers in the construction zone. *Id.* at 768-69. The general contractor was the named insured on a commercial general liability policy issued by Liberty Mutual Insurance Company. *Id*. at 769. It was also an additional insured under the CGL policy issued by Mid-Continent Insurance Company to the sub-contractor responsible for signs and dividers. *Id*. Both CGL policies had limits of $1,000,000 and contained identical "other insurance" clauses that provided that each insurer would pay only equal or pro rata shares of the loss if it was covered by other valid and collectible insurance. *Id*. The policies also each contained a "voluntary payments" clause, a subrogation clause, and a "no action" clause. *Id*.

Liberty Mutual and Mid-Continent disagreed on their insured's potential exposure in the underlying lawsuit. *Id*. at 770. Based on the disparity in their evaluations, Mid-Continent agreed to contribute only $150,000 at mediation, and Liberty Mutual paid the remaining $1,350,000 ($350,000 over its CGL policy limit was paid by the Liberty Mutual excess policy) to settle the case for $1,500,000. *Id*. Liberty Mutual reserved its right to seek recovery of Mid-Continent's share of the settlement. The federal district court ruled that Mid-Continent was liable for half of the $1,500,000 settlement. Mid-Continent appealed, and the U.S. Fifth Circuit Court of Appeals certified questions of law to the Texas Supreme Court. *Id*. at 771.

The court first addressed whether Liberty Mutual had a direct action for contribution against Mid-Continent. In doing so, the court reaffirmed the rule of contribution recognized in *Hicks Rubber* and reiterated in *Employers Casualty*. *Id*. at 772 (citing *Traders & Gen. Ins. Co. v. Hicks Rubber Co.*, 169 S.W.2d 142 (Tex. 1943) and *Employers Cas. Co. v. Transport Ins. Co.*, 444 S.W.2d 606 (Tex. 1969)). It also reaffirmed, however, the exception to the rule where the co-insurers' insurance policies contain "other insurance" or "pro rata" clauses. *Id*.

> The effect of the pro rata clause precludes a direct claim for contribution among insurers because the clause makes the contracts several and independent of each other. With independent contractual obligations, the co-insurers do not meet the common obligation requirement of a contribution claim – each co-insurer contractually agreed with the insured to pay only its pro rata share of a covered loss; the co-insurers did not contractually agree to pay

> each other's pro rata share. In addition, the co-insurer paying more than its contractually agreed upon proportionate share does so voluntarily; that is, without a legal obligation to do so.

Id. (citing *Hicks Rubber*, 169 S.W.2d at 147 and *Employers Cas.*, 444 S.W.2d at 609-10). The court thus held that the pro rata clauses in the CGL policies at issue precluded an equitable contribution claim. *Id*. at 772-73.

The court next considered whether Liberty Mutual had a right of reimbursement against Mid-Continent through contractual or equitable subrogation. *Id*. at 774. The court first noted that the Supreme Court's opinions in *Hicks Rubber* and *Employers Casualty* both contained language suggesting that a right of reimbursement through subrogation could exist. *Id*. (citing *Hicks Rubber*, 169 S.W.2d at 148 and *Employers Cas.*, 444 S.W.2d at 610). Comparing the two types of subrogation the court stated:

> Contractual (or conventional) subrogation is created by an agreement or contract that grants the right to pursue reimbursement from a third party in exchange for payment of a loss, while equitable (or legal) subrogation does not depend on contract but arises in every instance in which one person, not acting voluntarily, has paid a debt for which another was primarily liable and which in equity should have been paid by the latter. In either case, the insurer stands in the shoes of the insured, obtaining only those rights held by the insured against a third party, subject to any defenses held by the third party against the insured.

Id. (internal citations omitted).

Liberty Mutual argued that it was subrogated to its insured's contractual right to enforce Mid-Continent's policy language imposing a duty on Mid-Continent to defend and to indemnify the insured and to pay a pro rata share of settlement. *Id*. at 775. In addressing this argument, the court prefaced that where co-insurers' contractual duties to their insured include a several and independent duty to pay a pro rata share of a covered loss up to their respective policy limits, this duty cannot be viewed independent of the purpose of a pro rata clause or without consideration of the rules of indemnification. *Id*. It then reiterated that an insured's right of indemnity under an insurance policy is limited to the actual amount of loss. *Id*. But where two different insurance policies provide coverage for a loss, the pro rata clause informs the principal of indemnity by eliminating the potential for double recovery by the insured. *Id*. Concluding that an insured has no right to recover more than the sum of each insurer's pro rata share, the court held, "[A] fully indemnified insured has no right to recover an additional pro rata portion of settlement from an insurer regardless of that insurer's contribution to the settlement. Having fully recovered its loss, an insured has no contractual rights that a co-insurer may assert against another co-insurer in subrogation." *Id*. at 775-76.

The opinion in *Mid-Continent* is the precipice—the point at which mediations break down and policyholders and carriers alike grow frustrated. An informed carrier would not knowingly settle a case on behalf of a policyholder if there are other non-contributing carriers possibly owing concurrent coverage, for fear that doing so makes the paying carrier a volunteer and unable to

appropriately reallocate the indemnity payment to others that also owe the loss. *See e.g. Lexington Ins. Co v. Chicago Ins. Co.*, 2008 WL 3538700 (S.D. Tex. Aug. 8, 2008) (holding *Mid-Continent* barred Lexington's right to seek contribution or equitable subrogation from Chicago, both carriers having issued claims made and reported professional liability policies); *Nautilus Ins. Co. v. Pacific Employers Ins. Co.,* 303 Fed. Appx. 201 (5th Cir. 2008) (Nautilus and Pacific both provided additional insured coverage to EOG but Nautilus decided to settle some suits and Pacific proceeded to trial on other claim, the court rejected Nautlius' right to reallocate indemnity paid based on the holding in *Mid-Continent*). Since *Mid-Continent*, several federal district and appellate cases have restricted *Mid-Continent* to its facts and allowed reallocation. *See Amerisure Ins. Co. v. Navigators Ins. Co.*, 611 F.3d 299 (5th Cir. 2010) (in a situation in which Amerisure provided primary coverage, but argued no indemnity was owed due to exclusions, the court permitted Amerisure to seek reimbursement from Navigators limiting *Mid-Continent* to its facts, reasoning that prohibiting reallocation would discourage settlement and a carrier's ability to protect the insured's best interests); *American Southern Ins. Co v. Buckley*, 748 F. Supp.2d (E.D.Tex. 2010); *Maryland Cas. Co.v. Acceptance Indem. Ins. Co.,* 639 F.3d 701 (5th Cir. 2011).

In contrast, in a continuous coverage scenario, a policyholder may target a single carrier to fully fund the entire indemnity sum, leaving it to that targeted carrier to pursue, if possible, other sources of contribution. *See Lennar Corp. v. Markel American Ins. Co.*, 413 S.W.3d 750 (Tex. 2013). The Texas Supreme Court in *Lennar* held that Markel was required to fully indemnify Lennar for a loss, acknowledged to include damage inside and outside the Markel policy period, and left it to Markel to seek *subrogation* from the carriers in those other years for their allocated share of the loss. 413 S.W.3d at 759. While unstated, it appears that the Texas Supreme Court is making a distinction between the right to seek contribution or subrogation between consecutive carriers, while disallowing either for concurrent carriers.

A policyholder with available concurrent coverage is left with few options on indemnity. Creative solutions exist, but few give the policyholder or participating carriers finality at resolution of the case. If the policyholder is not made whole, subrogation rights still exist. If another carrier has denied coverage, contribution still exists. If carriers expressly agree to a funding mechanism with the right to reallocate, contractual right exists.

2. Court Outside of Texas

As discussed below, most courts recognize that a policyholder is entitled to full recovery on its loss to the extent of coverage under the policy, and the burden is on the paying insurance carrier to recover appropriate portions of its payment from other insurance carriers that also provide coverage for the loss. Courts generally do not allow carriers to use other insurance clauses as an exclusion of a limitation on the right of recovery under a policy.

Given the underlying purpose of the other insurance clause – to prevent double recoveries and to create a means for carriers to allocate their burdens to other carriers covering the same loss – this is entirely appropriate. Such rules place the burden of chasing all possible paths to coverage recovery on the insurance industry, as opposed to the single policyholder, and avoid the anomaly of a policyholder bargaining for more insurance and at the same time having less coverage under each individual policy.

B. Can The Paying Carrier Recover A Portion Of The Indemnity It Has Paid From Another Carrier On The Risk?

In virtually all states, insurance carriers that have paid covered losses can recover from other insurance carriers that have coverage obligations for the same loss. *Nucor Corp. v. Employers Ins. Co.*, 231 Ariz. 411 (Ct. App. 2012); *St. Paul Mercury Ins. Co. v. Mountain West Farm Bur. Mut. Ins. Co.*, 210 Cal. App. 4th 645 (2012); *Schmaelzle v. London & L. Fire Ins. Co.*, 75 Conn. 397 (1902); *General Star Indem. Co. v. Travelers Indem. Co.*, 2013 Conn. Super. (2013); *Nat. Cas. Co. v. Great Southwest Fire Ins. Co.*, 833 P.2d 741 (Col. 1992); *Levy v. HLI Operating Co.*, 924 A.2d 210 (Ch. Ct. Del. 2007); *Cont. Ins. Co. v. Federal Ins. Co.*, 153 Ga. App. 712 (1980); *Ins. Co. of the State of Pennsylvania v. Great Northern Ins. Co.*, 473 Mass. 745 (2015); *American Nat'l Fire Ins. Co. v. Frankenmuth Mut. Ins. Co.*, 199 Mich. App. 202 (1992); *Lexington Ins. Co. v. AXIS Surplus Ins. Co.*, 2014 U.S. Dist. LEXIS 75791 (D. Minn. June 4, 2014); *Nat. Fire Ins. Co. v. Dennison*, 93 Ohio St. 404 (1916); *Phila. Indem. Ins. Co. v. Pace Suburban Bus Serv.*, 2016 IL App (1st) 151659 (Nov. 17, 2016); *Highlands Ins. Co. v. Patrons Ins. Co.*, 2006 Kan. App. Unpub. LEXIS 1009 (May 19, 2006); *Mo. Pub. Entity Risk Mgmt. Fund v. Am. Cas. Co.*, 399 S.W.3d 68 (Ct. App. Mo. 2013); *Am. Family Mut. Ins. Co. v. Regent Ins. Co.*, 288 Neb. 25 (2014); *United States Fid. & Guar. Co. v. Federated Rural Elec. Ins. Corp.*, 2001 OK 81 (2001); *Carlton Lumber Co. v. Lumber Ins. Co.*, 81 Ore. 396 (1916); *Miller v. Home Ins. Co.*, 108 Pa. Super. 278 (1932); *Workers Comp. Fund v. Utah Bus. Ins. Co.*, 2013 UT 4 (2013); *Mut. Of Enumclaw Ins. Co. v. USF Ins. Co.*, 164 Wn.2d 411 (2008).

The standards governing the extent to which other insurance clause allocation specifications will apply varies among the states. States like New York will apply the specific allocations and even uphold so-called "escape clauses" that render one carrier excess to another carrier. Other states pay less deference to the other insurance clauses, and some deem all such clauses mutually repugnant and simply pro rate the loss among the carriers on the risk.

South Dakota follows the rule in Texas that if a carrier pays more than its share and its policies have "pro rata" allocation other insurance clauses, the court will deem amounts paid in excess of a carrier's pro rata share a "voluntary" payment that is not subject to reimbursement from another carrier that also is on the risk. *Mid-Continent Ins. Co. v. Liberty Mut. Ins. Co.*, 236 S.W.3d 765 (2007); *Nat'l Farmers Union Prop. & Cas. Co. v. Farm & City Ins. Co.*, 2004 SD 124 (2004). These two cases seem wrongly decided as they place the burden on the policyholder to chase down all possible paths to insurance recovery at its own expense, as opposed to placing the burden on the insurance company to seek contribution. In effect, the policyholder does not get full recovery on its contract, and the non-paying carrier with a coverage obligation gets a potential windfall.

CONCLUSION

Courts across the country have given practitioners the tools to avoid long and protracted litigation when more than one insurance policy provides defense of indemnity coverage for a single loss. Any carrier chosen by the policyholder to provide defense or indemnity coverage should provide that coverage in full with the right to assert subrogation or contribution rights against other carriers also on the risk after the policyholder is paid. To the extent that the chosen carrier presents substantive restrictions to coverage (i.e., other than an "other insurance" defense), it might be

necessary to involve another carrier's coverage to fill the gap. However, in most cases, complex other insurance and contribution issues should be litigated only after a final loss is determined and the policyholder is paid for that loss. Texas and South Dakota precedent should acknowledge this continent-wide application of law and adjust their rulings to conform.

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WAR AND PEACE (THE ABRIDGED VERSION): APPLICATION OF THE WAR AND TERRORISM EXCLUSIONS

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A fundamental precept of insurance is to provide coverage for a wide range of possible losses; this requires the insurer to evaluate empirical data collected on various risks in order to attempt to accurately set premiums.[1] The insurance industry sets premiums for insurance policies using a statistical and mathematical process by which a calculated rate justifies the risk, within defined areas of coverage.[2]

Calculating premiums during times of war and terrorism presents challenges to the insurance industry. As such, early insurance policies began including war exclusions to account for the uncertainties of war.[3] In the immediate aftermath of the attacks of September 11, 2001, there was a major contraction in the insurance market as reinsurers and then primary and excess insurers specifically excluded terrorism. This led to the United States government providing a "backstop" program to make sure that there was some property and liability insurance available for terrorism events. As time has passed without another major terrorism event, that backstop has remained in place, although under less generous terms, and there have been some offerings of standalone policies to insure against terrorism. All of these remain untested.

This paper will discuss both the war exclusions and terrorism coverage and exclusions, and their possible application to future events.

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1 Steven Plitt, *The Changing Face of Global Terrorism and A New Look of War: An Analysis of the War-Risk Exclusion in the Wake of the Anniversary of September 11, and Beyond*, 39 Willamette L. Rev. 31, 39 (2003).

2 *Id.*

3 *Id.*

I. WAR EXCLUSIONS

While war exclusions did not become a prominent fixture in insurance policies until World War I and World War II, certain insurance policies included these exclusion clauses as far back as the Civil War.[4] In an effort to mitigate the uncertainties caused by war, the United States insurance industry created war exclusions to preclude coverage for loss or damage caused by war in, among others, life, property and liability policies. Over time, the war exclusion developed to preclude coverage for 'loss or damage caused directly or indirectly by war and military action.'[5] This also includes undeclared or civil wars and 'warlike action by a military force,' as well as insurrection, rebellion or revolution."[6]

Today, the Insurance Services Office Inc. ("ISO") form for commercial general liability policies offers the following war exclusion:

> **2. Exclusions**
>
> This insurance does not apply to:
>
> * * *
>
> **i. War**

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4 George A. Pelletier, *Life Insurance – Military Service – Military Exclusion Clauses and Death from Nonmilitary Causes*, 36 Notre Dame Law Rev. 4, 47-48 (1960) ("Military exclusion clauses were used as long ago as the Civil War where extra premiums were charged on the basis of proximity to the war zone. World War I brought into existence the modern types of military exclusion clauses. The exclusion clause as it was developed during these wars sought to protect the insurance companies from the added risk of death due to war, which the companies in their actuarial planning, on the basis of normal experience, had not taken into consideration.").

5 *"Acts of War" Exclusions Won't Apply, Insurers Say*, 11 Andrews Ins. Coverage Litig. Rep. 934 (2001).

6 *Id.*

> "Bodily injury" or "property damage," however caused, arising, directly or indirectly, out of:
>
> (1) war, including undeclared or civil war;
>
> (2) warlike action by a military force, including action in hindering or defending against an actual or expected attack, by any government, sovereign or other authority using military personnel or other agents; or
>
> (3) insurrection, rebellion, revolution, usurped power, or action taken by governmental authority in hindering or defending against any of these.[7]

Litigation often results when an insurer declines coverage in reliance on exclusions.[8] The war exclusion is no different. Courts have been asked to interpret the application of a war risk exclusion and, on a number of occasions, have recognized the legality of the war exclusion as well as the insurer's right to limit its liability.

In *Stanbery v. Aetna Life Ins. Co*., a New Jersey court was asked to determine whether the war exclusion precluded a double indemnity recovery under a life insurance policy issued to an individual who subsequently became a United States Army Captain and who was killed on active duty in Korea in 1952 from a mine explosion while he was on a reconnaissance mission. After quoting numerous definitions of the term "war" from various sources, the court stated:

> The word "war" when used in a private contract or document should not be construed on a public or political basis, in a legalistic or technical sense, but should be given its ordinary, usual and realistic meaning, namely actual hostilities between the armed forces of two or more nations or states de facto or de jure. (Citation omitted.)
>
> The conflict still raging in Korea is a war in the ordinary and usual meaning of the word, and it was such on March 27, 1952, when

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7 CG 00 01 (Ed. 12/07) XS.

8 Jason B. Libby, *War Risk Aviation Exclusions*, 60 J. Air L. & Com. 609, 622 (1994-95).

> the insured met his untimely death. (Citation omitted.) To hold otherwise and rule the Korean war is not a war seems to me inexplainable and absurd.[9]

The court continued:

> The purpose of such a clause is not insidious or difficult to understand. Military or naval service in time of war, whether in training or combat, is admittedly hazardous, fraught with incalculable danger. It is difficult to determine the scope of risks assumed by members of the armed forces in view of the methods of warfare, keeping in mind the possible devastation of present and future developments. An insurance company has the right to limit its liability to particular risks. If it will only assume risks which it feels can be calculated and clearly and plainly so states, this court will not increase such liability. (Citation omitted.)[10]

Because courts have rejected public policy arguments[11] that the war exclusions should not apply, most coverage disputes revolve around the meaning of the exclusion. In addressing the war exclusion, courts generally focus on two issues: (1) whether there was a war, and (2) whether the exclusion precludes coverage only for the results of a war.[12]

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9 98 A.2d 134, 138 (N.J. Super. Ct. Law Div. 1953).

10 *Id.* at 139.

11 *See, e.g., Trimble v. Western & Southern Life Ins. Co.*, 82 N.E.2d 548, 550-51 (1948) (finding war clause in life policy excepting liability for accidental death during service of insured in military forces of a country at war or in time of war was not void as contravening public policy); *Jorgenson v. Metropolitan Life Ins. Co.*, 55 A.2d 2, 5 (1947) (explaining that it is also public policy to uphold the freedom of contract); *Selenack v. Prudential Ins. Co.*, 50 A.2d 736, 737 (1947) (finding the validity of a provision in a life or accident contract, entirely releasing, or restricting the liability of an insurer under the policy because of military service of the insured, is almost universally recognized).

12 Paul H. Rogers, *Modern Warfare and Its Effect on Policy Construction*, 1952 Ins. L. J. 360.

This article addresses the various meanings of the terms found in the exclusion, as interpreted by state and federal courts across the country, and highlights the challenges facing the courts in applying war exclusions.

A. WHAT CONSTITUTES A "WAR"?

In order to determine whether a loss is covered under an insurance policy, courts must first determine whether the conflict that caused[13] the loss constitutes a "war."

Pursuant to Article I, Section 8, Clause 11 of the United States Constitution, Congress has the sole power to declare war.[14] Article II, Section 2, which names the President Commander-in-Chief of the armed forces, bestows the President with the power to direct the military after a Congressional declaration of war.[15] Congress has only declared war on five occasions (against eleven countries)[16] throughout the history of the United States, but the country has engaged in numerous other conflicts[17] that beg the question: is a Congressional declaration necessary to establish that a state of war exists?

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13 Courts have been presented with substantial questions as to the extent to which a "causal connection" is required between the war and the resulting loss under war exclusions. This issue is beyond the scope of this paper, but for a more detailed discussion regarding the causation issues relevant to the application of war exclusions *see* Plitt, *supra* at 50-63.

14 U.S. Const. art. I, § 8, cl. 11 ("To declare War, grant Letters of Marque and Reprisal, and make Rules concerning Captures on Land and Water.").

15 U.S. Const. art. II, § 2.

16 James M. Crain, *War Exclusion Clauses and Undeclared War*, 39 Tenn. L. Rev. 328 (1971-72). Congress declared war with Great Britain in 1812 (War of 1812), Mexico in 1846 (Mexican-American War), Spain in 1898 (Spanish-American War), Germany in 1917 (WWI), Austria-Hungary in 1917 (WWI), Japan in 1941 (WWII), Germany in 1941 (WWII), Italy in 1941(WWII), Bulgaria in 1942 (WWII), Hungary in 1942 (WWII), and Romania in 1942 (WWII).

17 For example, in the 1991 Gulf War, the 1999 conflict in Kosovo, the response to the 2001 terrorist attacks and the 2003 conflict in Iraq, the President issued a statement publicly and formally announcing that the United States was entering into an armed struggle, articulating its reasons for doing so, and describing the conditions upon which peace

In *Bas v. Tingy,* one of the earliest cases to address this issue, the United States Supreme Court was called upon to decide whether the naval conflict with France from 1798 to 1800 was in fact a war, despite the absence of a formal declaration of war by Congress. In particular, the Supreme Court was asked to determine the meaning of the word "enemy" in a statute regulating prize awards when vessels are recaptured from an enemy.[18] If the naval conflict constituted a "war," then France would be considered an "enemy" within the meaning of the prize statute and, therefore, the prize statute would apply to any recaptured vessels.[19] In finding that Congress need not make a declaration for war to exist, the Supreme Court recognized two kinds of war: (1) there is solemn war, which is of the perfect kind, where one nation declares war against another, and (2) there is imperfect war, or "undeclared war,"[20] when "hostilities may subsist between two nations" on a limited basis.[21]

In making this determination, the Supreme Court examined both the facts of the conflict ("the scene of bloodshed, depredation and confiscation, which has unhappily occurred")[22] and the acts of Congress that had authorized limited military action:

> In March 1799, congress had raised an army; stopped all intercourse with France; dissolved our treaty; built and equipt ships of war; and commissioned private armed ships; enjoining the former, and authorising the latter, to defend themselves against the armed ships of France, to attack them on the high seas, to subdue and take them as prize, and to re-capture armed vessels found in their possession.[23]

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would be made. *See* Michael D. Ramsey, *Presidential Declarations of War*, 37 U.C. Davis L. Rev. 321, 324 (2003).

18 4 U.S. 37, 38 (1800).

19 *Id.* at 37 ("[T]he argument turned, principally, upon two inquiries: 1st. Whether the Act of March 1799, applied only to the event of a future general war? 2d. Whether France was an enemy of the United States, within the meaning of the law?").

20 *Anderson v. Carter*, 802 F.3d 4, 8-9 (D.C. Cir. 2015).

21 *Bas*, 4 U.S. at 40.

22 *Id.* at 39.

23 *Id.* at 41.

Given these events, the Supreme Court found the naval conflict constituted a public war on the basis that the conflict was an "external contention by force, between some of the members of the two nations, authorized by the legitimate powers."[24]

Following the decision in *Bas*, several other decisions adopted this reasoning and even expanded the circumstances in which a war can exist for purposes of triggering statutory and/or contractual provisions. *See, e.g., The Amy Warwick,* (known as "the *Prize Cases*") (finding that a blockade is an act of war);[25] *Dole v. Merchants' Mut. Marine Ins. Co.* (finding that when subjects of a civil government have rebelled, established another government, and resorted to arms to maintain it, the fact that such rebels are robbers on the land and pirates on the sea does not preclude the conflict from constituting a war);[26] *Montoya v. United States* (finding a conflict between the United States and an Indian tribe to constitute a war);[27] *Mitchell v. Laird* (explaining, in dicta, that "[t]here would be no insuperable difficulty in a court determining whether" the Vietnam conflict constituted a war in the Constitutional sense);[28] *Dellums v. Bush* (explaining, in dicta, that the court has no hesitation in concluding that an offensive entry into Iraq by several hundred thousand United States servicemen could be described as a "war" within the meaning of the Constitution);[29] *Koohi v. United States* (noting that, even absent a formal declaration, "no one can doubt that a state of war existed when our armed forces marched first into Kuwait and then into Iraq");[30] *Anderson v. Carter* (finding that the conflict in Afghanistan was a war for purposes of Administrative Procedure Act).[31]

These courts shared the central concept that war is an existing fact and not a legislative decree.[32] While Congress alone may have the power to declare war, it

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24 *Id*. at 40.
25 67 U.S. 635, 670 (1862).
26 51 Me. 465 (1863).
27 180 U.S. 261, 270 (1901).
28 488 F.2d 611, 614 (D.C. Cir. 1973).
29 752 F. Supp. 1141, 1146 (D.D.C. 1990).
30 976 F.2d 1328, 1334 (9th Cir. 1992).
31 802 F.3d 4, 8 (D.C. Cir. 2015).
32 *Dole,* 51 Me. at 470.

may also be initiated by other nations, or groups, independent of whether Congress made any declaration of it or not.[33]

B. INTERPRETING THE MEANING OF "WAR"

While the early cases that addressed war exclusions provided some guidance in interpreting the meaning of "war," these cases did not provide particular clarity, or develop set doctrines, that would assist future courts in interpreting, under all types of insurance policies, whether the nation was in a state of war during times in which war had not been declared.[34] During World War II, courts developed the following three doctrines[35] concerning the interpretation of the term "war" in order to provide some clarity to the unique situations where the state of war is uncertain: the technical meaning doctrine, common meaning, and inherently ambiguous.

In the rare instances that Congress has declared war, the question of whether a "war" exists for purposes of interpreting whether a certain loss is covered under

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33 *Id.*

34 *Id.*

35 In addition to the three doctrines, courts have also classified the variety of war exclusions that appear in life insurance policies into two categories: "status" clauses or "result" clauses. A "status" clause will relieve an insurer from liability merely because the insured at the time of his or her death occupied the status excepted by the contract. *Onze v. Prudential Ins. Co. of Am.*, 1 Pa. D. & C.2d 23, 29 (Pa. Ct. Com. Pl. 1954). A "result" clause on the other hand does not relieve the insurer from liability unless the death itself was caused by the risk which the insurer declined to assume. *Id.* In the one type of provision, the status itself is made the basis for nonliability of the insurance company while in the other type of clause the insurer is not relieved from liability unless the death is the result of the risk excluded by the coverage. *See Annotation, 36 A.L.R.2d 1018.* Courts explain that "[s]uch a limitation clause has generally been construed as being tied into the doctrine of causation, so that unless the accident and death resulted, i.e., were caused by, or flowed from, the military service, (the risk there excepted) the insurer was held liable. In other words, in the 'result' clause cases, mere status is usually held not to be determinative of liability, the real question being causation or increased hazard." *Onze,* 1 Pa. D. & C.2d at 29.

an insurance policy is straightforward. However, determining the meaning of "war" becomes challenging in at least these situations:

1. Where the loss occurs prior to the formal declaration of war;

2. Where the loss occurs after the cessation of hostilities, but prior to the official termination of the war;

3. Where the loss occurs in hostilities that are never formalized by a declaration of war; and

4. Where the loss occurs after the cessation of hostilities that were never formalized by a declaration of war.[36]

The first doctrine used by the courts applies a technical meaning to the term and explains that "war" means war in the legal sense, wherein it must be formally and constitutionally declared.[37] This doctrine favors providing coverage for an otherwise insured loss – particularly in light of the fact that Congress has only declared war five times.[38] In *Harding v. Pennsylvania Mut. Life Ins. Co*.,[39] a Pennsylvania court adopted the technical meaning of the term "war" to a dispute over a loss arising out of the conflict in Korea in the 1950s, and explained its reasoning as follows:

> Since "war" is a word which has been held to import various meanings, it is incumbent upon the insurer to make clear that it applies to undeclared war, as well as to declared war, for even if

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36 Crain, *supra* at 331.

37 *See, Beley v. Pennsylvania Mut. Life Ins. Co*., 95 A.2d 202, 249 (1953) (adopting the technical meaning doctrine, the court explained: "[t]he contract presumably was prepared by competent insurance company attorneys, who, no doubt, were familiar with the most recent decisions relating to war risk provisions in insurance contracts; and if the appellee did not intend to assume risks growing out of hostilities short of war it could have so provided by extending the phrase 'in time of war' to include undeclared war.").

38 Daniel James Everett, *The "War" on Terrorism: Do War Exclusions Prevent Insurance Coverage For Losses Due to Acts of Terrorism*, 54 Ala. L. Rev. 175, 184 (2002).

39 90 A.2d 589, 597 (1952), *aff'd*, 95 A.2d 221 (1953).

> the action in Korea should be held to be war, it is at most an undeclared war. In our opinion the insurer has failed to meet the burden cast upon it.… The phraseology of the policy was chosen by the insurer and tendered in fixed form to the prospective policyholder, and since its language is reasonably open to two constructions, we will adopt that construction which is more favorable to the insured.[40]

The problem with the technical meaning doctrine is that it does not take into account the original purpose of the war exclusion – that is, for the insurance industry to protect itself from catastrophic risks, not merely to avoid losses for declared wars.[41] Additionally, the declaration of war is a political determination, and certain political motivations may prevent Congress from declaring a war, as evidenced by its limited use throughout history.[42] Furthermore, because the "technical" state of war is irrelevant to the risks insured against, one can argue that it should not be determinative of liability.[43]

Colorado expressly followed Pennsylvania in adopting the technical meaning doctrine. *Pyramid Life Ins. Co. v. Masch* ("The existence or nonexistence of a state of war is a political, not a judicial, question and it is only when a formal declaration of war had been made by the Congress that judicial cognizance may be taken thereof. Once so declared by the political department, it becomes binding upon the courts, otherwise not").[44] As discussed below, the doctrine has been recognized by other courts as well.

The second doctrine gives the term "war" an ordinary, or common, meaning.[45] The common meaning doctrine was first formulated in *Stankus v. New York Life Ins. Co.* (finding that the term applies in general to every situation that ordinary people would commonly regard as "war").[46] The common meaning doctrine is

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40 *Id.*

41 Everett, *supra* at 183.

42 *Id.*

43 Crain, *supra* at 338.

44 299 P.2d 117, 119 (1956).

45 *See, e.g. Shneiderman v. Metro. Cas. Co. of N.Y.,* 220 N.Y.S.2d 947, 950 (N.Y. App. Div. 1961) (interpreting the word "war" as a common person would and not as a politician or a lawyer would).

46 44 N.E.2d 687, 688-89 (1942); Crain, *supra* at 334.

the predominant doctrine accepted by contemporary courts because it provides a much more realistic, risk-based approach as to how "war" should be defined.[47] By approaching a war exclusion clause under the common meaning doctrine, courts adhere to the generally accepted plain meaning rule of contract interpretation, which is most likely consistent with the intent of the parties because "the average man . . . presumably is unfamiliar with the existence of a state of war from the strictly political, military and/or legal standpoint."[48]

Courts did not begin adopting this doctrine with regularity until the Korean War.[49] Indeed, four out of the five reported cases arising out of the attack on Pearl Harbor in 1941 adopted the technical, and not the common meaning, doctrine. *See Rosenau v. Idaho Mut. Ben. Ass'n* ("An act of Congress is necessary to the commencement of a foreign war and is in itself a declaration. It fixes the date of the war.") (internal citations omitted);[50] *West v. Palmetto State Life Ins. Co*. ("[T]he declaration by Congress of war on Japan on December 8th was the only legal way in which this country could be placed in a state of war with that aggressor nation.");[51] *Savage v. Sun Life Assur. Co. of Canada* ("[W]ar was formally declared by the United States against the Japanese on December 8, 1941.");[52] *Gladys Ching Pang v. Sun Life Assur. Co. of Canada* ("War" does not exist merely because of an armed attack by the military forces of another nation until it is a condition recognized or accepted by political authority of the

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47 John G. Marshall, *The War Clause in Life Insurance Contracts*, 4 Utah L. Rev. 120, 120 (1954).

48 Everett, *supra* at 184.

49 Crain, *supra* at 334; *see also* Samuel J. Goldstein, *The War Clause in Life Insurance Contracts*, 1953 Ins. L. J. 458, 459 (recognizing the conflicting views at the time of the Korean conflict: "[i]t cannot be argued that the conflict in Korea is, in any sense, an attack upon the sovereignty or territory of the United States. It is conclusive that the military action … taking place in Korea is under the authority of the United Nations' members. Although it is war in the sense that … soldiers are dying and being wounded on a large scale, nonetheless it is not war in the legal sense, so that the insurer might resist the claims under this policy.").

50 145 P.2d 227, 229.

51 25 S.E.2d 475, 477 (S.C. 1943).

52 57 F. Supp. 620 (W.D. La. 1944).

government which is attacked, either through an actual declaration of war or other acts which recognize the existence of a state of war).[53]

The movement towards the common meaning doctrine stemmed from courts' interest in examining the loss in the context of the facts existing at the time.[54] As such, courts focused on evaluating, among other things, the following factors:

> whether the combatants wore uniforms, the nature and type of weaponry used, the actual organization of the operation, the act causing the loss, whether congressional appropriations were made, whether combat zone tax exclusions were provided, declarations by the Judge Advocate General initiating court-martial jurisdiction in cases arising from the conflict, whether heroism medals were awarded, an occasion that occurs only during periods of actual hostilities.[55]

Furthermore, in *Stankus*, the court found that, notwithstanding Congress' lack of a formal declaration of war, President Roosevelt's proclamation that a state of war existed, coupled with the surprise attack on Pearl Harbor and the open hostilities which existed between the United Kingdom, Germany and Italy, warranted a finding that "war" existed.

This common meaning doctrine also conforms to the general principle of policy interpretation that the test of coverage is what a reasonable person in the position of the insured would have believed to be covered, and the reasonable expectations of coverage of the insured should be honored.[56]

The third doctrine, which, in application, is essentially the same as the common meaning doctrine, provides that if the term "war" is inherently ambiguous, and if the issue is whether a war has ended, then the court must adopt a plain, rather

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53 37 Haw. 208, 208 (1945).

54 Everett, *supra* at 185.

55 *Id.*

56 Eric M. Larsson, *Insured's "Reasonable Expectations" as to Coverage of Insurance Policy*, 108 Am. Jur. Proof of Facts 3d 351 (originally published in 2009).

than a technical, meaning of "war" (*i.e.*, the cessation of actual hostilities), because this definition most likely will not bar the insured's recovery.[57]

C. THE APPLICATION OF THE WAR EXCLUSION TO HISTORICAL UNITED STATES CONFLICTS

1. Korean War and The Suez Canal Conflict

As stated above, the Korean War brought about much scrutiny as to how courts should interpret war exclusions that were asserted as defenses to coverage for losses resulting from the conflict. In particular, courts began adopting the common meaning doctrine as the chosen method for interpreting whether the conflict constituted a war. Disputes over application of the war exclusion to later events in the 1950s also applied the common meaning doctrine.

In *Shneiderman v. Metro. Cas. Co. of N.Y.*, the court addressed whether a beneficiary on a life insurance policy covering the life of a photographer-journalist who was killed while on a journalistic assignment would receive benefits under the journalist's life insurance policy. The court found that the Suez Canal conflict constituted a war under the exclusionary clause, but held that the beneficiary was entitled to benefits under the policy because the journalist died four days after the warring nations had agreed to a cease fire and, therefore, the journalist's death was not caused by war or any act of war within the scope of the exclusionary clause of the life insurance policy.[58] In making this determination, the court explained that it must interpret the exclusion under the common meaning doctrine as follows:

> We are to take cognizance of the fact that an insurance policy is generally a contract with the average man who presumably is unfamiliar with the existence of a state of war from the strictly political, military and/or legal standpoint. Such a man would read the term war in a policy exclusory clause in the sense that the term is commonly used and understood in the every day

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57 Everett, *supra* at 184; *see also Onze*, 1 Pa. D. & C.2d at 29 (Separate from these three doctrines, courts have also interpreted war exclusions that appear in life insurance policies as "status" clauses or "result" clauses).

58 *Shneiderman,* 220 N.Y.S.2d 947, 952-53 (N.Y. App. Div. 1961).

> expression rather than as used and understood in international relations or military affairs.[59]

The fact that there was no formal declaration of war during the Suez Canal conflict did not necessarily govern the rights of the parties or control the interpretation of the policy clause.[60] Instead, the court limited the meaning of the terms "war" and "act of war" as used in the exclusion clause to the meaning of war in its practical sense, which most accurately reflected the intention of the parties.[61] The court further explained:

> The usual purpose of exclusory clauses, such as the one here, is to protect the insurance company from extraordinary hazardous risks; and from the insurance company's standpoint, the risk of loss of life incident to actual warfare is the risk that it must guard against. The provision for exclusion of liability from such a risk is necessitated by the inability to properly gauge premiums to cover such a risk and the need of protecting the company from financial disaster which could result from wholesale death occurring from actual warfare. Thus, reasonably, an insured could be expected to understand that he was not to be insured against death occurring during such a calamity.[62]

Similarly, the court in *Goodrich v. John Hancock Mut. Life Ins. Co. of Boston* applied the common meaning doctrine, but found that a beneficiary was not entitled to accidental death benefits under a life insurance policy because the individual died prior to the cease fire.[63] The court noted that "[w]e are not so far removed from reality but to recognize that in the language of the average person, the conflict in Korea was considered a war, not by declaration, but by the fact that our armed forces were sent there and participated in the fighting and our soldiers were wounded and died on the battlefields of Korea."[64]

Courts were even apt to expand the technicality that war must be officially declared by Congress, and look to the acts of Congress during the conflict, to find

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59 *Id.* at 273.

60 *Id.*

61 *Id.*

62 *Id.* at 951.

63 234 N.Y.S.2d 587, 589-90 (N.Y. App. Div. 1962).

64 *Id.* at 590.

that the Korean conflict constituted a war. *See, e.g., Weissman v. Metro. Life Ins. Co*. (finding that even if a declaration of war was necessary to find that the Korean conflict was a "war" within the meaning of the insurance policy, this case met this requirement because of Congress' retaliatory actions, e.g. providing the "money necessary to carry on the conflict, furnish arms, munitions, ships and troops and to proceed in the same manner as if there has been a formal declaration of war," and therefore, the war exclusion applied).[65] While courts were seemingly moving in the direction of finding that the state of war existed in major conflicts following World War II, there remained a split among jurisdictions whether a Congressional declaration of war was necessary to trigger the war exclusion.[66] This split was the direct result of whether a court applied the common meaning doctrine or technical doctrine.

2. Vietnam War

As a result of the continuing split among jurisdictions, insurance policies began including clauses that expanded the definition of war to include terms such as "undeclared war" and "warlike conditions."[67] Expanding the definition of war in insurance policies was the insurance industry's attempt to further combat the uncertainties that were arising from the conflicts that the United States was engaged in during a more modern age of warfare.

In *Cohen v. Monumental Life Ins. Co*., plaintiff brought an action to recover benefits allegedly due to her under a life insurance policy following the death of the insured during the Vietnam conflict. The insured's death occurred on July 19, 1969 within the boundaries of an air base in Thailand as a result of injuries he

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65 112 F. Supp. 420, 423 (S.D. Cal. 1953).

66 *See, e.g. Beley v. Pennsylvania Mut. Life Ins. Co.,* 95 A.2d 202, 205 (Pa. 1953) (the Korean conflict did not constitute a "war" within the meaning of a war exclusion due to the absence of a formal declaration of war by Congress); *but see Lynch v. Nat'l Life & Accident Ins. Co.,* 278 S.W.2d 32, 38 (Mo. 1955) (Korean conflict was a "war" within war clause of insurance policy, although there was no declaration of war by Congress, and loss of foot resulting from wound suffered in Korea was not covered by policy).

67 Patrick McGheehan, *To Insurers, Terrorism Is Not Like War, New York Times*, April 23, 1995, http://www.nytimes.com/1995/04/23/business/to-insurers-terrorism-is-not-like-war.html

sustained when a U.S. Air Force helicopter in which he was riding crashed.[68] At the time of his death, the insured was serving on active duty in the U.S. Air Force as a pararescue and survival technician, and was engaged in a rescue mission involving a U.S. Air Force aircraft that had sustained an accident while taking off.[69] During the rescue mission, the aircraft, which was scheduled for a combat mission, exploded causing the rescue helicopter to crash.[70] The court found that because Thailand adjoins Vietnam, the aircraft was scheduled for a combat mission, and the United States of America was engaged in armed hostilities in and around Vietnam in July 1969, that the rescue helicopter crash was the result of an "undeclared war" or "act of war" within the meaning of the insurance policy.[71] As such, the insurance policy, which precluded coverage resulting "directly or indirectly, wholly or partly, from war or any act of war, declared or undeclared," did not entitle plaintiff to any benefits.

In *Airlift Int'l, Inc. v. United States*, owners of an aircraft that was destroyed in a mid-air collision with a military aircraft over Vietnam sued the government to recover benefits under a government "war risk" policy.[72] The policy at issue insured against "loss or damage due to or resulting from war or warlike operations."[73] While this case did not interpret a war exclusion, it still required the court to conduct the same analysis that courts are confronted with when determining whether a war exclusion applies, i.e., it needed to determine whether the mid-air collision was an "act of war," which, under the "war risk" policy, would trigger coverage.

The Southern District of Florida held that, because the military aircraft was returning from a reconnaissance mission and plaintiffs' aircraft was on a United States Military Airlift Command contract flight carrying general cargo and three passengers, neither aircraft was on a warlike operation.[74] The court explained that the mid-air collision and subsequent loss resulted from a peril of the air, not

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68 194 S.E.2d 867, 867 (1973).

69 *Id.*

70 *Id.*

71 *Id.*

72 335 F. Supp. 442 (S.D. Fla. 1971).

73 *Id.* at 446.

74 *Id.* at 447.

a peril or risk of war, and therefore, the accident was not caused by a warlike operation.[75]

Recognizing public policy concerns about excluding coverage – especially in life insurance policies – for losses sustained by military service personnel during warlike conflicts, the insurance industry began removing exclusions for acts of war and serving in the military following the Vietnam War.[76] The war exclusion clause was originally intended to deny civilian claims for losses sustained during unexpected conflicts, rather than to exclude claims submitted by military service personnel.[77] As such, war exclusions, mainly those in life insurance policies, started to disappear following the Vietnam War.

D. THE APPLICATION OF THE WAR EXCLUSION IN AN AGE OF TERRORISM

1. Insurance Industry Responses to Acts of September 11, 2001

The events in the United States on September 11, 2001 renewed the insurance industry's focus on the war exclusion. Many of the inherent difficulties in defining and interpreting the meaning of "war" within an insurance policy resurfaced following the events of September 11th.

In litigation following the terrorist attacks, the United States District Court for the Southern District of New York highlighted the fact that the historical questions regarding the application of the war exclusion remained:

> Does an "act of war" require a declaration of war by one nation-state against another? Can terrorist activities initiated by loosely-formed and organized groups, engaged in violence and operating in the interstices of nation-states, qualify as "acts of war"? Does

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75 *Id.*

76 Jay MacDonald, *When Your Life Insurance Policy Won't Pay*, Fox Business, October 4, 2011, http://www.foxbusiness.com/features/2011/10/04/when-your-life-insurance-policy-wont-pay.html.

77 Chantal Marr, *Does Life Insurance Pay Out for Acts of War?*, LSM Insurance, August 20, 2014, https://lsminsurance.ca/life-insurance-canada/2014/08/does-life-insurance-pay-out-for-acts-of-war.

the nature and extent of an attacked nation's response make a difference?[78]

In the aftermath of the attacks, President George W. Bush characterized the attacks of September 11, 2001, an "act of war," and declared it as such in executive policies and orders.[79] Additionally, President Bush, speaking to a joint session of Congress ten days after the attacks, declared, "[o]n September 11th, enemies of freedom committed an act of war against our country."[80] Congress passed the Authorization for Use of Military Force ("AUMF") on September 14, 2001.[81]

The AUMF authorized the "the President ... to use all necessary and appropriate force against those nations, organizations, or persons he determines planned, authorized, committed, or aided the terrorist attacks that occurred on September 11, 2001, or harbored such organizations or persons, in order to prevent any future acts of international terrorism against the United States by such nations, organizations or persons."[82] The AUMF further authorized the President to "exercise[ ]" his powers "as Commander–in–Chief to introduce United States Armed Forces into hostilities," and to engage in such hostilities for longer than sixty days.[83] There was concern all around when the President or other politicians stated that September 11th constituted an "act of war": would the insurance industry invoke the war exclusion to preclude coverage of the losses sustained in the attacks?

The U.S. House Financial Services Committee issued an opinion letter to the National Association of Insurance Commissioners ("NAIC"), highlighting the concern that the insurance industry might rely on this exclusion to preclude coverage for certain losses.[84] In its letter, the Committee strongly urged the industry to oppose taking a position that would limit coverage:

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78 *In re Sept. 11 Litig*., 931 F. Supp. 2d 496, 504 (S.D.N.Y. 2013), aff'd, 751 F.3d 86 (2d Cir. 2014).

79 *Id.* at 510.

80 *Id.*

81 *Id.*

82 AUMF, PL 107-40, 115 Stat. 224 (2001).

83 AUMF § 2(b); 50 U.S.C. §§ 1541(c), 1544(b) (1973).

84 *See* Letter from the U.S. House Committee on Financial Services to the National Association of Insurance Commissioners (Sept. 17, 2001).

> This tragedy will likely result in the greatest loss the insurance industry has ever faced, both in terms of human life and monetary losses. The ability and willingness of the industry to fulfill its obligations to provide compensation for the lost lives and the rebuilding of our country are absolutely critical. It is a testament to the good faith of the industry that numerous insurers have already publicly stepped forward and pledged their full cooperation and commitment to honoring their contracts. America has the strongest insurance industry in the world, and we are confident that our companies will be willing and able to keep the promises they have made to their policyholders while remaining structurally sound and solvent.
>
> With that said, there has been some concern expressed that companies may deny coverage to victims of this tragedy based on "exclusions for acts of war." While news releases from individual companies lead us to believe that this is unlikely, it would be completely unacceptable if it were to occur. Any attempt to evade coverage obligations by either primary insurers or reinsurers based on such legal maneuvering would not only be unsupportable and unpatriotic – it would tear at the faith of the American people in the insurance industry.

Understanding the gravity of the situation, the majority of insurance companies made it clear that they would not assert the war exclusion to preclude coverage. Within days after the attacks, Metropolitan Life advised that it would pay $300 million in death benefits for survivors of the World Trade Center attacks.[85] Chubb Corporation issued a news release saying that the act-of-war exclusions would not apply.[86] Northwestern Mutual acknowledged that "[n]o life or disability claims for the events of Sept. 11 will be refused on the basis of a war exclusion."[87] Hartford Financial Services Group, Inc. also said that it would not deny claims on the basis of the war exclusion.[88]

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85 *See "Act of War" Exclusion Doesn't Apply to Attacks, Insurers Say, L.A. Times*, Sept. 17, 2001 at Business 3.

86 *Id.*

87 *Id.*

88 *Id.*

Shortly thereafter, the National Association of Independent Insurers (NAII) stated, "'[i]n reference to concerns expressed in Chairman Oxley's letter, NAII wishes to confirm that insurers have strongly indicated that they do not intend to invoke the 'act of war' exclusion. This is a non-issue and all insurers we have heard from are treating the losses as covered claims."[89] Similarly, the National Association of Mutual Insurance Companies advised "that its member companies will honor their contracts and will proceed to adjust and pay claims in a responsible manner just as they have done when other disasters have struck this country."[90]

2. Earlier Case Law on War Exclusion in Terrorism Incidents

While the terrorist attacks on September 11th were unprecedented, courts have in fact analyzed the war exclusion in the context of terrorism before.

In *Pan American World Airways v. Aetna Casualty and Surety Co.,* the Second Circuit was tasked with resolving a coverage dispute brought by Pan American World Airways, Inc. to recover against the various underwriters that insured an aircraft hijacked over London by members of a Palestinian terrorist group and destroyed in Egypt in 1970. Pan American sought coverage from its various underwriters under its all-risk policies.[91] Each of the policies included standard war risk exceptions, which excluded any loss or damage due to or resulting from war.[92]

After reviewing a multitude of English and American cases, the Second Circuit concluded that "war is a course of hostility engaged in by entities that have at least significant attributes of sovereignty."[93] The Second Circuit summarized the definition of "war" as follows:

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89 Christine Fuge, Jack P. Gibson, and Robin Olson, Attack on America the Insurance Coverage Issues, International Risk Management Institute, Inc. September 2001. https://www.irmi.com/articles/expert-commentary/attack-on-america-the-insurance-coverage-issues-(part-1-war-risk-exclusions).

90 *Id.*

91 *Pan American,* 505 F.2d 989, 993 (2d Cir. 1974).

92 *Id.*

93 *Id.* at 1012.

> "English and American cases dealing with the insurance meaning of 'war' have defined it in accordance with the ancient international law definition: war refers to and includes only hostilities carried on by entities that constitute governments at least de facto in character."
>
> For insurance purposes, then, "[w]ar can exist between quasi-sovereign entities." It follows that "war" does not include "conflicts waged by guerrilla groups regardless of such groups' lack of sovereignty."[94]

The Second Circuit rejected the insurers' reliance upon the "war" exclusion because the Popular Front for the Liberation of Palestine ("PFLP"), to which the hijackers belonged, had not been accorded by Middle Eastern states "the rights of a government.... [n]o Arab state recognized the PFLP." The fact that the PFLP received financial support from several states does not give it the status of a "quasi-sovereign."[95] Nor could the PFLP's own exaggerated rhetoric, proclaiming itself to be "at war with the entire Western World," change the practical realities.[96] The court held the "war" exclusion inapplicable in *Pan Am* because the hijackers who constituted the efficient physical cause of the loss "were the agents of a radical political group, rather than a sovereign government."[97]

The few cases that have addressed the war exclusion in the context of terrorism since *Pan American* have followed its reasoning.[98] In *Holiday Inns Inc. v. Aetna Ins. Co.,* the insured brought a declaratory judgment action against its insurer to recover from loss suffered when the insured's hotel in Beirut, Lebanon was severely damaged by events occurring during a period from October 1975 to April 1976. The all-risk insurance policy issued to the insured contained a war risk exclusion, which precluded coverage for "[w]ar, invasion, act of foreign enemy, hostilities or warlike operations (whether war be declared or not), civil war, mutiny, insurrection, revolution, conspiracy, military or usurped power."[99]

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94 Plitt, *supra* at 63.

95 *Pan American*, 505 F.2d at 1015.

96 *Id.*

97 *Id.*

98 Plitt, *supra* at 63.

99 571 F. Supp. 1460, 1463 (S.D.N.Y. 1983).

The insurer argued that the damage was precluded by the war exclusion in the insurance policy because the damage to the hotel was caused by human forces constituting the excluded perils of insurrection, civil war, and war.[100] Relying heavily on the decision in *Pan American*, the district court reiterated the concept formulated in *Pan American* that, for insurance purposes, "[w]ar can exist between quasi-sovereign entities," and therefore, it follows that "war" does not include "conflicts waged by guerrilla groups regardless of such groups' lack of sovereignty."[101]

Ultimately, the district court rejected the insurer's arguments, finding instead that the insurer failed to sustain its burden of proving that the damage to the hotel was caused by "war."[102] Instead, the district court held that the Holiday Inn was damaged by a series of factional "civil commotions," of increasing violence.[103] The court stressed that the constitutional government existed throughout the conflict, the requisite intent to overthrow was not proved by the insurer, and, therefore, there was no "war" in Lebanon between "sovereign or quasi-sovereign states."[104]

3. September 11th Litigation

Based on public policy considerations and the decisions in *Pan American* and *Holiday Inns*, the insurance industry widely concluded that the war exclusion was inapplicable to the events of September 11th.[105] Many commentators thought that these cases demonstrated the difficulty that insurers would face in proving a causal link between terrorist activity and the constituent elements of the exclusion.[106]

There are no reported cases in which an insurer asserted the war exclusion to preclude coverage under its policies for any losses connected with the terrorist attacks of September 11th. However, one case addressed the analogous act-of-

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100 *Id.*

101 *Id.* at 1465.

102 *Id.* at 1503.

103 *Id.*

104 *Id.*

105 Randy J. Maniloff, *Coverage Opinions – September 11th: Revisiting the "War Risk Exclusion,"* LexisNexis Legal Newsroom, April 11, 2013.

106 Plitt, *supra* at 62-63.

war defense that is provided in the statutory scheme of the Comprehensive Environmental Response, Compensation, and Liability Act ("CERCLA").[107]

The act-of-war defense to CERCLA strict liability requires an alleged polluter to prove by a preponderance of the evidence that the "act of war" was the sole cause of the "spilling, leaking, pumping, pouring, emitting, emptying, discharging, injecting, escaping, leaching, dumping or disposing," of the subject hazardous substances.[108] CERCLA provides no definition of an "act of war."[109] Congress did not define the term in the text of CERCLA or in its legislative history.[110] Consequentially, courts addressing a CERCLA act-of-war defense are tasked with interpreting the meaning of "act of war" under the statutory framework, and whether a declaration of war by one nation-state against another is necessary or if terrorist activities initiated by loosely-formed and organized groups against the interstices of nation-states qualifies as an "act of war" under CERCLA.[111] This determination calls for essentially the same analysis of what the meaning of "war" is under a war exclusion found in an insurance policy. As such, we discuss this case in order to draw parallels into the type of examination that a court would likely undertake if faced with determining whether a terrorist attack constitutes a "war" under the war exclusion in an insurance policy.

In *In re Sept. 11 Litig.*,[112] the owner of the building near the World Trade Center Towers brought an action under CERCLA, which allows strict liability claims in pollution cases, for cleanup and abatement expenses for removing pulverized dust that infiltrated into the subject building after the collapse of the World Trade Center Towers.[113] American Airlines, United Airlines and their insurers asserted the CERCLA act-of-war defense in arguing that they did not owe the building owner cleanup and abatement expenses under CERCLA.[114]

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107 *In re Sept. 11 Litig.*, 931 F. Supp. 2d 496.

108 *Id.* at 512; *see also* 42 U.S.C. §§ 9607(b), 9601(22).

109 *In re Sept. 11 Litig.*, 931 F. Supp. 2d at 504.

110 *Id.*

111 *Id.*

112 931 F. Supp. 2d at 496.

113 *Id.*

114 *Id.*

On March 20, 2013, the United States District Court for the Southern District of New York found that the defendants, including the airlines and their insurers, could invoke the act-of-war exception to strict liability under CERCLA.[115] The court first explained that CERCLA applies to, in pertinent part, the "owner or operator" of the hazardous substances or "other responsible person[s] for each release of a hazardous substance."[116] The court noted that the airlines and their insurers were not sued as the "owner or operator" of the World Trade Center, or as a "person who ... owned or operated any facility at which ... hazardous substances were disposed of," or as a "person who ... arranged for disposal or treatment ... of hazardous substances," or as a "person who ... accepted any hazardous substances for transport to disposal or treatment facilities."[117] Because the airlines and their insurers did not fall into any of these categories, the court found that the plaintiff did not have a case against them under CERCLA.[118]

However, the court found that – even if the airlines and their insurers could be sued under CERCLA – the pollution for which plaintiff sued arose from the hijacked airplanes' collisions with the World Trade Center, which the court found was an "act of war."[119] In making this determination, the court relied on the holdings in *Hamdi v. Rumsfeld* and *Hamdan v. Rumsfeld*.[120] In *Hamdi* and *Hamdan*, the Supreme Court found that the United States government was permitted to prosecute detainees by a military commission because the September 11th attacks constituted "acts of war."[121]

In *Hamdan*, the United States Supreme Court explained:

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115 *Id.*

116 *Id.* at 513.

117 *Id.* at 513; *see also* 42 U.S.C. § 9607(a).

118 *Id.* (noting that no case has held that an airplane crash can constitute a "release" under CERCLA).

119 *Id.*

120 *Hamdi*, 542 U.S. 507 (2004) and *Hamdan*, 548 U.S. 557 (2006) are not insurance cases. However, similar to *In re Sept. 11th Litig.*, these cases offer insight into the analysis courts undertake in determining whether the September 11th attacks constituted an "act of war."

121 *In re Sept. 11 Litig.*, 931 F. Supp. 2d at 512.

> [N]othing in our analysis turns on the admitted absence of either a formal declaration of war or a declaration of martial law. Our focus instead is on the September 11, 2001, attacks that the Government characterizes as the relevant "act[s] of war," and on the measure that authorized the President's deployment of military force—the AUMF....[W]e do not question the Government's position that the war commenced with the events of September 11, 2001....[122]

Furthermore, in *In re Sept. 11th Litig.*, the Supreme Court distinguished *Pan American*, finding that the September 11th attacks far exceeded the terrorist events at issue in *Pan American*:

> But nothing in the cases approaches the catastrophe of 9/11, nor was the Popular Front for the Liberation of Palestine equal in organizational scope or destructive intent to al Qaeda, nor was the destruction of an airplane at an airport by that group the equivalent of the destruction of the World Trade Center and the damage to the Pentagon. Al Qaeda launched an attack on the most important commercial and political symbols of the United States—an attack that Congress and the President treated as an act of war against the United States. The events of September 11 were unique, and Congress, the President, and the American public treated 9/11 as unique. [123]

At the same time the court compared the CERCLA language to language in insurance policies, the Second Circuit noted distinctions:

> This reading [that the September 11, 2001 attacks were an "act of war" under CERCLA] is not at odds with precedent that "act of war" is construed narrowly in insurance contracts. *See, e.g., Pan Am. World Airways, Inc. v. Aetna Cas. & Surety Co.,* 505 F.2d 989 (2d Cir. 1974). The purpose of an all-risk insurance contract is to protect against any insurable loss not expressly excluded by the insurer or caused by the insured. *Id.* at 1003-04 ("The experienced all risk insurers should have expected the exclusions drafted by them to be construed narrowly against them, and should have

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122 *Hamdan*, 548 U.S. at 600 n. 31.

123 *In re Sept. 11 Lit.*, 931 F. Supp. 2d at 508.

> calculated their premiums accordingly."). A narrow reading of a contractual "act of war" exclusion thus achieves the parties' contractual intent, insulating the policyholder from loss. The remedial purpose of CERCLA is both different and unrelated.[124]

While a decision regarding CERCLA liability is not definitive as to how a court might apply a war exclusion in the event of a massive terrorist attack, this discussion is useful to note the competing interpretations.

E. CONCLUSION

It is often a straightforward determination whether a conflict is a "war" or a particular event constitutes "terrorism" from the eyes of a layperson.[125] However, as noted herein, making a legal determination of these issues can be particularly difficult, rife with complications, and loaded with public policy concerns. Such decisions carry heavy social, political and legal implications. The competing interests of the insurance industry to be able to calculate risk as accurately as possible and the need for the public to be protected in the event of catastrophic events, makes the war exclusion extremely problematic and laden with coverage issues that will certainly be at the center of the judicial system's and country's attention in the future.

II. TERRORISM COVERAGE AND EXCLUSIONS

A. SEPTEMBER 11, 2001 AND CHANGES TO THE TERRORISM COVERAGE MARKET

The September 11th attacks changed the market for insuring events of terrorism. Prior to those attacks, terrorism in the United States had been rare, and therefore underwriters had not frequently included terrorism exclusions in policies.[126] The September 11th attacks caused losses of a magnitude the

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124 *In re Sept. 11 Lit.*, 751 F.3d 86, 92-93 (2d Cir. 2014).

125 *See, e.g., Weissman v. Metro. Life Ins. Co.,* 112 F. Supp. 420, 421 (S.D. Cal. 1953) *("*The noun 'war' is one of those words in the English language which, tho' everyone understands the meaning thereof, few can definitely define.")

126 Jeffrey E. Thomas, *Terrorism Insurance Coverage in New Appleman on Insurance Law Library Edition* § 58.01[2] (2016).

insurance market had not faced before in a single event. Insured losses totaled about $32.4 billion.[127]

The first impact was felt in the reinsurance market. The reinsurers began to exclude terrorism coverage by January 2002, which left primary insurers exposed to potential losses without reinsurance.[128] This caused primary insurers to ask regulators to allow terrorism exclusions in their policies. ISO drafted a standard exclusion, the National Association of Insurance Commissioners approved it, and 45 states and the District of Columbia approved it by the end of 2002.[129]

That 2002 ISO terrorism exclusion for property coverage precluded any "loss or damage caused directly or indirectly by terrorism, including action in hindering or defending against an actual or expected incident of terrorism."[130] The general liability policy exclusion barred coverage for bodily injury, property damage and personal and advertising injury "arising, directly or indirectly, out of 'terrorism,' including any action taken in hindering or defending against an actual or expected incident of 'terrorism.'"[131]

The 2002 ISO Exclusion defined terrorism as follows:

> 'Terrorism' means activities against persons, organizations or property of any nature:
>
> 1. That involve the following or preparation for the following:
>   1. Use or threat of force or violence;
>   2. Commission or threat of a dangerous act; or
>   3. Commission or threat of an act that interferes with or disrupts an electronic, communication, information, or mechanical system; and
> 2. When one or both of the following applies:
>   1. The effect is to intimidate or coerce a government, or to cause chaos among the civilian population or any

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127 Jeff Woodward, *The ISO Terrorism Exclusions: Background and Analysis, IRMI Insights* (Feb. 2002) (irmi.com/articles).

128 Thomas, Terrorism Insurance Coverage, *supra* at § 58.01[2].

129 Jeff Woodward, *The ISO Terrorism Exclusions: Background and Analysis*, *supra*.

130 *Id.*

131 *Id.*

> segment thereof, or to disrupt any segment of the economy; or
> 2. It is reasonable to believe the intent is to intimidate or coerce a government, or to seek revenge or retaliate, or to further political, ideological, religious, social or economic objectives or to express (or express opposition to) a philosophy or ideology.[132]

No court has interpreted this language. However, as discussed in § D, courts have ruled on the issue of whether the existence of this exclusion required policyholders to procure separate terrorism coverage.

B. FEDERAL TERRORISM RISK INSURANCE PROGRAM

In the face of this withdrawal of the private insurers from covering terrorism, Congress was forced to act. Beginning in 2002, Congress enacted a series of public acts designed to encourage the insurance market to cover events of terrorism rather than to exclude them.[133] Because the Terrorism Risk Insurance Program ("Program") is considered temporary, it has not been codified into the United States Code, but has been appended as a note to 15 U.S.C. § 6701.

Terrorism is difficult to define. As a result, the Program has given the power to certain federal officials to certify an event as an act of terrorism. Under the present law, the Secretary of the Treasury, in consultation with the Secretary of Homeland Security and the Attorney General, must certify that an event was an act of terrorism.[134] This certification is exempted from judicial review by section 102(1)(C) of the statute. There are various requirements for an event to be certified:

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132 *Id.*

133 *See* Terrorism Risk Insurance Act of 2002, Pub. L. No. 107-297, 116 Stat. 2322; Terrorism Risk Insurance Extension Act of 2005, Pub. L. No. 109-144, 119 Stat. 2660; Terrorism Risk Insurance Program Reauthorization Act of 2007, Pub. L. No. 110-160, 121 Stat. 1839; Terrorism Risk Insurance Program Reauthorization Act of 2015, Pub. L. No. 114-1, 129 Stat. 3.

134 Terrorism Risk Insurance Program Reauthorization Act of 2015, § 102(1)(A).

- It must be a violent act that is dangerous to human life, property or infrastructure in the United States or one of its vessels or missions;

- It must have been committed "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;"

- It must cause aggregate property and casualty losses in excess of $5 million; and

- It cannot be part of a war declared by Congress."[135]

The Program covers terrorism "committed by an individual or individuals" who can be acting either on behalf of a foreign or domestic interest.[136] An act cannot be "committed as part of the course of war declared by Congress," thus preserving the ability of insurers to exclude acts of war.[137]

The Program essentially acts as a backstop for insurers. Assuming that there is a certified event of terrorism (there have not been any yet under the Program), the government will reimburse insurers after they pay a certain amount of claims. Insurers will retain a portion of the risk. The government will bear the costs of the Program, with some or all of those costs being recouped later through premium taxes on property and casualty insurance. Currently, the Program applies to "lines of property and casualty insurance, including excess insurance, workers compensation insurance, and directors and officers liability insurance."[138] Those lines of insurance must participate and cannot exclude coverage for terrorism. Indeed, the Program expressly preempts and nullifies preexisting exclusions such as those discussed in the preceding section of this

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135 *Id.*

136 *Id.* Originally, the Program only applied to individuals "acting on behalf of any foreign person or foreign interest." Pub. L. No. 107-297 at § 102(1)(A)(iv).

137 Terrorism Risk Insurance Program § 102(1)(B)(i).

138 Terrorism Risk Insurance Program, § 102(12). A number of types of insurance are specifically excluded by the language of this section.

paper.[139] The policies that must comply with the Program typically include an endorsement titled Federal Terrorism Risk Insurance Act Disclosure.

Under the current iteration of the Program, the federal share of insured losses started at 85% in 2015, with an annual 1% reduction down to 80% in 2020.[140] As that amount of government reimbursement declines, the total amount of "aggregate industry insured losses" necessary to trigger reimbursement is rising $20 million each year from $100 million per year in 2015 to $200 million in 2020.[141] The cap on total government contribution is $100 billion.[142]

According to Marsh, as a result of the continuation of the Program, the terrorism insurance market has remained stable, costs have remained low, and about 60 percent of the property insurance market buys insurance that includes this coverage.[143]

It also is possible now to purchase standalone terrorism insurance. This property insurance typically does not require a certified act of terrorism and can provide broader coverage terms, coverage for a wider area, high limits and terms up to three years.[144]

C. NUCLEAR, BIOLOGICAL, CHEMICAL AND RADIOLOGICAL ("NBCR") TERRORISM AND CYBERTERRORISM.

The Terrorism Risk Insurance Program does not apply to nuclear, biological, chemical or radiological ("NBCR") terrorism. Indeed, the statute only requires insurers to offer terrorism insurance on the same terms and conditions as they do for non-terrorism losses.[145] With the exception of workers compensation insurance, which has a mandatory scope, most of these policies exclude nuclear events and pollution, which likely would exclude these four types of terrorism.[146] Moreover, most ISO form policies explicitly exclude Certified Acts of Terrorism

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139 *Id.* at § 105.

140 *Id.* at § 103(e)(1)(A).

141 *Id.* at § 103(e)(1)(B).

142 *Id.* at § 103(e)(2)(A)(i).

143 Marsh & McLennan Companies, *2016 Terrorism Risk Insurance Report* at 5 (July 2016).

144 Marsh & McLellan Companies, *supra* at 5.

145 Terrorism Risk Insurance Program at § 103(c).

146 Thomas, Terrorism Insurance Coverage, *supra* at § 58.04[4][a].

involving Nuclear, Biological, Chemical or Radiological Terrorism.[147] The 2007 extension of the Program required a study of this NBCR coverage gap issue, and the United States Government Accountability Office came up with a report in December 2008, but Congress has not changed the Program to address these types of attacks.[148] Several insurers do offer standalone NBCR coverage.[149]

The Program is silent as to cyberterrorism. If a cyber event was certified as an act of terrorism under the Program, the policies that are mandated to include terrorism coverage do not have form exclusions for cyberterrorism as they do for NBCR risks, and they could provide coverage if the other terms of the policies were met. However, property policies typically require damage or destruction to tangible property and general liability policies have not consistently been held to cover cyber events.[150] Finally, the latest iteration of the Program specifically exempts professional liability insurance from the Program, and to the extent that cyber insurance is considered a professional liability insurance product, it may not be part of the Program.[151]

Political Risks often are excluded, but separate standalone coverage is available for those.

D. JUDICIAL INTERPRETATION OF THE FEDERAL TERRORISM RISK INSURANCE PROGRAM

Only one reported case has discussed the Terrorism Risk Insurance Act.[152] The plaintiff attempted to enforce a $200 million default judgment against the Republic of Cuba and various Cuban officials for acts of torture.[153] Although the court noted that Cuba had been designated by the United States Department of State as a state sponsor of terror, it held that the Act did not apply because the

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147 *See* ISO Form BP 05 26 01 08.

148 *See* United States Government Accountability Office, Terrorism Insurance: Status of Coverage Availability for Attacks Involving Nuclear, Biological, Chemical or Radiological Weapons (Dec. 2008).

149 Marsh & McLellan Companies, *supra* at 6.

150 *See generally* Thomas, Terrorism Insurance Coverage at § 58.04 [4][b].

151 Terrorism Risk Insurance Program at § 102(11).

152 *Jerez v. Republic of Cuba*, 777 F. Supp. 2d 6 (D.D.C. 2011); *objections overruled*, 964 F. Supp. 2d 52 (D.D.C. 2013), *aff'd*, 775 F.3d 419 (D.D.C. 2014), *cert. denied*, 136 S. Ct. 38 (2015).

153 *Id.* at 10.

torture did not "result in damage within the United States" and was not committed to coerce the United States population or influence United States policy.[154] Thus, the Court concluded that the judgment was not based on an "act of terrorism" and thus the Act did not provide an exception to the Cuban Assets Control Regulations' prohibition on enforcement of a judgment creditor's writ of attachment against Cuban assets.[155]

There is a case presently pending in the Central District of California that may interpret the statute and the policy forms that incorporate it.[156] Two entertainment companies have brought a coverage action against their production insurer, Atlantic Specialty Insurance Company. They allege that they were filming a new television program, "Dig," in Israel in 2014 when Hamas began launching rockets into Israel from the Gaza Strip.[157] Hamas has been designated as a terrorist organization by the United States since 1997.[158] The policyholders originally postponed production and then moved the "Dig" production out of Israel.[159] When they submitted a claim for their extra expenses, Atlantic denied coverage, asserting the war exclusion.[160] The policyholders contend that they have coverage for "imminent peril," and they sued to have a court rule that no exclusion barred coverage.[161]

In their complaint, the entertainment companies claim that Atlantic misrepresented the terms of the policy by claiming that the terrorism coverage did not apply because there was no certified act of terrorism and the focus of the actions was not the United States or its policy.[162] The entertainment companies assert in their complaint that this was a misrepresentation because (1) there is no terrorism exclusion, (2) terrorism coverage does not modify the extra expense provision, and (3) the policy does not say that only certified acts of

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154 *Id.* at 28-29.

155 *Id.* at 29.

156 Complaint (ECF No. 1), *Universal Cable Productions LLC v. Atlantic Specialty Ins. Co.*, No. 2:16-cv-04435-PA-MRW (C.D. Cal.)

157 *Id.* at ¶ 1.

158 *Id.*

159 *Id.*

160 *Id.*

161 *Id.* at ¶ 2.

162 *Id.* at ¶ 35.

terrorism are covered.[163] Atlantic denies these allegations and does not assert any terrorism coverage provisions or terrorism exclusion as an affirmative defense.[164] It does, however, assert the war exclusion as an affirmative defense.[165]

Courts have ruled on whether parties needed to procure terrorism coverage. These cases have tended to turn on an interpretation of the contractual documents (leases, mortgages, etc.) that required insurance. In a case arising out of the period when there was an ISO exclusion but before the passage of the Terrorism Risk Insurance Act, the New York Court of Appeals held that a commercial tenant violated the terms of its lease that required terrorism coverage by securing an "all-risk" policy that included the ISO terrorism exclusion.[166] However, in an earlier decision by New York's Appellate Division, First Department, the court held that a ground lease tenant was entitled to a preliminary injunction preventing a default where the mortgage did not explicitly require terrorism insurance.[167]

Two other courts have looked at whether loan documents that require "all risks insurance" and "other insurance" mandate that borrowers purchase terrorism insurance. Both concluded that the "other insurance" clause in those loan documents required borrowers to purchase terrorism coverage.[168] Both courts concluded that terrorism was a peril commonly insured against and that therefore the borrowers should have procured terrorism insurance.[169] Notably, in one of those cases, the Southern District of New York Court held that the "all risks" clause in the loan document did not require terrorism coverage, and

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163 *Id.* at ¶ 38.

164 Answer at ¶¶ 35-38; Affirmative Defenses (ECF No. 14).

165 *Id.* at Second and Third Affirmative Defenses.

166 *TAG 380, LLC v. Commet 380, Inc.*, 890 N.E.2d 195 (N.Y. 2008).

167 *Four Times Square Assocs. LLC v. CIGNA Investments, Inc.*, 764 N.Y.S.2d 1 (N.Y. App. Div. 2003).

168 *Omni Berkshire Corp. v. Wells Fargo Bank, N.A.*, 367 F. Supp. 2d 534 (S.D.N.Y. 2004); *ECF North Ridge Assocs., L.P. v. Orix Capital Markets, LLC*, 336 S.W.3d 400 (Tex. Ct. App. 2011).

169 *Omni Berkshire Corp*., 307 F. Supp. 2d at 541-42; *ECF North Ridge Assocs., L.P.*, 336 S.W.3d at 407-10.

observed that the lenders explicitly could have stated that terrorism insurance was part of the "all risks" that should have been insured.[170]

E. CONCLUSION

As long as the Terrorism Risk Insurance Program remains in effect and incidents of terrorism against the United States remain at a low level, most policyholders should be able to obtain insurance coverage for incidents of domestic and foreign terrorism directed at the United States. The real test for the operation of the Program will be if there is a significant event that is certified. That may cause litigation that interprets the coverage, particularly if the event involves nuclear, biological, chemical or radiological terrorism or cyberterrorism.

The other real test could come if Congress does not renew the Program in 2020. As of this writing, although standalone terrorism coverage exists, the private market for insurance products to cover terrorism has not been robust.[171] It would take some time for that market to fully develop on its own.

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170 *Omni Berkshire Corp.*, 307 F. Supp. 2d at 539-41.

171 *See generally* Andrew Gerrish, Note, *Terror Cats: TRIA's Failure to Encourage a Private Market for Terrorism Insurance and How a Federal Securitization of Terrorism Risk May Be a Viable Alternative*, 68 Wash. & Lee L. Rev. 1825 (2011).

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How are Building Product Class Actions Weathering?

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INTRODUCTION

The United States Supreme Court, through its Class Action Predominance Trilogy, *Amchem*, *Dukes*, and *Comcast*,[1] has set a high bar for certifying class actions seeking damages that differ among class members. Still, building product class actions seeking damages for consequential property damage – physical injury to something other than the product itself – continue to be filed. A pair of recent decisions from the District of South Carolina, however, may temper the class action bar's enthusiasm for such actions.

This paper considers the history of building product class actions and the future of such litigation. It also considers insurance coverage issues presented by such cases. When is the duty to defend triggered by a class action complaint? How are defense costs typically allocated among numerous sequential triggered policies? Does a class action complaint trigger the duty to defend when the representative plaintiff's claim is not potentially covered, but the claims of the putative class may be? Who should select defense counsel? Does the duty to defend end if the claims of the putative class are potentially covered but the claims of the certified class are not?

PART 1: HISTORICAL OVERVIEW &

[1] *Amchem Prod., Inc. v. Windsor*, 521 U.S. 591 (1997); *Wal-Mart Stores, Inc. v. Dukes*, 564 U.S. 338 (2011); *Comcast Corp. v. Behrend*, 133 S. Ct. 1426 (2013).

CURRENT STATE OF BUILDING PRODUCT CLASS ACTIONS

A. Historical Overview Of Class Actions' Predominance Requirement

1. *Amchem Prod., Inc. v. Windsor*, 521 U.S. 591 (1997).

A review of the legal standard governing Rule 23(b)(3)'s application to building product class actions begins with the Supreme Court's decision *Amchem Prod., Inc. v. Windsor*, 521 U.S. 591 (1997).[2] "The settlement-class certification . . . confront[ed in *Windsor*] evolved in response to an asbestos-litigation crisis." *Amchem Prod., Inc. v. Windsor*, 521 U.S. 591, 597 (1997) (citing *Georgine v. Amchem Prod., Inc.*, 83 F.3d 610, 618 (3d Cir. 1996)).

In September 1990 Chief Justice Rehnquist created an Ad Hoc Committee on Asbestos Litigation in response to a "perceived failure" by the federal judiciary to respond to the crisis. One possible solution to the crisis, a "global settlement class action of historic proportion," came off the table when the *Amchem* Court affirmed the Third Circuit's vacating of such a settlement. At the same time as its *Amchem* decision, the Court vacated a Fifth Circuit "$1.535 billion global settlement . . . [that was] virtually identical to that decertified by the Third Circuit." Alex Raskolnikov, *Is There A Future for Future Claimants After Amchem Products, Inc. v. Windsor?*, 107 YALE L.J. 2545, 2545–46 (1998) (citing *Georgine*, *supra*; *In re Asbestos Litig.*, 90 F.3d 963 (5th Cir. 1996)).

In *Amchem*, the Supreme Court held that the certified settlement class did not meet Rule 23(b)(3)'s predominance requirement due, in part, to the individual nature of the class members' asbestos bodily injury damages. *Amchem*, at 622-23.

The *Amchem* decision has received extensive review and criticism. *See generally* Raskolnikov, *supra*; Mark C. Weber, *A Consent-Based Approach to Class Action*

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[2] Rule 23(b)(3) permits certification if:

> [T]he court finds that the questions of law or fact common to class members predominate over any questions affecting only individual members, and that, a class action is superior to other available methods for fairly and efficiently adjudicating the controversy.

Settlement: Improving Amchem Products, Inc. v. Windsor, 59 OHIO ST. L.J. 1155 (1998) (criticizing the *Amchem* decision); Judith Resnik, *Postscript: The Import of Amchem Products, Inc. v. Windsor*, 30 U.C. DAVIS L. REV. 881 (1997).

Since *Amchem*, class action plaintiffs have been required to weigh the likelihood of insurance coverage against the likelihood of certification. Pleading "bodily injury" or consequential "property damage" enhances the likelihood of coverage but diminishes the likelihood of certification. The plaintiffs' bar appears to have resolved this dilemma by declining to seek damages because of "bodily injury" in class actions but continuing to seek damages because of consequential "property damage." *See HPF, L.L.C. v. General Star Indemnity Co.*, 338 Ill. App. 3d 912 (2003) (herbal products) (determining the underlying complaint did not allege that the product caused bodily injury; therefore declining to find coverage); *Medmarc Casualty Insurance Co. v. Avent America,* 612 F.3d 607 (7th Cir. 2010) (concluding that the "omission" of "bodily injury" claims in the complaint was "not a drafting whim (or mistake) on the part of the plaintiffs' attorneys, but rather a serious strategic decision.").[3]

2. *Dukes* and *Comcast*:
Completing the Class Action Predominance Trilogy.

The late Justice Antonin Scalia[4] built upon *Amchem* in *Wal-Mart Stores, Inc. v. Dukes*, 564 U.S. 338 (2011) *and Comcast Corp. v. Behrend*, 133 S. Ct. 1426 (2013) (with *Amchem*, the "Class Action Predominance Trilogy").

[3] *Compare with* Part 2, *infra* at p. 14, discussing this strategic decision in the context of building product class actions and concluding that such actions almost always plead such damages.

[4] The jury is out on how Gorsuch's confirmation to the Supreme Court would affect class actions and specifically Rule 23(b)(3)'s predominance requirement. For an analysis of Gorsuch's views on class actions, *see generally* Wystan Ackerman, *Gorsuch on Class Actions: How Might He Compare to Scalia?*, CLASS ACTION INSIDER (February 2, 2017) available at https://www.classactionsinsider.com/2017/02/gorsuch-on-class actions-how-might-he-compare-to-scalia/ (collecting and discussing Judge Gorsuch's three class certification and CAFA cases).

In both *Dukes* and *Comcast*, the Supreme Court rejected the proposed settlement class. The Court concluded, as in *Amchem*, that individual damages determinations and a proposed model for measuring damages could not be applied on a class-wide basis. The proposed settlement classes, therefore, failed to satisfy Rule 23(b)(3)'s predominance requirement.

Some courts have interpreted the Class Action Predominance Trilogy as imposing a categorical rule that any proposed class seeking individual damages determinations cannot meet Rule 23(b)(3)'s predominance requirement, thereby prohibiting certification.[5] But this isn't the view concerning building product class actions, at least not in the Seventh Circuit. *See In re IKO Roofing Shingle Products Liability Litigation,* 757 F.3d 599, 602 (7th Cir. 2014) (Easterbrook J.) ("The [district] court read *Comcast* . . . [t]o require proof 'that the plaintiffs will experience a common damage and that their claimed damages are not disparate.' . . . Elsewhere the district court wrote that 'commonality of damages' is essential . . . If this is right, then class actions about consumer products are impossible. . . . The district court denied plaintiffs' motion to certify under a mistaken belief that 'commonality of damages' is legally indispensable. With that error corrected, the district court can proceed using the proper standards."); *and Butler v. Sears, Roebuck & Co.*, 727 F.3d 796, 801 (7th Cir. 2013) *cert. denied,* 134 S. Ct. 1277 (2014) (Posner, J.) ("It would drive a stake through the heart of the class action device . . . that every member of the class have identical damages. If the issues of liability are genuinely common issues, and the damages of individual class members can be readily determined . . . the fact that damages are not identical across all class members should not preclude certification.").

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[5] For both sides of this argument, *see generally* Robert H. Klonoff, *The Decline of Class Actions*, 90 WASH. U.L. REV. 729, 799–800 (2013) ("Prior to Comcast, most courts had recognized that the presence of individualized damages issues normally did not defeat class certification. [*See, e.g.*, *Cochran v. Oxy Vinyls LP*, 2008 WL 4146383, at *12 (W.D. Ky. Sept. 2, 2008) ("Of course, a need for individualized damages determinations is not necessarily fatal to (b)(3) certification.")] After Comcast, this proposition has arguably been called into question. . . . It remains to be seen whether Comcast will now cause lower courts to depart from the traditional rule that individualized damages issues normally do not defeat class certification. Courts and commentators are already divided on what the impact of the case will be. . . .") (collecting cases and articles).

The conventional reading of the Class Action Predominance Trilogy is that the class action plaintiffs' alleged damages must, at the very least, be consistent with their theory of liability, so that individual damages determinations do not "overwhelm questions common to the class." *Comcast* at 1433. It now appears that if causation issues are common among the class, and only the extent of damages differs among class members, then common issues may predominate and certification may be proper.

The Class Action Predominance Trilogy creates a hurdle for certification of classes seeking individual consequential damages. Still, the class action plaintiffs' bar continues to file building product actions seeking these damages.

B. The Current State of Building Product Class Actions

1. A Recent Increase In Building Product Class Actions.

There has been an increase in the number of building product class action lawsuits filed in the two decades since *Amchem*. *See* Gavin G. McCarthy, *Construction Defect Class Action Suits Becoming More Common*, 17 UNDER CONSTRUCTION 3 (Winter 2016).[6]

The increase in the number of these lawsuits began around 2000. The likely cause?: the commercialization of residential housing. *See* Gary E. Mason and Alexander Barnett, *How To Successfully Pursue A Class Action Involving Construction Defects*, 1 Ann.2004 ATLA-CLE 349 (July 2004) ("Since the 1990s, residential housing has

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[6] Examples of recent building product class action filings and settlements include:

(1) GAF Timberline Defective Roof Shingles – Settlement 4/22/2015;
(2) Goodyear Tire Defective Radiant Heating System – Filed 10/4/2013;
(3) Pella Corporation Defective Windows – Filed 11/15/2013;
(4) MW Defective Windows – Settlement 12/29/2014;
(5) Maibec Defective Wood Shingles – Third Amended Complaint Filed 3/31/2014;
(6) Mastic and Deceunick Oasis Defective Decking – Filed in January 2014;
(7) Fiberon Noncapped Decking – Settlement 9/4/2013;
(8) James Hardie Building Products Defective Siding – Complaint Filed 8/9/2013;
(9) Zurn Pex F1807 Fittings – Class Certified 7/6/2011;
An overview of these and other recent building product class actions is available at: http://www.classactionsnews.com/product/home-building-products

increasingly become a mass-produced product. . . . [often] marketed without adequate testing. As a result, defective construction materials [listing examples] have been incorporated in[to] residential housing throughout the country to devastating effect.").

Mr. McCarthy, among others, observes that as an inevitable result of this increased use of allegedly defective construction materials, "[o]ver the last several years . . . a new type of 'construction defect' case has become more prevalent — the construction defect class action, in which a few construction defect plaintiffs (generally consumers) seek to represent everyone that bought the product." McCarthy, *supra*. Summarizing these cases' shared characteristics, he notes:

> You would hardly recognize it as a construction case. The plaintiffs say they need not prove injury or causation,[7] at least not in the traditional sense. That is, the claim is not the windows are leaking, but simply that they are prone to leaking. And, rather than seeking repair costs, the plaintiffs seek so-called 'price premium' damages: the difference between the purchase price of the windows and the hypothetical price the plaintiffs would have paid had they known that the windows were prone to leaking.

Id. These actions continue to be filed for two reasons. First, a non-trivial number have been certified. Second, class counsels' fees can be substantial. In the words of Mia Hamm, "success breeds success." *See, e.g.*,:

a) Decisions Certifying, or Not Dismissing, Defective Product Class Actions:

i. *In re IKO Roofing Shingle Products Liab. Litig.*, 757 F.3d 599 (7th Cir. 2014) (decision pending; but holding commonality of damages is not required for class certification). For a status update of this lawsuit, motions for class certification and summary judgment are pending, *see* Halunen & Associates, *IKO Roofing Shingle Litigation*, available at: http://www.ikoshingleslawsuit.com/content/iko-status-update-august-2016;

ii. *In re AZEK Building Prods., Inc. Marketing & Sales Practices Litig.*, 82 F. Supp. 3d 608 (D.N.J. 2015) (denying, in part, deck manufacturer's motion to dismiss plaintiff class);

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7 To position their class within the Class Action Predominance Trilogy's confines.

iii. *Brunson v. Louisiana-Pac. Corp.*, 266 F.R.D. 112, 2010 WL 503099 (D.S.C. 2010) (certifying class action against manufacturer of wood exterior trim product, alleging breach of express and implied warranties);

iv. *In re Zurn Pex Plumbing Prod. Liab. Litig.*, 644 F.3d 604 (8th Cir. 2011) (applying Minnesota law) (certifying class action against manufacturer of plumbing systems, even for homeowners whose systems had not yet leaked —"dry plaintiffs" — as part of warranty claims);

v. *Ross v. Trex Co.*, 2009 WL 2365865 (N.D. Cal. July 30, 2009) (provisionally certifying class against a company that manufactures wood-composite deck products);

vi. *Brooks v. GAF Materials Corp.*, 301 F.R.D. 229 (D.S.C. 2014) (defective roof shingles) (declining to decertify a class asserting claims for negligence, breach of warranty, implied warranties, and unjust enrichment);

vii. *Nieberding v. Barrette Outdoor Living, Inc.*, 302 F.R.D. 600 (D. Kan. 2014) (bifurcating class action against manufacturer of outdoor railing products with allegedly defective brackets, since damages determinations required resolution of individual issues);

viii. *Fleisher v. Fiber Composites, LLC*, 2014 WL 866441 (E.D. Pa. Mar. 5, 2014) (approving settlement class);

ix. *Richison v. Am. Cemwood Corp.*, 2003 WL 23190948 (Cal. Super. Ct. Nov. 18, 2003) (approving phase 2 settlement of $83 million for defective roofs).

b) Decisions Awarding Attorney's Fees to Class Counsel:

i. *Pelletz v. Weyerhaeuser Co.*, 592 F. Supp. 2d 1322 (W.D. Wash. 2009) (defective deck-building products) (granting a fee award of $1,750,000, representing a "modest" 1.82 multiplier of Class Counsel's lodestar);

ii. *In re CertainTeed Fiber Cement Siding Litig.*, 303 F.R.D. 199 (E.D. Pa. 2014) (defective fiber cement siding) (approving $18.5 million fee award totaling 17.8% of the common fund and an approximate lodestar multiplier of 2.6);

iii. *In re MI Windows & Doors Inc. Prod. Liab. Litig.*, 2015 WL 4487734 (D.S.C. July 23, 2015), *appeal dismissed* (Sept. 3, 2015) (awarding Homeowner Plaintiffs' counsel $7,091,921.30 for attorneys' fees and $907,198.18 for reasonable expenses);

iv. *In re Zurn Pex Plumbing Prod. Liab. Litig.*, No. 08-MDL-1958 ADM/AJB, 2013 WL 716460, at *6 (D. Minn. Feb. 27, 2013) (defective brass fittings used in plumbing systems) (awarding $8.5 million for attorney's fees and reimbursement of all costs);

v. *In re Bldg. Materials Corp. of Am. Asphalt Roofing Shingle Prod. Liab. Litig.*, No. 8:11-CV-00983-JMC, 2015 WL 1840098, at *4 (D.S.C. Apr. 22, 2015) (finding an award of $3 million in attorney's fees and $700,00 in expenses was warranted);

vi. *Nieberding v. Barrette Outdoor Living, Inc.*, 129 F. Supp. 3d 1236 (D. Kan. 2015) (defective bracket used to connect vinyl guardrails on residential decks and porches) ($118,587.24 fee award, which "amounts to about one third of the total common fund").

Still, a consensus may be emerging that building product claims, at least those seeking consequential damages, are not suitable for class action treatment.

2. An Emerging Consensus?
Questioning the Viability of Building Product Class Actions.

While building products class actions have seen some success in recent years, *see, e.g.*, *In re IKO Roofing Shingle Products Liab. Litig.*, 757 F.3d 599 (7th Cir. 2014) (admonishing the district court for concluding individual damage determinations completely preclude class certification), a new view may be emerging.

A recent pair of decisions, issued together, from the District of South Carolina may signal a new consensus on the shortcomings of building product classes that seek

consequential damages. *See Romig v. Pella Corp.*, 2016 WL 3125472 (D.S.C. June 3, 2016) *and Naparala v. Pella Corp.*, 2016 WL 3125473 (D.S.C. June 3, 2016).

Romig and *Naparala* were decided as part of the *Pella* MDL in the District of South Carolina. Of the approximately 20 cases in the MDL, the court selected *Romig* and *Naparala* as the bellwethers on certification.[8]

As in most building product class action cases, the *Romig* court found the proposed classes met Rule 23(a)'s requirements of ascertainability,[9] numerosity, commonality, typicality, and adequacy of class representation. *See Romig*, 2016 WL at *3-9. The court also concluded, however, that individual issues concerning causation and damages predominated over the common liability issue — whether the Pella window is defective. *Id.* at *9-13.

In addition, the court concluded that certifying a liability-only class[10] under Fed. R. Civ. P. 23(c)(4), which the court acknowledged it could do, was not a superior method of adjudicating the class members' claims. *Id.* at *13-15. The court reached this conclusion by determining that even after resolving liability on a class basis, the remaining issues: "(i) whether the original warranty claim caused by defect; (ii) whether any of Pella's affirmative defenses apply; (iii) causation of each class member's damages;

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[8] Because the two decisions are virtually verbatim, the remainder of this Paper cites solely to *Romig*.

[9] For a review of the heightened standard of ascertainability being applied by some federal courts, *see* Kimberly J. Winbush, *Heightened Requirement of "Ascertainability" for Federal Class Action Certifications Arising Under Fed. R. Civ. P. 23(b)(3) After Third Circuit "Trilogy" of Marcus, Hayes, and Carrera*, 19 A.L.R. FED. 3D ART. 7 (2017).

[10] For a review of courts' different interpretation of the legal standard for certifying liability-only classes under Federal Rule of Civil Procedure 23(c)(4), *see* Robert H. Klonoff, *The Decline of Class Actions*, 90 WASH. U.L. REV. 729, 807-15 (2013) (discussing the divergent use of the issue-only class amongst the federal circuits). *See also* § 4:91.Rule 23(c)(4) issue certification's relationship to the predominance requirement of Rule 23(b)(3), Newberg on Class Actions § 4:91 (5th ed.).

and (iv) the amount of such damages" would require substantial resources to resolve in individual adjudications.

The court also noted that "if the alleged [window] defects are as uniform as plaintiff suggests, then much of the information other class members need to bring their case may already be available." *Id.* In sum, the Court concluded that certifying a class as to one issue would simply not bring the plaintiffs significantly closer to their sought after recovery.

The *Romig* and *Naparala* decisions highlight the shortcomings of certifying a liability-only class when the remaining member-specific issues are fact-intensive, as in most building products class actions. The March 28, 2017 order in *Sullivan v. Maibec,* in the United States District Court for the District of New Jersey, which denies class certification but does not, at least at this point, explain why, may further support a trend against certification of building product classes.

For other decisions decertifying or declining to certify a building products class action, *see, e.g.*,:

a) *Shuette v. Beazer Homes Holdings Corp.*, 121 Nev. 837, 866, 124 P.3d 530, 550 (2005) ("When single-family residence constructional defect cases present substantial issues requiring individualized determinations, they are not appropriate for class action treatment. Because the homeowners' claims and Beazer Home's defenses presented just such issues in this instance . . . we conclude that the district court abused its discretion in allowing the homeowners' case to proceed as a class action.");

b) *Welch v. Atlas Roofing Corp.*, 2007 WL 3245444, at *8 (E.D. La. Nov. 2, 2007) ("In summary, individual determinations of liability, the extent of that liability, damages, and the timeliness of each class member's claims will predominate over any issues common to the participating class members. Such individual determinations clearly indicate that a class action is not the superior method of fairly adjudicating the class members' claims. Therefore, the Court finds that Welch's action is not appropriate for class certification pursuant to Rule 23(b)(3).");

c) *Pagliaroni v. Mastic Home Exteriors, Inc.*, 2015 WL 5568624 (D. Mass. Sept. 22, 2015) (denial of motion for class certification);

d) Doster Lighting, Inc. v. E-Conolight, LLC, 2015 WL 3776491 (E.D. Wis. June 17, 2015) (same);

e) *Porcell v. Lincoln Wood Prod., Inc.*, 713 F. Supp. 2d 1305 (D.N.M. 2010) (denying motion for class certification because the plaintiff failed to satisfy Rule 23(b)(3)'s predominance and superiority requirements).

Courts' hesitance to certify liability-only classes, or classes requiring individual damage determinations, may stem from uncertainty in the procedural practice of adjudicating the next phase in a class action — trial.

3. Managing Building Products Class Actions Upon Certification.

The vast majority of class actions settle upon certification. *Cf. Eubank v. Pella Corp.*, 753 F.3d 718, 720 (7th Cir. 2014) ("[A] study of certified class actions in federal court in a two-year period (2005 to 2007) found that all 30 such actions had been settled."). As a consequence, case law providing guidance for administering the trial phase of a class action is sparse.

Courts typically bifurcate a class action trial when there is a common question of liability but individual damages questions. *See Olden v. LaFarge Corp.*, 383 F.3d 495, 509 (6th Cir. 2004) ("As the district court properly noted, it can bifurcate the issue of liability from the issue of damages, and if liability is found, the issue of damages can be decided by a special master or by another method.") (citing Fed. R. Civ. P. 23(c)(4)(A) *and Simon v. Philip Morris Inc.*, 200 F.R.D. 21, 30 (E.D.N.Y.2001) ("By bifurcating issues like general liability or general causation and damages, a court can await the outcome of a prior liability trial before deciding how to provide relief to the individual class members.")).

See also 11:7.Bifurcating liability and damages in class actions—Effect of *Comcast* and *Dukes*, Newberg on Class Actions § 11:7 (5th ed.) ("In sum, neither *Comcast* nor *Dukes* addressed bifurcation directly, and neither held anything that would foreclose bifurcation. In some sense, bifurcation is the *answer* to the problems found by

both Courts in that it enables the separation of the common questions (of liability) and individual questions (of damages).").

For a comprehensive overview of how courts will handle "phase two," of a class action's bifurcated trial, *see generally* § 11:9.Bifurcating liability and damages in class actions—Phase two: approaches to trying damages, Newberg on Class Actions § 11:9 (5th ed.).

In sum, building product class actions seeking relief for consequential damage continue to be filed in the wake of the Class Action Predominance Trilogy. The most recent decisions concerning class certification may indicate a trend away from certifying building product classes, at least those seeking damages because of consequential property damage, based on the recognition that individual causation and damage issues predominate over common liability issues.

Part 2: General Duty to Defend Considerations In Building Product Class Actions

A. When Is An Insurer's Duty To Defend Triggered?

The principle issue in determining whether an insurer has a duty to defend a building product class action, as in most building defect cases, is whether the complaint seeks damages because of potentially covered property damage caused by an occurrence.

The "occurrence" issue is largely settled — in most jurisdictions a builder's faulty workmanship or a product manufacturer's faulty design or production can be an occurrence. Whether damage to the product itself is "property damage" differs from state to state. But whatever a particular state's "occurrence" and "property damage" case law, the "your product" exclusion provides that only consequential damage, that is damage to something other than the product itself, is potentially covered.

Consequently, the duty to defend a building product class action frequently depends on whether the complaint seeks damages for consequential property damage. Since consequential damage is an individual damages issue, including it in a putative class action cuts against certification.[11] Still, most building product class action complaints allege damages to property other than the product itself. *Compare with* Part I,

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[11] *See generally* Jill B. Berkeley, *Finding Insurance Coverage for Consumer Products Class Action Complaints*, THE WOMEN OF THE SECTION OF LITIGATION (November 2014) ("The tension between the goal of certifying the class versus triggering the elements of insurance coverage is clear. On the one hand, certification requires common facts and injuries among the class members. Once individual damages are alleged, it becomes more difficult to overcome objections to class certification.").

See also Carlos Del Carpio, *Triggering the Duty to Defend a Class Action*, INSURANCE COVERAGE AND PRACTICE SYMPOSIUM (December 2015) ("Courts are divided on "the proper outcome where a class action complaint is drafted to avoid seeking relief for property damage or bodily injury that could preclude certification but could, at least arguably, fall within a policy's coverage. Courts that have addressed this issue have adopted divergent approaches . . .") (collecting and analyzing cases).

supra at p. 4 (noting that class action plaintiffs usually do not allege individual bodily injury damages).

1. Defective Work is an Occurrence

With rare exception, the majority rule is that defective workmanship – and by extension, defective design or manufacture of a product – is an occurrence. *See Cherrington v. Erie Ins. Prop. & Cas. Co.*, 231 W. Va. 470 (2013) (recognizing the majority rule that defective workmanship is an occurrence and overruling recent West Virginia precedent to the contrary that was "based upon reasoning which has [quickly] become outdated."). *But see Kvaerner Metals Div. of Kvaerner U.S., Inc. v. Commercial Union Ins. Co.*, 589 Pa. 317 (2006) (holding defective work is not an occurrence); *Millers Capital Ins. Co. v. Gambone Bros. Dev. Co.*, 2007 PA Super 403 (2007) (same). In most jurisdictions, therefore, a building product class action complaint's allegations of defective work allege an occurrence.

2. "Your Product" Exclusion Limits Coverage; Consequential Damages

The "Your Product" Exclusion in a CGL policy, however, limits an insurer's duty to defend to those complaints that contain allegations of damage to property other than the insured's allegedly defective product. *See* Steven Plitt, *et al.*, *"Your product" exclusion*, 9A COUCH ON INS. § 129:20 (3d ed. December 2016) ("[T]he primary purpose of . . . the 'your product' exclusion is to prevent liability policies coverage for damage to the insured's own product.").

Of course, "[t]he standard definition of 'your product' expressly provides that real property is not included within the purview of this phrase. The work performed by contractors on dwellings, buildings, structures, and any other form of realty is therefore not considered to be the product of the insured." *Id.* (collecting cases). A potentially interesting wrinkle in the application of the "product" exclusion is whether an insured's allegedly defective building product ceases to be a "product" when it becomes a fixture in a building. Does the product at that point become "real property" that is outside the "product" definition in standard general liability policies?

When determining whether an insured's product is "real property" for purposes of the exclusion, courts usually apply the black letter law and their state statute's definitions of "real property." *See, e.g.*, *Stuart v. Weisflog's Showroom Gallery, Inc.*, 311 Wis. 2d

492, 523–24 (2008) (relying on *Black's Law Dictionary's* and Wisconsin Stat. § 990.01's definitions of "real property" to conclude an addition to the plaintiff's home was within the "real property" exception to the "your product" exclusion); *Auto-Owners Ins. Co. v. Am. Bldg. Materials, Inc.*, 820 F. Supp. 2d 1265 (M.D. Fla. 2011) (same conclusion for drywall that was installed into a home).

On the other hand, in *Am. Home Assur. Co. v. AGM Marine Contractors, Inc.*, 467 F.3d 810 (1st Cir. 2006) (applying Massachusetts law) the First Circuit held that floating docks attached to a "pier built upon and planted in submerged land" were not real property within the real property exception of the "assured's product" exclusion. The court also cited to "the technical definition of real property" as well as Massachusetts case law defining real property as "so annexed that it cannot be removed without material injury to the real estate or to itself." *Id.* at 814. After acknowledging the non-uniform case law on whether floating docks are real property, the court determined that "the general definition of real property excludes floating docks that can be removed without damage . . . [T]he floating docks may be *close* to the line-being big structures that ordinarily are not moved about-does not make the line itself uncertain." *Id.* at 815.[12]

See also Colorado Cas. Ins. Co. v. Brock USA LLC, 2013 WL 4550416, at *5 (D. Colo. Aug. 28, 2013) ("These cases collectively stand for the proposition that once materials that were once 'your product' have been incorporated into real property, damage *to the resultant real property* does not constitute damage to 'your product.'") (citing:

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[12] The court also opined on the origin of the real property exception:

> It would be a different matter if there were some obvious rationale for the real property exception in the policy that would be frustrated by applying the classic definition. But, so far as we can tell, the exception came about almost by happenstance; . . . Earlier CGL policies did not have the real property exception; and, in construing such policies, courts divided as to whether the phrase "manufactured, sold, handled, or distributed" implicitly excluded real property . . . The ISO inserted the real property language to resolve the matter.

AGM, at 815–16. (citing Cunningham & Fischer, *Insurance Coverage in Construction-The Unanswered Question,* 33 TORT & INS. L.J. 1063, 1095-96 (1998)).

i. *Auto–Owners Ins. Co. v. Am. Bldg. Materials, Inc.*, 820 F.Supp.2d 1265, 1272 (M.D.Fla.2011) (described above);
ii. *Stuart v. Weisflog's Showroom Gallery*, Inc., 311 Wis.2d 492 (Wis.2008) (above);

iii. *Scottsdale Ins. Co. v. Tri–State Ins. Co. of MN.*, 302 F.Supp.2d 1100, 1104 (D.N.D. 2004) (citing to the definition of "real property" under North Dakota law, N.D. Cent. Code § 47-01-01, *et seq.*, and when strictly construing the real property exception against the insurer, finding prefabricated modular units, each a separate room, that were attached or affixed to a motel's foundation prior to the time they sustained water damage were within the real property exception to the your product exclusion);

iv. *Wanzek Const., Inc. v. Emp'rs Ins. of Wausau*, 679 N.W.2d 322, 326–28 (Minn.2004) (citing to Black's Law Dictionary's definition of "real property" and determining that coping stones added to a pool were within the real property exception to the your product exclusion)).

But see McMath Const. Co. v. Dupuy, 2003-1413 (La. App. 1 Cir. 11/17/04) ("McMath argues that because Dupuy's materials became incorporated into real property, the 'product' exclusion is inapplicable. We reject this argument, because the clear import of the exception is to remove only real property itself from the definition of 'your product.' Had the exception meant to remove materials incorporated into real property from the definition of 'your product,' it would have said so.") (defective stucco).

Another possible wrinkle is addressed in *Liberty Mut. Fire Ins. Co. v. MI Windows & Doors, Inc.*, in which a Florida appellate court reversed a trial court's holding that doors were so "materially changed by addition of the transoms [frames] that they were no longer [insured's] product." 131 So. 3d 15, 17 (Fl. Dist. Ct. App. 2013). After acknowledging the "dearth" of case law on this question, the court distinguished three cases[13] in which the defective product was held to be transformed and no longer the

[13] *See Imperial Casualty & Indemnity Co. v. High Concrete Structures, Inc.*, 858 F.2d 128 (3d Cir.1988) (defective steel cut and shaped into beveled washers); *Pittsburgh Plate Glass Co. v. Fidelity & Casualty Company of New York*, 281 F.2d 538 (3d Cir. 1960) (flaking paint baked onto venetian blinds); *Aetna Cas. & Sur. Co. v. M & S Indus., Inc.*, 64 Wash.App. 916 (1992) (defective plywood panels into concrete form systems).

insured's product when it was combined with another product. The court invoked "common sense" to conclude in the case before it, the addition of frames to doors did not make the doors into something else. *Id.* ("No alchemy confronts us. . . . They continue to operate as sliding glass doors.").

B. Allocation Of Defense Costs Among Insurers On The Risk

The first question insurers with a duty to defend a building product class action must evaluate and answer is how to allocate defense costs among themselves. Because the putative classes in these actions frequently seek damages because of consequential damage occurring over a long period of time, multiple sequential policies of insurance are typically triggered by such actions. These leads to a negotiation among the insurers over who pays how much of the defense.

The rule applied by the overwhelming majority of courts to have answered this question is to allocate the defense costs based on consecutive policies' time on the risk.

The chart below sets forth the law in 27 jurisdictions. Of the 24 jurisdictions that have an established rule on the issue, 22 apply time on the risk allocation and two apply equal shares allocation. Three additional jurisdictions have conflicting authority or implement a different allocation method.

This survey is principally based on the secondary source: Allocation of Losses in Complex Insurance Coverage Claims, Thompson Reuters, 2016, authored by Scott M. Seaman and Jason R. Schulze. That source catalogues allocation decisions concerning defense, indemnity, concurrent insurance policies, consecutive policies, disputes between policy holders and insurers, and disputes among insurers only. The chart below only provides the authority applicable to allocation of (1) defense costs, (2) among consecutive policies, and (3) among insurers.

Allocation of Defense Costs Survey

State	Rule for Allocation of Defense Costs Among Consecutive Policies	Authority
Alabama	Time on the risk	*Commercial Union Ins. Co. v. Sepco Corp.*, 918 F.2d 920 (11th Cir. 1990)

Arizona	Time on the risk	*Owners Ins. Co v. Illinois Union Ins. Co.*, 1 CA-CV 07-0115, 2007 WL 5471953 (Ariz. Ct. App. Dec. 24, 2007)
California	Time on the risk	*St. Paul Mercury Ins. Co. v. Mountain W. Farm Bureau Mut. Ins. Co.*, 148 Cal. Rptr. 3d 625, 640 (Ct. App. 2012)
Colorado	Probably time on the risk	*D.R. Horton, Inc. - Denver v. Mountain States Mut. Cas. Co.*, 12-CV-01080-RBJ, 2013 WL 674032, at *3 (D. Colo. Feb. 25, 2013) ("This is not to say that there should not or will not be an apportionment of the defense costs among the insurers, either under a 'time on the risk' or some other appropriate allocation method.")
Connecticut	Time on the risk	*Travelers Cas. & Sur. Co. of Am. v. Netherlands Ins. Co.*, 95 A.3d 1031 (Conn. 2014)
District of Columbia	Allocation among insurers determined by "other insurance" and contribution clauses of policies; joint and several as to insured	*Keene Corp. v. Ins. Co. of N. Am.*, 667 F.2d 1034, 1051 (D.C. Cir. 1981)
Florida	No contribution among insurers allowed; joint and several as to insured	*Miami Battery Mfg. Co. v. Boston Old Colony Ins. Co.*, 97-3410-CIV, 1999 WL 34583205, at *16 (S.D. Fla. Apr. 28, 1999)
Georgia	Equal shares, based on contribution language of the policies	*St. Paul Fire & Marine Ins. Co. v. Valley Forge Ins. Co.*, CIVA.106-CV-2074-JOF, 2009 WL 789612 (N.D. Ga. Mar. 23, 2009)
Illinois	Time on the risk	*Knoll Pharm. Co. v. Auto. Ins. Co. of Hartford*, 210 F. Supp. 2d 1017 (N.D. Ill. 2002)
Kentucky	Time on the risk	*Kentucky League of Cities Ins. Services Ass'n v. Argonaut Great Cent. Ins. Co.*, 5:11-CV-00187, 2013 WL 120013 (W.D. Ky. Jan. 8, 2013)
Louisiana	Time on the risk	*Arceneaux v. Amstar Corp.*, 200 So. 3d 277 (La. 2016)
Maryland	Time on the risk	*Nationwide Mut. Ins. Co. v. Lafarge Corp.*, CIV.A. H-90-2390, 1994 WL 706538, at *12 (D. Md. June 22, 1994); *Pennsylvania Nat. Mut. Cas. Ins. Co. v. Roberts*, 668 F.3d 106, 114, 2012 WL 336150 (4th Cir. 2012) (concerning indemnity but citing *Ins. Co. of N. Am. v. Forty-Eight Insulations, Inc.*, 633 F.2d 1212, 1225 (6th Cir. 1980), a seminal case on time on the risk allocation of defense costs)

Michigan	Time on the risk	*Ins. Co. of N. Am. v. Forty-Eight Insulations, Inc.*, 633 F.2d 1212 (6th Cir. 1980), *decision clarified on reh'g,* 657 F.2d 814 (6th Cir. 1981); *Century Indem. Co. v. Aero-Motive Co.*, 318 F. Supp. 2d 530, 545 (W.D. Mich. 2003)
Minnesota	Equal shares	*Cont'l Cas. Co. v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA*, CIV. 09-287 JRT/JJG, 2014 WL 4546039, at *6 (D. Minn. Sept. 12, 2014), *aff'd and remanded,* 812 F.3d 1147 (8th Cir. 2016), *reh'g denied* (Mar. 14, 2016)
Missouri	Time on the risk	*Cont'l Cas. Co. v. Med. Protective Co.*, 859 S.W.2d 789 (Mo. Ct. App. 1993)
Nebraska	Time on the risk	*Dutton-Lainson Co. v. Cont'l Ins. Co.*, 778 N.W.2d 433, 440 (Neb. 2010)
New Jersey	Time on the risk	*Columbus Farmers Mkt., LLC v. Farm Family Cas. Ins. Co.*, CIV A 05-2087, 2006 WL 3761987, at *14 (D.N.J. Dec. 21, 2006) (citing *Owens-Illinois, Inc. v. United Ins. Co.*, 138 N.J. 437 (1994))
New York	Includes support for time on the risk, but also other methods	Time on the risk—*Travelers Cas. & Sur. Co. v. Alfa Laval Inc.*, 954 N.Y.S.2d 23, 24 (App. Div. 2012) (trial court denied Travelers and OneBeacon's "cross motions for summary judgment declaring that they have a duty to defend the underlying asbestos claims only on a pro rata 'time on the risk' basis"; appellate court, in two page opinion, affirmed that holding, but reversed summary judgment against OneBeacon, holding that "Travelers, as the long standing insurer, should provide a complete defense, and OneBeacon may eventually be required to contribute to both defense costs and indemnification on a pro rata basis"). Equal shares—*State of New York Ins. Dept., Liquidation Bureau v. Generali Ins. Co.*, 844 N.Y.S.2d 13, 15 (App. Div. 2007); *Cont'l Cas. Co. v. Employers Ins. Co. of Wausau*, 865 N.Y.S.2d 855, 861 (Sup. Ct. 2008), *rev'd,* 923 N.Y.S.2d 538 (App. Div. 2011) (trial court allocated based on equal shares among insurers; appellate court held one insurer's policies were exhausted, obviating the allocation issue, but did not assert that, in the event allocation were needed, the equal shares method was incorrect)

		In proportion to limits—*Avondale Indus., Inc. v. Travelers Indem. Co.*, 774 F. Supp. 1416, 1438 (S.D.N.Y. 1991), *judgment entered,* 86 CIV. 9626 (KC), 1993 WL 427035 (S.D.N.Y. Oct. 15, 1993) Dicta that pro-rata contribution is permitted, but declining to set forth the appropriate method for pro-ration—*Cont'l Cas. Co. v. Rapid-Am. Corp.*, 609 N.E.2d 506, 514 (N.Y. 1993) ("When more than one policy is triggered by a claim, pro rata sharing of defense costs may be ordered, but we perceive no error or unfairness in declining to order such sharing, with the understanding that the insurer may later obtain contribution from other applicable policies.") (denying as premature CNA's request for pro-rata allocation of defense costs among consecutive policies issued by National Union and among uninsured periods) Interim ruling that insurer should pay 50% of defense costs and thereafter permitting contribution from other insurers—*Consol. Edison Co. of New York v. Fyn Paint & Lacquer Co.*, CV 00-3764 DGT MDG, 2005 WL 139170, at *4 (E.D.N.Y. Jan. 24, 2005)
Ohio	Time on the risk	*Lincoln Elec. Co. v. St. Paul Fire & Marine Ins. Co.*, 210 F.3d 672, 689 (6th Cir. 2000) ("We are persuaded that the Ohio Supreme Court would adopt principles in harmony with the compelling rationale articulated in *Forty–Eight Insulations,* 633 F.2d at 1222, 1224–25"); *Pennsylvania Gen. Ins. Co. v. Park-Ohio Indus., Inc.*, 902 N.E.2d 53, 62 (Ohio Ct. App. 2008), *aff'd sub nom. Pennsylvania Gen. Ins. Co. v. Park-Ohio Indus.*, 930 N.E.2d 800 (Ohio 2010) (pro-rata but not specifying the how defense costs should be pro-rated)
Oregon	Probably time on the risk, but authority exists for considering policy limits in addition to time on the risk	Time on the risk—*Fireman's Fund Ins. Co. v. Oregon Auto. Ins.*, CV 03-0025-MO, 2010 WL 1542552, at *1 (D. Or. Apr. 15, 2010), *vacated and remanded on other grounds sub nom. Fireman's Fund Ins. Co. v. N. Pac. Ins. Co.*, 446 Fed. Appx. 909 (9th Cir. 2011)

		Time on the risk and policy limits—*Nw. Pipe Co. v. RLI Ins. Co.*, 3:09-CV-01126-PK, 2012 WL 2268413, at *5 (D. Or. June 13, 2012), *adhered to on reconsideration,* 3:09-CV-01126-PK, 2013 WL 3712416 (D. Or. July 11, 2013)
Rhode Island	Time on the risk	*Century Indem. Co. v. Liberty Mut. Ins. Co.*, 815 F. Supp. 2d 508 (D.R.I. 2011)
South Carolina	Time on the risk	*Liberty Mut. Fire Ins. Co. v. J.T. Walker Indus., Inc.*, CIV.A. 2:08-2043-MBS, 2010 WL 1345287, at *5 (D.S.C. Mar. 30, 2010), *modified,* 817 F. Supp. 2d 784 (D.S.C. 2011)
Texas	Probably time on the risk	*Texas Prop. & Cas. Ins. Guar. Ass'n/Sw. Aggregates, Inc. v. Sw. Aggregates, Inc.*, 982 S.W.2d 600, 604 (Tex. App. 1998) (joint and several as to insured, noting that "insurers may apportion defense costs among themselves any way they choose") ("Furthermore, *Gulf Chemical* and *Lafarge* rely on *Forty–Eight Insulations* for the proposition that where defense costs can be readily apportioned among insurers, each owes only a pro rata portion of those costs based on its time on the risk. We believe that *Forty–Eight Insulations* and its progeny are irreconcilable with *Keene's* holding that each insurer is fully liable to the insured for defense costs.") (following *Keene Corp. v. Ins. Co. of N. Am.*, 667 F.2d 1034 (D.C. Cir. 1981)). *Sw. Aggregates, Inc.*, permitting the insured to select the policy from which it seeks its defense, reduces the persuasive value of the following federal cases, which required the insured to bear defense costs for uninsured or "fronting policy" years. Nevertheless, *Sw. Aggregates* did not address disputes among insurers, and the following cases are arguably good authority for applying time on the risk *vis-a-vis* insurer disputes—*Nat'l Standard Ins. Co. v. Cont'l Ins. Co.*, CA-3-81-1015-D, 1984 WL 23448, at *1 (N.D. Tex. Apr. 9, 1984), *abrogated on trigger of coverage issues by Guar. Nat. Ins. Co. v. Azrock Indus. Inc.*, 211 F.3d 239 (5th Cir. 2000) (time on the risk); *Lafarge Corp. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa.*, 935 F. Supp. 675, 680, 1996 WL 459771 (D. Md. 1996) (applying Texas law) (describing prior order in

		which the court "adopted a *pro rata* allocation formula based upon each insurer's time 'on the risk.'"); *Gulf Chem. & Metallurgical Corp. v. Associated Metals & Minerals Corp.*, 1 F.3d 365 (5th Cir. 1993) (time on the risk); *Lafarge Corp. v. Hartford Casualty Insurance Co.,* 61 F.3d 389 (5th Cir. 1995) (time on the risk) Pro rata but not specifying method of pro-ration—*Trinity Universal Ins. Co. v. Employers Mut. Cas. Co.*, 592 F.3d 687, 695 (5th Cir. 2010) (permitting pro-rata allocation of defense costs, but leaving open the method of pro-ration) Joint and several as to insured—*Mid-Continent Cas. Co. v. Acad. Dev., Inc.*, CIV.A. H-08-21, 2010 WL 3489355, at *8 (S.D. Tex. Aug. 24, 2010), *aff'd,* 476 Fed. Appx. 316 (5th Cir. 2012)
Utah	Time on the risk, except insured is not required to contribute for uninsured periods	*Ohio Cas. Ins. Co. v. Unigard Ins. Co.*, 268 P.3d 180, 187 (Utah 2012)
Vermont	Time on the risk	*Towns v. N. Sec. Ins. Co.*, 964 A.2d 1150 (Vt. 2008)
Virginia	Probably time on the risk, provided that the defense costs can be pro-rated between covered and non-covered periods.	*Morrow Corp. v. Harleysville Mut. Ins. Co.*, 101 F. Supp. 2d 422, 430 (E.D. Va. 2000) (citing *Insurance Co. of North America v. Forty–Eight Insulations, Inc.,* 633 F.2d 1212, 1224 (6th Cir.1980))
Washington	Fact specific	*In re Consol. Feature Realty Litig.*, CV-05-0333-WFN, 2008 WL 220271 (E.D. Wash. Jan. 25, 2008) (allocating defense costs based on evidence demonstrating that 80-90 percent of defense costs related to discrete acts taking place in one policy period, and therefore allocating 80 percent of defense costs to that policy's issuer)

In the vast majority of jurisdictions, therefore, insurers defending a class action can predict with confidence that their defense costs will be allocated by the time-on-the-risk method. In Georgia and Minnesota, however, insurers must share defense costs by the equal shares method.

In jurisdictions that have not decided this issue or require a fact-intensive inquiry, insurers should be prepared to litigate this issue or reach quick resolution with co-triggered insurers. *See also* Allan D. Windt, *Allocation of defense costs among consecutive insurers, 1 Insurance Claims and Disputes*, INSURANCE CLAIMS & DISPUTES § 4:45 (6th ed.).

C. If No Class Representative's Claim Triggers an Insurer's Duty To Defend, But The Claims of Some Unidentified Class Members Would, Does The Insurer Have A Defense Obligation?

Generally, if the claims of any putative class member creates the potential for coverage under an insurer's policy, the insurer must defend the class action. *See Hartford Acc. & Indem. Co. v. Beaver*, 466 F.3d 1289 (11th Cir. 2006) (holding under Florida law that an insured is entitled to a defense despite the fact that the claim of the single remaining class representative, standing alone, was not covered). *See* Carlos Del Carpio, *Triggering the Duty to Defend a Class Action*, INSURANCE COVERAGE AND PRACTICE SYMPOSIUM (December 2015) ("While this issue has not been addressed in many jurisdictions, certain courts have held similarly [to *Beaver*], finding a duty to defend prior to class certification based on potential allegations of putative class members.") (citing *LensCrafters, Inc. v. Liberty Mut. Fire Ins. Co.*, 2005 WL 146896 (N.D. Cal. 2005)).

In *Omega Flex, Inc. v. Pac. Employers Ins. Co.*, 78 Mass. App. Ct. 262, 268 (2010), the Massachusetts Appeals Court explained its rationale for the rule as follows:

> [W]e do not believe that an insured must demonstrate that the plaintiffs will satisfy [Massachusetts'] rule 23 in order to receive a defense from its insurer. . . . In the context of a class action complaint, we understand that principle to mean that we should avoid anticipating the possible outcome of the certification process. . . . The fact that some of the claims may ultimately be deemed unsuitable for class treatment should not deprive the insured of the benefit of a defense, provided the complaint fairly can be read to assert one or more claims that fall within the scope of the policy.

Id. Typically then, an insurer must defend a class action if the claims of any putative class member are potentially covered.

D. If No Certified Claim Triggers an Insurer's Duty to Defend, Does the Insurer Retain A Defense Obligation?

Coverage issues abound when a putative class action complaint pleads both potentially covered and uncovered claims, but the court certifies only the uncovered claims.

In this situation, the insurer may argue that its duty to defend terminates with the certification of the class. There is some authority for this position. *See, Del Webb's Coventry Homes, Inc. v. National Union Fire Ins. Co.*, 2014 WL 7639486 (C.D. Cal. Nov. 19. 2014)(granting insurer's motion to dismiss on the duty to defend and indemnify because only expressly excluded claims for cost of repairing the policyholder's product had been certified).

Arguments exist to the contrary, however. One court refused to terminate an insurer's duty to defend when potentially covered individual (non-representative) claims remained in the lawsuit after certification of a class containing solely uncovered claims. *See Universal Underwriters Insurance Co. v. CARSDIRECT.COM,*2003 WL 22669016 (C.D. Cal. Oct. 28, 2003)(holding presence of potentially covered individual common-law claims for tortious intrusion required the insurer to continue defending an action in which only specifically excluded penal claims had been certified). The holding in this case is consistent with the standard rule that "[a]n insurer that has issued an insurance policy that includes a duty to defend must defend any legal action brought against an insured that is based in whole or in part on any allegations that, if proven, would be covered by the policy . . . ." *See, e.g.,* RESTATEMENT OF THE LAW OF LIABILITY INSURANCE § 13(1)(Tentative Draft No. 1 Apr. 11, 2016).

Even when no individual claims have been plead, legal authority exists that an insurer cannot terminate the duty to defend on the basis of a class certification order because such an order does not constitute one of the limited types of circumstances in which courts have allowed an insurer to terminate the duty to defend once it has arisen. *See, e.g.,* RESTATEMENT OF THE LAW OF LIABILITY INSURANCE § 18(1)-(8) and Comment *a* (Tentative Draft No. 1 Apr. 11, 2016). For example, policyholder lawyers are likely to argue that a class certification order is

not a "[f]inal adjudication or dismissal of part of the action that eliminates any basis for coverage of any remaining components of the action" because a certification order is not a final adjudication on the merits or a dismissal. Notably, in the *Del Webb's Coventry Homes, Inc.* case, the federal district court held that an excess insurer's duty to defend had not arisen because the class certification order was issued before the primary policy was exhausted. It did not address the issue of whether a duty to defend, once triggered, may terminate on the basis of a class certification order.

Policyholders also can be expected to argue that basing a duty to defend decision on whether or not legal theories have been crafted to ensure class certification violates the rule that "the duty to defend is triggered when 'any of the allegations in the complaint potentially include conduct that is covered by the indemnity contract.'" *Pancakes of Haw. v. Pomare Props. Corp.,* 944 P.2d 83, 89-91 (Haw. Ct. App. 1997). The policyholder's potential liability to class members still exists for claims that have not been certified, as does the insurer's duty to the policyholder based on that potential liability. The scope of releases in class settlements illustrate this point. When a class defendant settles a class action, the class defendant typically does not seek a release solely of the certified claims, the class defendant seeks a release of all allegations, transactions, facts and occurrences set forth in the complaint whether certified or not. *See, e.g., 9 NEWBERG ON CLASS ACTIONS, at App. 385, Agreement and Release.*

E. Selecting Defense Counsel; Reasonableness & Conflicts Of Interest

Building product class actions are expensive to defend, but much of the indemnity may not be covered because it is for the cost of the product itself. There is risk to insurance companies in insisting on counsel of their choice when a policyholder has significant indemnity exposure. The policyholder may argue that its indemnity cost would have been less if it had been defended by counsel of its choice.

Is the policyholder entitled to select counsel when much of the indemnity will not be covered? "[T]here are varying views as to how that independent counsel must be selected . . . [which] cannot be reconciled except to note that the holdings of the court are jurisdiction specific." Steven Plitt, *et al.*, *Who Is Entitled to Select Independent Counsel*,

14 COUCH ON INS. § 202:35 (3d ed. December 2016) (collecting cases). *See also* James L. Cornell and Trevor B. Hall, *What Every Business Lawyer Should Know About the Insurance Carrier's Duty to Defend and the Policyholder's Right to Select Counsel*, TEX. J. BUS. L. (2007).

If insurers wish to select counsel, or even participate in the selection of counsel, they should do so promptly, as a delay may create an estoppel. *See Haley v. Kolbe & Kolbe Millwork Co.*, 97 F. Supp. 3d 1047, 1051–52 (W.D. Wis. 2015)[14] ("I will assume that insurers have a right to choose counsel even when they defend the insured under a reservation of rights. Even making that assumption, however, I conclude that . . . insurers lost whatever right they had through their own inaction."). In *Kolbe & Kolbe*, the insurers waited four months after the policyholder tendered its defense to object to the policyholder's selection of counsel.

[14] A certification decision in this case is pending. *See* Wes Dvorak, *Judge Won't Close Curtain on Insurers' Duty to Defend Window Maker*, 11 WESTLAW JOURNAL INSURANCE BAD FAITH 5 (2015).

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INTRODUCTION

Every year, according to the FDA, the food industry experiences an average of ten recalls *per week*, and that figure does not even include meat products regulated by the USDA.[1] In the past, the food industry treated recall expenses as a "cost of doing business," particularly to the extent that recall-related losses were limited or excluded altogether by their comprehensive general liability (CGL) and property insurance policies. Now, specialty insurance products exist that may fill the apparent gap in coverage between standard CGL, first-party commercial property and business interruption insurance, and other policies. Nevertheless, coverage gaps persist, largely due to inconsistencies in drafting borne of the insurance industry's uncertainty with respect to how much risk it really wants to bear in this space.

There is no single "food recall insurance" policy that a company can purchase. Rather, insurance coverage for losses and liabilities arising out of a food recall may be found in a conglomeration of multiple different insurance policies. These include first-party commercial property insurance, along with attendant business interruption insurance; commercial general liability (CGL) and umbrella liability insurance; specialty "recall" insurance or product contamination insurance (PCI); as well as directors and officers (D&O) liability insurance, and perhaps errors and omissions (E&O) insurance .[2] A brief summary of the coverages provided (and not provided) by each type is set forth below.[3]

I. PART ONE: ANATOMY OF A RECALL INSURANCE PORTFOLIO

A. Recall Coverage under CGL Policies

To the extent that a food contamination or recall incident involves illness, bodily injury, or damage to downstream customer's products and property, the CGL policy is paramount. In the event of outbreak and damage claims against the food company, its CGL insurer would be the one to defend against suits, process claims under the policy's medical payments provision, and otherwise respond to–and pay for–damage and injury claims.

1. Bodily Injury/Property Damage Requirement

A CGL policy typically defines the term "bodily injury" as "bodily injury, sickness, or disease." Without a definition that expressly includes emotional distress and other non-physical manifestations of injury, a majority of courts have interpreted this somewhat circular definition as requiring that the claimant suffer an actual physical injury to trigger coverage. Consequently, "bodily injury" might not include coverage for emotional distress or "fear-of" claims when there is no associated physical effect. *See Allstate Ins. Co. v. Diamant*, 518 N.E.2d 1154 (Mass. 1988) (bodily injury includes only physical injuries to the body and its attendant consequences); *Aim Ins. Co. v. Culcasi*, 229 Cal. App. 3d 209 (1991) (emotional distress is not bodily injury under CGL policy).

In addition to bodily injury coverage, CGL insurance also covers liability for property damage incurred by downstream customers in the food supply chain. The typical CGL definition of "property damage" includes

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[1] *See* U.S. Food and Drug Administration. List of Recalls of Foods & Dietary Supplements, *available at* https://www.fda.gov/Safety/Recalls/default.htm#additional-info (listing seven to fourteen recalls per week since January 20, 2017, and noting that "Not all recalls have press releases or are posted on this page.").

[2] Specimen policy forms are too voluminous to attach hereto but are available upon request.

[3] Other types of insurance coverage might also be available for certain recall-related losses and liabilities, *e.g.*, marine cargo, professional liability, "Tech E&O" and others. Because of the paucity of relevant case law, a discussion addressing these and other coverage types is beyond the scope of this paper.

"physical injury to or destruction of tangible property, including consequential loss of use thereof" and "loss of use of tangible property which has not been physically injured or destroyed."

Courts have found coverage for "property damage" under CGL insurance in multiple instances. For example:

- Coverage was allowed where faulty flavoring ingredients contaminated a finished food flavoring company's products.[4]
- Coverage was allowed where nut clusters containing wood splinters were incorporated into a customer's breakfast cereal product.[5]
- Coverage was allowed where benzene had contaminated carbon dioxide incorporated into soft drinks;[6] and where trace amounts of food grade propylene glycol had contaminated orange juice.[7] Similarly, some courts have found covered "property damage" where the contamination resulted in "loss of use" rather than physical damage.[8]

On the other hand, courts have found no covered "property damage" where contamination occurred in the policyholder's "own work" or "own product" rather than the property of its customer.[9] For example:

- Court found economic loss instead of "property damage" where the finished product was indeed contaminated, but the soft drink bottler's faulty process constituted a breach of contract or warranty rather than "property damage" to a third party.
- Court found no "property damage" or "impaired property" where a policyholder's individually sealed packets of peanut butter were found to be rancid, but were able to be removed from a customer's cookie mix boxes without damaging other ingredients, because "[t]he paste was sealed in individual packets and those packets were simply removed from the boxes of cookie mix."[10]
- Court found no "property damage" where defective cans were used to package Del Monte fruit, and Del Monte disposed of the fruit as well as the cans, because "[t]he parties do not dispute that there was no actual physical damage to the fruit itself that caused an alteration in appearance, shape, color, or other material dimension."[11] The court also refused to find that the disposal of the fruit cups amounted to a "loss of use."

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[4] *Travelers Indem. Co. v. Dammann & Co.*, 592 F. Supp. 2d 752 (D. N.J. 2008).

[5] *Shade Foods, Inc. v. Innovative Prods. Sales & Mktg., Inc.*, 78 Cal. App. 4th 847, 865-66 (2000) (also holding that impaired property exclusion did not apply because splinters could not be removed).

[6] *Nat'l Union Fire Ins. Co. of Pittsburgh v. Terra Indus., Inc.*, 346 F.3d 1160 (8th Cir. 2003) (Iowa law).

[7] *Zurich Am. Ins. Co. v. Cutrale Citrus Juices USA, Inc.*, No. 5:00-CV-149, 2002 WL 1433728, at *11 (M.D. Fla. Feb. 11, 2002).

[8] *See, e.g., Stark Liquidation Co. v. Florists' Mut. Ins. Co.*, 243 S.W.3d 385 (Mo. Ct. App. 2007) (failure of bacterially infected apricot trees to produce fruit); *Hendrickson v. Zurich Am. Ins. Co.*, 72 Cal. App. 4th 1084 (1999) (loss of strawberry production after herbicide drifted onto grower's fields).

[9] *Atlantic Mut. Ins. Co. v. Hillside Bottling Co.*, 903 A.2d 513, 520 (N.J. App. Div. 2006) (soft drink bottler's process resulted in ammonia contamination of products it had contracted to formulate for Snapple).

[10] *Sokol & Co. v. Atlantic Mut. Ins. Co.*, 430 F.3d 417, 422 (7th Cir. 2005).

[11] *Silgan Containers Corp. v. Nat'l Union Fire Ins. Co.*, No. 4:08-cv-02246, 2010 U.S. Dist. LEXIS 30100, at *20 (N.D. Cal. Mar. 29, 2010).

Further, even where a faulty ingredient has clearly been inextricably incorporated into a product, rendering the finished product unsaleable, at least one court in Wisconsin has found that the mistake did not cause "property damage," instead characterizing the finished product as a combination of the faulty ingredient with other ingredients to create an "integrated system." As such, according to the majority, no "other property" (separate from the supplier's faulty ingredient) had been damaged.[12]

2. CGL Exclusions

Depending on the nature of the claims, however, insurers might refuse to cover certain liabilities, based on certain exclusions.

a. The "Recall" or "Sistership" Exclusion

At first glance, the standard CGL insurance policy would appear to exclude coverage for recalls, based on the "recall" or "sistership" exclusion. This exclusion typically bars coverage for:

> Damages claimed by you for any loss, costs or expenses incurred by you or others for the loss of use, withdrawal, recall, inspection, repair, replacement, adjustment, removal or disposal of:
>
> (1) "Your product";
>
> (2) "Your work"; or
>
> (3) "Impaired property";
>
> if such product, work, or property is withdrawn or recalled from the market or from use by any person or organization because of a known or suspected defect, deficiency, inadequacy or dangerous condition in it.

This exclusion is not as straightforward as it might seem. Most courts have applied the exclusion to bar coverage for damages resulting from the insured's withdrawal of its own product from the market. However, courts have allowed coverage, finding the exclusion inapplicable, when recall-related costs are claimed against the insured as an element of third-party damages.[13]

The seminal case involving the recall exclusion is *Thomas J. Lipton, Inc. v. Liberty Mutual Insurance Co.,*[14] which involved contaminated noodles supplied to Lipton for dry-soup mixes. Lipton recalled its soups and sought damages against the noodle manufacturer for its recall-related expenses. In distinguishing between a recall of the insured's products and a recall of the customer Lipton's products, the New York court observed that Lipton's recall-related damages "would usually be some of the largest foreseeable

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[12] *Wis. Pharmacal Co. v. Neb. Cultures of Cal. Inc.,* 876 N.W.2d 72 (Wis. 2016). The dissent did not accept this characterization, arguing that CGL policies expressly *allow* coverage for damage involving "integrated systems" through the policies' exception to the "impaired property" exclusion. *Id*. at 98 (¶¶ 141-143) (Abrahamson, J., dissenting). For further discussion of the "impaired property" exclusion, *see* Section I.A.2.c., below.

[13] *See, e.g., Sec. Nat'l Ins. Co. v. GloryBee Foods, Inc.,* 2011 U.S. Dist. LEXIS 27267 (D. Or. March 15, 2011) (allowing coverage for customer's recall costs due to recall of peanuts sold by insured); *Parker Prods., Inc. v. Gulf Ins. Co*., 486 S.W.2d 610 (Tex. Ct. Civ. App. 1972), *aff'd sub nom. Gulf Ins. Co. v. Parker Prods., Inc.*, 498 S.W.2d 676 (Tex. 1973) (allowing coverage for damage to customer's ice cream product caused by incorporation of policyholder's defective candy flavoring).

[14] 314 N.E.2d 37 (Ct. App. N.Y. 1974).

elements" of damages that would be claimed against a supplier.[15] Accordingly, such damages related to property damage claims that were not barred by the recall/sistership exclusion.

b. The "Your Product" and "Your Work" Exclusions

The "your work" and "your product" exclusions apply to coverage for "'Property damage' to '*your product*' arising out of it or any part of it," and "'Property damage' to '*your work*' arising out of it or any part of it and included in the 'products-completed operations hazard.'" In the product recall or contamination context, courts have applied these exclusions to bar coverage for the cost of the policyholder's ingredient or the cost of repairing the policyholder's product, but not for the cost of other kinds of property damage caused by the policyholder's product. For example:

- In *Tradin Organics*, the policyholder sold its raspberry crumble to a food company in Canada. After the food company accepted delivery, the crumble was discovered to contain plastic, glass, and other objects, and the Canadian government ordered it recalled. The policyholder compensated its customer for the contaminated crumble and then sought coverage from its insurer for the payment. The court determined that the "your product" exclusion unambiguously barred coverage.[16]

- In another case, a dead mouse was found in the hose leading from the policyholder's milk truck to its customer's storage silo. The court held that the "your product" exclusion barred coverage for the loss of the milk, which was the policyholder's own product, but did not apply to the cost of cleaning the customer's silo.[17]

- Similarly, in *Hartog Rahal Partnership v. American Motorists Insurance Co.*,[18] the court distinguished between the cost for damage to the policyholder's product and other costs. There, the policyholder sold a juice concentrate to manufacturers that used it in their products advertised as one hundred percent juice. The customers' products could not be sold after it was discovered that the juice concentrate contained an artificial sweetener. The policyholder settled with its customers, and the insurer agreed to reimburse the policyholder for 80% of the settlement amount, but argued that the remaining 20% represented the cost of the policyholder's product to the customers. The court agreed.[19]

- The outcome in *Holsum Foods Division v. Home Insurance Co.* was similar.[20] *Holsum*, the policyholder, manufactured and packaged barbecue sauce using ingredients supplied by its customer. It then shipped them from its warehouse at its customer's direction. After glass chips were discovered in some of the bottles, the bottles had to be destroyed and *Holsum* paid its customer for the costs of the destroyed product. The court held that the barbecue sauce was *Holsum's* product which was excluded by the "your product" exclusion:

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[15] *Id.* at 39.

[16] *Tradin Organics USA, Inc. v. Maryland Cas. Co.*, No. 06 Civ. 5494, 2008 U.S. Dist. LEXIS 5820 (S.D.N.Y. Jan. 29, 2008), *aff'd*, 325 Fed. Appx. 10 (2d Cir. 2009).

[17] *Lowville Producer's Dairy Coop., Inc. v. Am. Motorists Ins. Co*., 198 A.D.2d 851 (N.Y. 1993).

[18] 359 F. Supp. 2d 331 (S.D.N.Y. 2005).

[19] *Id.* at 332. The court did not discuss or evaluate how the discounted percentage was calculated.

[20] The policy in *Holsum* denied contained an exclusion for "property damage to the named policyholder's products arising out of such products or any part of such products." *Holsum Foods Div. of Harvest States Coops. v. Home Ins. Co.*, 162 Wis. 2d 563, 567 (Wis. Ct. App. 1991).

> [W]e conclude that *Holsum* was manufacturing a product. *Holsum* was provided with someone else's ingredients to be sure. However, *Holsum* then provided an ingredient of its own, did the mixing and cooking, and created a tangible item -- the barbecue sauce.[21]

In both *Hillside* and *Holsum*, the policyholder manufacturers provided multiple ingredients to the finished product and performed work that resulted in the production of the final product. Thus, because the finished product was deemed to actually be the policyholder's "own product" or "own work," and not damaged third-party property, it was excluded.

c. The Impaired Property Exclusion

"Impaired property" is a defined term in the CGL policy. It means third-party property (not "your product" or "your work") that cannot be used or is less useful because it has incorporated into it a defective or adulterated component *and* that property can be restored to use by the repair, replacement, adjustment or removal of "your product" or "your work," or by your fulfilling the terms of the contract or agreement with the aggrieved party.[22]

The exclusion for "impaired property" bars coverage for such damage or loss of use; however, the "if" clause creates an important exception: if the property *cannot* be restored to use by removing or repairing the insured's defective or contaminated product, then the exclusion does not apply.

The first step in determining whether this exclusion applies is deciding whether the injured property is "impaired." Where a defective component, like the peanut butter packets in *Sokol,* could be removed from the customer's boxes of cookie mix and replaced without damaging the other ingredients in the mix, the policyholder's spoiled products were "impaired property." Accordingly, the claim fell squarely within the exclusion, because the customer's product could be–and was–"restored to use" by removing the defective products.[23]

This exclusion is not in play if the third party's property has suffered "physical injury." The exclusion also does not apply if adulterating or contaminating ingredient cannot be removed from the third party's property in order to restore it. In *Shade Foods*, for instance, the nut clusters were not "impaired property" because it was not possible to remove the contaminated almonds. As the court noted:

> [The insurer] has presented no evidence that the contaminated products manufactured from the diced almonds could be 'restored to use' by removal of the wood splinters. Indeed, it is fanciful to suppose that the nut clusters composed of congealed syrups and diced nuts or the boxed cereal product containing the nut clusters could be somehow deconstructed to remove the injurious splinters and then recombined for their original use. [24]

Finally, as noted by the dissent in *Wisconsin Pharmacal*, discussed above, the impaired property exclusion's proviso regarding damage that can be remedied by "repair, replacement, adjustment or

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[21] *Supra* note 20, at 569. *See also Nu-Pak, Inc. v. Wine Specialties Int'l Ltd*, 643 N.W.2d 848 (Wis. Ct. App. 2002) (applying the "your product" exclusion to a freezable alcoholic beverage, where the policyholder mixed and packaged the product with ingredients provided by the manufacturer).

[22] CG 00 01 12 07, *supra* note 1, definition V.8.

[23] *Supra* note 10, at 422.

[24] *Supra* note 5, at 866.

removal of '[the insured's] product' or '[the insured's] work," should operate to restore coverage if the property cannot be so remedied.[25] In other words, once a faulty ingredient has been blended with a third party's ingredients and cannot be removed from the integrated product, coverage should be *preserved*, not excluded, by this policy provision.

d. The "Fungi or Bacteria" Exclusion

Some CGL policies now contain an exclusion for "fungi or bacteria."[26] Originally intended to address toxic mold-related property damage claims, the exclusion typically contains an exception for a "good or product intended for [bodily] consumption." Nevertheless, some insurers have tried to use the exclusion to deny coverage for bacteria-related claims against food companies.[27]

Relatedly, to the extent that insurers may have tried to use pollution exclusions to bar CGL coverage for food contamination claims, those attempts have been unsuccessful, at least judging by the dearth of case law on the subject.

3. "Additional Insured" Coverage

When multiple companies in the food supply chain are implicated in bodily injury or property damage claims, "additional insured" coverage may be in play. A full analysis of "additional insured" issues and case law is beyond the scope of this paper; however, policyholders and insurers should be aware of the following practical considerations:

- The extent to which per-occurrence and aggregate limits of liability might reduce the overall amount available to multiple claimants under a single policy;
- The priority and effect of "other insurance" clauses on claims by purported additional insureds that have their own liability insurance;
- Which company's primary insurer should (or wants to) take the lead on handling the crisis;
- Whether separate adjusters should be retained for multiple additional insureds under the same policy.

In addition, lawyers for insurers and policyholders must carefully navigate potential conflicts of interest that might arise in the "additional insured" context, which may involve multiple companies insured under the same insurance policy, and/or the same insurance company insuring multiple different policyholders for the same contamination- or recall-related event.

B. Recall Coverage under First-Party Property Policies

First-party commercial property insurance policies protect the insured from financial loss associated with damage to property it owns. Such insurance typically covers either specific causes of loss ("named peril" policies) or all causes of loss that are not specifically excluded or limited ("all risk" policies) that result in

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[25] *Supra* note 12, at 96-98 (Abrahamson, J., dissenting).

[26] *See* CG 21 27 04 02.

[27] *See Camden Fire Ins. Ass'n v. Mincing Trading Corp.*, No. L-3955-10 (N.J. Super. Ct. June 22, 2011) (allowing coverage for alleged salmonella contamination because neither fungi/bacteria exclusion nor communicable disease exclusion applied).

physical damage to property. In a food recall context, the physical loss is usually the actual contamination (or reasonable supposition of actual contamination) of food that remains on hand as inventory or "stock."

Where there is covered physical damage, commercial property policies also often provide business interruption coverage for loss of business income arising from the damage and reimbursement for extra expenses the insured incurs to minimize or avoid the loss of income and return the business to its pre-recall operating status.

1. "Direct Physical Loss or Damage" Requirement

Property insurance policies typically require "direct physical loss of or damage to"[28] property to trigger coverage for property damage. "Physical loss" and "damage" are not defined terms. Many courts have ascribed the terms broad meaning, and have not limited them to structural damage or unfitness for human consumption. For example, courts have found that "physical damage" exists in the following circumstances:

- Pillsbury's cream-style corn product was deemed physically damaged where spoilage *could* occur from potentially unsafe processing, even though there was no showing that the food actually was spoiled.[29]
- A Virginia ham wholesaler's destruction of its entire lot of ham that had been exposed to ammonia was covered as a total loss, even though only some of the ham posed a potential health hazard.[30]
- Beans imported from Europe and treated with a pesticide not approved in the U.S. were "damaged" because they were not marketable under U.S. regulations even though they were not unfit for consumption.[31]
- A contractor's use of a harmless but unapproved pesticide on oats to be used in General Mills's *Cheerios®* was "property damage" even though the pesticide did not render the oats unfit for human consumption.[32]

All that was required in these cases was that the property be "injured in some way."[33] As the court in the *General Mills* case reasoned, "The business of manufacturing food products requires conforming to the appropriate FDA regulations. Whether or not the oats could be safely consumed, they legally could not be used in General Mills' business."[34] Thus, the loss was covered property damage.

In contrast, a government embargo may not constitute "property damage." This is what happened with the U.S. "mad cow" ban on Canadian beef in 2003. A Canadian beef producer whose cattle were not diseased was nevertheless subject to the embargo. A customer in the U.S. who made oils and shortening from beef tallow argued that he suffered a direct physical loss because his supply of Canadian beef was

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[28] ISO Form CP 00 10 04 02 (2002).

[29] *Pillsbury Co. v. Underwriters of Lloyd's London*, 705 F. Supp. 1396, 1399 (D. Minn. 1989).

[30] *S. Wallace Edwards & Sons, Inc. v. Cincinnati Ins. Co.*, 353 F.3d 367 (4th Cir. 2003) (noting that had all of the ham not been discarded, USDA would have recommended a recall).

[31] *Blaine Richards & Co. v. Marine Indem. Ins. Co. of Am.*, 635 F.2d 1051 (2d Cir. 1980).

[32] *Gen. Mills, Inc. v. Gold Medal Ins. Co.*, 622 N.W.2d 147, 152 (Minn. Ct. App. 2001).

[33] *Id.*

[34] *Id.*

treated as though it were physically contaminated. The court held that this producer's loss was caused solely by the ban order, not by contamination, and so it was not covered.[35]

2. Business Interruption

Business interruption insurance provides coverage for lost "business income" during the length of time needed to restore damaged property. A critical feature of business interruption insurance is that it does not stand alone: business interruption losses must be tied to property damage. A typical policy wording states: "the suspension [of the business] must be caused by direct physical loss of or damage to property." Key coverage issues entail (a) what property was physically damaged, (b) whether the "suspension" of business was total or partial, and (c) the duration of the interruption and the associated restoration period.

a. Which or Whose Property Damage

Many policies require that the damage occur to property "at the premises described in the Declarations."[36] It is important to examine the policy to determine exactly which or whose property must be damaged in order to trigger the business interruption coverage.[37] For example, after a restaurant was required to shut down due to an offsite sewage leak that led to *E. coli* contamination of an onsite well, the insurer argued that the sewer leak was not "damage to covered property" because it did not occur "at the described premises." The court allowed coverage, holding that the closure of the restaurant "resulted from direct physical damage to the property at the insured premises" and that "[d]amage to 'covered property' is not required by the terms of the policy to trigger coverage of loss of business income.'"[38]

b. Total or Partial Suspension

Some insurers have argued that the policy's coverage of "the necessary suspension of your 'operations'"[39] requires a total suspension or cessation of the business, as opposed to a partial shutdown.[40] Until ISO's addition of a broader definition to its business interruption forms, "total cessation" had been the rule under most states' laws under policies that do not define the term "necessary suspension." In recent

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[35] *Source Food Tech., Inc. v. U.S. Fid. & Guar. Co.*, 465 F.3d 834 (8th Cir. 2006).

[36] ISO Form CP 00 30 04 02. Many policies do not expressly require the damage to occur to "*covered* property." The differences among "property," "property at the described premises" and "covered property" are important, because policyholders may claim business interruption losses as a result of damage to or destruction of someone else's property.

[37] Examples of the "which property" problem arose after the 2001 destruction of the World Trade Center, when numerous businesses in the "Ground Zero" area of New York made business interruption claims even though their businesses suffered no physical damage. Coverage depended on a number of factors, including which damaged property had to be linked to the business interruption. *Compare, e.g., Royal Indem. Co. v. Retail Brand Alliance, Inc.*, 822 N.Y.S.2d 268 (N.Y. 2006) (allowing business interruption coverage to retail store across the street from World Trade Center but only until store reopened in 2002 and not until WTC is rebuilt), *with Zurich Am. Ins. Co. v. ABM Indus., Inc.*, No. 01 Civ. 11200, 2006 WL 1293360 (S.D.N.Y. May 11, 2006) (allowing business interruption coverage until WTC is rebuilt for company that provided janitorial and engineering services to World Trade Center, even though towers were not owned by policyholder).

[38] *Cooper v. Travelers Indem. Co. of Ill.*, No. C-01-2400, 2002 WL 32775680 (N.D. Cal. Nov. 4, 2002).

[39] ISO Form CP 00 30 04 02 (2002 business interruption and extra expense coverage form).

[40] *Compare Am. Med. Imaging Corp. v. St. Paul Fire & Marine Ins. Co.*, 949 F.2d 690 (3rd Cir. 1991) (awarding BI coverage for six weeks of disrupted operations even though accounting and other clerical functions resumed within one day), *with Home Indem. Co. v Hyplains Beef, L.C.*, 893 F. Supp. 987, 991-2 (D. Kan. 1995), *aff'd,* 89 F.3d 850 (10th Cir 1996) (no BI coverage where operations continued throughout the period that computer difficulties existed, "albeit at a reduced level of efficiency").

years, however, ISO has added a definition of "suspension" to clarify that partial interruptions and slowdowns are covered as well as total cessations of business.[41] Thus, it is important to know which language the policy contains.

c. Duration of Business Interruption

Most policies limit business interruption coverage to a set "period of restoration," usually defined to begin 72 hours after the physical loss and to end when the property "should be" restored or when operations resume at a new location.[42] When the suspension of business operations is shorter than the period of restoration (for example, if a business can operate temporarily at a different plant while the damaged one is being restored), no issues should arise. But when the suspension of operations extends beyond the restoration of the damaged property (for example, if the plant has been restored but customers have moved elsewhere in the meantime), the insurer might resist coverage. For example, in *Brand Management, Inc. v. Maryland Casualty Co.,* involving listeria contamination at a sushi plant, the plant closed for 15 days to disinfect the premises, but its largest customer refused to purchase from the company unless it moved from the premises. The insurance company denied coverage for any losses after the plant was disinfected, and a court agreed.[43]

3. Exclusions

When analyzing a commercial property policy for "food recall" coverage, one should look for at least three exclusions, which insurers might raise in a food recall situation: the "contamination" exclusion, the "virus or bacteria" exclusion, and the "governmental action" exclusion.

a. Contamination Exclusion

Most first-party property policies exclude losses caused by contamination or pollution. Unlike liability insurance, commercial property policies have been the subject of a large body of case law interpreting pollution exclusions in the context of food contamination and recall claims. Court rulings have been inconsistent as to whether insurance is meant to exclude only industrial or environmental pollutants or is broad enough to exclude virtually any foreign substance.

Some courts have barred first-party coverage based on the pollution exclusion:

- The contamination exclusion was applied to preclude coverage for dressed poultry contaminated by heptachlor, a banned insecticide.[44]
- The pollution exclusion was applied to preclude coverage for *Listeria* contamination of a sandwich processor's products. The court found the bacteria to constitute a "pollutant," notwithstanding

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[41] The most recent ISO business interruption form includes a definition of "suspension" as "the slowdown or cessation of your business activities…." CP 00 30 04 02. Pre-2001 versions of ISO's business interruption insurance form did not contain a definition of "suspension" and thus were subject to debate -- and lawsuits -- over the term's meaning.

[42] An ISO form states: "on the earlier of: (1) the date when the property at the described premises should be repaired, rebuilt or replaced with reasonable speed and similar quality; or (2) the date when business is resumed at a new permanent location." ISO Form CP 00 30 04 02; *see Pennbarr Corp. v. Ins. Co. of N. Am.*, 976 F.2d 145, 153 (3rd Cir. 1992).

[43] *Brand Mgmt., Inc. v. Md. Cas. Co.,* No. 05-CV-02293, 2007 WL 1772063, at *3 (D. Colo. June 18, 2007).

[44] *Townsends of Ark., Inc. v. Millers Mut. Ins. Co.*, 823 F. Supp. 233 (D. Del. 1993).

the policyholder's argument that the exclusion was only meant to exclude industrial pollutants and other inorganic substances.[45]

Other courts have allowed first-party coverage notwithstanding the exclusion:

- The contamination exclusion was not applied, and coverage was allowed, where plastic screening ended up in a pre-mix for Pillsbury biscuits. The court found the plastic was *not* a contaminant, disagreeing with the insurer's theory that "almost any substance or foreign object qualifies as a contaminant."[46]

- The contamination exclusion was not applied, and coverage was allowed, where contaminated ingredients caused an off taste in soft drinks. The court reasoned that the "pollution and/or contamination" exclusion was "directed to environmental pollution, and not product contamination."[47]

- As explained by one court, agreeing with the narrower view of the exclusion, "[T]he unreasonableness of [the insurance company's] interpretation becomes clear when its full implications are considered. Virtually any substance can act under the proper circumstances as an 'irritant or contaminant.'"[48] That court deemed such a reading of the exclusion to be overly broad.[49]

Where contamination exclusions contain an exception for losses "directly resulting from other physical damage not excluded by this Policy," some courts have found coverage for contamination resulting from "otherwise covered" perils.

- Coverage was allowed when millions of pounds of Leprino cheese, which was stored in a third party's warehouse, took on an "off" smell given off by fruit products stored in the same warehouse. After trial, the appeals court affirmed a jury verdict that the policy's contamination exclusion did not apply, because the loss was caused by "some event or condition other than mere storage of other food products with its damaged cheese," *i.e*., the warehouse operator's negligent spillage and damage of fruit products that gave off odors, which in turn damaged the cheese.[50]

- Coverage was allowed when one million cases of Nabisco products were contaminated by chemicals present at a new warehouse where the products were stored. The court reasoned that "the actions of a third party," which included the construction company's failure to seal and clean up chemicals it used, were "classic 'perils' covered by an 'all risks' policy."[51]

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[45] *Landshire Fast Foods of Milwaukee, Inc. v. Emp'rs Mut. Cas. Co.,* 676 N.W.2d 528 (Wis. Ct. App. 2004).

[46] *Pillsbury Co. v. Zurich Am. Ins. Co.*, No. Civ. 03-6560, 2005 WL 2778752 (D. Minn. Oct. 25, 2005).

[47] *Pepsico, Inc. v. Winterthur Int'l Am. Ins. Co*., 788 N.Y.S.2d 142, 144-45 (N.Y. 2004).

[48] *MacKinnon v. Truck Ins. Exch.*, 31 Cal. 4th 635, 652 (Cal. 2003).

[49] *Id.*

[50] *Leprino Foods Co. v. Factory Mut. Ins. Co.*, 653 F.3d 1121 (10th Cir. 2011). Also of interest in the court's opinion was a reduction in the damage amount awarded to Leprino. During the course of the insurance litigation, Leprino reached a settlement with the warehouse that had stored the cheese and fruit products. The court allowed the insurer's payment to be offset by the amount of the warehouse settlement, in order to avoid a "double recovery" for the same damage.

[51] *Allianz Ins. Co. v. RJR Nabisco Holdings Corp.,* 96 F. Supp. 2d 253, 254-55 (S.D.N.Y. 2000).

Exceptions to exclusions must be read carefully. At least one court has reached the opposite conclusion about the contamination exclusion, based on a somewhat different carve-out in the policy language:

- The contamination exclusion was applied to bar coverage for contaminated HoneyBaked® ham products, notwithstanding the policyholder's argument that a roller in its conveyor system harbored the bacteria that eventually made its way to the ham, and thus it was the roller, not the contamination, that caused the loss.[52] Importantly, the court distinguished *Leprino* based upon the policies' differing policy language: in *Leprino*, the policy contained an exception for other causes of the loss, whereas in *HoneyBaked*, the policy contained an exception for ensuing losses that occurred as a result of the initial contamination.[53]

b. Fungus, Rot and Bacteria Exclusion

A related commercial property insurance exclusion is the exclusion for the "presence, growth, proliferation, spread or any activity of fungus, wet or dry rot or bacteria."[54] Policy definitions of "fungus" include mold and mildew.[55] Like its liability insurance counterpart, this exclusion was initially designed to limit coverage for mold-related claims. To our knowledge, commercial property policies do not contain the same carve-out for products intended for consumption.

- Instead, like pollution and contamination damage, discussed above, mold damage may nevertheless be covered under a first-party property insurance policy if the exclusion carves out mold-related losses that were themselves caused by an insured peril. Thus, for example, in *Bruce Oakley, Inc. v. Farmland Mutual Insurance Company,* a case involving soybeans that developed mold and then auto-oxidized, the court held that the damage was actually caused by the heat that the fungus generated (heat and fire were covered perils), and coverage was allowed.[56]

- Mold coverage also may be added by endorsement, although such coverage is often sublimited to such an extent that it is arguably not worth the cost.

c. Governmental Action Exclusion

Commercial property insurance policies also typically contain an exclusion for damage caused by government seizure or detention. Governmental action occurs frequently in food contamination cases, *e.g.*, when the FDA mandates a recall or prohibits shipment of a product. In many cases, the recalled product is destroyed or otherwise rendered unusable.

In *Townsends of Ark. v. Millers Mut. Ins., supra* note 44, the federal court in Delaware concluded that, since neither the FDA nor the USDA ordered Townsend Farms to close its poultry slaughtering operations due to heptachlor residues found in the chickens, the "governmental action" exclusion relied on by the insurer did not apply. Since no governmental body ordered the seizure or destruction of property, the court

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[52] *HoneyBaked Foods, Inc. v. Affiliated FM Ins. Co.*, 757 F. Supp. 2d 738, 749 (N.D. Ohio 2010).

[53] *Id.* at 748-49. Notwithstanding policy language to the contrary, the *HoneyBaked* court left open the possibility that the insured might still be covered for its loss under the "reasonable expectation of the insured" doctrine. Unsure as to whether Ohio had adopted such a doctrine, the court instructed to parties to propose questions on this issue for certification to the Ohio Supreme Court, *id.* at 752, however, the Ohio Supreme Court declined to answer the certified question. *HoneyBaked Foods, Inc. v. Affiliated FM Ins. Co.,* 947 N.E.2d 681 (Table) (Ohio 2011).

[54] *See, e.g.,* ISO Commercial Property Policy Form CP 10 30 06 07, exclusion B.1.h.

[55] *See, e.g.,* ISO Commercial Property Policy Form CP 10 30 06 07, definition G.1.

[56] 245 F.3d 1027 (8th Cir. 2001).

concluded that the claimed loss did not result from the enforcement of a statute and therefore the law/ordinance/regulation exclusion did not apply. (The court nevertheless barred coverage based on the contamination exclusion.)

C. Recall Coverage under D&O Policies

Directors and Officers (D&O) liability insurance is designed to cover certain types of financial losses. Accordingly, D&O policies typically contain exclusions for a whole host of claims that could relate to food contamination and recall incidents, such as illegal acts, intentional misconduct, punitive damages, fines and penalties, bodily injury, property damage, professional liability, and contamination. Notwithstanding these exclusions, coverage is available under D&O insurance for certain types of contamination and recall-related liabilities.

First, some D&O policies may cover the costs of a criminal investigation arising out of a food contamination issue. The successful prosecution of the Peanut Corporation of America and its executives,[57] related to the massive PCA recall and subsequent investigation, may have inspired the criminal investigation of executives of several other companies, including Chipotle and Blue Bell Creameries. In at least one case, involving the Quality Egg salmonella outbreak, executives were fined and jailed.[58] In a grand jury investigation of a food company, under the "Park Doctrine,"[59] violations of the Food, Drug, and Cosmetic Act were asserted. These violations can be strict liability offenses for corporate executives; criminal intent is not required to support a misdemeanor conviction. Although D&O policies typically exclude intentional misconduct, actions that stop short of intentional conduct but nonetheless result in an investigation–or even a conviction–might be covered by D&O insurance depending on the wording of the policy.

Second, D&O insurance might provide protection against shareholder suits to the extent that a food contamination and recall adversely affects the company's stock value. D&O policies typically exclude suits against food company executives for claims of "... bodily injury and property damage." However, under some D&O policy wordings this would not necessarily bar coverage for secondary claims by stockholders who sustain financial loss resulting from (or "because of" or "related to") the bodily injury or property damage of others.

At a minimum, D&O insurance may provide coverage for defense in situations involving investigations of or shareholder derivative suits against executives, depending upon the wording of the policy. Because having access to a defense is so important, policyholders should seek to eliminate any policy provision,

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[57] In 2014, a jury found former PCA owner Stewart Parnell guilty on 67 federal felony counts, including felony charges of introducing adulterated food into interstate commerce "with the intent to defraud or mislead," stemming from the 2008 salmonella outbreak that sickened 714 people and left 9 dead. The jury found Parnell covered up information and falsified documents. In 2016, Parnell was sentenced to 28 years in prison, the toughest penalty ever for a corporate executive in a food illness outbreak.

[58] Stevens, Shawn, "FDA's War on Pathogens: Criminal Charges for Food Company Executives and Quality Assurance Managers," (Food Industry Counsel LLC white paper 2016), *available at http://www.foodindustrycounsel.com/wp-content/uploads/sites/478/2016/02/FDAs-WAR-ON-PATHOGENS-Criminal-Charges-for-Food-Company-Executives-and-Quality-Assurance-Managers.pdf.*

[59] The U.S. Supreme Court specifically noted that the focus of criminal liability under the FDCA is not due to a corporate officer's position within the company, but is determined by whether the officer had "by reason of his position in the corporation, responsibility and authority either to prevent it in the first instance or promptly to correct the violation complained of and that he failed to do so." *United States v. Park*, 421 U.S. 658 (1975). This is known as the "Park Doctrine."

common in some insurers' D&O forms, that would allow the insurer to recoup its defense costs in the event that the policy ultimately is found not to provide coverage.[60]

D. Recall Coverage under E&O Policies

Food-related bodily injury lawsuits often include every company involved in the supply chain, up to and including farmers and growers. In addition, processors, formulators, packagers, shippers, and even food safety audit firms may be pulled into such litigation. To the extent that a recall is precipitated by a processor's or other service provider's faulty work, that company should have professional liability or errors and omissions (E&O) insurance to cover liabilities arising out of its professional services, as opposed to its products, which might otherwise be precluded by the "your product," "your work" and related CGL exclusions.[61]

For example, E&O insurance provided a defense to a food safety audit firm that was accused of negligence in performing a "food safety" audit, which allegedly led to the sale of Listeria-contaminated cantaloupe and the subsequent injuries and deaths of consumers.[62] The audit firm, Primus Labs, had given Jensen Farms a "superior" rating shortly before the facility was found by the FDA to be the source of a multistate outbreak of Listeria monocytogenes. Primus Labs did not produce a product, but its audit services created a duty to consumers to ensure that Jensen Farms cantaloupe was safe for human consumption, a service that was covered by the firm's E&O insurance.[63]

E. "Recall" Coverage under Product Contamination Insurance and Other Specialty Policies

Although product recalls have been around since the Tylenol tampering incident of the 1980s, product recall insurance is still a relatively new and non-standardized type of coverage. Specialty insurance policies created and developed to address product contamination and recall issues have evolved extensively over the past 15 years. Modern versions of product contamination insurance (PCI) provide coverage for a variety of costs related to contamination incidents, including first-party coverages as well as, sometimes, third-party coverages and coverage for crisis management costs. Further, the popularity of product contamination insurance has created a market for expanded coverage offerings, including "product recall" policies, which differ somewhat from product contamination insurance, and which might respond to a recall occasioned by the determination that there is a threat, whether or not anyone has actually been harmed and whether or not there has been actual contamination.[64]

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[60] *See Protection Strategies, Inc. v. Starr Indem. & Liab. Co.*, No. 1:13–CV–00763, 2014 WL 1655370 (E.D. Va. April 23, 2014) (although a defense was provided in response to a criminal subpoena from the NASA Office of the Inspector General, the federal court in Virginia, citing Fourth Circuit precedent, found that the insurer was entitled to recoupment of all defense costs since the insured was not entitled to coverage for the "loss" and the D&O liability policy included a reimbursement of costs provision).

[61] E&O coverage might have provided some relief to the policyholders in the *Hillside Bottling* case, discussed above, where general liability coverage was disallowed because the company had been providing a service, not a product that caused property damage, and losses due to the faulty work were excluded by the "your work" exclusion. *See, e.g., Hillside Bottling,* (barring coverage under CGL policy for bottling operations that constituted policyholder's "work").

[62] *Lloyd v. Frontera Produce, Ltd.*, No. WDQ–13–2232, 2014 U.S. Dist. LEXIS 135582 (D. Md. Sept. 24, 2014).

[63] Unfortunately, Primus's E&O policy had only $5 million in eroding limits, which was almost entirely exhausted by defense costs.

[64] For example, ISO's 2013 Product Withdrawal Coverage Form promises to pay for "product withdrawal expenses" because of a "product withdrawal" ordered by the government or deemed necessary by the policyholder. "Product withdrawal" is defined as a product recall "because of *known or suspected 'defects'* in 'your product,' or known or suspected 'product tampering', *which has caused or is reasonably expected to cause '*bodily injury' or physical injury

1. What Triggers Coverage under PCI or Recall Policies

What limited case law that exists involving PCI policies has focused predominantly on the trigger of coverage and, in particular, whether there was actual contamination. Recently, though, at least two cases indicate greater flexibility under policies with more policyholder-friendly language covering "government recall" and "adverse publicity" circumstances. These cases are briefly discussed below.

a. Actual Contamination

Most PCI policies provide coverage for recall-related costs when product contamination has in fact occurred, not when it is merely suspected. For example, ACE's "Recall Plus" insurance policy form promises to reimburse for losses caused by an "insured event," which means "accidental contamination or malicious tampering." "Accidental contamination" in turn is defined as

> any accidental or unintentional contamination, impairment or mislabeling of an insured product(s), which occurs during or as a result of its manufacture, production, processing, mixing, blending, compounding, packaging or distribution, *provided that the use or consumption of the insured product(s) has resulted in or would result in bodily injury or property damage*.[65]

None of the terms in this definition is modified by the words "suspected," "potential," "possible," or even "probable." By the definition's plain terms, there must be contamination (period), and that contamination must have resulted in or [definitely] would – not "likely" or "probably" would – result in bodily injury or property damage.

The issue of actual versus potential contamination or injury is particularly important for companies further down supply chains, who may never receive contaminated or harmful product but are nevertheless required to conduct a product recall. One only has to review recent recall history involving products such as peanut butter or hydrolyzed vegetable protein to understand that many companies involved with the affected supply chains were only concerned with products that might have been contaminated as opposed to products that actually were demonstrated to be contaminated.

Although very few insurance coverage decisions have been rendered about modern PCI policies, to date most courts that have ruled have hewn closely to the policy language requiring actual contamination and found no coverage for suspected or potential contamination.[66] For example:

- No coverage allowed for a recall of Mexican food products containing spice mix from a supplier that had recalled its mix due to possible salmonella contamination, because tests

to tangible property other than 'your product.'" ISO Product Withdrawal Coverage Form CG 00 66 04 13. Thus, although the "actual contamination" requirement has been dropped, the policy still requires at least a "suspected defect" and a "reasonably expected" resulting bodily injury.

[65] ACE Recall Plus Insurance for Consumable Products Policy Form (REC-7519 (01/13) (internal quotations omitted, emphasis added).

[66] *See Fresh Express Inc. v. Beazley Syndicate 2623/623 at Lloyd's*, 199 Cal. App. 4th 1038 (2011); *Little Lady Foods, Inc. v. Hous. Cas. Co.*, 819 F. Supp. 2d 759 (N.D. Ill. 2011); *Caudill Seed & Warehouse Co. v. Hous. Cas. Co.*, 835 F. Supp. 2d 329, 331 (W.D. Ky. 2011).

on the finished products came back negative, and the policy required actual contamination to trigger coverage.[67]

- No coverage allowed for voluntary recall of meat products containing ground beef from the Westland/Hallmark Meat Company, the slaughterhouse whose operations were suspended by the U.S. Department of Agriculture (USDA) because of its now notorious use of non-ambulatory disabled cattle – or "downer" cows.[68] The California Court of Appeal found no coverage for three reasons: (1) the policyholder had not shown that there was contamination to an insured product, only that an ingredient supplied by a third party might have been adulterated; (2) the recall was based on Westland's failure to notify it about the "downer" cows, rather than any actual contamination or tampering; and (3) no Insured Event had taken place because the policy required injuries within 120 days of consumption and no injuries were reported.[69]

Notably, the dissent in *Windsor Foods* protested that the majority did not properly construe the policy. According to Judge King:

> [T]he policy does not clearly and explicitly state what the majority says it does. Within the context of the present matter, the more reasonable reading of the policy is that the product, and all of its ingredients, are insured for adulteration regardless of when the adulteration occurs. Thus to the extent there are two reasonable interpretations, the policy is ambiguous and should be construed against the insurer; the summary judgment should be denied.[70]

On the other hand, policyholders have been allowed to proceed with their claims, or have won coverage outright, in some cases that did not involve actual contamination:

- Coverage was allowed in a case involving salmonella and cockroaches found at a poultry processing plant, although there was no "conclusive evidence" that any food products would have caused harm.[71] The court based its decision on the definition of "accidental contamination," which included "an error in the production, processing, or preparation of any Insured Products provided that their use or consumption has led to or would lead to bodily injury, sickness, disease or death."[72] The court refused to interpret the policy in a way that would require the insured to market the products to see whether people got sick from consuming them. Instead, it was sufficient that FSIS had concluded the product could not be sold because it was not safe to eat.[73]

- An insurer's motion to dismiss was denied in a case involving an FDA advisory that prompted the voluntary recall of canned shellfish that might have been exposed to

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[67] *Ruiz Food Products, Inc. v. Catlin Syndicate Ltd.*, 2014 WL 7243262, at *1 (9th Cir. Dec. 22, 2014) (unpublished opinion).

[68] *Windsor Food Quality Co. v. Underwriters of Lloyds of London*, 234 Cal. App. 4th 1178 (2015).

[69] *Id*. at 1185-6.

[70] *Id.* at 1190 (King, J., dissenting).

[71] *Foster Poultry Farms, Inc. v. Certain Underwriters at Lloyd's, London,* No. 1:14-cv-953 (E.D. Cal. Jan. 20, 2016) (dismissed after settlement).

[72] *Id.*, slip. op. at 9.

[73] *Id.*, slip. op at 11-12.

norovirus due to a Korean supplier's inadequate sanitation standards.[74] The court based its decision on Tri-Union's broad PCI policy language, covering "accidental contamination" if use or consumption of its product "would result in clear, identifiable, internal or external visible physical symptoms of bodily injury…." or if contamination caused the product to be "injurious to health or unfit for human consumption and as a result… a recall order by the competent authority is imminent in order to comply with regulations on food safety."[75]

- A case involving a Class III recall (i.e., FDA determined that use of the product would not cause adverse health consequences) was ordered to trial based on the factual question whether bodily injury "may likely result" from the consumption of breakfast sandwiches containing MSG, an undeclared allergen that prompted the recall.[76]

Some "recall" policies are not limited to actual contamination events, focusing instead on the probability of contamination and injury. For example, Chubb offers recall insurance for Class 1 recalls, which are those involving a "situation in which there is a reasonable probability that the use of, or exposure to, such product will cause serious adverse health consequences or death."[77]

Similarly, ISO's Product Withdrawal Coverage Form agrees to reimburse "product withdrawal expenses," defined to include suspected defects:

> "Product withdrawal" means the recall… of your products, or products which contain your products, because of known *or suspected* defects in your product, or known or suspected product tampering, which has caused or is reasonably expected to cause bodily injury or physical injury to tangible property other than your product.[78]

Here, actual contamination and actual injury are not required. Instead, a defect may only be suspected. On the other hand, that defect must be "reasonably expected" to cause injury or damage. Thus, if a product is considered defective but would not result in bodily injury or property damage, coverage might not be available. Outcomes may vary depending on the terms of the policy and the "reasonableness" of the expectation of harm.

b. Government Recall

Some specialty policies provide coverage for a "governmental recall" in addition to or as an alternative to actual contamination. This provision requires a governmental determination that there is a "reasonable probability" that the recalled product will cause "serious adverse health consequences or death."[79]

In a recent case involving both "accidental contamination" and "governmental recall" coverage, a poultry manufacturer successfully claimed coverage for losses suffered when it destroyed millions of pounds of chicken that had not been approved for sale by the USDA, due to poor pest control and sanitation provisions at the plant, including the presence of salmonella. In addition to its denial of coverage on

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[74] *Tri-Union Seafoods, LLC v. Starr Surplus Lines Ins. Co.*, No. 3:14-cv-2282, slip op. at 20-25 (S.D. Cal. Feb. 5, 2015).

[75] *Id.*, slip op. at 21.

[76] *Hot Stuff Foods, LLC v. Hous. Cas. Co*., 771 F.3d 1071, 1081 (8th Cir. 2014).

[77] Chubb Product Withdrawal and Crisis Management Insurance, Form 80-02-6427 (Ed. 8-04).

[78] Insurance Services Office, Product Withdrawal Coverage Form (CG 00 66 12 04) (internal quotations omitted).

[79] *Supra* note 71, slip op. at 20-21.

"actual contamination" grounds (see above), the insurer also argued that because Foster destroyed its products before sending them into the market, there was no "governmental recall" of the products. The court disagreed and found coverage under both grants of coverage.[80]

The key to these findings was in the definitions. "Accidental Contamination" was defined as "an error in the production, processing, or preparation of any Insured Products provided that their use or consumption has led to or would lead to bodily injury, sickness, disease or death." The court rejected the insurer's contention that Foster needed "conclusive evidence" that the products would have caused harm, noting that it would not interpret the policy to require the insured to send products out to market to see whether people got sick from consuming them.[81] Under this policy language, it was sufficient that USDA had concluded the product could not be sold because it was not safe to eat.

c. Adverse Publicity

In at least one case, adverse publicity was enough to trigger coverage under a PCI policy even without actual contamination. In *Wornick Co. v. Houston Casualty Co.*,[82] the insured, *Wornick*, was an assembler of "meals-ready-to-eat (MRE)," which included dairy shake packets manufactured by Trans-Packers Services Corp. As a supply-chain integrator, *Wornick* purchased the component items for MREs from manufacturers, consolidated them into a final MRE package, and sold them to the Government. The dairy shake packets contained instant dried milk that Trans-Packers purchased from Franklin Farms East, Inc. who, in turn, purchased from Plainview Milk Products Cooperative.

Salmonella was found in some of the dairy shake packets at the Trans-Packers facility. As a result, the FDA began an investigation and found salmonella at Plainview's facilities. Plainview, Trans-Packers, and *Wornick* initiated recalls for the products. *Wornick* then sought coverage under its Malicious Product Tampering/Accidental Product Contamination Insurance Policy, arguing that the MREs were subject to recall for failing to meet product specifications, that the MREs were impaired by the potential contamination, and that Government reports implying that the MREs were contaminated triggered coverage under the Policy's publicity coverage. However, no salmonella was found in *Wornick's* MREs, because *Wornick* never received the salmonella-tainted batch from its suppliers.

The court nevertheless found that coverage was possible even in the absence of actual contamination, under the Policy's publicity clause. The Policy defined "Accidental Product Contamination" to include "PUBLICITY implying [contamination]," and defined "Publicity" as "[t]he reporting of an actual *or alleged* [accidental product contamination] . . . in local, regional or national media . . . or any governmental publication where the Named Insured's [products] and the Named Insured are specifically named."[83]

Under those terms, the Court found that government "Do Not Consume" orders which specifically named *Wornick's* products constituted "Publicity" within the meaning of the policy, and concluded that a dispute of fact remained about whether *Wornick's* losses resulted directly from such publicity. The Court came to this conclusion despite that *Wornick's* products had not actually been contaminated, emphasizing that the Policy's publicity definition encompassed "actual or *alleged*" contamination. Requiring "actual physical symptoms or physical damage in the event that there is merely publicity that *implies*

[80] *Supra* note 79, slip op. at 20-21, 24-26.

[81] *Id.*, slip op. at 21-22.

[82] No. 1:11-cv-00391, 2013 U.S. Dist. LEXIS 62465 (S.D. Ohio May 1, 2013).

[83] *Id*. at *4.

contamination of the product," the Court said, would make "the inclusion of the word 'alleged' …meaningless."[84]

The Court ultimately denied both parties' motions for summary judgment, finding that there were genuine issues of fact remaining as to whether there was a fault in design specification or performance amounting to an Accidental Product Contamination; whether there was a basis for Publicity coverage; and whether the insurer had acted in bad faith in denying *Wornick's* claims.

2. Types of Potentially Covered Costs

Specialty insurance has also been extended to cover adverse publicity and crisis management. "Crisis management service" under the Chubb policy form, for example, includes coverage for "professional services or advice provided by a crisis management service firm in connection with a Class 1 recall." Adverse publicity coverage involves reporting in the media or the release of a government publication where an insured or its product is identified as being involved with an insured event, such as malicious contamination.[85] Adverse publicity and crisis management coverages may be provided as standalone coverage or as part of contamination coverage, often by amendatory endorsement, and sometimes with sublimits that cap the amount of insurance available.

The types of costs or expenses covered under specialty crisis policies usually include the costs of the recall itself (*e.g.*, repair/replacement, disposal, notification, employee overtime, temp workers, transportation, warehousing/storage); often include related losses that result from the recall (*e.g.*, business interruption, loss of gross profit, rehabilitation costs, redistribution, increased cost of working, product extortion/ransom costs, as well as pre-recall costs, extra expense); and may sometimes include liability for third-party costs (*e.g.*, customer loss of gross revenue, third-party recall costs, product liability and defense costs). Specialized policy forms have not been standardized, and different insurers offer different levels and types of coverage. It therefore can be critical to involve knowledgeable brokers and risk management personnel in the insurance placement and renewal process.

Some insurance companies offer coverage for some but not all of the aforementioned loss types. For example, ISO's Limited Product Withdrawal Expense Endorsement (a narrow CGL endorsement) is limited indeed, covering logistical costs of a recall but excluding lost profits, expenses for regaining goodwill, lost market share, or other costs of restoring and rehabilitating the product; and it also excludes third-party liability and defense costs.[86] Similarly, Swiss Re stated in a 1998 brochure that coverage for lost profits and lost market share is available, but recommended sublimiting such coverage and "defin[ing] precisely how indemnifications of this type are to be quantified."[87]

Product contamination and product recall policies also might provide critical pre- and post-crisis consultant coverage. When a company faces a product crisis event, it may need a team of experts to help it survive the onslaught of customer, governmental and regulatory inquiries, intrusions and investigations. Specialty crisis policies provide companies with the ability to engage a panel of experts in public relations, governmental interaction, root cause investigation, laboratory testing, contamination identification, manufacturing or production processing and legal assistance before and after a crisis. Pre-crisis

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[84] *Id*.

[85] *See, e.g.,* ACE, Adverse Publicity Coverage Endorsement, Form REC-7546 (01/13).

[86] Insurance Services Office, Limited Product Withdrawal Expense Endorsement (CG 04 36 04 13).

[87] Swiss Reinsurance Company, "Product Recall and Product Tampering Insurance," at 40-41 (1998).

consultancy can assist a company with preparation for a crisis event, including the review or creation of a crisis response plan. When the event takes place, these specialty crisis policies provide a company with a hotline number used to immediately engage its team of experts. If a company begins to search for experts after a crisis event commences, it may find that its actions are too little and too late: the list of qualified experts in the field of food contamination and product recalls is quite short, and they might already be retained by other parties involved in the recall.

But insurers may seek to avoid coverage for costs they deem unrelated to the contamination or the recall, such as recall-related advertising costs that replace the company's normal advertising expenses in the same amount. Costs and expenses related to the design or redesign of products also are typically excluded. Similarly, some policies expressly exclude costs of rehabilitating a product and regaining the company's goodwill and brand reputation, whereas others might include such coverage by endorsement. Such brand/goodwill coverage is significant, because such losses can far outstrip the expenses associated with the physical recall itself.[88]

4. What [Else] Recall Policies Might Not Cover

Like all insurance, coverage under specialty contamination, recall and crisis policies is bounded by their terms, which necessarily include the policy's definitions, conditions and exclusions. Terms vary widely from insurer to insurer and from policy form to policy form; therefore, policyholders must be diligent in reviewing and understanding what coverage they have.[89]

In addition to the issues described above, specialty recall policies are generally not designed to provide coverage for mere quality issues that have no bearing on the potential for bodily injury or property damage. That being said, however, certain insurers may offer product guarantee coverage for certain industries.

Like other types of insurance policies, specialty policies contain various exclusions that bar coverage for losses arising out of certain circumstances. Some specialty policies exclude coverage for third-party liability claims attributable to the use or consumption of an insured product, which would ordinarily be covered under a company's third-party liability policy. Some policies also exclude losses attributable to circumstances involving a competitor's product; although, coverage may be available for product refusal, regardless of the cause of the refusal.

Predictably, intentional and wrongful violations of governmental regulations or industry best practices are often excluded under specialty policies. Similarly, circumstances of which an insured had actual or constructive knowledge before the policy's inception are usually excluded.

4. Rescission

In addition to denials based on intent exclusions, some insurers are trying to use rescission as a weapon in order to void policies *ab initio* on such grounds. Results have been mixed, but recent cases indicate that insurers may be gaining ground.

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[88] See Brad Murlick, "Contemporary Product Recall Issues and Strategies for Remediation," ABA Section of Litigation, Insurance Coverage Litigation Committee CLE Seminar (February 29, 2008).

[89] *See id.* (listing exclusions for losses arising out of a "known defect" (exclusion f), "pollution-related expenses" (exclusion k) and "chemical transformation" (exclusion c), among others).

In *Certain Underwriters at Lloyd's, London v. Abbott Laboratories*,[90] the insurers, Certain Underwriters at Lloyd's, London, sought to rescind coverage to Abbott Laboratories based on a recall involving a weight loss drug made by a company Abbot had recently acquired. After Abbott had signed the final insurance application, but before all of the Underwriters had agreed to the terms of coverage, The Wall Street Journal ran an article regarding the possibility of an FDA recall of the acquired company's drug. An Abbott representative advised Underwriters about the article, but did not forward a copy of it. Underwriters and Abbott eventually reached agreement as to the additional premium tied to the acquisition. Abbott then paid the premium and provided a copy of the Wall Street Journal article to Underwriters. Underwriters accepted the premium payment. Several months later, Abbott recalled the product. After Abbott sough coverage under its recall insurance, Underwriters balked and sought to rescind their policy instead.

The court found that Abbott was entitled to coverage and that the insurers had waived their right to rescission based on their knowledge of the facts and their delay in seeking rescission.[91] The court held that an insurer who wishes to rescind a policy needs to do so as soon as they learn of the information upon which they base the rescission.[92]

The policyholder was not so fortunate in the recent *Heinz* rescission case. In January 2017, the Third Circuit Court of Appeals allowed Starr Surplus Lines to rescind a product contamination policy it had issued to multinational food corporation H. J. Heinz Company. The insurer's rescission was based on Heinz's failure to disclose several recall-related losses on its insurance application, which Starr characterized as "material misrepresentations." Heinz argued that the undisclosed prior losses were too small and too unrelated to be material to its insurance application, and that the insurer could not have relied on them in issuing the new policy with a $5 million self-insured retention. The court disagreed, holding: "Heinz's misrepresentations were of such magnitude that they deprived Starr of its 'freedom of choice in determining whether to accept or reject the risk upon full disclosure of all the facts which might reasonably affect that choice.'"[93]

Less than a month later, the same insurer filed suit in New York federal court against a frozen food manufacturer involved in a listeria recall, seeking to rescind a $10 million policy. The grounds for rescission, according to Starr, were that the food company allegedly gave "false answers, omissions and concealment of material facts" involving state and federal inspections, notwithstanding that the company had corrected violations noted by inspection authorities.[94]

Policyholders are fighting back. In March, National Frozen Foods Corp. filed suit against its insurer, a unit of W.R. Berkley Corp., seeking coverage under a contaminated products insurance policy for $3.5 million in damages due to possible listeria contamination, which resulted in a recall of approximately 470,000 pounds of frozen peas. According to the complaint, the insurer is allegedly withholding coverage because it believes National Frozen Foods was dishonest about prior recall events in its policy application.[95]

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[90] 16 N.E.3d 747, 756 (App. Ct. Ill. 2014).

[91] *Id.* at 756 (¶¶ 49-50).

[92] *Id.* at 758 (¶53).

[93] *H.J. Heinz Co. v. Starr Surplus Lines Ins. Co*., No. 16-1447, slip op. at 11 (3d Cir. Jan. 11, 2017) (internal citation omitted).

[94] Complaint, *Starr Surplus Lines Ins. Co. v. CRF Frozen Foods, LLC*, No. 1:17-cv-01030 (S.D.N.Y. Feb. 10, 2017).

[95] Complaint, *Nat'l Frozen Food Corp. v. Berkley Assur. Co*., No. 2:17-cv-00339 (W.D. Wash. March 6, 2017).

These cases show that insurers who underwrite specialty product recall or contamination policies are not afraid to use insurance applications as vehicles for rescission actions. Policyholders could risk having their insurance policies rescinded if they failed to disclose losses and circumstances–even small or seemingly unrelated–that relate to the type of risk for which they seek coverage later. Companies that operate in the food industry should be very cautious when completing initial or renewal applications, at the risk of becoming embroiled in litigation that could result in the forfeiture of future insurance coverage for similar claims.

II. PART TWO - PRACTICAL ADVICE FOR COMPANIES IN THE FOOD RECALL INSURANCE MARKET

In addition to the material above, the Authors will discuss at the seminar various difficult issues and practical tips that Food Recall cases present.

CONCLUSION

Any company in manufacturing, packaging or distribution of any product must consider the possibility that something could go wrong with its product, and that a recall might be necessary. Many companies choose to focus their risk management for product recalls on avoiding the necessity for such recalls in the first place, but the right insurance portfolio at the right price could be part of a prudent strategy for managing and minimizing a recall's impact on the company's bottom line.

Most companies already have basic coverage for certain specific types of losses under their existing CGL and commercial property insurance. Those companies desiring greater assurances with regard to recalls and contamination coverage may turn to specialty insurance policy forms, or even bespoke, manuscript policies. While the insurance industry continues to develop its coverage products to address such risks, the market's offerings are widely disparate. To the extent that the recall insurance market has a "wild west" quality, the largest companies in the food industry might enjoy increased bargaining power. Smaller companies in the supply chain, however, might lack such advantage, particularly if their internal risk management personnel and outside insurance brokers are not up to speed on the latest developments in this area.

As case law continues to develop to clarify the scope of CGL, first-party property, and specialized insurance policies, companies must ensure that the specifics of the policies purchased are appropriately tailored to the recall risks they face, and must be prepared to navigate the terms and conditions of their coverage in the event a recall must be conducted. As the case law shows, similar facts can result in different coverage outcomes depending on policy language, and in particular definitions of the triggering events. These language differences should be carefully considered when placing or renewing this type of coverage.

Policyholders should also be attentive to the application process itself when purchasing product recall and other specialty insurance. Recent litigation indicates that, when faced with a substantial recall-related claim, insurers might look beyond triggering limitations and policy exclusions to deny coverage, potentially seeking to rescind the policy based on omissions or inaccuracies in the policyholder's application.

With all of these concerns on the policyholder side, insurers, too, would be well advised to carefully consider the coverage products they make available in the marketplace.

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BAD FAITH: THE ADMISSIBILITY OF EXPERT TESTIMONY AND THE CHALLENGES THAT FOLLOW

A. *Introduction*

The issues involved in most bad-faith cases tend to be fairly complex. This is not completely surprising in a circumstance where there must be a strong disagreement between the two sides as to some insurance issue before there will be any action. Apart from potential concerns that a jury may weigh expert opinions too heavily, there is little denying that expert testimony may serve the cause of both sides to a bad-faith action.

Professor Samuel Gross from the University of Michigan outlined the 'essential paradox' of expert testimony by noting that: "We call expert witnesses to testify about matters that are beyond the ordinary understanding of lay people (that is both the major practical justification and a formal legal requirement for expert testimony), and then we ask lay judges and jurors to judge their testimony."[1]

Accordingly, while courts hold that expert testimony in a bad-faith case is not a necessity,[2] it is widely held that expert testimony on pertinent issues and insurer practices is admissible in the general discretion of the trial court when offered by an appropriately qualified expert.[3]

B. *The Issue*

The admissibility of expert witness testimony and the documentary evidence upon which such testimony is based are currently subject to a myriad of challenges in all types of litigation, both at the state and federal levels. A clear understanding of the application of *Daubert v. Merrell Dow Pharmaceuticals, Inc.*,[4] *General Electric v. Joiner*,[5] and *Kumho Tire Co. v. Carmichael,*[6] is critically important to defense practitioners and their ability to exclude expert evidence offered by the plaintiff/policyholder/insured. The wrangling about whether *Daubert* standards apply only to scientific evidence or whether the *Daubert* gatekeeping function applies equally to nonscientific evidence has been laid to rest. Consequently, as noted below, those practicing in the insurance-related defense and coverage arenas must be prepared to challenge a plaintiff's proof in bad faith, claims handling, and policy interpretation cases. Similarly, counsel must be prepared to challenge the documentary evidence upon which any expert opinion is based that is offered by plaintiff's counsel to justify plaintiff's interpretation of the policy. Of course, counsel for the insurance company should be aware that the insurer/defense expert's testimony undoubtedly will undergo similar challenge.

A proactive approach that challenges expert testimony within the nonscientific, insurance-related fields must begin with an understanding of *Daubert, Joiner,* and *Kumho*. However, if the applicable state jurisdiction does not follow *Daubert* and its progeny, the practitioner should consider the test articulated in *Frye v. United States,*[7] or perhaps a combination of the two. Though it is beyond the scope of this article, the practitioner should also consider whether the expert is qualified in its field of expertise. This article will next consider a historical analysis of these cases together with their applicable tests. Defense counsel will be urged to consider several projects covering application of these tests to expert evidence within the context of the traditional insurance case.

C. *The Standard*

1. *Daubert*, et al.

Any analysis of the standard that courts will apply to "junk science" and "junk expert testimony" must begin with *Daubert, Joiner* and *Kumho* since difficult questions clearly remain regarding how these opinions apply outside scientific disciplines. Junk science has been defined as "jargon-filled, serious-sounding deception."[8]

a. *Daubert v. Merrell Dow Pharmaceuticals, Inc.*[9]

In *Daubert*, the parents of children suffering birth defects allegedly caused by the drug Bendictin instituted an action against the manufacturer of that drug. Bendictin was an anti-nausea drug used by mothers during pregnancy. Procedurally, the defendant moved for summary judgment on the issue of causation contending there was no link between the use of Bendictin and the alleged birth defects. To support its motion, defendant offered the affidavit of a scientific expert. Plaintiff countered this proof with affidavits from eight expert witnesses who argued that there was a causal link. The district court granted the defendant's motion and plaintiffs appealed to the Ninth Circuit Court of Appeals. Affirming the lower court's holding, the Ninth Circuit cited *Frye v. United States*,[10] noting that scientific testimony would only be admitted if it were "generally accepted in the relevant scientific community."[11] Plaintiff petitioned the United States Supreme Court contending that since *Frye*, the United States Congress had enacted the Federal Rules of Evidence (specifically Rules 104(a) and (b) and Rule 702), which arguably liberalized evidentiary standards. These rules provide as follows:

> **Federal Rule of Evidence 104(a):**
> Preliminary questions concerning the qualifications of a person to be a witness . . . or the admissibility of evidence shall be determined by the Court.

Federal Rule of Evidence 104(b):
When the relevancy of evidence depends on the fulfillment of a condition of fact, the Court shall admit it upon, or subject to, the introduction of evidence sufficient to support a finding of the fulfillment of the condition.

Federal Rule of Evidence 702:
If scientific, technical or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training or education, may testify thereto in the form of an opinion or otherwise.

Recognizing that the Federal Rules of Evidence were intended to be more liberal than the historical *Frye* test, the Supreme Court noted that the *Frye* Court's "rigid general acceptance requirement would be at odds with the liberal thrust of the Federal Rules."[12] With that said, the Court defined the trial court's "gatekeeping" function and its obligation to exclude evidence based only on "subjective belief or unsupported speculation."[13] The Court also enumerated several factors for the trial court to consider when analyzing the reliability of evidence:

1) Can the theory or technique be tested or has it been tested?
2) Has the theory or technique been subject to peer review and publication?
3) Is there a known or potential rate of error?
4) Do standards and controls exist and are they maintained?
5) Has the theory been generally accepted?[14]

The Court emphasized, however, that these factors are "general observations" that should not be considered a definitive test.[15] The Court also cautioned that it had only addressed scientific expert evidence; it was not addressing technical or other specialized knowledge. Legal analysts immediately questioned whether the *Daubert* "gatekeeping" function extended to other types of expert testimony.

In his dissenting opinion, Justice Rehnquist initiated this same concern: "[D]oes all of the dicta apply to an expert seeking to testify on the basis of 'technical or other specialized knowledge' the other types of expert knowledge to which Rule 702 applies, or are the 'general observations' limited only to scientific knowledge?"[16] Other commentators speculated as well.[17] Further, there developed a significant split among the various lower courts about how *Daubert* would be interpreted and whether it would apply to nonscientific evidence.[18]

It should be noted that the Supreme Court remanded *Daubert* to the Ninth Circuit Court of Appeals. On remand, the Ninth Circuit found that the evidence was inadmissible. In addition to the *Daubert* factors, it noted that expert testimony is presumptively unreliable if the research was conducted in anticipation of, rather than independent of, the litigation.[19]

b. *General Electric v. Joiner*[20]

The *Daubert* Court also left unresolved the issue of what standard should be applied by an appellate court when reviewing a trial court ruling on the admissibility of evidence. In *Joiner*, the Supreme Court addressed this issue and resolved the conflict among the various districts that had developed after *Daubert*.[21]

The *Joiner* dispute involved a plaintiff's claim that his cancer was caused by exposure to PCB and chemical fumes. The district court had ruled that a causal link did not exist between the exposure and the cancer. On appeal, the Eleventh Circuit reversed the district court's ruling, applying a de novo standard of review. The United States Supreme Court rejected this standard, however, ruling that the decision of the district court should not be revised unless that court abused its discretion.[22] Of significance, the Court reaffirmed the *Daubert* standard but without the clarification that had been anticipated:

> [N]othing in either *Daubert* or the Federal Rules of Evidence requires a district court to admit opinion evidence, which is connected to existing data, only on the *ipse dixit* of the expert. A Court may conclude that there is simply too great an analytical gap between the data and the opinion proffered.[23]

Subsequent to *Daubert* and *Joiner*, confusion still existed among the federal district and state courts regarding which standard to apply.[24] Further, the Court did not answer the question posed by Chief Justice Rehnquist in *Daubert*: Did the Court's ruling apply to nonscientific and other technical evidence? As a result, after *Daubert* and *Joiner*, courts in the various circuits answered this question differently. For example, the Second, Ninth, and Tenth Circuits held that *Daubert* was limited to scientific testimony and not applicable to experience-based testimony.[25] In contrast, the Fifth, Sixth, Seventh, and Eighth Circuits authorized the use of *Daubert* factors to analyze admissibility of expert evidence, both scientific and nonscientific in nature.[26]

c. *Kumho Tire Co. v. Carmichael*[27]

Recognizing the foregoing conflict, the Supreme Court in *Kumho* confronted the issue directly, analyzing whether the "gatekeeping" function of the

district court applied to scientific, nonscientific and other technical evidence. The *Kumho* plaintiffs had been injured as the result of a tire blowout on a minivan. They sued the tire manufacturer, claiming that either a design or manufacturing defect caused the blowout. In support of their theory, plaintiffs offered the testimony of a tire expert. On motion of the defendant, the trial court excluded the tire expert's testimony utilizing *Daubert* factors (general acceptance, rate error, peer review and publication). The Eleventh Circuit reversed, holding that *Daubert* was limited to scientific evidence and did not apply to the tire expert's testimony since that testimony was skill- or experience-based.[28] The United States Supreme Court reversed the Eleventh Circuit, noting that the language of Rule 702 makes no distinction between "scientific" knowledge and "technical" or "other specialized" knowledge. Further, the high Court determined that the evidentiary rationale underlying the basic *Daubert* "gatekeeping" function was not limited to "scientific" knowledge:

> [W]e conclude that the trial judge must have considerable leeway in deciding in a particular case how to go about determining whether particular expert testimony is reliable. That is to say, a trial court should consider the specific factors identified in *Daubert* where they are reasonable measures of the reliability of expert testimony."[29]

Citing *Joiner,* the Supreme Court further noted that the appellate courts must apply an abuse of discretion standard when reviewing a trial court decision to admit or exclude expert testimony.[30] The Court then applied the abuse of discretion standard to the relevant facts, concluding that the testimony of plaintiffs' tire expert was properly excluded by the trial court under that standard.

Several recent cases have considered the application of *Daubert* standards post-*Kumho*. The case of *Jaurequi v. Carter Manufacturing Co.*,[31] involved the testimony of a mechanical engineer and human factors expert regarding safety barriers and improper safety warnings. The court there noted that when applying the *Daubert* standard to all types of expert testimony, the trial court is left with "great flexibility in adapting its analysis to fit the facts of each case." Further, the trial court did not abuse its discretion when excluding evidence that was nothing more than "unabashed speculation."[32]

The United States Supreme Court later refused to grant the plaintiff's petition for *certiorari* in *Moore v. Ashland Chemical, Inc.*[33] This case involved a doctor's causation testimony based on clinical assessment and diagnosis of the plaintiff's illness following exposure to chemical toxins. Relying on *Daubert* and Federal Rule of Evidence 702, the district court excluded the testimony. The Fifth Circuit reversed, however, noting that *Daubert* factors do not apply to clinical medicine which is not hard science. An en banc court subsequently

abandoned the panel determination, holding that no such distinction exists and that Rule 702 and *Daubert* apply to both scientific and nonscientific expert testimony.

The court in *Johnson v. District of Columbia*[34] refined the issue further. That case involved scalding injuries to an infant child amid allegations that a water heater malfunction caused the injuries. Pursuant to the defendant's motion *in limine,* the trial court excluded the testimony of plaintiff's plumbing expert on grounds that he was only experienced in the installation of water heaters, did not have any experience in the design or control function, and was unfamiliar with commercial heaters. The court of appeals determined that as long as the trial judge has the facts necessary to assess the expert's qualifications, the judge can admit or exclude expert testimony without a hearing, based on those facts contained in the record or the attorney's offer of proof.[35]

d. *Frye v. United States*[36]

Under *Frye*, the sole determinant of the reliability and admissibility of an expert's testimony is whether the expert's testimony is based on scientific principles or procedures, or whether the principles or procedures have sufficiently gained "general acceptance" in the specific field to which the principles or procedures relate. Decided over seventy-five years ago, the attorneys representing Frye attempted to admit expert testimony on the reliability of a systolic blood pressure test to disprove that Frye committed a murder. The federal court excluded the offer of proof because the test had not "gained general acceptance in the particular field to which it belongs;" therefore, it was inadmissible because it was "experimental" as opposed to "demonstrable."[37] The *Frye* standard is often considered less flexible than the *Daubert* standard. Under *Frye,* the party offering the scientific evidence must conclusively show general acceptance. If the proof is accepted only by a minority of scientists in the applicable/relevant field, such expert proof would be excluded. Under *Daubert,* however, proof that is accepted by a minority of scientists would provide only a basis to impeach the expert witness.[38]

D. *Application to Insurance Issues*

There is considerable authority holding that expert testimony is generally not required to establish bad faith or other improper handling of claims.[39] In some instances, courts have held that the admission of expert testimony was prejudicial,[40] although the admission of expert testimony on the point has been deemed nonprejudicial in other cases.[41]

1. General Principles

There is little doubt that the insurance industry held serious interest in *Daubert* and its progeny because inconsistencies that developed after *Daubert* could have adversely affected the standards by which claims professionals, underwriters, and the insurance industry as a whole would be judged. For example, concerns of the American Insurance Association and the National Association of Independent Insurers were expressed in their amici curiae briefs,[42] where they encouraged the Court to extend *Daubert* standards to "applied science," including insurance issues within the context of Y2K litigation.[43] The ultimate concern was whether the testimony of an insurance expert, which is based on general personal experience, skill, and knowledge, would withstand application of the relevant standards.

Under existing standards, it must be determined initially whether the testimony offered assists the trier of fact in understanding the issues at hand and leaves undisturbed the province of the jury. The case of *Buckner v. Sam's Club, Inc.*[44] confirms this analysis when discussing the testimony of a safety management expert.[45] Within the insurance context, the court of appeals in New York has traditionally held that "the opinions of experts, which intrude on the province of the jury to draw inferences and conclusions are both unnecessary and improper."[46]

The court in *Kulak v. Nationwide Mutual Insurance Co*.[47] similarly excluded expert testimony when deciding whether an insurer acted in bad faith in allegedly failing to settle:

> While it might be suggested that an experienced trial attorney . . . who has had frequent occasion to observe the results of juries' deliberations in personal injury actions might be expected reliably to predict the outcome in a particular case, we know of no empirical support for such a conclusion. Moreover, any such result would be based on exposure rather than expertise; and would treat of subject matter calling for no special scientific or professional education, training or skill.[48]

After recognizing the underlying need for special qualifications *and* testimony, the court further noted: "[a]ny experience advantage enjoyed by such witnesses would not establish the inability or incompetence of jurors, on the basis of their day-to-day experience and observation, to comprehend the issues, to evaluate the evidence, and finally to estimate the likely outcome of a specific action."[49] Citing Federal Rule of Evidence 702, the one dissenting judge in *Kulak* endorsed an approach that takes a more realistic view of the need for expert testimony in today's complex society. He also identified areas where expert testimony is necessary in a bad faith case.[50]

With this overview, the practitioner should next assess how the *Daubert* standards become operative. What is certain is that each situation must be assessed on a case-by-case basis because not all *Daubert* factors will apply to all experts and, in fact, none will apply in some cases. As one commentator has observed:

> [T]he *Daubert* factors may or may not apply in each case. Rather than employ a mechanistic application of specific factors, courts should focus on *Daubert's* goal, which is to make certain that the expert, whether basing testimony on professional studies or personal experiences, employs the same level of intellectual rigor that characterizes the practice of an expert in the relevant field.[51]

As noted in *Tyus v. Urban Search Management*,[52] "the measure of intellectual rigor will vary by the field of expertise, and the way of demonstrating expertise may vary."[53] However, the court in *Tyus* also concluded that: "In all cases . . . the district court must ensure that it is dealing with an expert, not just a *hired gun*."[54]

While there is limited case law to govern whether a particular "insurance expert" meets the applicable *Daubert* tests, there are several recent cases within the coverage context that provide some guidance. In each case under scrutiny, the practitioner should determine whether the expert's opinion is based on mere speculation or whether the expert used the "types of information, analyses, and methods relied on by experts in his field." Also, "the information that he gathers and the methodology he uses must reasonably support his conclusions."[55]

When applying the foregoing principles, several interesting cases that postdate *Daubert* but predate *Kumho* should be considered. These address whether the *Daubert* standards are applicable to expert testimony concerning-claims handling procedures. In *Reedy v. White Consolidated Industries, Inc.*,[56] the insured alleged, among other things, that his employer acted in bad faith in refusing to pay workers' compensation benefits. The plaintiff had designated two individuals or experts to testify on claims-handling procedures, and the defendant moved to strike the testimony of these witnesses. In denying the defendant's motion, the court made several statements that will assist the practitioner in determining when the testimony of "insurance experts" should be allowed:

> 1) An individual can qualify as an expert where that individual possesses significant knowledge gained from practical experience, even though academic qualifications in the particular field of expertise may be lacking.
> 2) The central issue is whether the expert's testimony will assist the trier of fact; merely telling the jury what result to reach is not helpful.

3) Competency goes to weight, not admissibility.
4) Expert testimony must be reliable and relevant under *Daubert*.
5) The witness should have specialized knowledge about relevant activities in the case with which most jurors are not familiar.

The court held that the "claims adjusting procedure is . . . something about which the average juror is unlikely to have sufficient knowledge or experience to form an opinion without expert guidance, thus expert testimony would not be superfluous."[57] In reaching its decision to permit expert testimony about whether the defendant's claims procedure was usual and appropriate, the court reviewed the expert's practical experience with claims adjustment and the types of claims processed. However, while the testimony of the two experts was admissible, the defendant was still "entitled to pursue further challenges to these expert's skill or knowledge in order to attack the weight to be accorded their expert testimony."[58]

In *United States Fidelity & Guaranty Co. v. Sulco, Inc.*,[59] the court likewise considered the proffered expert testimony of a claims processing manager and, without discussing the *Daubert* factors, allowed it as sufficient. Again, in *Kraeger v. Nationwide Mutual Insurance Co.*,[60] the court considered the testimony of the insured's bad faith expert and denied the insurer's motion *in limine*. In doing so, the court made certain observations that are helpful in assessing the parameters of a bad faith expert's testimony:

1) Testimony about how insurance claims are managed and evaluated and the statutory or regulatory standards to which insurance companies must adhere could be helpful to the jury in evaluating whether the claim was handled in bad faith.
2) The expert witness cannot provide legal conclusions that the insurer violated a particular statute or that the insurer acted in bad faith.
3) The expert witness can testify that, based upon expertise and experience, the insurer had no reasonable basis for its actions.

In reaching its conclusion, the court specifically determined that the *Daubert* factors did not apply to this type of testimony.

There are many post-*Kumho* nonscientific cases that likewise provide some guidance to those practitioners who litigate insurance issues. For example, in the antitrust case of *City of Tuscaloosa v. Harcros Chemicals, Inc.*,[61] the Eleventh Circuit considered the nonscientific testimony of a certified public accountant and the testimony of a statistician and held: "[w]e conclude that the district court abused its discretion in excluding Garner's [CPA] testimony . . . . We further conclude that the district court's interpretations of *Daubert* and of Rules 104 and 702 . . . were erroneous as a matter of law."[62] With respect to the statistician's

testimony, the court excluded portions of his testimony only because such testimony was outside his competence and the methodology was flawed.[63]

It should be noted that the defense bar also has been successful in excluding the insured/policyholder's expert in the following cases:

- *Hyde Athletic Industries, Inc. v. Continental Casualty Co.*[64] The court in this case excluded the plaintiff's expert testimony when determining whether the environmental containment was "sudden or accidental" or whether it occurred over a long period of time. The exclusion of the evidence initially was based on inconsistencies between the expert's deposition testimony and the affidavits submitted on the summary judgment motion. In addition, the court noted that it was "concerned that Robertson's opinion would be inadmissible at trial under Federal Rule of Evidence 702 because it may not meet the standards outlined in *Daubert* . . . ."[65]

- *Brown v. Auto-Owners Insurance Co.*[66] This case involved expert testimony by a civil engineer regarding the structural damage to a warehouse, which was alleged to be speculative. In rejecting the expert testimony proffered by the insured/policyholder, the court noted that "the expert's testimony must be grounded in the methods and procedures of science and not subjective belief or unsupported speculation."[67] Because the testimony was based on nothing more than the witness's subjective belief and personal observations regarding the cause of the damages, rather than mathematical calculation or scientific methodology, it was excluded.

- *Talmage v. Harris*[68] Plaintiff, a former client, filed a legal malpractice suit against his former attorney in connection with his handling of the client's suit against his fire insurer. Plaintiff retained an expert witness on liability. The expert was an attorney, with over 20 years of experience performing defense work for insurance companies. The expert's work as an insurance defense attorney included adjusting claims. He never represented a claimant who was pursuing a claim against an insurer for fire loss and making a claim under the insurance policy. The expert had never defended an insurance company against a claim by its own insured for coverage arising out of a fire loss.

The court explained the Seventh Circuit's test for evaluating the admissibility of expert testimony under F.R.E. 702 and *Daubert*:

> First, the court must decide "whether the expert's testimony pertains to scientific knowledge" and "must rule out subjective belief or unsupported speculation."[69]

> Second, the court needs to determine "whether the evidence or testimony assists the trier of fact in understanding the evidence or in determining a fact in issue."[70] Regarding this second inquiry, "[a]n expert's opinion is helpful only to the extent the expert draws on some special skill, knowledge, or experience to formulate that opinion; the opinion must be an *expert* opinion (that is, an opinion informed by the witness' expertise) rather than simply an opinion broached by a purported expert."[71] "Because an expert's qualifications bear upon whether he can offer special knowledge to the jury, the *Daubert* framework permits-indeed, encourages-a district judge to consider the qualifications of a witness."[72]

The court held that the expert was qualified to offer an opinion regarding the reasonableness of the insurer's handling of the plaintiff's claim. The expert was a lawyer with substantial experience in insurance law. The court noted that although he did not specialize in fire loss claims, the expert had special knowledge of the insurance claims adjustment process in general as a result of his 20 years' experience as a lawyer defending insurance companies against claims by policy holders. The court concluded by stating that it was satisfied that the expert had "enough experience with insurance claims and knowledge of the law of bad faith in Wisconsin to make his opinion regarding the viability of plaintiff's bad faith claim admissible under *Daubert*."[73]

- *Jordan v. Allstate Insurance Company*[74] In this 2007 California Court of Appeals case, the court held that expert testimony on statutory violation was admissible. Over Allstate's objection, the trial court considered the declaration of an expert on insurance industry claims settlement practice.[75] In his declaration, the expert expressed the opinion that various actions undertaken by Allstate violated certain provisions of the Unfair Insurance Practices Act (Ins.Code, § 790.03, subdivision (h)).[76] Allstate objected to the trial court's consideration of the expert's declaration on the ground that section 790.03, subdivision (h) cannot provide the basis for a bad faith action.[77] Allstate did not counter the expert's declaration, but objected on the ground that it was inadmissible for the reason stated above.[78] The court overruled that objection.

The court held that the plaintiff was not seeking to recover on a claim based on a violation of section 790.03, subdivision (h). Rather, her claim was based on a claim of common law bad faith arising from Allstate's breach of the implied covenant of good faith and fair dealing which she is

entitled to pursue.[79] Plaintiff's reliance upon the expert's declaration was for the purpose of providing *evidence* supporting her contention that Allstate had breached the implied covenant by its actions. This is a *proper* use of evidence of an insurer's violations of the statute and the corresponding regulations.[80] (See *Rattan v. United Services Automobile Assn.* 84 Cal.App.4th 715, 724, 101 Cal.Rptr.2d 6, 4th Dist. 2000).

To the contrary, there exist several other cases where the insurer has not been successful in excluding the testimony of the insured/policyholder's expert or where the insurer's own expert testimony has been excluded:

- *Michigan Millers Mutual Insurance Co. v. Benfield*.[81] In this case, the testimony of the insurer's fire and origin expert was excluded because it was not sufficiently reliable for admission under *Daubert*. Specifically, the court rejected the opinion evidence because it was not supported by reliable procedure and scientific methodology.

- *Douglas v. State Farm Lloyds*.[82] Though the issue here did not arise in the *Daubert* context, its determination affects the use of experts in insurance cases. In this "failure to investigate and settle" case, the court noted that "an insurer's reliance upon an expert report, standing alone, will not necessarily shield the carrier if there is evidence that the report was not objectively prepared or the insurer's reliance on the report was unreasonable."[83]

- *Aetna Casualty & Surety Co. v. Dow Chemical Co.*[84] This environmental case involved a claim by an insurance carrier that it was prejudiced because the insured's report regarding the removal of underground storage tanks did not contain information as to when releases or contamination occurred. The court noted that because the insurer did not utilize an expert on hydrogeology to establish the nature and timing of the discharge, the insurer's claim for prejudice was in doubt.

- *Watts v. Organogenesis, Inc*.[85] In a case involving the construction and interpretation of the phrase, "underlying medical condition," within a medical insurance contract, the insured's doctor had testified that dysreflexia was an underlying medical condition. Accepting the insured's expert testimony, the court noted: "If the phrase is a term of art, then a medical expert's unrebutted designation of the dysreflexia as such is sufficient as the last word on this issue. If it is not, then use of the phrase in the plan document is ambiguous, and therefore should be construed in accordance with the singular/plural rule . . . ."[86]

- *California Shoppers, Inc. v. Royal Globe Ins. Co.*[87] California Shoppers and four of its shareholders brought an action against its insurance carrier, Royal Globe to recover damages allegedly resulting from the breaches of two duties arising under the policy. One such breach was the refusal to indemnify the insured for a judgment awarded against it in a third-party action (the *Uneedus* action) brought by a competitor. The other was the failure to defend the *Uneedus* action. The main action also included a count for willful breach of the implied covenant of good faith and fair dealing allegedly occurring in connection with the failure to defend, as well as a count for fraud allegedly occurring at the time the insurance was purchased. The appellate court held that the lawyer who represented the policyholders against the shareholders did *not* qualify as a bad faith expert. The court reasoned that he could not testify as an expert because he had never been employed by an insurance company, or even retained as counsel by an insurance company.[88]

By virtue of the determination in *Kumho,* the rules espoused by these cases also apply to nonscientific evidence. Within the insurance context, these include bad faith, policy interpretations and claims-handling cases.

As the various district and state courts begin applying the *Kumho* analysis of *Daubert* to nonscientific evidence, inconsistencies between rigid application of the standards and a flexible approach should dissolve. For example, in *Moore v. Ashland Chemical, Inc.*,[89] the Fifth Circuit sitting en banc likely applied *Daubert* too rigidly when it held that the district court had discretion to exclude the causation testimony of the plaintiff's clinical physician because there existed an "analytical gap between the causation opinion and the scientific knowledge and data that were cited in support."[90] "Courts that have applied *Daubert* broadly have demonstrated that, as a general framework, *Daubert* plays an important role in requiring experts to do more than 'come to court with their credentials and a subjective opinion.'"[91] Since inconsistency is still a possibility, it is absolutely necessary that the practitioner grasp the standards applied in both state and federal courts within the applicable jurisdictions. An example of such analysis is included below. It considers the status of New York law subsequent to *Daubert, Joiner*, and *Kumho*. Such an analysis should be undertaken within the practitioner's relevant jurisdiction.

E. *New York Approach*

1. State Court

a. *Scientific Testimony*

New York state courts have not yet adopted the *Daubert* standard as enhanced by *Joiner,* or *Kumho*. Specifically, the New York Court of Appeals has

not embraced the *Daubert* standard of scientific reliability; instead, it has retained the *Frye* "general acceptance" test. In *People v. Wesley*,[92] the court noted in a footnote that *Daubert* was not applicable, remarking that, under *Frye*, the particular procedure need not be unanimously "endorsed" by the scientific community if it is "generally accepted as reliable."[93] The *Frye* standard became the basis for New York's two-part test on the admissibility of scientific expert testimony.[94] Under the first prong of the test, the proffered expert's testimony must be based upon scientific knowledge and skill that is not within the scope of the jury's ordinary training or intelligence. The expert need only have gained knowledge or expertise (formal or otherwise) that would assist the jury in interpreting the issues before it. If the proffered proof is based solely on common knowledge or intelligence, the testimony should be excluded because jurors can form these same reasonable opinions. The second prong requires that the expert's testimony be based on scientific principles or procedures under the "general acceptance" test.[95] It is within the province of the trial court to determine whether the expert's testimony is both necessary to assist in the jury's interpretation and whether the expert's theory has gained general acceptance. Once that determination is made, the weight accorded to the expert's testimony is left to the jury. The court traditionally has conducted a "*Frye* hearing" during which each party presents its position to support or challenge admissibility. One court has noted that such a hearing is not necessary, deciding the admissibility issue without a formal hearing.[96]

b. *Nonscientific Testimony*

Consistently, the courts in New York have held that the *Frye* "general acceptance" test is not applicable to nonscientific or non-novel evidence.[97] In *Wahl v. American Honda Motor Co.*,[98] when considering the testimony of an engineer regarding the design defects of an ATV, the court ruled as follows: "inasmuch as the testimony is that of an engineer, and . . . is based upon . . . recognized technical or other specialized knowledge, the Court finds that the stricter general acceptance standard of *Frye* is not applicable. The Court will apply the reliability standard as derived from *Daubert* and *Kumho Tire*."[99]

Following suit, another court in *Clemente v. Blumenberg*[100] questioned the continued application of *Frye* not only to scientific, but to nonscientific expert testimony as well:

> [T]he accelerated pace at which science travels is today far faster than the speed at which it traveled in 1923 when *Frye* was written. Breakthroughs in science which are valid may be relevant to a case before the courts. Waiting for the scientific community to "generally accept" a novel theory which is otherwise valid and reliable as evidence may deny a litigant justice before the court.[101]

Thus, when considering the testimony of a biomedical engineer, the court analyzed the issues under both *Frye* and *Daubert* standards:

> [T]his court finds that the proffered biomedical engineer is qualified as an expert in biomedical engineering based upon his professional training and may render an opinion as to the general formula of forces upon objects. . . . However, he may not render an opinion based on his report and testimony at the *Frye* hearing because the source of the data and the methodology employed by him in reaching his conclusion is not generally accepted in the relevant scientific or technical community to which it belongs.[102]

The court continued: "applying the *Daubert/Kumho* factors . . . this court finds that the data and the methodology employed by the biomechanical engineer are not scientifically or technically valid."[103] In addition to these findings, the court observed:

> A trial judge's role as a gatekeeper of evidence is not a role created by *Daubert* and rejected by the Court of Appeals; it is an inherent power of all trial court judges to keep unreliable evidence ("junk science") away from the trier of fact regardless of the qualifications of the expert. A well-credentialed expert does not make invalid science valid merely by espousing an opinion.[104]

By virtue of the *Clemente* decision, at least one New York judge is willing to move away from the rigors of *Frye* to a more liberal approach.

c. *Parker v. Mobil Oil Corporation*

In a recent New York State Court of Appeals case, *Parker v. Mobil Oil Corporation*, a plaintiff, who had been diagnosed with acute myelogenous leukemia (AML), sued various oil corporations, claiming that his exposure to gasoline containing benzene caused his AML.[105] The Third Department established a three-step process for evaluating whether an expert witnesses' methodology was appropriate to determine scientific reliability. Specifically, the three-step process included: (1) A determination of the Plaintiff's level of exposure to the toxin in question, (2) from a review of the scientific literature, proof that the toxin is capable of producing the illness in question (general causation) and the level of exposure to the toxin which will produce that illness, and (3) establishing specific causation by demonstrating the probability that the toxin caused the plaintiff's particular illness.

While the Court of Appeals affirmed the Third Department's Decision and held that plaintiff's experts' submissions were property precluded and defendants'

motions for summary judgment were properly granted, the Court of Appeals deviated from the Third Department's rationale. Specifically, the court rejected the Third Department's holding that it was necessary for plaintiff to always quantify exposure levels or a dose-response relationship. Rather, the court held, a variety of methodologies may be acceptable so long as they are generally accepted in the scientific community. Thus, whereas the Third Department primarily founded its decision upon that plaintiff's experts' submissions failed to adequately quantify plaintiff's level of exposure to the toxin needed to contract AML, the Court of Appeals focused on the generally unreliable nature of plaintiff's experts' submissions which relied upon studies of direct exposure to benzene rather than studies of exposure to benzene in gasoline.

2. Federal Court

Since the Supreme Court's decision in *Daubert*, there have been a handful of federal court cases in New York that have addressed the *Daubert/Kumho* standards.

- *Gray v. Briggs*[106]

In *Gray v. Briggs*, which involved a dispute between an attorney and former law firm employees who had participated in the firm's pension plan, it was alleged that defendants breached a fiduciary duty in violation of the Employee Retirement Income Security Act (ERISA). Plaintiff had retained an expert who asserted, among other things, that defendants had violated ERISA, made speculative personal investments, and violated industry standards against churning. The defendants challenged the plaintiff's expert and moved to preclude the testimony. Citing *Kumho,* the court rejected the expert's testimony and concomitant report on various grounds:

1) The testimony was outside the expert's expertise;
2) The expert lacked the qualifications to express the opinion for which his testimony was offered;
3) The expert's opinion was nothing more than strained speculations or bare legal conclusions; it was without sufficient evidentiary basis to be helpful to the court or reliable.

When applying the *Kumho* standard, the court offered that expert testimony is admitted under Federal Rule of Evidence 702 where it will assist the trier of fact to understand the evidence or determine a fact in issue. Further, an expert must be qualified to testify (i.e., by knowledge, skill, experience, training or education). As noted in *Kumho*, the expert must have "sufficient specialized knowledge to assist in deciding the particular issue in the case."[107]

- *Grdinich v. Bradlees*[108]

Another district court judge considered *Daubert* and its progeny in *Grdinich v. Bradlees*, which involved a claim by a plaintiff who was injured while shopping at defendant's store when ironing boards fell from a display case. The plaintiff had retained an expert to testify that defendant ignored or failed to follow the industry guidelines applicable to self-service department stores. The defendant challenged the admissibility of the expert's testimony. Citing the "gatekeeping" function articulated by *Daubert* and *Kumho* (application of *Daubert* to technical and other specialized knowledge), the court noted that it must decide "whether this particular expert [has] sufficient specialized knowledge to assist the 'jurors in deciding the particular issue in the case.'"[109] The court precluded the expert testimony because:

1) none of the *Daubert* factors were present, including that of "general acceptance" within the relevant expert community; and
2) there were no countervailing factors which favored admissibility which so as to outweigh those identified in *Daubert*.

As a result, the testimony was precluded because it was neither reliable nor relevant.

- *Prohaska v. Sofamor*[110]

In *Prohaska v. Sofamor, S.N.C.*, a patient brought a products liability action against the manufacturer of pedicle bone screws that allegedly cause spinal problems and other consequences. One of plaintiff's experts was a board-certified neurosurgeon with 35 years of experience who claimed he was "well acquainted" with defendant's and others' spinal instrumentation, "'even though I do not personally install it myself surgically.'"[111] He had not performed any neurological surgery since 1997 following cancer treatment. His specialty was acoustic tumors of the brain and implantation of continuous infusion pumps into the spinal column for control of intractable pain in cancer patients. He was not trained to do lumbar fusions - the type of surgery at issue in the case.[112]

The court detailed the expert's lack of experience with the specific fixation devices and related surgery involved in the case at hand. Because the focus under *Daubert* is not simply raw qualifications in the abstract but, rather, qualifications to testify reliably, the court found the proffered expert was unqualified by skill, experience, training, knowledge or education in the specific subject at issue. Instead, he demonstrated a "litigation driven expertise", asserted "conclusory allegations," failed to personally examine plaintiff or her scans, made a differential diagnosis absent "intellectual rigor" and indulged in assumptions

rather than relying on medical fact.[113] Accordingly, his proffered testimony was found unreliable under a *Daubert* analysis.

- *Brooks v. Outboard Marine Corp.* [114]

In *Brooks v. Outboard Marine Corp.*, the parent of a minor whose hand was amputated by a propeller on an outboard boat motor brought a product liability action on behalf of the minor against the manufacturer of the motor. Outboard deposed the plaintiff's expert witness. After the close of discovery, the plaintiff requested permission to extend discovery in order to obtain a new expert witness. During this time, Outboard filed a motion for summary judgment, arguing that the plaintiff's current expert should be precluded from testifying and that summary judgment was proper on the plaintiff's theories of liability.[115] This was referred to a magistrate judge. Meanwhile, the plaintiff filed a curriculum vitae and one-page report of a new expert witness. The new expert's report concluded that a certain safety mechanism on the boat could have prevented the accident or lessened its severity. The magistrate recommended denying OMC's motion for summary judgment, finding that it was "premature" because the defendant had not properly responded to the plaintiff's new design defect theory.[116] In addition, the magistrate found it premature to rule on the admissibility of Mr. Warren's testimony, noting that such rulings are usually made on a more complete record.[117] The district court adopted the magistrate's recommendation.

On appeal, plaintiff argued that the Supreme Court's decision in *Kumho*,[118] required the party challenging the admissibility of its opponent's expert witness to first use its own expert to call the challenged expert's testimony "sufficiently into question."[119] Only then, contended the plaintiff, can the district court analyze the admissibility of the testimony of the expert witness. The Second Circuit held that this argument was without merit. The court explained that in *Daubert*,[120] the Supreme Court instructed that the Federal Rules of Evidence require the trial court to "ensure that any and all scientific testimony or evidence admitted is not only relevant, but reliable."[121] The subsequent decision in *Kumho Tire* makes clear that this gate-keeping function applies not just to scientific expert testimony as discussed in *Daubert,* but also to testimony based on " 'technical' and 'other specialized' knowledge."[122]

The court held that "plaintiff's argument that this gate-keeping role disappears when a proposed expert witness is not challenged by an opposing expert witness thus runs counter to the thrust of *Daubert* and *Kumho Tire*. Nowhere in either opinion is there language suggesting that testimony could only be "called sufficiently into question" by a rebuttal expert."[123] Having determined that the district court acted within its discretion in excluding Mr. Warren's testimony, the plaintiff had no evidence in the record to support his theory that the motor had a design defect which caused the accident or increased

its severity. As a result, the Court of Appeals held that summary judgment was properly granted.

- *American Home Assurance v. Merck & Co., Inc.* [124]

In the 2006 case, *American Home Assurance Company v. Merck & Co., Inc*. the insurer brought an action for declaration that it properly denied Merck's claims for coverage under the transit insurance policy. American Home asserted a counterclaim for bad faith, amongst other causes of action. Courts within the Second Circuit "have liberally construed expert qualification requirements" when determining whether a witness can be considered an expert.[125]

The Second Circuit has instructed that a trial court, in determining whether a witness is qualified to render an expert opinion, "must first ascertain whether the proffered expert has the educational background or training in a relevant field."[126] Then the court " 'should further compare the expert's area of expertise with the particular opinion the expert seeks to offer [and permit t]he expert … to testify only if the expert's particular expertise … enables the expert to give an opinion that is capable of assisting the trier of fact.' "[127] With this guidance in mind, the court addressed the parties' Motions to preclude expert testimony.

American Home sought to preclude the testimony of Merck's insurance expert, who Merck planned to have testify at trial about: custom and practice in the transit insurance industry; whether American Home acted in accordance with those industry customs and practices under the Transit Policy; whether American Home acted in bad faith as that term is understood in the industry; and the construction and meaning, as understood in the industry, of the Transit Policy and its provisions.[128]

American Home asserted several challenges to Merck's expert's testimony. Specifically, American Home objected to (1) to his credentials to testify as a transit insurance expert, (2) to the foundation for his opinions to the extent Jervis relied on the report of the prior insurance expert retained by Merck, and (3) to his opining on the meaning of the Transit Policy clauses at issue in this action.[129]

Regarding the expert's credentials, the court held that it appeared that the expert had substantial experience dealing with transit insurance policies covering policyholders in the United States. The documents Merck had submitted in support of its expert indicated that Jervis has over twenty-five years of experience in the transit insurance business across the globe and has handled and adjusted over 12,500 transit claims during his career.[130] The court held that American Home's objection to the expert's testimony to the extent it relied on the report of Merck's prior insurance expert was overstated.[131] In the instant case, the

expert reviewed all the underlying materials that informed the previous expert and reached similar conclusions. Under such circumstances, the court reasoned that there was nothing improper about the expert incorporating the previous expert's findings in his report.[132]

Finally, the court addressed American Home's concerns about the expert's report and the areas he was likely to opine on at trial. The expert's report proffered his readings of the CDG Clause, Sue and Labor clause, and the Valuation clause. In discussing these clauses, the expert's report clearly impinged upon the province of the court, in so far as he essentially proffered his own version of contractual interpretation.[133] "Expert testimony that usurp[s] either the role of the trial judge in instructing the jury as to the applicable law or the role of jury in applying the law to the facts before it by definition does not aid the jury in making a decision; rather it undertakes to tell the jury what result to reach, and thus attempts to substitute the expert's judgment for the jury's."[134] Thus, the court precluded Merck's expert from testifying as to his interpretation of the clauses at issue in the Transit Policy.

The court explained that:

> "Testifying as a transit insurance expert, Jervis's testimony should be limited to what he understands to be the standard practices and customs of his business and what he regards as the standard expectations of insurer and insured. While the expert may be an expert on customs and practices generally under transit insurance policies, he is not an expert on this Transit Policy, having had nothing to do with the negotiating, drafting or performance of it. Thus, absent sufficient basis for addressing this matter, the expert cannot testify as to his understanding of the specific provisions of this policy or the import of specific words or phrases of various clauses therein."

F. *Reliable Data*

It is obvious that an expert cannot testify in a vacuum. The court in *Joiner*[135] focused on the "analytical gap" concept, excluding expert testimony that exposure to certain chemicals caused lung cancer because the expert's opinion was based on animal epidemiological studies with no explanation as to how such studies applied to humans. In *Moore v. Ashland Chemical*,[136] the Fifth Circuit conducted a similar analysis, excluding the expert testimony of a physician who did not rely on established studies to support his opinion. These cases illustrate the significance to admissibility and relevancy of research studies and data upon which the expert relies.

The recent decision of the Tenth Circuit in *Roberts v. Farmers Insurance Co.*[137] provides a case in point. At issue on appeal was whether the district court had properly granted the insurer's motion for summary judgment on grounds that the policy contained a "resident exclusion," which precluded the insured from recovering for personal injuries sustained at her home. The insured contended that even though the policy excluded such coverage, she should be entitled to recover under the doctrine of reasonable expectations because the exclusion was either ambiguous or hidden in the policy (i.e. printed in small font and buried on page seven amid a laundry list of exclusions. Attempting to prove that the resident exclusion was ambiguous, the insured offered the expert testimony of a psychology professor and an accompanying survey of 126 college students. The survey was conducted by the professor and purportedly concluded that, after reading the exclusion, sixty-nine percent of the students believed that the policy provided coverage. The district court excluded the survey noting:

> The plaintiff's only support of a claim of ambiguity is the survey of Dr. Donovan, intended to show that the contract must be ambiguous if a group of college students find it to be so. This Court disagrees. The Oklahoma Supreme Court has admonished courts not to indulge in forced or strained construction to create and thus construe ambiguities where they do not otherwise exist. Because this Court must determine if the policy is ambiguous as a matter of law, the survey of Dr. Donovan is inappropriate and irrelevant to establish the existence of an ambiguity.[138]

Affirming the district court's refusal to consider the survey evidence, the Tenth Circuit noted that under Oklahoma contract law, whether an insurance policy is ambiguous is decided as a matter of law. Extrinsic evidence can be considered only after a finding of ambiguity. In the instant case, however, the court determined that the residence exclusion was not ambiguous; therefore, the survey was irrelevant.

What would have happened had the court determined the existence of an ambiguity? Would the survey of college students have been admissible? The circuit court noted that "well-conducted public opinion surveys may play an important role in the courtroom."[139] The court also referenced two cases cited by the insured pertaining to such surveys. In *Brunswick Corp. v. Spinit Reel*,[140] a trademark case, the confusion between two products surfaced as a legal issue. The trial court admitted a survey, in addition to other evidence, when determining the likelihood of confusion about the source of a product with a similar trademark or trade dress. The survey involved individuals in shopping areas within five cities who were shown a Sprint SR210 reel and asked to name the manufacturer. The Tenth Circuit held that the district court did not abuse its discretion in admitting the survey. It noted: "[s]urvey evidence may be admitted as an

exception to the hearsay rule if the survey is material, more probative on the issue than other evidence, and if it guarantees trustworthiness."[141] When determining materiality in cases involving confusion over product source, a survey may be the only available method of demonstrating the public state of mind. A survey is considered *trustworthy* when it is conducted according to accepted principles.[142] In *Brunswick*, the survey was apparently conducted using reasonably acceptable market research techniques. The court therefore admitted the survey on the issue of confusion and further indicated that any technical or methodological deficiencies would affect its weight; not its admissibility.

The second case referenced by the Tenth Circuit was *Harold's Stores, Inc. v. Dillard Department Stores, Inc.*,[143] which involved alleged injury to the plaintiff's public reputation and goodwill. Plaintiff there utilized the services of a marketing professor as an expert. Based on the results of a survey of college-aged women who had visited the plaintiff's store or examined its catalog and visited the defendant's store, that expert calculated damages due the plaintiff nationwide because of defendant's alleged copyright infringement and antitrust actions. Again, the appellate court determined that the district court did not abuse its discretion in admitting the survey as an exception to the hearsay rule. The survey was determined to be material, probative to the issue of copyright infringement damages, and conducted according to generally accepted survey principles. The court further noted:

> The survey should sample an adequate or proper universe of respondents. "That is, the persons interviewed must adequately represent the opinions which are relevant to the litigation." The district court should exclude the survey "when the sample is clearly not representative of the universe it is intended to reflect."[144]

With respect to the insured's survey offer in *Roberts*, the court determined that the survey would not be allowed even if it was determined that the policy was ambiguous: "In the case before us, there is no link between the legal question and the survey evidence; what the public expects from an insurance policy is simply not relevant to the legal question of whether the contract is ambiguous."[145] The court did not decide the application of the reasonable expectation doctrine because that doctrine only applied where the court found the policy ambiguous or the exclusion hidden. Here, the insured failed to make a *prima facie* case.

It would appear from these authorities that courts will not admit survey-type evidence or other data, studies, or methodological evidence where there is no "link" between the offered evidence and the legal issue before the court. This is true whether that be a bad faith standard, claims-handling procedure, or policy interpretation. It would that this "link" is the same "analytical gap" that the court

referred to in *Joiner* when it stated: "A court may conclude that there is simply too great an analytical gap between the data and the opinion offered."[146]

G. *Procedural Attack*

Justice Breyer, in his concurring opinion in *Joiner*, entered an interesting observation:

> [J]udges have increasingly found in the Rules of Evidence and Civil Procedure ways to help them overcome the inherent difficulty of making determinations about complicated scientific or otherwise technical evidence. Among these techniques are an increased use of Rule 16's pretrial conference authority to narrow the scientific issues in dispute, pretrial hearings where potential experts are subject to examination by the court, and the appointment of special masters and specially trained law clerks.[147]

The procedural mechanisms referenced by Justice Breyer are generally initiated at the discretion of the court and often occur well into the litigation process. For example, the circuit court of appeals in *Harold Stores* stated: "we cannot conclude the district court abused its discretion in admitting the survey. The district court conducted an extensive voir dire of Dr. Howard and satisfied itself that the survey met the appropriate standard."[148] In light of this observation, defense counsel should ask whether any procedural mechanisms are available that can be implemented early in the litigation process to facilitate the economies of handling these types of cases.

The parties and the court must develop a procedural mechanism that challenges the testimony of plaintiffs' insurance industry experts sooner rather than later. Such a procedural device has been developed within recent years in toxic tort and environmental cases and should be tested within the context of other cases as well. *Lore v. Lone Pine Corp.*[149] is instructive. This case involved a toxic tort claim against a landfill operator and the generators and haulers of toxic materials to that landfill. The plaintiffs alleged that their property values depreciated because the landfill existed. They also claimed personal injuries from exposure to various toxic substances. The defendants in *Lore* served an order to show cause seeking a case management order requiring the plaintiff to furnish "basic facts" on the causation issues to support their claims of personal injury and property damage. The order sought by the defendants has come to be known as a "*Lone Pine* order." Since the plaintiffs failed to provide the expert evidence required by the case management order, the court dismissed the plaintiff's complaint with prejudice consistent with the procedural rules of the State of New Jersey.[150] It then noted: "[t]he Court is not willing to continue the instant action with the hope that the defendants eventually will capitulate and give a sum of

money to satisfy plaintiffs and their attorneys without having been put to the test of proving their cause of action."[151]

Other courts have refined and modified the *Lone Pine* order to require plaintiffs to delineate the amount of substance or chemical to which they were exposed or to provide expert medical opinions eliminating other causes.[152] Several recent cases also have considered the problem of a plaintiff's failure to provide any proof of causation at a relatively early stage in the litigation process. These have reinforced the concept that a plaintiff should not even file a lawsuit until there is adequate reason to believe that the plaintiff is injured and that the defendant caused that injury.[153] The same arguments can be made within the insurance context. Relevant areas of inquiry include the following:

1) How does plaintiff's expert know the practice and procedure is not readily acceptable in the insurance industry?
2) Does the plaintiff's expert conform to peer review?
3) Is the testimony of the plaintiff's expert on issues of reconstruction consistent with industry standards and reconstruction principles?
4) Is there a gap between the expert opinion offered and the data or study relied upon?

The use of *Lone Pine* orders has been recognized as useful in achieving judicial efficiencies and economies, regulating complicated evidentiary issues, and avoiding duplication of efforts.[154] Therefore, when faced with evidentiary and expert issues in this type of litigation, defense counsel should seek a case management order early on in the litigation process. That order also should seek a prima facie showing that any expert evidence satisfies the appropriate standard as articulated in *Daubert, Joiner* and *Kumho* or *Frye*.

H. *Conclusion*

"Junk science" and the "junk expert" must be challenged early in the litigation process to thwart frivolous and speculative litigation and to preclude testimony of expert witnesses bearing specious credentials. The plaintiffs' bar should be tested and required to provide the defense with evidence concerning the qualifications, reliability and relevance of expert opinions well in advance of trial. Such an approach certainly will control the litigation and settlement costs and is critical to a proactive approach that challenges the "hired gun."[155]

Appendix "A"

STATES:	WHAT ISSUE(S) REQUIRES EXPERT TESTIMONY TO ESTABLISH BAD FAITH?	ON WHAT ISSUE(S) IS EXPERT TESTIMONY PRECLUDED?
ALABAMA	None. There is no requirement for a plaintiff to present expert testimony in a bad faith claim. It is not uncommon for a plaintiff to utilize expert testimony to meet a heavy burden of proof ***Acceptance Ins. Co. v. Brown,* 832 So. 2d 1 (Ala. 2001)** In civil disputes, the admissibility of expert testimony is evaluated by the state under the ***Frye*** "general acceptance" test. Alabama has yet to adopt the rigid standards est. in ***Daubert***. Whether a witness is qualified as an expert and whether their qualification allows them to give their expert opinion or testimony are questions left largely to the trial judge's discretion. ***Bagley v. Mazda Motor Corp.*, 864 So.2d 301 (Ala. 2003)**	Rule 704 of the Alabama Rules of Evidence precludes an expert from testifying on the "ultimate issue" being decided by the trier of fact. An expert would be precluded from offering their opinion that a denial of a claim was made by an insurer in bad faith.
ALASKA	None. Expert testimony has however been admitted on various subjects. *Nelson v. Progressive Corp.,* 976 P.2d 859, 865 (Alaska 1999)	None. ***Nelson v. Progressive Corp.,* 976 P.2d 859, 865 (Alaska 1999)**
ARIZONA	None. Although, commonly both plaintiffs and insurers use experts to evaluate the reasonableness of an insurer's behavior. ***Rawlings v. Apodaca, 151 Ariz. 149, 157-58 (1986)***	None. Nevertheless, the Arizona Supreme Court has noted: "the admission of expert testimony regarding the credibility or subjective motivation of the persons involved in the claim is "dubious." ***Gurule v. Illinois Mut. Life & Cas. Co.,* 152 Ariz. 600, 604 (1987)**
ARKANSAS	Not specifically addressed in Arkansas; seems to not be required.	Expert testimony in a bad faith claim is inadmissible. ***Aetna Cas. & Sur. Co. v. Broadway Arms Corp.,* 281 Ark. 128 (1984)**

STATES:	WHAT ISSUE(S) REQUIRES EXPERT TESTIMONY TO ESTABLISH BAD FAITH?	ON WHAT ISSUE(S) IS EXPERT TESTIMONY PRECLUDED?
CALIFORNIA	In California, expert testimony is required on whether the insurer conducted a thorough investigation of the facts, handled the claim promptly, acted reasonably based on the information available to it, and made a reasonable evaluation of and response to settlement opportunities. It is not required where the insurer's misconduct involves commonly understood bad acts, such as lying. ***Neal v. Farmers Ins. Exch.*, 21 Cal. 3d 910, 924 (1978)**	Issues of law. ***Summers v. A.L. Gilbert Co.*, 69 Cal. App. 4th 1155, 1179-80 (1999)**
COLORADO	Expert testimony is admissible to explain the applicable statutes governing claim processing and issues regarding claims management practice. ***Brewer v. American & Foreign Ins. Co.***, 837 P.2d 236 (Colo. App. 1992) Expert testimony is not admissible to permit experts to tell a jury what result(s) to reach. ***Hines v. Denver & Rio Grande W.R.R. Co.*, 829 P.2d 419, 422-23 (Colo.App. 1991).** If an expert is used at trial he or she does not need to be a former employee of the insurance industry. ***Southerland v. Argonaut Ins. Co.*, 794 P.2d 1102, 1106 (Colo.App. 1990)**	Not addressed.
CONNECTICUT	No court in Connecticut has decided what role an expert should play in a bad faith trial; ergo there is no case law to determine when an expert is required to show bad faith.	There are no cases precluding expert testimony with regard to bad faith claims.
DELAWARE	Delaware has not decided on this issue. ***Smith v. Keystone Ins., Co.*, 2005 WL 791387 (Del. Super. Ct. Mar. 22, 2005).** From a general perspective, expert testimony is admissible on any issue where the expert's testimony will be beneficial to a trier of law; particularly in complex cases. ***North American Philips Corp. v. Aetna Cas. & Sur. Co.*, 1995 WL 628447 (Del. Super. Ct. 1995).**	From a general perspective, expert testimony is admissible on any issue where the expert's testimony will be beneficial to a trier of law; particularly in complex cases. ***North American Philips Corp. v. Aetna Cas. & Sur. Co.*, 1995 WL 628447 (Del. Super Ct. 1995).**

STATES:	WHAT ISSUE(S) REQUIRES EXPERT TESTIMONY TO ESTABLISH BAD FAITH?	ON WHAT ISSUE(S) IS EXPERT TESTIMONY PRECLUDED?
DISTRICT OF COLUMBIA	District of Columbia Courts have not addressed this issue.	District of Columbia Courts have not addressed this issue
FLORIDA	None.	None.
GEORGIA	None.	None.
HAWAII	No reported cases.	No reported cases.
ILLINOIS	There is no requirement for expert testimony to prevail or defeat a claim for bad faith. ***Cal. Union Ins. Co. v. Liberty Mut. Ins. Co.,* 920 F. Supp. 908, 919 (N.D. Ill 1996).**	Expert testimony cannot be called on to resolve a controverted fact or to resolve a question of law. ***Norman v. Am. Nat'l Fire Ins. Co.,* 198 Ill. App. 3d 269, 299, 555 N.E. 2d 1087, 1106 (Ill.App. 1990).**
INDIANA	None.	An expert may not offer opinions about legal issues that will determine the outcome of a case. ***Bartlett v. State Farm Mut. Auto Ins. Co.,* 2002 U.S. Dist. LEXIS 23541 (S.D. Ind. Nov. 27, 2002).**
IOWA	When it assists the trier of fact. ***M-Z Enters., Inc. v. Hawkeye-Sec. Ins. Co.,* 318 N.W.2d 408 (Iowa 1928).**	An "opinion on a mixed question of law and fact" is inadmissible and not a proper subject of opinion evidence. ***Higgins v. Blue Cross of Western Iowa & S.D.* 319 N.W. 2d 232 (Iowa 1982).**
KANSAS	None. In considering whether an insurer's conduct is consistent with its contractual duties, expert testimony is admissible.	Only when it's not admissible under the rules of evidence.
KENTUCKY	It is not required in all bad faith cases.	When the proffered expert had no experience working in the insurance industry or adjusting claims.
LOUISIANA	None. May be relevant on some issues in a bad faith claim.	It is not necessary in Louisiana.
MAINE	Has not been addressed.	Has not been addressed.
MARYLAND	There are no appellate cases reported that require expert testimony to establish bad faith. Expert testimony is admissible, if it will assist the trier of fact.	Generally, experts are not allowed to testify as to their interpretation of policy, ***Truck Insurance Exchange v. Marks Rentals, Inc.,* 288 Md. 428, 434, 418 A.2d 1187 (1980).** Expert testimony may be introduced to assist in interpreting particularly specialized policies. ***Johnson & Higgins of Pa., Inc. v. Hale Shipping Corp.,* 121 Md. App. 426, 710 A.2d 318 (1998).**

STATES:	WHAT ISSUE(S) REQUIRES EXPERT TESTIMONY TO ESTABLISH BAD FAITH?	ON WHAT ISSUE(S) IS EXPERT TESTIMONY PRECLUDED?
MASSACHUSETTS	Expert testimony is required on the standard of care an insurance company owes the insured in investigating and evaluating a claim; and in overseeing the defense of a third party claim, unless the insurer's negligence is so gross or obvious that jurors can rely on their common knowledge. ***Herbert A. Sullivan, Inc. v. Utica Mut. Ins. Co.,* 788 N.E.2d 522, 537-38 (Mass. 2003).**	Courts have not identified any general subject on which expert testimony is precluded in a bad faith claim.
MICHIGAN	Not addressed in DRI Compendium	Not addressed in DRI Compendium
MINNESOTA	There are no reported cases interpreting Minnesota law that has mandated the use of expert testimony to establish bad faith. It is implied that expert testimony may be necessary, ***Ortega-Maldonado v. Allstate Ins. Co.*, 519 F. Supp. 2d 981 (D. Minn. 2007).**	The question of coverage is a legal issue for the court as to which no expert testimony will be allowed.
MISSISSIPPI	Mississippi courts have not specifically addressed this issue.	Generally, Mississippi courts have excluded expert testimony on legal issues that invade the province of the court. Additionally, an expert may not testify that an insurer failed to comply with an insurance contract or that an insured fulfilled the conditions of an insurance contract since testimony embraces the ultimate fact which is reserved for the jury's consideration.
MISSOURI	Has not been specifically addressed in Missouri.	In Missouri, an expert probably may not testify as to whether insurer's conduct constituted bad faith. Where the subject of the expert's testimony is within a lay person's experience, the testimony may not be admitted. ***Van Meter v. Dahlsten Truck Line,* 943 S.W.2d 680, 682 (Mo.Ct.App.1997).**

STATES:	WHAT ISSUE(S) REQUIRES EXPERT TESTIMONY TO ESTABLISH BAD FAITH?	ON WHAT ISSUE(S) IS EXPERT TESTIMONY PRECLUDED?
MONTANA	Expert testimony is not required to prove or disprove bad faith. Allowing expert testimony is left to the court's discretion on issues of liability and bad faith in accordance with Rules 702 and 703 of the Montana and Federal Rules of Evidence. ***Federated Mut. Ins. Co. v. Anderson,* 1999 MT 28i, 297 Mont. 33, 991 P.2d 915 (1999).**	There has been no specific rule established regarding what expert testimony is either admissible or inadmissible.
NEBRASKA	Not specifically addressed.	Not specifically addressed.
NEVADA	It is proper where investigations management testified that the insurer's investigation was improper, incomplete, poorly done, in violation of the insurer's own procedures, and rendered the opinion that insurer's conduct amounted to bad faith. ***Powers v. United Svcs. Auto. Ass'n.* 114 Nev. 690, 703, 962 P.2d 596 (1998).**	None.
NEW HAMPSHIRE	There is no New Hampshire law that addresses the same.	There is no New Hampshire law that addresses the issue.
NEW JERSEY	This issue is not addressed in New Jersey.	This issue is not addressed in New Jersey.
NEW MEXICO	Not included in DRI Compendium.	Not included in DRI Compendium.
NEW YORK	The Courts in New York have held that if the issue presented to the jury is within the scope of the common knowledge and experience of laymen, then expert testimony is not necessary on matters the jury is qualified to draw its own conclusions on.	New York courts do not seem to preclude expert testimony in a bad faith case unless it infringes on the jury province. Primarily, if the evidence is within the common knowledge and experience of a layperson where the jury is allowed to draw its own conclusion such testimony may be excluded.**
NORTH CAROLINA	No case has been reported that has required expert testimony to establish bad faith.	Expert testimony is precluded on two grounds (a) that no case law was offered for the proposition that insurance adjusters could testify as experts, and (b) the expert would have offered legal conclusions that would have been substituting his judgment of the jury and trial court. ***Burrell v. Sparkkles,* 189 N.C. App. 104, 657 S.E.2d 712 (2008).**

STATES:	WHAT ISSUE(S) REQUIRES EXPERT TESTIMONY TO ESTABLISH BAD FAITH?	ON WHAT ISSUE(S) IS EXPERT TESTIMONY PRECLUDED?
NORTH DAKOTA	Insured may assert a claim for bad faith failure to defend where an insurer provided inadequate defense. Expert testimony is required to establish that an insurer provided inadequate defense. ***Continental Cas. Co. v. Kinsey,* 513 N.W.2d 66, 69-70 (N.D. 1994).** If an insurer challenges the reasonableness of the Miller-Shugart agreement that forms the basis of the assignment of the insured's bad faith claim to a third party, the assignee may be required to establish the reasonableness of the settlement through expert testimony regarding the likely evidence and likely outcome if the matter has been tried. ***D.E.M. v. Allickson,* 555 N.W.2d 596, 603 (N.D. 1996).**	"An insurance expert may not testify that the insurer properly denied benefits under a policy because the insured was "malingering" if the expert cannot testify to a reasonable medical certainty that there was malingering." ***Smith v. American Family Mut. Ins. Co.,* 294 N.W. 2d 751, 764 (N.D. 1980).** "An expert will not be permitted to express an opinion if the facts and circumstances disclosed by the evidence are such that it may be assumed that the jury is capable of understanding them and arriving at its own conclusions." ***Praus ex rel. Praus v. Mack,* 2001 N.D. 80 ¶34, 626 N.W.2d 239, 250 (2001).** If expert testimony is probative it is not admissible if its "probative value is substantially out weighted by the danger of unfair prejudice, confusion of the issues or misleading the jury, or by considerations of undue delay, waste of time, or needless presentation of cumulative evidence." Id.
OHIO	There is no opinion given that requires expert testimony to establish bad faith. The standard is, expert testimony may be used if the issue is technical and the testimony is beneficial to the jury. ***Hoskins v. Aetna Life Ins. Co.,* 6 Ohio St. 3d 272, 279, 452 N.E.2d 1315 (Ohio 1983).** "Expert testimony is admissible if it will assist the trier of fact to understand the evidence or to determine an issue of fact." ***LeForge v. Nationwide Mut. Fire Ins. Co.,* 82 Ohio App. 3d 692, 612 N.E.2d 1318 (Ohio App. 1992).**	There is no court opinion that has ruled that expert testimony is categorically precluded on any particular issues necessary to establish bad faith. From a general perspective, the trial may use its broad discretion in determining the admissibility of expert testimony, and a higher court may reverse if the trial court abuses its discretion. ***Donegal Mut. Ins. v. White Consol. Industries, Inc.,* 852 N.E.2d 215 (Ohio App. 2006)**(Citing *Kumho).* The trial court must perform a "gatekeeping" role to insure that expert testimony is sufficiently (a) relevant and (b) reliable to justify its submission to the jury. **Id.** (citing *Daubert).*

STATES:	WHAT ISSUE(S) REQUIRES EXPERT TESTIMONY TO ESTABLISH BAD FAITH?	ON WHAT ISSUE(S) IS EXPERT TESTIMONY PRECLUDED?
OKLAHOMA	Expert testimony is not a requirement to establish bad faith. However, expert testimony is permissible within the court's discretion on the ultimate issue of whether or not the insurer breached the duty of good faith and fair dealing. ***Vining v. Enter. Fin. Group, Inc.,* 148 F.3d 1206 (10th Cir. 1998).**	Admissibility of expert testimony is left to the discretion of the court. ***Thompson v. State Farm Fire & Cas. Co.,* 34 F.3d 932 (10th Cir. 1994).**
OREGON	No reported cases exist. In practice, because bad faith failure to settle is based upon a negligence standard, both parties usually present evidence as to what a "reasonable insurer" would or would not do.	Issues of "reasonableness" which do not require specialized training to knowledge.
PENNSYLVANIA	None. ***Bergman v. United Servs. Auto Ass'n,* 742 A.2d 1101 (Pa. Super. Ct. 1999).**	None. ***Bergman v. United Servs. Auto Ass'n,* 742 A.2d 1101 (Pa.Super.Ct.1999).**
RHODE ISLAND	Expert testimony is required on the issue of reasonableness of an insurer's claims processing. ***R.I. Insurer's Insolvency Fund v. Leviton Mfg. Co.,* 763 A.2d 590, 595 (R.I.2000).**	This issue has not been specially addressed by the state.
SOUTH CAROLINA	Courts in South Carolina have not specifically addressed which issues require expert testimony. In practice, insured and insurers have utilized expert testimony in the field of claims adjustment on the issue of reasonableness in adjustment practices.	Courts in South Carolina have not specifically addressed this issue within the context of bad faith.**
SOUTH DAKOTA	No reported cases exist.	No reported cases exist.
TENNESSEE	None.	None.
TEXAS	Expert testimony is not required to establish bad faith.	Courts have not precluded expert testimony on any issue that is presented in a bad faith claim, unless it violates Rule 702 of the Texas Rules of Evidence.
UTAH		
VERMONT	There are not cases in Vermont that address this issue.	There are no cases in Vermont that address this issue.
VIRGINIA	This issue has not been specifically addressed by Virginia courts.	This issue has not been specifically addressed by Virginia courts.
WASHINGTON	There are no reported cases.	There are no reported cases.

STATES:	WHAT ISSUE(S) REQUIRES EXPERT TESTIMONY TO ESTABLISH BAD FAITH?	ON WHAT ISSUE(S) IS EXPERT TESTIMONY PRECLUDED?
WEST VIRGINIA	Expert testimony is not required to establish bad faith.	Expert testimony is precluded if the testimony is the expert's own opinion as to whether an insurer's actions violated the Unfair Claim Settlement Practices Act or that an insurer's action constituted a general business practice of that insurer. ***Jackson v. State Farm Mut. Auto. Ins. Co.,* 215 W.Va. 634, 600 S.E.2d 346 (2004).**
WISCONSIN	In ***Weiss v. United Fire & Cas. Co.***, the Wisconsin Supreme Court held that expert testimony "is only required for cases presenting particularly complex facts and circumstances outside the common knowledge and experience of an average juror." ***Weiss v. United Fire & Cas. Co.,* 197 Wis. 2d 365, 541 N.W.2d 753 (1995).** In contrast, if the claim does not involve circumstances of this nature, then no expert testimony is needed. ***DeChant v. Monarch Life Ins. Co.,* 200 Wis.2d 559, 547 N.W.2d 592 (1996).**	There are no published Wisconsin decisions that preclude expert testimony.
WYOMING	No reported cases exist. It may be presented to establish good faith and fair dealing standards in the investigation and handling of claims. ***Hatch v. State Farm Fire & Cas. Co.,* 930 P.2d 382 (Wyo. 1997).**	Not addressed.

[1] Samuel R. Gross, *Expert Evidence*, 1991 Wis.L.Rev. 1113, 1182.

[2] *Douglas v. U.S. Fidelity & Guaranty Co.*, 81 N.H. 371, 127 A. 708 (1924).

[3] See, for example, *American Cas. Co. of Reading, Pa. v. Howard*, 187 F.2d 322 (4th Cir. 1951) (opinions as to advisability of going to trial rather than accepting compromise); *Kabatoff v. Safeco Ins. Co. of America*, 627 F.2d 207 (9th Cir. 1980); *Hanson By and Through Hanson v. Prudential Ins. Co. of America*, 783 F.2d 762 (9th Cir. 1985); *Worden v. Tri-State Ins. Co.*, 347 F.2d 336 (10th Cir. 1965); *Clark v. Interstate Nat. Corp.*, 486 F.Supp. 145 (E.D. Pa.), *aff'd*, 636 F.2d 1207 (3d Cir. 1980); *Rawlings v. Apodaca*, 151 Ariz. 149, 726 P.2d 565 (1986); *Neal v. Farmers Ins. Exchange*, 21 Cal.3d 910, 582 P.2d 980, 21 Cal. Rptr. 389 (1978); *Associated Wholesale Grocers, Inc. v. Americold Corp.*, 261 Kan. 806, 934 P.2d 65 (1997).

[4] 509 U.S. 579 (1993).

[5] 522 U.S. 136 (1997).

[6] 526 U.S. 137 (1999).

[7] 293 F. 1013 (D.C. Cir. 1923).

[8] *PETER W. HUBER, GALILEO'S REVENGE: JUNK SCIENCE IN THE COURTROOM* (Basic Books 1991); *see also* Erica Beecher-Monas, *Blinded by Science: How Judges Avoid the Science in Scientific Evidence*, 71 TEMP. L. REV. 55 (1998). For an excellent discussion of the *Daubert* progeny *see* Neil E. Mathews & Leondra M. Hanson, *Daubert After Kumho Tire; How the Gatekeeper Evaluates the "Non-Scientific Expert,"* DRI Business Litigation Seminar 131 (1999); Scott R. Jennette, *Attacking the Plaintiff's Hazardous Substance Expert in the Post-Kumho Era*, 41 FOR THE DEFENSE 33 (May 1999); Jonathan M. Hoffman & Bert Black, *Old Tires and New Limbs: The Effect of* Kumho Tire *on Expert Testimony*, 27 PROD. SAFETY & LIAB. REP. (BNA) 354 (Apr. 2, 1999).

[9] 509 U.S. 579 (1993).

[10] 293 F. 1013 (D.C. Cir. 1923).

[11] *Daubert*, 509 U.S. at 588.

[12] *Id.* at 588.

[13] *Id.* at 590.

[14] *Id.* at 593-94.

[15] *Id.* at 592.

[16] *Id.* at 600.

[17] *See generally* Bert Black et al., *The Law of Expert Testimony—A Post-Daubert Analysis*, *in* Bert Black & Patrick W. Lee, Expert Evidence: A PRACTITIONER'S GUIDE TO LAW, SCIENCE AND THE FJC MANUAL 9, 47 (West 1997).

[18] *See* discussion in section B.1.b., *infra*.

[19] *Daubert v. Merrell Dow Pharm., Inc.*, 43 F.3d 1311 (9th Cir. 1995).

[20] 522 U.S. 136 (1997).

[21] For a discussion of which circuits applied the abuse of discretion standard of review or the de novo standard, *see United States v. Jones*, 107 F.3d 1147 (6th Cir.), *cert. denied*, 521 U.S.1127 (1997).

[22] *Joiner*, 522 U.S. at 137.

[23] *Id.* at 146.

[24] For a discussion of the standard adopted by the various states, *see* Mathews & Hanson, *supra* note 8, at 150.

[25] *See Iacobelli Const. v. County of Monroe*, 32 F.3d 19 (2d Cir. 1994); *Tamarin v. Adam Caterers, Inc.*, 13 F.3d 51 (2d Cir. 1993). The First, Fourth and Eleventh Circuits allowed district judges to review nonscientific expert evidence, but held that they could not utilize the *Daubert* factors. *See Bogosian v. Mercedes-Benz of N. Am., Inc.*, 104 F.3d 472 (1st Cir. 1997); *Michigan Millers Mut. Ins. Co. v. Benfield*, 140 F.3d 915 (11th Cir. 1998).

[26] *See Watkins v. Telsmith, Inc.*, 121 F.3d 984 (5th Cir. 1997); *Deimer v. Cincinnati Sub-Zero Prod.*, 58 F.3d 341 (7th Cir. 1995); *Cummins v. Lyle Indus.*, 93 F.3d 362 (7th Cir. 1996); *Peitzmeier v. Hennessy Indus.*, 97 F.3d 293 (8th Cir. 1996), *cert. denied,* 520 U.S. 1196 (1997). For a discussion of the conflict among the circuits, *see* Hoffman & Black, *supra* note 8, at 356-59.

[27] 526 U.S. 137 (1999).

[28] *Carmichael v. Samyang Tires, Inc.*, 923 F. Supp. 1514, 1521-22 (S.D. Ala. 1996), *rev'd.*, 131 F.3d 1433 (11th Cir. 1997).

[29] *Kumho*, 526 U.S. at 152.

[30] *Id.*

[31] 173 F.3d 1076 (8th Cir. 1999).

[32] *Jaurequi,* 173 F.2d at 1084; *see also Peitzmeier v. Hennessy Indus., Inc.*, 97 F.3d 293 (8th Cir. 1996), *cert. denied*, 520 U.S. 1196 (1997).

[33] 151 F.3d 269 (5th Cir. 1998), *cert. denied,* 526 U.S. 1064 (1999).

[34] 728 A.2d 70 (D.C. 1999).

[35] *Id.* at 75.

[36] 293 F. 1013 (D.C. Cir. 1923).

[37] *Id*. at 1014.

[38] *See Castrichini v. Rivera,* 175 Misc.2d 530, 669 N.Y.S.2d 140 (Sup. Ct., Monroe Co. 1997).

[39] *Thompson v. State Farm Fire and Cas. Co.*, 34 F.3d 932 (10th Cir. 1994); *State v. Merchants Ins. Co. of New Hampshire*, 109 A.D.2d 935, 486 N.Y.S.2d 412 (3d Dept. 1985); *Groce v. Fidelity General Ins. Co.*, 252 Or. 296, 448 P.2d 554 (1968); *Weiss v. United Fire and Cas. Co.*, 197 Wis. 2d 365, 541 N.W.2d 753 (1995).

[40] *Thompson v. State Farm Fire and Cas. Co.*, 34 F.3d 932 (10th Cir. 1994).

[41] In *Groce v. Fidelity General Ins. Co.*, 252 Or. 296, 448 P.2d 554 (1968), the court held that the fact that jury did not necessarily need expert testimony as to whether insurer acted in bad faith in failing to settle claim did not render his testimony inadmissible.

[42] *Kumho Tire Co. v. Carmichael*, 526 U.S. 137 (1999).

[43] For a recent discussion of the applicability of the *Daubert* standards to the insurance industry, see Walter J. Andrews, *Insurance 'Experts' and the Daubert Doctrine After Kumho Tire*, presented at the Defense Research Institute, Insurance Coverage and Practice Seminar, December 9-10, 1999.

[44] 75 F.3d 290, 293 (7th Cir. 1996).

[45] *See also United States v. Hall*, 165 F.3d 1095 (7th Cir. 1999).

[46] *Kulak v. Nationwide Mut. Ins. Co.*, 40 N.Y.2d 140, 351 N.E.2d 735, 386 N.Y.S.2d 87 (1976) (citations omitted).

[47] *Id*.

[48] *Id.* at 148.

[49] *Id.*

[50] *Id*. at 151.

[51] Patricia A. Krebs & Bryan J. De Tray, *Kumho Tire Co. v. Carmichael: A Flexible Approach to Analyzing Expert Testimony Under Daubert*, 34 TORT & INS. L.J. 989, 1003-04 (1999) (citation omitted).

[52] 102 F.3d 256 (7th Cir. 1996).

[53] *Id.* at 263.

[54] *Id.* (emphasis added).

[55] *Tassin v. Sears, Roebuck & Co.*, 946 F. Supp. 1241, 1248 (M.D. La. 1996). For a discussion of the admissibility of computer models on environmental cases, *see* Allen Kezsbom & Alan V. Goldman, *The Boundaries of Groundwater Modeling Under the Law: Standards for Excluding Speculative Expert Testimony*, 27 TORT & INS. L.J. 109 (1991).

[56] 890 F. Supp. 1417 (N.D. Iowa 1995).

[57] *Id.* at 1447.

[58] *Id.* at 1448.

[59] 171 F.R.D. 305 (D. Kan. 1997).

[60] No. 95-7550, 1997WL109582 (E.D. Pa. Mar. 7, 1997).

[61] 158 F.3d 548 (11th Cir. 1998).

[62] *Id.* at 563.

[63] *Id.*

[64] 969 F. Supp. 289 (E.D. Pa. 1997).

[65] *Id.* at 299 n.7.

[66] 121 F.3d 697 (4th Cir. 1997).

[67] *Id.* at 697.

[68] 354 F.Supp.2d 860 (W.D. Wis. 2005).

[69] *Porter v. Whitehall Lab.,* 9 F.3d 607, 614 (7th Cir.1993).

[70] *Ancho v. Pentek*, 157 F.3d 512, 515 (7th Cir. 1998).

[71] *Id.* at 518 (quoting *United States v. Benson,* 941 F.2d 598, 604 (7th Cir.1991)).

[72] *United States v. Vitek Supply Corp.,* 144 F.3d 476, 486 (7th Cir.1998).

[73] *Talmage v. Harris*, 354 F.Supp.2d 860, 866 (W.D. Wis. 2005).

[74] 56 Cal.Rptr.3d 312 (Cal.App.2d Dist. 2007).

[75] *Id*.

[76] *Id.*

[77] *Moradi-Shalal v. Fireman's Fund Ins. Companies*, 46 Cal.3d 287, 304-305, 758 P.2d 58, 250 Cal.Rptr. 116 (1988).

[78] *Jordan v. Allstate*, 56 Cal.Rptr.3d 312 (Cal. App. 2nd Dist. 2007).

[79] See *Moradi-Shalal v. Fireman's Fund Ins. Companies*, *supra*, 46 Cal.3d at pp. 304-305, 758 P.2d 58, 250 Cal.Rptr. 116 (1988).

[80] *See, Rattan v. United Services Automobile Assn.*, 84 Cal.App.4th 715, 724, 101 Cal.Rptr.2d 6 (4th Dist. 2000).

[81] 140 F.3d 915 (11th Cir. 1998).

[82] 37 F. Supp. 2d 532 (S.D. Tex. 1999).

[83] *Id.* at 541.

[84] 10 F. Supp. 2d 800 (E.D. Mich. 1998).

[85] 30 F. Supp. 2d 101 (D. Mass. 1998).

[86] *Id*. at 110.

[87] 175 Cal. App. 3d 1, 221 Cal. Rptr. 171 (4th Dist. 1985).

[88] *Id.*

[89] 151 F.3d 269 (5th Cir. 1998), *cert. denied,* 526 U.S. 1064 (1999).

[90] *Id.* at 279 (citing *Joiner)*. *See Krebs & De Tray, supra* note 51, at 1007 and the dissenting opinion in *Moore*, 151 F.3d at 284, which calls for a grant of wide latitude to the district court when exercising its gatekeeping function.

[91] Krebs & De Tray, *supra* note 51, at 1007 (citing *Tassin v. Sears Roebuck,* 946 F. Supp. at 1248).

[92] 83 N.Y.2d 417, 633 N.E.2d 451, 611 N.Y.S.2d 97 (1994).

[93] *Id*. at 435. *See also People v. Wernick*, 89 N.Y.2d 111, 674 N.E.2d 322, 651 N.Y.S.2d 392 (1996); *People v. Green*, 250 A.D.2d 143, 683 N.Y.S.2d 597 (3d Dept. 1998); *People v. Roraback*, 242 A.D.2d 400, 662 N.Y.S.2d 327 (3d Dept. 1997).

[94] *See People v. Hughes*, 59 N.Y.2d 523, 453 N.E.2d 484, 466 N.Y.S.2d 255 (1983); *People v. Philips*, 180 Misc.2d 934, 692 N.Y.S.2d 915 (Sup. Ct., Queens Co. 1999).

[95] *People v. Wernick*, 89 N.Y.2d 111, 674 N.E.2d 322, 651 N.Y.S.2d 392 (1996).

[96] *Wesley,* 83 N.Y.2d 417.

[97] *People v. Persaud*, 244 A.D.2d 577, 665 N.Y.S.2d 671 (2d Dept. 1997); *People v. DiNonno*, 171 Misc.2d 335, 659 N.Y.S.2d 390 (App. Term 1997).

[98] 181 Misc.2d 396, 693 N.Y.S.2d 875 (Sup. Ct., Suffolk Co. 1999).

[99] *Id.* at 399.

[100] 183 Misc.2d 923, 705 N.Y.S.2d 792 (Sup. Ct., Richmond Co. 1999).

[101] *Id*. at 932.

[102] *Id.* at 934.

[103] *Id.*

[104] *Id*. at 932.

[105] 7 N.Y.3d 434, 857 N.E.2d 1114, 824 N.Y.S.2d 584 (2006).

[106] 45 F. Supp. 2d 316 (S.D.N.Y. 1999).

[107] *Kumho Tire Co. v. Carmichael*, 526 U.S. 137, 156 (1999).

[108] 187 F.R.D. 77 (S.D.N.Y. 1999).

[109] *Kumho*, 526 U.S. at 156.

[110] 138 F.Supp.2d 422 (W.D.N.Y. 2001).

[111] *Id.* at 435.

[112] *Id.* at 436.

[113] *Id.* at 437.

[114] 234 F.3d 89 (2d. Cir. 2000).

[115] *Id.* at 90.

[116] *See Brooks v. Outboard Marine Corp.,* 47 F.Supp.2d 380, 388 (W.D.N.Y.1999).

[117] *Id.*

[118] 526 U.S. 137 (1999).

[119] *Id.* at 149.
[120] 509 U.S. 579 (1993).
[121] *Id.* at 589.
[122] *Kumho Tire,* 526 U.S. at 141 (quoting Fed.R.Evid. 702).
[123] *Brooks v. Outboard Marine Corp.*, 234 F.3d at 92.
[124] 462 F.Supp.2d 435 (S.D.N.Y. 2006).
[125] *TC Sys. Inc. v. Town of Colonie, New York,* 213 F.Supp.2d 171, 174 (N.D.N.Y.2002); *see also McCullock v. H.B. Fuller Co.,* 61 F.3d 1038, 1042 (2d Cir.1995) ("The decision to admit expert testimony is left to the broad discretion of the trial judge and will be overturned only when manifestly erroneous."); *United States v. Brown,* 776 F.2d 397, 400 (2d Cir.1985) (qualification requirements of Rule 702 "must be read in light of the liberalizing purpose of the rule"); *Canino v. HRP, Inc.,* 105 F.Supp.2d 21, 27 (N.D.N.Y.2000) ("liberality and flexibility in evaluating qualifications should be the rule").
[126] *TC Sys.,* 213 F.Supp.2d at 174.
[127] *Zwillinger v. Garfield Slope Housing Corp.,* No. 94 Civ. 4009, 1998 WL 623589, at *7 (E.D.N.Y. Aug.17, 1998) (*quoting* Federal Judiciary Center, Reference Manual on Scientific Evidence 55-56 (1994) (alterations in original)).
[128] *American Home Assurance Company*, 462 F.Supp.2d at 447.
[129] *Id.*
[130] *Id.* at 448. *See Cary Oil Co., Inc. v. MG Refining & Marketing, Inc.,* No. 99 Civ. 1725, 2003 WL 1878246, *7 (S.D.N.Y. Apr. 11, 2003).
[131] *Id.*
[132] *Id.*
[133] *Id.*
[134] *Nimely v. City of New York,* 414 F.3d 381, 397 (2d Cir.2005).
[135] Gen. Elec. Co. v. Joiner, 522 U.S. 136, 146 (1997).
[136] 151 F.3d 269 (5th Cir. 1998).
[137] 201 F.3d 448 (10th Cir. 1999).
[138] 23 F. Supp.2d 1298, 1303 (N.D. Okla. 1998) (citation omitted).
[139] 1999 WL 1063826 at 2, n.2 (10th Cir. 1999).
[140] 832 F.2d 513 (10th Cir. 1987).
[141] *Id.* at 522 (citations omitted).
[142] *See* 5 JACK B. WEINSTEIN & MARGARET A. BERGER, WEINSTEIN'S EVIDENCE, ¶ 901(b)(9)[03] at 901-120 (1997).
[143] 82 F.3d 1533 (10th Cir. 1996).
[144] *Id*. at 1544 (citations omitted).
[145] *Roberts v. Farmers Ins. Co.*, 201 F.3d 448 (10th Cir. 1999).
[146] *Gen. Elec. Co. v. Joiner*, 522 U.S. 136, 146 (1997).
[147] *Id.* at 149 (citations omitted).
[148] *Harold Stores,* 82 F.3d at 1545.
[149] No. L-33606-85, 1986 WL637507 (N.J. Super. Ct. Law Div. Nov. 18, 1986).
[150] N.J. Rules 4:23-2(b)(3) and 4:37-2(a).
[151] *Lore, supra* note 151, at 10. *See also In re Love Canal Actions*, 145 Misc.2d 1076, 547 N.Y.S.2d 174 (Sup. Ct. Niagara Co. 1989), *aff'd as modified*, 161 A.D.2d 1169, 555 N.Y.S.2d 519 (4th Dept. 1990); *Grant v. E.I. DuPont de Nemours & Co.,* No. 91-55-CIV-4-H, 1993 WL146634 (E.D.N.C. Feb. 17) *aff'd*, 1993 WL146638 (E.D.N.C. Mar. 26, 1993); *Kinnick v. Schierl, Inc.*, 197 Wis.2d 855, 541 N.W.2d 803 (Wis.App. 1995). *See generally* Don G. Rushing & Mary A. Lehman, *Toxic Tort Litigation; Using Case Management Orders*, FOR THE DEFENSE, June 1999, at 41.
[152] In *Grant v. E.I. DuPont De Nemours & Co.*, 1993 WL146634 the court required specific dates of exposure to toxic substances. *See also Zwillinger v. Garfield Slope Hous. Corp.*, No. CV 94-4009, 1998 WL 623589 (E.D.N.Y. Aug. 17, 1998); *Cottle v. Superior Court*, 3 Cal.App.4th 1367, 5 Cal. Rptr. 2d 882, 886-87 (2d Dist. 1992); *Atwood v. Warner*

Elec. Brake & Clutch Co., 239 Ill.App.3d 81, 605 N.E.2d 1032, 1036 (2d Dist. 1992); *Eggar v. Burlington N. R.R.*, No. 89-159-BLG-JFB, 1991 WL315487 (D. Mont. 1991), *aff'd sub nom. Claar v. Burlington N. R.R.*, 29 F.3d 499 (9th Cir. 1994); *Gallagher v. Fibreboard Corp.*, 641 So. 2d 953, 955 (Fla. Dist. Ct. App. 1994).

[153] *In re* Mohawk Rubber Co., 982 S.W.2d 494, 499 (Tex. Ct. App. 1998); *In re* Colonial Pipeline Co., 968 S.W.2d 938, 943 (Tex. 1998).

[154] *See* D. Alan Rudlin, *Strategies in Litigating Multiple Plaintiff Toxic Tort Suits*, *in* ENVIRONMENTAL LITIGATION 122, 137-42 (J.S. Kole et al. eds., 1991).

[155] *See* Appendix "A" which is a state by state Compendium on the issues addressed in this paper. A special thanks to Emery Lewis a student at the SUNY at Buffalo Law School for his work on this Appendix.

ACCEC
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MASTER CLASS: BAD FAITH TRIAL TACTICS FROM THE BEST, FOR THE BEST

American College of Coverage and Extra-contractual Counsel
5th Annual Meeting

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MASTER CLASS: BAD FAITH TRIAL TACTICS
FROM THE BEST, FOR THE BEST

Lawyers who tried insurance bad faith cases more than fifteen years ago commit a grave error of miscalculation if they assume the strategies, techniques and methods which they previously learned or with which they previously experience success will automatically work with equal success today. Across all types of civil litigation, but particularly insurance coverage and bad faith litigation, jury perceptions, venire makeup, common expectations, judicial temperament and the law itself have all changed substantially in the past fifteen years. As such, any lawyer bringing trial training or war-story successes from fifteen or more years ago may painfully learn that changes in case dynamics, jurors, judges, and the substantive law all combine to make their previously learned strategies and techniques far less effective in many current circumstances and completely irrelevant in many other present circumstances. The purpose of this article is to look at the radically changing landscape of insurance bad faith litigation across America and make suggestions for counsel to increase their odds of winning coverage and bad faith cases at trial.

I. PRETRIAL STRATEGIES

A. Depositions

1. Company Witnesses

a. Policyholders: Taking Company Witnesses

The best preparation for the deposition of company witnesses is to get the most complete set of pertinent documents through written discovery prior to the deposition. It is critical to have determined the entire cast of characters involved or potentially involved ahead of time. In Watergate, Woodard and Bernstein were instructed by Deep Throat to "follow the money." In insurance cases, the watch-word is follow the communications.

Discovery requests should seek at a minimum the "claims" file, but the most helpful information is kept in the "personal" files of each claims participant and supervisor. This can be a hard paper file or an electronic file. It is usually kept outside of the normal document management system, which is why can contain some of the most helpful information. The company deposition should have multiple, pre-selected topics that are focused on topics other than just the handling of the particular claim:

- **Create an evidence roadmap**: Use the deposition to gather information that will identify and locate key sources of information. Learn how the document management system works. Find "personal" or "over" or "shadow" files kept by each witness. Determine if there are large general repositories of information, such as a coverage opinion data bank.

- **Identify Knowledgeable Persons:** In addition to claims personnel, a number of other players will have critical information and roles. Determine what reporting and communications typically happen in connection with

underwriters and what happened in your given case. Some companies use intermediaries or liason's to smooth customer complaints out between underwriting and claims. Also, remember that underwriters will be kept apprised of claims as they proceed. Renewals can generate a great deal of information that may not find its way to the claims file.

- **Identify roles and lines of authority:** In addition to identifying personnel, the deposition can shed light on each participant's areas of responsibility and authority. It can be very helpful to go into the company procedure used when litigation incepts. Many companies send out a "litigation hold" email and other follow-up communications that provide an incredible list of persons with knowledge of the handling of the claim. It can also identify the universe of documents the company identified as relevant before you even sent a request for production.

- **Grade their paper:** The deposition can be used to grade the paper of the carrier's responses to discovery. Early, pre-deposition production is usually woefully incomplete. Find out if your witness was involved or not in developing the carrier's production. The defense counsel will typically only work with one person in gathering documents, and they are often busy and do a less than steller job of finding relevant information.

Company witnesses are often shown very limited documents in preparation for their deposition and cannot remember key points in the claims-handling. When trial comes, they suddenly have a much better memory. Develop what they did to prepare and question them in a way that shows the jury that they simply made no effort to inform themselves, that they could have and that they and their lawyers chose not to do so. Willful ignorance is just another form of obstruction, and it is a tactic that can backfire for the carrier.

Incorporation of controlling legal standards and duties into your questioning can add a bit of spice to the mix. Many claims personnel will admit to standards of claims-handling conduct that exceed what the law actually requires. Once admitted, it is an assumption of a greater duty that may control their liability.

Pretext is a critical part of showing bad faith. It is an important symptom of institutional bad faith. Claims files seldom reveal reality, claims personnel disagreeing on policy interpretation and factual evaluations, such as assessment of commercial property losses. The obvious lack of conflict shows a mindset that was steered towards denial or delay. Ask yourself, what would ordinary people do in the course of making such decisions. The same is true as to the evaluation of expert reports by claims personnel. Claims personnel who have marked up nothing and asked no follow-up questions are simply providing a rubber-stamp, or at least that is what you should try to show.

Make your questions simple. Cover and bad faith counsel often get lost in the weeds. Tedious coverage debates are not that interesting to the jury. The more complex the question, the less likely it is to result in helpful testimony.

Finally, counsel for some carriers use a number of tactics in defending the claims deposition that deserve some note. One well-known carrier regularly has an additional videographer at the deposition to film the policyholder counsel exclusively during the claims deposition. Getting one for defense counsel solves nothing and just adds expense. A few defense counsel cannot resist the temptation to object to everything. The objections count up. The younger the defense counsel, the more likely the number of objections will exceed the number of deposition pages. This type of thing can get you sanctioned, especially in federal court.

b. Defensive Depositions: Presenting Company Witnesses

For decades, defense lawyers have dutifully presented their clients for depositions and, at the conclusion, uttered those infamous words: "we reserve our questions until the time of trial." While this may have worked in years past, it is a very bad idea today. In fact, it borders on legal malpractice in many instances. The reason is simple: defense counsel has no guarantee they will still have any control or influence over that witness at the time of trial. Like most American businesses, the insurance industry is in constant employment flux. Adjusters, in particular, come and go with each passing year. The advent of technological advances in job opening notifications, increased professional networking, and increased social mobility have pushed adjuster turnover to an all-time high. The social stigmas once associated with changing jobs has evaporated as has the American dream of prior generations of staying with the same company for one's entire career. This is particularly true with catastrophe adjusters and independent adjusters.

Long term CAT adjusters, for example, move across the country following each seasonal storm and, even if employed, are frequently unavailable for depositions and trials due to redeployment issues. The exceptionally long hours of daily work and the relational problems associated with out-of-state deployments also make employment turnover very high for CAT adjusters. While less frequent than CAT adjusters, independent adjusters also experience an unusually high rate of turnover making their availability for trial equally suspect in most instances today.

Even less frequent, but potentially far more detrimental, is the move of an adjuster or claim professional from an industry employee to an independent consultant or expert witness. While the facts are the facts, what counsel may have expected to be favorably-presented testimony could become neutral, or worse, filled with "I don't knows" and "I don't remembers."

These changing social and professional changes make it important for defense counsel to consider asking at least *some questions* of their witnesses at the time of their deposition under the assumption they may <u>not</u> be available at trial. We believe the wisest course of action is to determine what testimony from the witness being deposed is absolutely essential for the trial of the case. When presenting a company witness for deposition, defense counsel should assume for strategic planning purposes the witness will <u>not</u> be available. If they are, that is a fortunate development. If they are not, wise defense counsel will have already anticipated the testimony they need from that witness at trial in order to fully present their critical evidence and case themes at trial through their deposition testimony.

For most witnesses, the type of testimony we are recommending does not involve the same type of "complete" direct examination which that same lawyer would do with that same witness at trial. Remember, this is simply contingency planning in the event the witness is unavailable at trial. Defense counsel does not need to spend half an hour covering every aspect of their life history and another hour or two covering every minute aspect of their involvement in the particular insurance claim made the basis of the lawsuit. This strategy involves a determination of the *most critical* aspects of the witness's testimony and memorializing that when opposing counsel takes their deposition in the unfortunate event they are not available at the time of trial. By focusing on the most critical aspects of their testimony, it is actually possible to elicit the key aspects of their testimony through a limited number of important questions. We have rarely seen a need to ask more than 5 to 15 minutes of questions in this context because much of the witness' background and much of their claims handling will have already been fully developed by opposing counsel during the deposition.

In this context, defense counsel should give particular attention to those things that might create evidentiary problems at the time of trial, such as document authentication and hearsay. The absence of the claim witness at trial can easily create authentication, hearsay and other problems because the lack of a witness to prove up a document or prove up the exception to one of the hearsay rules. Thinking in advance of exactly how certain critical pieces of evidence and certain important testimony will be admissible at trial makes it easier to then determine how an individual claim witness can be used through their deposition (and trial testimony) to guarantee the admissibility of evidence that otherwise might have evidentiary hurdles at the time of trial without a "sponsoring" witness.

We realize that the goal of most defense counsel is to get the company witness out of the deposition as quickly as possible. We also realize that asking *any* additional questions increases the odds opposing counsel will ask follow up questions which they previously forgot or which were opened by the new questions from defense counsel. In our experience, that is a risk worth taking. Too many claims witnesses change jobs, leave their profession, get sick, die, or otherwise refuse to cooperate, and the failure of defense counsel to ask questions of them at their deposition leaves defense counsel crippled at the time of trial when the witness is no longer available.

2. Offensive Depositions

a. Policyholder Fact Witnesses

Nothing can substitute for thorough preparation. A policyholder witness should be the polar opposite of the typical claims witness, knowledgeable and prepared to discuss what happened, not evasive and devoid of any real memory. Err on the side of reviewing more documents than less. Know the chronology. As an example, in commercial hail damage cases, late notice is often an issue. The same is true of whether the damage was pre-existing and the result of poor maintenance. If appraisals of the property were done before the alleged loss, you have to be prepared to address them or at least acknowledge them. Similarly, knowing that the carrier either inspected and approved the roof each policy year or at least had the opportunity to do so is also critical to know and understand. Credibility is key. Usually, there is an understandable reason for the delay, such as the roof was basically working and manifested serious issues some time later.

Policyholder witnesses are understandably uncomfortable dealing with facts such as their corporate negligence in maintaining a building.

b. Carrier Fact Witnesses

For most defense counsel, the taking of depositions of the plaintiff's witnesses has evolved into something more like playing checkers than chess. Most defense counsel delegate these depositions to younger associates. Most use the same general outline for every deposition. Most spend little, if any, predeposition preparation time with the carrier's fact or expert witnesses to maximize the value of the questions beginning asked. And, sadly, most lawyers taking depositions in these cases do so for discovery purposes and not trial purposes. Because most defense lawyers taking depositions have never tried an insurance coverage or bad faith case, they simply don't know the right questions to ask for trial. Unfortunately, a discovery deposition differs radically from a trial deposition.

Defense lawyers need to be taking more depositions with an eye on how such testimony will be used at trial and not exclusively concerned about turning over every last discovery "stone" which they can find. For an example, most lawyers asking deposition questions could care less whether or not their questions are proper for trial purposes. With some witnesses, asking leading questions is not appropriate even if the witness is on plaintiff's witness list. Most lawyers asking deposition questions give no conscious thought as to whether their questions are "trial permissible." Unfortunately, many lawyers ask compound questions which occasionally border on incomprehensible. Senior lawyers with trial experience who believe a case is likely to be tried should delegate less depositions to younger associates. All lawyers need to give more creative thought to whether their deposition questions can be used at trial and every lawyer needs to consider how their deposition questions might be used at trial in order to frame better questions.

B. Written Discovery

1. Policyholder Perspective

Serve your written discovery early. If the judge is not a stickler for open discovery, the objection and delay game will be played to the hilt. You have to elave time to attempt to resolve disputes and move to compel if necessary. Controlled requests with reasonable geographic and temporal limitations are the most likely to succeed. It is easier to prepare written discovery after a couple of preliminary depositions are taken of claims personnel. As noted above, this gives you a view of the company organization and document retention and management arrangements.

Request drafts of key documents, such as denial letters and reservation of rights letters. In some cases, claims adjusters will use a reservation from a similar case they are handling to prepare the next reservation letter. Drafts sometimes leave tell-tale references to the other case, which can open discovery into related matters handling and blended by the adjuster.

Discovery of other related claims can reveal critical inconsistencies and other misbehavior. The courts vary in their approach to discovery relating to other claims. The key is to target the discovery so it does not appear to be a mere fishing expedition.

In *Cactus Drilling Corp. v. National Union Fire Ins. Co., et al.,* 5:12-CV-00191-M (Okla. W.D.), the policyholder was successful in obtaining documentary discovery of the handling of other claims in an case involving an excess employer's liability policy. The carrier denied that there was coverage for "substantial certainty" torts under an excess employer's liability policy. The policyholder attempted to show that the defendant insurer, and other carriers, had frequently defended and/or paid similar claims. In fact, the primary carrier in *Cactus* had paid its underlying limits for such claims. The policyholder believed that the evidence showed:

(1) The policyholder's interpretation of the policy was consistent with the interpretation of the defendant carrier and other carriers, primary and excess, had used in other claims, and was thus a "reasonable" alternative interpretation of the policy supporting a finding of ambiguity.
(2) The carrier had paid other claims because it allegedly feared that a court would find the coverage illusory if it failed to recognize coverage, and thus the carrier's interpretation was itself unreasonable.
(3) The carrier acted in bad faith in ignoring its own prior actions in handling similar claims when it decided to deny coverage in the Cactus case.

The defendant carrier had a typical response, objections and motions for protection asserting irrelevance and burdensomeness.

In response, Cactus argued:

> As to breach of contract, a multitude of cases hold that other claims files can lead to admissible ***evidence of ambiguity***. As to bad faith, the Tenth Circuit and the Western District have found discoverable other claims files as evidence of business practices.
>
> In *Broadway Park,* this Court applied *Vining v. Enterprise Fin. Group*, 148 F.3d 1206, 1218–19 (10th Cir. 1998), in holding that the claims files for similar claims were discoverable. *Broadway Park, L.L.C. v. Hartford Cas. Ins. Co.,* 2006 U.S. Dist. LEXIS 55914, at *4–5 (W.D. Okla. Aug. 9, 2006) (Miles-LaGrange, J., opinion) (citing Vining for the rule that "evidence of an insurance company's general business practices is relevant in a bad faith case"). In *Broadway Park*, the insured sought discovery of similar claims against the insurer following a hail storm. *Id*. at 4. The request was limited geographically and temporally, as is Cactus' request here, and the Court compelled the insurer to comply with the Request for Production. *Id*. at 4–5.
>
> In *Sullivan v. USAA Gen. Indemn. Co.,* 2006 U.S. Dist. LEXIS 32670, at *6–7 (W.D. Okla. May 10, 2006) (Miles-LaGrange, J., opinion), this Court held that several years' worth of claims files were discoverable where the same software and adjuster were used in adjusting the plaintiff's claim and claims in years past. The Court allowed discovery of ***three years' worth of claims*** files where the particular adjuster was used and that had relied on the same software the Plaintiff was

> contesting. Id. at *7. Here, Cactus' claim shares important policy language and adjuster/supervisor similarities with numerous other claims.
>
> In *Metzger v. Am. Fid. Assur. Co.,* 2007 U.S. Dist. LEXIS 90235 (W.D. Okla. Dec. 7, 2007), the plaintiff sought discovery of similar claims denied by the insurer. This Court found that "evidence regarding [similar] policies within the state of Oklahoma is relevant and is therefore, admissible." *Id.* at *4 (emphasis added). The Court's order was limited to Oklahoma-insureds and similar policies. *Id*. Plaintiff Cactus seeks discovery of similar claims within the bounds set by this Court. These Western District cases upheld discovering other insurance claims files.

(Cactus Response to Motion for Protection (footnotes omitted)).

In *Cactus,* the District Court held that evidence of other claims was discoverable, but the court required substantial topical, temporal and geographical limitations to address the burdensomeness issues raised by the defense:

> First, defendants contend that these requests are irrelevant and not reasonably calculated to lead to the discovery of admissible evidence. Specifically, defendants assert that whether National Union may have defended, indemnified, or paid or denied coverage for other substantial certainty claims has no bearing on whether there is coverage for this claim because Cactus did not rely on any payment of any other substantial certainty claim in purchasing this policy and the language of the policy is clear and unambiguous under Oklahoma law and, thus, extrinsic evidence is not allowed.
>
> Second, defendants contend that these requests are overbroad and seek documents that are privileged, or contain trade secrets, proprietary and confidential business records, and/or other protected materials. Specifically, defendants contend that these requests are overbroad because the requests have no geographic limitation, and Request 7 is unbounded by time. In addition, defendants assert that Request Nos. 7 and 8 are not reasonably tailored because they seek documents relating to all affiliates of National Union and Chartis – which includes ten AIG member insurance companies, primary employer liability policies which have no bearing on the pertinent commercial liability umbrella policy at issue, and to other claims and lawsuits, with no limitation on the type of documents or information sought.
> Lastly, defendants assert that complying with these requests would be oppressive and disproportionally costly. Specifically, defendants assert that they have no method of conducting a computer search for files containing "substantial certainty torts", and as such, searching for these documents through 210,461 identified claim files of National Union and its affiliates would cost approximately $4,200,000. In addition, the production of such documents involves confidential, privileged, and private information gathered in other claims, and such screening will cost additional money. Moreover, even if the requests were to be limited to excess or umbrella policies, opened between January 1, 2005 through January 22, 2013, for losses in

> Oklahoma, a search for such documents would still require searching 1,839 files. Thus, defendants conclude that the burden and expense of responding, even if limited by the Court, outweigh any relevant benefit to Cactus. To the extent the Court orders defendants to produce such documents, defendants seek to be allowed to redact privileged, confidential, and other legally protected documents and provide a privilege and confidentiality log to support the redactions.
>
> Having carefully reviewed the parties' submissions, the Court finds that Request for Production Nos. 7 and 8 seek relevant documents. Specifically, *the Court finds the documents requested are relevant to plaintiff's breach of contract and bad faith claims as they bear directly on whether the policy's language at issue is clear and unambiguous as defendants assert and may also show that Chartis has held coverage positions that are not advanced by the original drafters of the policy at issue.* The Court also finds that these requests are overbroad and not reasonably tailored in scope. Specifically, the Court finds that these requests should be limited to commercial employers excess or umbrella liability policies opened between January 1, 2005 and January 1, 2011, for losses in Oklahoma.

(Cactus, Order on Motion for Protection and to Quash (10-3-13) [Doc. 208] at 5 (emphasis added).)

Fortunately, the Court reconsidered its ruling restricting the production and discovery to excess policies. Because the excess policy "followed the form" of the primary policy, Cactus moved to clarify the Court's initial order as to whether depositions could examine knowledge of those with knowledge as to whether they were aware of other primary and excess claims for "substantial certainty" torts where either Chartis/AIG or other insurers had paid employers liability indemnity dollars towards settlement or defense. The Court reasoned:

> Plaintiff may depose witnesses regarding the witnesses' personal knowledge/involvement with primary employment liability claims in the context of substantial certainty claims. There is no undue burden to defendants resulting from the deponents responding to plaintiff's questions during deposition.
>
> Accordingly, the Court finds plaintiff may re-depose [various claims and claims liaison personnel]. The Court also instructs the parties that plaintiff may depose said witnesses on discoverable knowledge of the claim and related matters, including deponents' knowledge of or involvement with other substantial certainty claims in Oklahoma involving primary or excess/umbrella liability.

(Cactus, No. 5:12-CV-00191-M, [Doc. 263] at 2.)

2. Carrier Perspective

Defense lawyers need to pay careful attention to the instructions in plaintiff's requests for production which ask for documents in "native format." Electronic data and other forms of e-discovery can be extremely burdensome on any defendant, particularly an insurance company. Some plaintiff lawyers now push for e-discovery regardless of how ridiculous it is on a particular

insurance claim. Defendants hurt themselves if they miss a discovery instruction that asks them to produce their electronic discovery documents in native format. Don't assume all generic instructions and request for production are indeed generic. Electronic discovery definitions can create a nightmare for defendants and their lawyers.

C. Attorney Fee Discovery

1. Policyholder's Perspective

In Texas, a policyholder must prove reasonable fees by following a multi-factor test. Proof of a contingency agreement without more will not support an award of fees. Thus, discovery turns to billing records, which many plaintiff's counsel simply do not typically keep. Discovery of billing records creates enormous privilege and redaction issues. Many like to agree with the defense to have fees tried separately after trial, if necessary. Discovery is delayed typically until this fee trial or hearing as well.

There is something to be said about trying fees before the jury. If the fees are greater than the recovery sought, a jury might better understand that the carrier's tactics at trial and otherwise needlessly increased costs. I have also seen devastating testimony from policyholder counsel in the guise of fee testimony, which addressed substantive bad faith issues regarding the carrier's conduct. Where the policyholder counsel is on board during the claims handling process, their knowledge of what occurred can be devastating.

2. Defensive Perspective

The trial of insurance bad faith cases has undergone a massive paradigm shift in recent years due to the current willingness of many plaintiff's counsel to try relatively small damage claims with significantly higher attorney fee claims. Fifteen years ago, few lawyers were willing to ask a jury for $200,000 or more in attorneys fees on a property damage claim realistically worth no more than $10,000 or $15,000. That is not the case in 2014. The majority of the bad faith cases tried in Texas in 2012 and 2013, for example, involved property damage claims of less than $50,000 and attorney fee claims greater than $250,000. Defense lawyers must radically change their strategy for dealing with insurance lawsuits in light of the changing prominence of attorneys fees as a component of plaintiff's damage claim in Texas bad faith cases.

Initially, settlement offers made under Rule 68 of the Federal Rules of Civil Procedure, or under a similar state counter-part, have taken on immeasurable importance because such tools are the only ones in a defendant's arsenal which can be used to cap or limit fees. Many other states across the country have similar settlement offer statutes.

Federal Rule 68 allows a defendant to make a formal offer of settlement or "offer of judgment," and potentially shift some or all of its post-offer litigation costs to the plaintiff in certain circumstances. However, there are some important differences from state practice.

An Offer of Judgment may be made at least 14 days before the date set for trial and a defendant may serve on an opposing party an offer to allow judgment on specified terms, with the

costs then accrued. If, within 14 days after being served, the opposing party serves written notice accepting the offer, either party may then file the offer and notice of acceptance, plus proof of service. The court must then enter judgment.

Another key difference is when the cost shifting mechanisms under Rule 68 triggered. There is no "buffer zone." Unlike some state statutes, if the judgment obtained by the plaintiff is not more favorable than the Rule 68 offer, the plaintiff must pay the costs incurred after the offer was made. Additionally, if a defendant obtains a take-nothing judgment, Rule 68 does not shift cost.

Rule 68 only shifts fees unless fees are specifically included as part of recovery by another statute. As such, recovery of post-offer attorney fees is not certain under Rule 68, and is determined on a case-by-case basis with reference to the federal statute or substantive state law governing the causes of action asserted in the lawsuit.

Defense lawyers also need to do more with the Excessive Demand Doctrine. One well known plaintiff's lawyer with several thousand bad faith lawsuits over the last few years is notorious for making six figure attorney fee demands on simple property damage claims prior to or contemporaneous with the filing of the lawsuit as a part of the pre-suit demand. This gives a tremendous opportunity for defense counsel to assert the Excessive Demand Doctrine as an affirmative defense to the EC claim, do discovery on it, and use it at trial. The presence of an excessive demand requires the defendant to plead it as an affirmative defense and submit a jury issue on it. It also requires discovery of all work performed by the plaintiff's lawyer, all-time records relating to such work from the date of client retention through the sending of the excessive demand. The case law in Texas is currently very favorable. In general, a creditor who makes an excessive claim upon a debtor is not entitled to attorneys' fees for subsequent litigation required to recover the debt. *See,* generally, *Findlay v. Cave*, 611 S.W.2d 57, 58 (Tex. 1981). This doctrine can be used in first party insurance cases. A demand that is greater than that which a jury later determines is actually due may be some evidence that a demand is excessive. *Panizo v. Young Men's Christian Ass'n of Greater Houston Area*, 938 S.W.2d 163, 169 (Tex. App.—Houston [1st Dist.] 1996, no writ). The dispositive question in determining whether a demand is excessive is whether the claimant acted unreasonably or in bad faith. *See Findlay*, 611 S.W.2d at 58; *Standard Constructors, Inc. v. Chevron Chem. Co.*, 101 S.W.3d 619, 627–28 (Tex. App.—Houston [1st Dist.] 2003, pet. denied).

Texas Courts, for example, have found that a demand was unreasonable under several different fact patterns. For example, a demand is unreasonable, and therefore excessive, when a jury awards less than half the amount of the original demand. *Pennington v. Jerry F. Gurkoff, D.O., P.A.*, 899 S.W.2d 767, 772 (Tex. App.—Fort Worth 1995, no writ). As such, attorney's fees were not recoverable. *Id.* A demand was also found unreasonable because the claimant included in the demand amounts for which he was not entitled to recover. *Wayne v. A.V.A. Vending, Inc.*, 52 S.W.3d 412, 418 (Tex. App.—Corpus Christi 2001, pet. denied). That court held that "[i]f a claimant demands monies to which he is not entitled, that demand is unreasonable and consequently excessive." *Id.* When a claimant unilaterally increased the amount due by 10% to

cover "collection costs" which were not part of the amount owed, the court held "the demand was excessive and that petitioners were not chargeable with attorneys' fees." *Collingsworth v. King*, 283 S.W.2d 30, 33 (Tex. 1955). To assert such a defense, it needs to be pled by the defendant.

D. Initial case evaluation reports/pretrial reports – Carrier Perspective

In personal lines cases especially, defense counsel can never underestimate any and all factors that may generate sympathy for the plaintiff with the jury. Too many defense lawyers get over-focused on claims handling, coverage, timeliness of communication, and other claims factors. A "strong" claims file is much less defensible if the insured possesses unique sympathy factors. Advanced age is typically a strong sympathy factor. Other high sympathy factors in coverage and bad faith cases include families with disabled children, widows, or insurance claims with unusual high emotional components.

One of the best ways to combat plaintiff's sympathy is to focus on these things the insured has or has not done with the insurance money they have received in the claim. In homeowner bad faith cases, for example, an insured that receives insurance funds but fails to make repairs or fix the damage will almost inevitably lose some sympathy with the jury. Obviously the *ability* to make repairs is a critical component. But, if a plaintiff has *some* ability to make repairs, most jurors expect them to do so.

E. Witness Prep -

1. Carrier Perspective

A. Depo prep

We believe witness prep is one of the most important, if not *the* single most important, aspect of defending an insurance coverage or bad faith case. Several years ago, one of the nation's largest P&C carriers experienced an internal revolt when the Claims Department executives expressed extreme hostility towards their counter-parts in the Law Department for settling bad faith lawsuits with what the claim execs thought were excessive amounts of money. The claim executives felt they could resolve claims prior to suit being filed for far less money than the Law Department was paying after one to three years of litigation. They were angry because they believed their hard work to reach the right claim result was not being recognized when the Law Department litigated a "good" claim file for one to three years and then settled it for large amounts of money on the eve of trial. So, in order to attempt to address this growing internal conflict, the senior leadership of both the Law Department and the Claims Department conducted a joint *post mortem* on the last five hundred first party bad faith suits settled by the carrier over the prior two years in order to assess why those cases settled for the amounts for which they did. The results were shocking. The overwhelming reason why more than 70% of the carriers' bad faith files settled was because of the reported poor performance of its claim witnesses during their depositions and the belief of defense counsel that these witnesses would perform equally poorly at trial. In some files, additional facts were discovered which changed an early analysis, but these were a very small minority. Venue, the strength of opposing counsel, and a litany of other factors also combined to generate some settlements but, even in the aggregate, these factors were still a

small minority. The overwhelming economic driver based upon this carrier's review of 500 files from across the country reemphasized the absolute importance of thoroughly preparing a company's claim witnesses prior to their depositions.

In recent years, many of the large carriers have realized the importance of intense witness prep and now demand it for all of their witnesses to an exacting degree of intensity. Still, however, many carriers put no expectations on their counsel regarding the preparation of the company's witnesses for deposition and even fewer give guidance as to what is expected in a witness prep. This is unfortunate given the critical role witness prep plays on the strength of a case proceeding to trial.

Witness prep in most insurance coverage and bad faith cases cannot be done in several hours. Even veteran deponents need a full day of deposition prep on an "average" claim. Refreshing recollection, reviewing the documents produced in litigation, and preparing for the questions and topics to be covered by opposing counsel are simply the start of the prep process. Most lawyers fail to do any practice questions. Most lawyers fail to review other depositions opposing counsel has personally taken of other claims witnesses in other cases so the witness can increase their understanding of the manner in which counsel asks questions. We have found it very effective to have lead counsel in the case do the primary witness prep and then have another lawyer (either an associate or co-counsel) conduct mock questioning. Practice questions are the only way to truly understand if the things covered in the witness prep have been understood by this witness and can be implemented by them. Exceptionally bright claim professionals may understand all of the nuances of claims handing and a company's claims procedures, but such expertise does not automatically make them a good witness. Being a good witness is like anything else in life; it requires training and experience. Sadly, the prep given by most lawyers to most claim professionals remains pathetically inadequate.

B. Trial Prep

For the last decade, most plaintiffs' counsel in insurance coverage and bad faith cases opt to call the insurance company witnesses adversely during the insured's case-in-chief. As most trial lawyers know, undergoing cross-examination in trial in front of a jury is radically different than answering the questions in their deposition in their lawyer's conference room. Because the questions are different, the emotional intensity is different, the audience is different and the stakes are different, the prep has to be different. Unfortunately, there is little difference in the way most lawyers prep their witnesses for deposition and trial. There are radical differences.

Although there are substantial differences in preparing an insurance professional for deposition and trial, they share the common similarity of needing to refresh the witness' recollection and in mastering their understanding of the claim (and their role in it) in the lawsuit. The similarities end there. Because the nature of the questions differs significantly on cross, and because most witnesses have no experience in undergoing cross examination at trial, practice questions take on an even greater role in trial prep. Any witness being presented at trial must undergo extensive and repeated trial cross practice exercises. Unlike the deposition, this is also an opportunity where defense counsel must prepare their witnesses for a full direct examination. This

presents a tremendous opportunity for the carrier because it is an opportunity to "hijack" the plaintiff's case before they rest.

We used to believe that juries expected us to try a "quick" case and we feared the jury and would get irritated at the number of days they were in trial if we did not move very quickly. We now believe that a careful and methodical presentation of our case is critical to our ability to win even if it results in our witnesses being on the stand for several hours or even several days more than we would have done in trying the same case ten years ago. If plaintiff's counsel is going to call our company witnesses during their case in chief, we believe defense counsel should fully utilize the opportunity to do an *extensive* direct-examination then, during the Plaintiff's case, this is a tremendous opportunity to tell the insurer's complete side of the story, conduct a detailed review of the claim chronology, present a detailed discussion of the information received by the carrier from experts, show the insured's failure to cooperate or timely provide information, and explain other key issues in the case. Every key issue should be could be explored in great depth with testimony, exhibits, and demonstratives during the direct exam when plaintiffs call the claim witnesses in their case. If plaintiff's counsel is going to call the insurer's witnesses during its case in chief, defense counsel should attempt to turn the tables as much as possible by doing as thorough and persuasive of a direct-exam as possible. In one recent, trial we had our senior claim professional on the stand for *three days* during the plaintiff's case-in-chief because the plaintiff was foolish enough to call him adversely. His three days of testimony gave the jury the greatest understanding possible of the claim chronology, the reasons for every decision made, the plaintiff's role in all of the claim delays, and the extraordinary lengths the company went through to resolve the claim despite the insured's greed and fraud. We believe it was a key strategic decision in helping us win the case.

2. Policyholder's Perspective

A. Deposition Preparation

We have already discussed above some critical issues in preparing for and conducting the deposition of insurance company personnel. Despite some renewed effort in preparing for claims depositions, many defense counsel simply devote too little time to this process.

As a policyholder, it is important to know what happens in a more thorough preparation process so it can be exploited if need be. First, the witness should be given copies of produced documents from the claim file that refresh their recollection. Second, they may be shown or may discuss privileged documents in preparation sessions. Whatever they are given to prepare, it is potentially discoverable. Often, the real history of the case is interspersed in privileged documents, which are hard to prepare the witness on without danger.

Find out how many prep sessions have been held and with whom. It is certainly helpful to learn that the witness was prepped by special bad faith counsel not on the pleadings. Witnesses are also given key depositions. Sometimes, general preparation films are used. Some witnesses are given detailed preparation checklists.

Attention to detail and chronology by policyholder counsel can yield some great results. In most cases, you will know the file better than the claims person.

There seems to be more movement from one job to another in the insurance industry than at other any time. The best claims witness is someone who has moved on to another company or industry and is no longer beholding to the defendant carrier. Preparation of such witnesses is more problematic for the carrier.

It is also helpful to ask claims personnel who they have talked to since finding out the claim has gone into suit. If still with the company, company employees cannot resist the temptation to hash over what happened. This is especially true of upper level management.

It is very hard for policyholder to resist the temptation to show everything at claims depositions. Early settlement is helpful. As a defense counsel, the greatest fear is the claims deposition that is short and general. But, the danger is that with movement among companies, the claims witness might well not be at trial or may not otherwise be available. So, the deposition makes it a do or die proposition.

B. Trial Preparation

A basic difficulty for the policyholder is identifying who is best to tell its story. This will vary depending on whether the case is a first party or third party bad faith case. Do not assume the jury will not understand and consider complex claims/legal concepts. Take the time to explain them and put them in perspective.

Like claims personnel, policyholder witnesses have to be thoroughly prepared. Do not assume deposition preparation shortcuts the time for trial preparation. The cross-examination fodder is much greater at trial. Company representatives must also be apprised of the pleadings and claims made on their behalf in the pleadings.

Incorporation of technology into the preparation and testimony is vital. We are in a time of sound bites and short attention spans, where the visual controls the day. Coverage and bad faith law are a bit dense even with a jazzy presentation. Simplify and visually explain.

Do not assume that your client or its employees and agents know how to dress or behave at a trial. We had one real estate client who seemed very bright and articulate. We told her to wear something conservative at trial. She showed up in fishnet hose with a Geisha bone through her hair. Fetching but ineffective. Another client's employee was amazing in preparation sessions, but when he got to trial and got to use a microphone, he suddenly became a DJ. The jury was not amused. Also, behavior at the courthouse must be carefully controlled. Nothing boisterous or involving laughter or anger. Poker faces are best. Behave.

F. Mock trial exercises

1. Defense Perspective

We are strong believers in the value of mock trial exercises. The key is knowing when to use them. Most lawyers (and clients) make the mistake of trying to use the mock trial to predict how a jury will actually decide the liability and damages issues at trial. Any mock trial exercise which attempts to ascertain the results of a real jury's answers to real liability and damage questions is doomed to failure and is a complete waste of money. A one or two day mock jury exercise cannot accurately capture the dynamics of a real trial, particularly one that lasts for multiple weeks. There are too many witness dynamics, counsel dynamics, judge dynamics and jury-perception dynamics, all of which fluctuate wildly over a multi-week trial. If a carrier or counsel attempt to compress a two or three week trial into a one or two day mock trial, it is almost inevitable they will receive a "false positive" typically leading to overconfidence regarding the probable trial outcome. This fails to yield meaningful information about how to shape trial themes or evidence issues in a way to successfully impact a positive jury result.

An effective mock jury exercise must be laser-focused. The more narrow it is, the more accurate it is. The ideal mock jury exercise we seek to resolve one single simple question. The perfect scope of a mock jury exercise is to determine how a mock jury feels about a single witness, such as a senior claim executive or the primary claims handler. Likewise, attempting to evaluate a single element of damage is another excellent use of a mock jury exercise.

We did a mock jury exercise in 2013 in order to answer one discrete question regarding how the jury would likely filter our trial evidence based upon our assertion of a single affirmative defense. We went through one exercise where we presented the affirmative defense we were trying to test and then went through an identical exercise with the same claim liability and damage evidence but omitted the affirmative defense in question. The results confirmed our initial fear that the affirmative defense was dangerous and its introduction at trial would have a negative consequence on the jury's filtering of our liability and damage evidence. As such, six months before trial we had an opportunity to modify or eliminate that affirmative defense from the presentation of the evidence to the jury. That was an exceptionally effective and accurate mock jury exercise because it was so finely tuned and so narrowly focused so as to maximize its accuracy when extrapolating probable results to a Texas jury in a real trial.

2. Policyholder Perspective On Mock Trials

Mock trials are very expensive. Mock trials help identify core equities that may well persuade the jury to decide one way or the other. Watching deliberations help you to assess which core equities work and which ones do not. Live testimony of key witnesses at the mock trial can resolve critical credibility issues. Presenting live testimony can also be part of the trial and deposition preparation process. Mock trials can also reveal trial tactics that do not work. Mock trials as predictors of success or failure? We believe they can be, but it is a very inexact predictor. In the insurance setting, we use them more often than not to convice excess carriers that the case truly could come into their limits. For that, it is very effective.

G. Expert witnesses

1. Policyholder Perspective

In commercial property cases, experts of all sorts are necessary. We like to have them in effect *Daubert* the carrier's expert. In other words, their purpose is to (a) explain why the insured's position or evaluation is correct, and (b) explain why any reasonable insurer would not rely on the carrier's expert's reports and analysis. Claims experts are not always necessary. Where the case turns on coverage, the trial court will, hopefully, have ruled on the carrier's coverage issues before trial. As a result, the trial court will typically be instructing the jury that it has so ruled. The devastation of such rulings and instructions cannot be over-estimated. In such scenarios, a claims expert for the carrier must in effect appear to disagree with the judge, a dangerous thing for any expert to do. Explaining why the judge rejected a position but the position was still a reasonable is no small task.

Claims experts are very hard to find. The worst I have seen were public adjusters who really came from other states. Many lawyer experts are available, but they face a presumption that they are providing testimony that invades the province of the judge. Such experts must be careful to carefully explain and develop their expertise and familiarity with industry standards and practices. Former in-house counsel who have worked for insurers in both a claims and legal role are the best. They are knowledgeable about controlling legal standards, but they understand the special and different industry perspective.

Experts must be careful not to populate notes and billing with stray comments that could be damaging to the expert's image of objectivity. Some experts have a hard time not seeing the whole trial process as adversarial, noting "we" should argue this or that or that something is harmful to "us." Objectivity is what is sought, not another advocate.

The trial court in *OneBeacon Ins. Co. v. T. Wade Welch & Associates,* Not Reported in F.Supp.3d (2014), granted the claimant/policyholder's motion in limine regarding expert testimony that the carrier had a reasonable basis for denying the claim, as a defense to a common law *Stowers* and Insurance Code claim for failure to settle when liability was reasonably clear. The court held that testimony from an attorney expert as to whether OneBeacon could consider its policy defenses in evaluating the reasonableness of DISH's *Stowers* Demand involved a pure legal question, that no witness can testify regarding legal issues, and that it is the duty of the court to instruct the jury on the law. More importantly, the court refused to allow testimony that there was a reasonable basis as to the *Stowers* claim, but it allowed it as to the Insurance Code claim, with instructions to the jury.

A more recent decision in the appeal of the OneBeacon case addressed the expert issue a bit differently. In *OneBeacon Insurance Company v. T. Wade Welch & Associates*, 841 F.3d 669 (5th Cir. 2016), the court held that expert testimony could in fact support a finding of knowing misconduct in a statutory failure to settle case. The court noted that "knowingly" means:

> To have acted "knowingly," OneBeacon must have acted with actual awareness of the falsity, unfairness, or deceptiveness of the act that made it liable under Chapter 541. *See St. Paul Surplus Lines Ins. Co., Inc. v. Dal–Worth Tank Co., Inc.*, 974 S.W.2d 51, 54 (Tex. 1998). " 'Actual awareness' does not mean merely that a person knows what he is doing; rather, it means that a person knows that what he is doing is false, deceptive, or unfair. In

> other words, a person must think to himself at some point, 'Yes, I know this is false, deceptive, or unfair to him, but I'm going to do it anyway.' " *Id.* at 54–55..

Id. at 680. The court noted:

> DISH's expert testified that OneBeacon's conduct was not that of a reasonable insurer acting prudently, but was an instance of prohibited "post-claim" underwriting, which he defined as occurring when "the insurance company realizes that they have a problem, and they desperately look for a way to avoid paying the claim. And what they'll do is they'll try to search for a morsel of evidence that they can conceivably turn into a material misrepresentation, such as we have here."

Id. at 679-80. The court observed that "the jury was free to disregard that evidence and credit the testimony of DISH's expert." *Id.* at 680.

2. Carrier Perspective

It is important to remember that the bills and invoices of trial experts are discoverable. Witnesses should be cautioned against time entries and billing invoices that include summaries of discussions of counsel or other experts, especially before reports are drafted are finalized. Expert time entries should be limited to analysis, investigation documents reviewed, factual background, testing, the drafting of the report, and the finalization of the report. National accounting firms and national engineering firms have grown accustomed to detailed time summaries because they are frequently hired by insurers during a claim investigation. They need to know that such detail can open up cross examination points in litigation that are unnecessary.

Most importantly, if the insured's counsel places any limitations on the expert's inspection, analysis, or evaluation, those limitations restrictions must be expressly documented and made part of the expert's file, if not directly identified in the expert's report. It is very common for inspectors to only be given a limited amount of time to complete their inspection or to be prohibited from looking at certain things, examining certain documents, or doing certain types of tests. If this is not adequately documented, the insured or their lawyer will deny it at trial and the carrier's expert will have no way to really capitalize on the issue. As such, any and all limitations must be adequately documented by the expert shortly after their inspection in their report.

One of the inventible questions we get is whether or not carriers should retain a "good faith" expert in the defense of a bad faith case, particularly when the plaintiff has designated a bad faith expert. In general, we think it is a good idea to designate one in order to call them if needed. The actual decision to call one, however, is the decision that can't be made until the end of most trials. Over the last decade, most plaintiff lawyers have started to designate and call a bad faith expert. Although the topic of what to do with such experts exceeds the scope of this paper, the mere fact that most insureds have such experts in bad faith cases is enough to justify the carrier's retention of a similar expert. The key for the carrier is for the witness to focus their testimony on the reasonableness of the insurer's claim investigation and claim decisions without crossing the

line into testifying about what the law is or what it should be. The other key is having an expert with sufficient claims management history and experience to be truly beneficial to a jury. The sad reality of most good faith experts is that the claims professionals don't know the law and the lawyers who are frequently engaged lack sufficient personal experience in insurance claims management or insurance company operations. It is our collective experience that a good claims handling expert can be a very powerful way to end the carrier's case-in-chief at trial.

H. Apologies as a trial strategy – Defense Perspective

Although we apologize in our social and family relationships regularly, most lawyers never contemplate doing so as a claim resolution or lawsuit resolution strategy. Based on recent scientific literature, they should in some cases. It is important to understand we are not advocating this strategy in most cases. In many cases, it is not necessary and it many cases it would not be effective. However, recent scientific research has shown that an apology can be very effective in certain types of cases and a good insurance lawyer should know when an apology may be an effective litigation strategy. "Companies Can Apologize: Corporate Apologies and Legal Liability," *Business Communication Quarterly* (Vol. 66:1) (March 2003, p.9). Recent studies have shown that an apology can be very effective in resolving insurance claims and lawsuits that have a very high personal emotional damage component. Helmreich, Jeffrey, "Does 'Sorry' Incriminate? Evidence, Harm and the Meaning of Apologies," *Cornell Journal of Law and Public Policy* (Vol. 23: 1) (2012). Medical malpractice cases have been demonstrated to be prime candidates for an apology. Pearlmutter, Maria "Physician Apology and General Admissions of Fault: Amending the Federal Rules of Evidence," *Ohio State Law Rev*. (Vol. 72:3) 2011. Likewise, sexual assault cases and other premises liability cases resulting in severe personal injuries are appropriate for apologies in certain circumstances. "The Science of Effective Apologies," *Psychology Today* (Dec. 9, 2010). Likewise, some homeowner claims may be appropriate for an apology. In general, commercial losses, commercial business disputes, and non-emotional damage claims are <u>not</u> generally susceptible to apology strategies. See, generally, Wagatsuma & Rosett, "The Implications of Apology," 20(4) *Law & Society Review* 461 (1986); Felstiner & Abela, "The Emergence and Transformation of Disputes: Naming, Blaming, Claiming" 15 *Law & Society Review* 631 (1980). "Sometimes, An Apology Can Deter a Lawsuit," *California Bar Journal* (July 2010).

An apology strategy can be very effective in resolving certain types of claims prior to filing of suit. Jennifer Robbennolt, "Apologies and Settlement," *Court Review* (Vol. 45:90) (2010). Likewise, apology strategies have demonstrated success at mediation when the parties are in closer physical proximity and an apology can be given directly in person. Apologies can also work in ligation before a jury. Morrison & Heyoka, "The Shifting Shape of Dispute Resolution Healthcare," 21 *Georgia State Univ. Law Rev*. 931 (2005). Recent scientific studies have shown that juries, who are not directly affected by the alleged wrongdoing of the defendant, are generally *more willing* to accept an apology and less willing to award damages if they think that an apology was owed and was genuinely given. *Science Daily* (August 24, 2009). In this context it does not matter whether the plaintiff accepts the "apology" or not. In a jury trial, all that matter is whether the jury believes the apology is sincere. Cohen, Jonathan "Advising Clients to Apologize," *Southern California Law Review*s. Vol. 72:1009 (1999). Robbennolt, Jennifer, "Attorneys, Apologies and Settlement Negotiations," *Harvard Negotiations Law Rev.,* Vol. 13:349 (Spring

2008). In fact, some of the academic research has established that when a jury believes a defendant's apology and the insured refuses to accept it, the jury's sympathy quickly turns against the plaintiff and can prove very beneficial for the defendant on both liability and damage issues. "The Science of Apologies: What is the Best Way to Say Sorry," *The Huffington Post* (Oct. 31, 2011). Bennett and Duberry 13 *Current Psychology* 10 (1994). An apology is not an appropriate trial strategy for every case, or even most cases. Although it should be used sparingly, when it is appropriate it can be a very powerful strategy. Robbennolt, Jennifer "Apologies and Civil Justice" Civil Juries and Civil Justice (2008). Unfortunately, most civil trial lawyers never contemplate it because of their fears that it will amount to an admission of liability. In our experience, lawyers do a great disservice to their clients if they do not at least contemplate the possibility of using the apology strategy as an effective litigation tool when appropriate.

I. A Note About Phasing

Many counsel on both sides of the bar try to "phase" the case in separate parts. For example, many carriers prefer abating the bad faith case and focusing on the breach of contract case. Certainly, this keeps evidence of offers of settlement and settlement practices out of the presence of the jury while deciding critical contract questions. The problem is that once you lose the breach of contract phase, the judge will likely have to instruct or inform the jury of what happened, which in the end makes the breach of contract pahse easier but the bad faith phase harder. One thing for sure, abating bad faith can save the carrier costs.

For the policyholder, abatement takes critical pressure off the carrier. Bad faith discovery is broader and potentially more damaging as the case goes along. The policyholder is also potentially harmed by the fact that the jury is not restricted by the evidence and opinions it may consider in a pure breach of contract phase. Bad faith, on the other hand, typically focuses on what the carrier had in its evidence basket before it denied or delayed. If the carrier has misbehaved, many policyholder counsel would prefer to try everything together so the jury deciding contract issues also knows the full story and motivation and behavior of the carrier.

Another aspect of phasing is bifurcation of punitive or additional damages claims. As the decision in *OneBeacon Ins. Co. v. T. Wade Welch & Associates,* Not Reported in F.Supp.3d (2014), shows, when issues are tried together, testimony on the additional or punitive damages, especially from experts, can be particularly damning.

Finally, a short note about pre-emptive declaratory actions by the carrier. The *OneBeacon* case is one where the carrier sued for recission first. The carrier decided it would take advantage of that fact and go first in presenting its case to the jury. This resulted in the carrier making an affirmative case for recission and also having to answer bad faith claims before the bad faith evidence and expert opinions had been presented. As the final decision reveals, this problematic approach will likely not be tried again.

II. Substantive Issues Impacting Both Pre-trial and Trial Strategies

A. Replacement costs/actual cash value

This topic is of critical importance in almost all property damage claims and the bad faith suits arising out of such claims. Most insurance policies provide that replacement costs benefits are only available after an insured actually makes repairs or actually replaces the property. In our experience, most insureds trying bad faith cases have not made *any* repairs or attempted to fix the allegedly damaged property at all. Most property policies are clear that if the allegedly damage property is not repaired or replaced within a certain amount of time, the policy *only* pays actual cash value (which is typically defined by case law as the replacement cost minus depreciation). As such, on an older structure, the ACV is typically substantially less than the RC.

Most plaintiff lawyers refer to property policies as "replacement cost" policies because, under certain circumstances, those benefits are payable. In reality, most property policies litigated in Texas courts are actually "reimbursement policies." This is a more accurate term because virtually every property policy we have ever seen litigated in Texas provides that the insurance company's obligation to pay replacement cost benefits *only triggers* when the insured has repaired or replaced the allegedly damaged property and, in that instance (and only in that instance), the insurer reimburses the insured for their cost to repair or replace. Most carriers and their lawyers do not do anything strategic with this distinction during any aspect of the insurance coverage or insurance bad faith lawsuit. The law in Texas is well settled: an insured is not entitled to Replacement Cost Value ("RCV") unless and until it **actually repairs or replaces the damaged structure**. *See*, generally, *Fitzhugh 25 Partners, L.P. v. KILN Syndicate KLN 501*, 261 S.W.3d 861, 863 (Tex.App.—Dallas 2008, pet. denied); *see also Lerer Realty Corp. v. MFB Mut. Ins. Co.*, 474 F.2d 410, 413 (5th Cir. 1973) (interpreting Texas law and finding liability for replacement cost is triggered only after the insured actually repairs or rebuilds); *Ghoman v. New Hampshire Ins. Co.*, 159 F.Supp. 2d 928, 932 (N.D. Tex. 2001)("Obviously, an insured cannot recover repair or replacement costs unless and until he actually repairs or replaces the insured structure"). The requirement to repair or replace the damaged property is a condition precedent for recovery of RCV. "Conditions precedent to an obligation to perform are those acts or events, which occur subsequently to the making of a contract, that must occur before there is a right to immediate performance and before there is a breach of contractual duty." *Hohenberg Brothers Co. v. Gibbons*, 537 S.W.2d 1, 3 (Tex. 1976). A party seeking to recover on a breach of contract claim must first establish that it has performed its obligations that are conditions precedent under the contract. *Associated Indem. Corp. v. CAT Contracting, Inc.*, 964 S.W.2d 276, 283 (Tex. 1998)("a party seeking to recover under the contract bears the burden of proving that all conditions precedent have been satisfied"). Merely pleading that an insurer breached the insurance policy does not excuse the insured's non-compliance with the requirements necessary to recover RCV. Otherwise, the insured, by filing a lawsuit, essentially seeks to make a profit as a result of the claims made under this Policy without actually repair the damaged property. By failing to satisfy requirements to recover under the RCV clause, an insured is only entitled to the Actual Cash Value ("ACV").

Texas and several jurisdictions throughout the United States unanimously enforce this policy language regarding replacement cost coverage as a standard condition precedent without exception in commercial property insurance. An insured is not entitled to replacement cost recovery unless and until the damaged structure is repaired or replaced. *Lerer Realty Corp. v. MFB Mut. Ins. Co.*, 474 .F.2 410, 412–13 (5th Cir. 1973)(applying Texas law the Fifth Circuit noted that "[a] reading of the [repair or replace endorsement] discloses a clear and unambiguous

undertaking to pay the insured the actual cash value of the damaged property at the time loss, less depreciation, unless the insured actually repaired, rebuilt, or replaced within a reasonable time. If restoration is made, then and only then, the liability of [insurer] would be calculated under the endorsement"]; *Ghoman v. New Hampshire Ins. Co.*, 159 F.Supp. 2d 928, 932 (N.D. Tex. 2001)("Obviously, an insured cannot recover repair or replacement costs unless and until he actually repairs or replaces the insured structure.") *Nicolaou v. Vermont Mutual Ins. Co.*, 931 A.2d 1265, 1271-72 (N.H. 2007)("Allowing a policyholder to recover replacement costs without actually repairing or rebuilding would leave him in a better position as a result of the fire than the position he was in before the fire, which is a "moral hazard" that the repair or replacement requirement is intended to avoid"); *Truesdall v. State Farm*, 960 F.Supp. 1511, 1516 (N.D. Okla. 1997)("the Court looks to other jurisdictions which have addressed the issue of the enforceability of replacement cost clauses. Uniformly, and without exception, these cases have held that such terms are enforceable as long as they are clear and unambiguous."); *Hess v. North Pacific Ins. Co.*, 859 P.2d 586, 590 (Wa. 1993) ("replacement cost provisions have been interpreted as providing a condition precedent to an insurer's duty to pay repair or replacement costs of an insured building. A party who has not repaired or replaced the building has not complied with the condition precedent to recovery under the policy and so cannot recover"); *Burchett v. Kansas Mut. Ins. Co.*, 48 P.3d 1290, 1291-92 (Kan. Ct. App. 2002)("The unambiguous terms of the contract require the insured to actually repair or replace the damaged property before he or she may collect the full replacement cost. If the insured does not repair or replace the damaged property, he or she is only entitled to actual cash value. . . [courts of this country have] unanimously held that actual repair or replacement is a precondition to recovery on a replacement cost policy.").

Similarly, other jurisdictions in the United States have held that a recovery beyond the ACV is possible under and insurance policy only when the condition precedent for RCV recovery is satisfied by the repair or replacement of the damaged structure, and the amount expended to repair or replace the damaged structure exceeds the prior actual cash payment. *See Kalis v. Aetna Cas. and Surety Co.*, 378 F.Supp. 392,400–01 (S.D. Iowa 1974). ("It is clear from ... the Replacement Cost Endorsement that it is necessary for the insured to repair and replace the property *and expend an amount in excess [of the actual cash payment] before they may recover under the Replacement Cost Endorsement."* (emphasis added); *Colorado Cas. Ins. Co. v. Sammons,* 157 P.3d 460, 468 (Wyo. 2007)("it is the nature of replacement cost insurance that, if an insured spends less for replacement than the actual cash value of the loss, he or she is not entitled to replacement cost coverage amounts").

The damage model utilized by most policyholder lawyers is a replacement cost damage model in property cases. It is rare that the plaintiff's experts or their damage model attacks the insurers' ACV calculations from the claim investigation and claim payment. Insurers and their counsel would be wise to make more use of the extremely favorable law on this issue in Texas.

B. Standing/insurable interest

In many commercial property cases, the entity bringing the bad faith lawsuit lacks standing and/or an insurable interest in the property made the basis of the lawsuit. In an effort to avoid corporate tax liability and in an effort to minimize tort liability for property owners, many commercial property owners have gotten very creative in how they establish the corporations and

partnerships that own and manage real estate. In commercial real estate, single asset entities are very popular. For example, in our experience, the insureds in whose name commercial property policies are frequently issued usually do not match the names of the corporations or partnerships that actually own the properties. Many commercial property policies are placed in the name of property management companies, real estate advisors, or other consultants who have no ownership interest in the property. This is significant because many commercial property policies *require* that the insured have an actual ownership interest in the property. As a general point of law, any insured must have an insurable interest. Because there is frequently some commonality of individuals, partnership or corporations within the a larger corporate family with commercial property holdings, many carriers and their lawyers overlook the differences in named insured status in contrast to those whom actually own the property in question. It is a very significant issue in the defense of bad faith claims because an insurer cannot be liable for breach of contract or bad faith to an individual, corporation or partnership with whom it has no contractual privity or to whom it owes no legal duty. If standing or insurable interest is an issue in an insurance coverage or bad faith lawsuit, an important predicate question involves how and when to address these issues. We believe these issues are best raised in a plea to the jurisdiction raised before trial and resolved outside the presence of the jury. Texas case law established in other types of litigation creates clear precedent for following this approach.

For example, in our home state, Texas law on the procedural standards for a jurisdictional challenge is well summarized in *Texas Dept. of Parks and Wildlife v. Miranda*. *Texas Dept. of Parks and Wildlife v. Miranda*, 133 S.W.3d 217 (Tex. 2002). That case explains what standards apply in a plea to the jurisdiction when (i) the challenge can be decided as a matter of law, (ii) when the challenge cannot be determined as a matter of law but the jurisdictional challenge does not inextricably implicate the case on the merits, and (iii) when the challenge cannot be resolved as a matter of law and the jurisdictional challenge inextricably implicates the merits. *Id.*

Following the "decision tree" outlined in "civil-*Miranda*," a trial court must first determine if the defendant's challenge can be resolved as a matter of law in its favor; if so, the process ends and the case is over. *Id.* at 228. A fact is "material" only if it affects the ultimate outcome of the suit under the governing law. *Lampasas v. Spring Ctr., Inc.*, 988 S.W.2d 428, 433 (Tex. App.—Houston [14th Dist.] 1999, no pet.). A material fact issue is "genuine" only if the evidence is such that a reasonable jury could find the fact in favor of the nonmoving party. Second, if instead the trial court finds a genuine issue of material fact, then it must decide whether the jurisdictional challenge "inextricably implicates" the merits of the plaintiff's case. *Miranda*, 133 S.W.3d at 226. The Texas Supreme Court explained, "Whether a district court has subject matter jurisdiction is a question for the court, not a jury, to decide, even if the determination requires making factual findings, unless the jurisdictional issue is inextricably bound to the merits of the case." *Id.* If the merits of the two are *not* inextricably implicated, then the Court—not the jury—must determine the plea to the jurisdiction as fact finder. *University of Texas v. Poindexter*, 306 S.W.3d 798, 806 (Tex. App.—Austin 2009, no pet.). Third, if the court's review of the material facts for jurisdiction demonstrates that the merits of the case are inextricably implicated, then (and only then) must the jurisdictional challenge be tried before a jury.

Trial courts must serve as diligent evidentiary gate keepers when hearing a party's plea to the jurisdiction because a party may be tempted to try their case in such a way to confuse the issue

as to whether the material jurisdictional facts implicate the merits of its underlying case. *Bland Indep. Sch. Dist. v. Blue*, 34 S.W.3d 547, 555 (Tex. 2000) ("[T]he proper function of a dilatory plea [like a plea to the jurisdiction] does not authorize an inquiry so far into the substance of the claims presented that plaintiffs are required to put on [the merits of] their case simply to establish jurisdiction."). When conducting an evidentiary hearing, it is imperative that the court review all the jurisdictional evidence and testimony. A district court would not know whether the challenge could resolved as a matter of law or if it does or does not inextricably implicate the underlying claims until after all the jurisdictional evidence and testimony is heard. At that point, the court must travel down the *Miranda* decision tree to determine if the court or the jury must act as the fact finder.

In the insurance bad-faith arena, at least one trial court exemplified its duty as a diligent evidentiary gate keeper when it recognized the risk of jurisdictional facts regarding plaintiffs' standing might be easily confused with the litigation of their Hurricane Ike claims. In a large bad faith case we tried in 2013, *GPM Houston Properties, LTD., et al. v. Fireman's Fund Insurance Company,* cause No. 2010-47654, the defendant insurer challenged each of the plaintiffs' insurable interest in two shopping malls that were damaged by Hurricane Ike. Specifically, carrier argued that that none of the plaintiffs had an insurable interests in the properties because they were not named insureds under the insurance policy. Plaintiffs argued that whether they had rights under the insurance policy is no different than proving the first element of breach of contract; and, they argued the issue of their insurable interest should be decided by the jury. Judge Jeff Shadwick found that there were issues of fact regarding plaintiffs' standing and applied the civil-*Miranda* decision tree in determining the issue of whether the plaintiffs had an insurable interest in the malls should go to a jury, or be decided by the court. He ruled:

> Taking the next step in the *Miranda* decision tree, having heard the evidence, the Court believes that ruling upon the standing issue does not implicate the merits of the Hurricane Ike insurance claim raised under the subject Policy. Since the existence, terms, and conditions of the 2008 insurance policy are not contested, ruling upon the standing question will not interfere with the jury's determination of an insurance claim. Accordingly, the standing issue will not be submitted to the jury in the insurance claim trial. *Triyar Companies, LLC v. Fireman's Fund Ins. Co.*, 2013 WL 6805197 (Tex.Dist.) Order and Findings of Defendant's Plea to the Jurisdiction (J. Shadwick).

Thus, if the jurisdictional challenge cannot be resolved as a matter of law, but the standing issues do not inextricably implicate the claimant's case, the trial court *must* resolve any genuine issue of material fact as fact-finder and rule on the jurisdictional challenge.

III. Discovery Strategies In "Institutional" Bad Faith Litigation

A. Introduction

It is axiomatic that wars are won in the trenches. In the case of first-party bad-faith litigation, those trenches are in discovery. Both policyholders and insurers battle over what documents and evidence can be discovered, and then used, to demonstrate when an insurer has

breached its duties under the law. In the end, like many wars, the ultimate question is whether the gain is worth the price. Increasing discovery requests and production orders require the enormous expenditure of resources, but may ultimately have little effect. As a result, the true victor of the war between policyholder and insurer is debatable.

We wish to examine three "theaters" in the ever evolving bad-faith battles between policyholders and policyholders. The first is an examination of the long-standing discovery of information regarding the policyholder's particular claim. Generally, those documents are discoverable. The next is an examination of the newer species of "institutional bad faith," and the attempt by policyholders to expand discovery to a new level. Here, decisions are widely mixed. Finally, we will examine discovery in the context of catastrophe claims. Hurricane Ike has provided the opportunity to study discovery in first-party bad-faith cases across tens of thousands of lawsuits, and the practical effect of each tactic discussed in the preceding sections.

It is important to point out that the phrase "first party" is intended to encompass all matters brought directly by a policyholder (or their beneficiary) against an insurer and includes claims for property loss under auto or homeowner's policies as well as life and health insurance. In some limited circumstances, it can also include demands for defense and indemnification benefits made by a policyholder to its liability insurer. Due to the specific nature of this presentation, however, this paper cannot provide a detailed analysis of all of the practical implications involved in the discovery process, *i.e.*, procedural mechanisms or procedural limitations though which discovery is conducted or privileges are protected. For those who handle or are involved in first-party insurance lawsuits, this paper is intended to discuss the diverse rulings and writings regarding an overwhelmingly large topic that varies on a case-by-case basis.

B. Claim-Specific Discovery

The typical bad-faith situation arises out of a policyholder's allegation that the insurer failed to pay, or unreasonably delayed in paying a covered claim.[1] In these situations, discovery is directed towards the specific allegations regarding the specific policy and facts of the denial or underpayment. Despite frequent objections, the nationwide trend is that discovery targeted solely at the facts of the case will be permitted. Such discovery usually seeks three specific types of documents from the insurer: (1) the insurer's claim file; (2) the policy underwriting file; and (3) personnel files of the specific individuals that handled the policyholder's claim.[2]

1. Claim File Discovery

The claim file is the most important piece of evidence in a first-party bad-faith case[3] and frequently "the most eloquent witness for or against the insurer will be the claim file."[4] It can reveal such

[1] *See* Douglas R. Richmond, Defining and Confining Institutional Bad Faith in Insurance, Tort Trial & Insurance Practice Law Journal, (Fall 2010).

[2] To be sure, these three categories do not constitute the entire discovery available to a policyholder; they only represent the documents readily available from an insurer.

[3] Stephen S. Ashley, Bad Faith Actions Liability & Damages §10:37.

[4] *See, e.g.,* Ashely, Bad Faith Actions Liability & Damages § 10:28; 1 Paul R. Rice, Attorney-Client Privilege in the United States §4:29; *Pete Rinaldi's Fast Foods, Inc. v. Great Am. Ins. Co.*, 123 F.R.D. 198, 203 (M.D. N.C. 1988); *Prisco Serena Strum Architects, Ltd. v. Liberty Mut. Ins. Co.*, 1996 WL 89225 (N.D. Ill. 1996).

damaging notes as:

- an adjuster's comment that he "has never paid a policy limit to date, and does into to start with the subject claim,"[5]
- or, the comment of an adjuster faced with a claim clearly exceeding policy limits, "I will start at a low price and work my way up. There is no harm offering a lower amount at first. I can always go up."[6]

On the other hand, the claim file can also document the insurer's good faith.[7] For example, prompt payment statutes in some states allow an insurer to show its compliance through the claim file.[8] As such, the claim file frequently defines the battlefield in a first-party bad-faith case, but that has not always been the case.[9]

Not long ago, some courts held that discovery of the claim file was irrelevant until coverage was actually determined.[10] For example, in 1982, the Texas Supreme Court presciently observed that allowing discovery of the claim based merely on an allegation of bad faith would cause every case to contain bad-faith allegations:

> if a plaintiff attempting to prove the validity of a claim against an insurer could obtain the insurer's investigative files merely by alleging the insurer acted in bad faith, all insurance claims would contain such allegations.[11]

And, that is exactly what has happened over the last two decades.

Many, if not most, first-party petitions now include multiple allegations of either common law or statutory bad faith, and several violations of a state's insurance code. As a result, in the typical bad-faith case, discovery of the insurer's claim file for the specific claim is almost a given.[12] This has left insurers in the position of trying to protect only key pieces of claim files.[13] Barring an objection based on the drafting of the request, the most frequently asserted defenses to production are assertions of attorney-client privilege or work product.[14]

a. Attorney-Client Privilege

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[5] *See Groce v. Fidelity Gen. Ins. Co.*, 448 P.2d 554, 558 (Ore. 1968).
[6] *Davis v. Allstate Ins. Co.*, 303 N.W. 2d 596 (1981).
[7] *See* Dawn R. Bonnett, The Use of Colossus to Measure the General Damages of a Personal Injury Claim Demonstrates Good Faith Claims Handling, 53 Clev. St. L. Rev. 107 (2005).
[8] *See e,g.,* Tex. Ins. Code §542
[9] Allan D. Windt, 2 Ins. Claims and Disputes 5th §9:19 (2011).
[10] *See, e.g., Maryland Am. Gen. Ins. Co. v. Blackmon*, 639 S.W.2d 455, 458 (Tex. 1982).
[11] *Maryland Am. Gen. Ins. Co. v. Blackmon*, 639 S.W.2d 455, 458 (Tex. 1982).
[12] *See, e.g.,*2 Dennis Wall, Litig. & Prev. Ins. Bad Faith 3rd ed. §17:62 ("In a bad faith claim there is generally no reason why the court will not compel production of the claim files for the claim at issue."); *Consugar v. Nationwide Ins. Co. of Am.*, 2011 WL 2360208, *2 (M.D. Pa. June 9, 2011).
[13] James R. Jebo, *Overcoming Attorney-Client Privilege and Work Product Protection in Bad-Faith Cases*, 70 DEF. COUNS. J. 261, 263 (2003).
[14] *See, e.g.,* 17A Couch on Insurance §250:29 (2011).

Generally, the attorney-client privilege is "narrowly defined, riddled with exceptions and subject to continued criticism."[15] But, in insurance litigation, the attorney-client privilege can become the infamous "riddle wrapped in a mystery inside an enigma."[16] Like many corporations, insurers utilize large staffs of in-house counsel, in addition to outside counsel.[17] As a result, quite frequently, e-mails, notes, or observations by in-house counsel appear in the claim file.[18] The problem for the unsuspecting is that those communications may not be privileged simply because an attorney was involved.[19]

The riddle frequently seen in discovery of bad-faith case is when an attorney is not an attorney. In no other area of commercial litigation have courts so readily dismissed attorneys as mere investigators as when the case involves counsel for insurers.[20] When asserting that attorney-client privilege protects claim-file documents, counsel for the insurer must remember that the burden of proving privilege is on them.[21] While the retention of counsel is a factor to consider, an insurance company may not insulate itself from discovery by hiring an attorney to conduct ordinary claims investigation.[22] This is because the work performed by both in-house and outside counsel in investigating and adjusting a claim is viewed as an ordinary business function that does not require any specialized type of legal knowledge.[23]

Whether the attorney was actually acting as an attorney is the mystery. The United States Supreme Court rejected a hard line "control group" test in *Upjohn Co. v. United States.*[24] But, in ruling that counsel acting in ordinary business functions are not privileged, it opened the door to a plethora of opinions and contradictions fit only for the world of bad-faith litigation.[25] There is not trend because there is not a consistent ruling on when counsel for an insurer transitions from an

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[15] *U.S. v Schwimmer*, 892 F.2d 237 (2d Cir. 1989); *see also Fine v. Bellefonte Underwriters Ins. Co*., 91 F.R.D. 420, 422 (S.D.N.Y.1981).
[16] Winston Churchill, "Russia: A Riddle, Wapped in a Mystery, Inside an Enigma," (Oct. 1, 1939).
[17] *In re Central Gulf Lines*, 2000 WL 1793395 (E.D. La. 2000). *See also* Susan Page White, Attitude Adjustment Case Law Makes It Clear That the Attorney-Client Privilege Does Not Attach When an Attorney Acts As A Claims Adjuster, L.A. Law., February 2010, at 18.
[18] *See* Jebo, 70 DEF. COUNS. J. at 263.
[19] *See, e.g.,* Susan P. White, Attitude Adjustment, Case Law Makes it clear that the Attorney-Client Privilege Does Not Attach When Aan Attorney Acts as a Claims Adjuster, 32-Feb L.A. Law. 18 (2010).
[20] Edward F. Donahue, Detective or Advisor – the Attorney-Client Privilege in the Coverage Evaluation, 11 Fidelity L.J. 65, 72 (2005).
[21] *See, e.g., U.S. v. Wilson*, 798 F.2d 509, 512–13 (1st Cir. 1986); *U.S. v. Adlman*, 68 F.3d 1495, 1500, (2d Cir. 1995); *U.S. v. Costanzo*, 625 F.2d 465, 468 (3d Cir. 1980); *U.S. v. Aramony*, 88 F.3d 1369, 1389 (4th Cir. 1996); *U.S. v. Ponder*, 475 F.2d 37, 39 (5th Cir. 1973); *U.S. v. Dakota*, 197 F.3d 821, 825 (6th Cir. 1999); *U.S. v. Lawless*, 709 F.2d 485, 487 (7th Cir. 1983); *Hollins v. Powell*, 773 F.2d 191 (8th Cir. 1985).
[22] *See Arkwright Mut. Ins. Co. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa.*, 90 CIV. 7811 (AGS), 1994 WL 510043 (S.D.N.Y. Sept. 16, 1994); *Mission Nat'l Ins. Co. v. Lilly*, 112 F.R.D. 160, 163 (D.Minn.1986).
[23] *See, e.g, Chicago Meat Processors Inc. v. Mid-Century Ins. Co.*, 1996 U.S. Dist. Lexis 4495, *8 (N.D. Ill. 1996), *citing Mission Nat'l Co. v. Lilly*, 112 F.R.D. 160, 163 (D. Minn. 1986); *.Mission Nat'l Ins Co. v. Lilly*, 112 F.R.D. 160, 163 (D. Minn. 1986); *St. Paul Reinsurance Co. v. Commerical Fin. Corp*. 197 F.R.D. 620, 641 (N.D. Iowa 2000); *National Farmers Union Prop. & cas. Co. v. District Court*, 718 P.2d 1044, 1049-50 (Cal. 1986) (en banc); *Bertalo's Rest. Inc. v. Exchange Ins. Co.*, 658 N.Y.S. 2d 656, 659 (N.Y. App. Div. 1997).
[24] 449 U.S. 383 (1981).
[25] *See, e.g.,* 1 Paul R. Rice, Attorney-Client Privilege in the United States §4:29 (2011).

investigator or adjuster to actually being a lawyer.[26]

Some courts have focused on a "shift" when the attorney changes from an investigating businessperson to relying on legal knowledge in providing advice to a client.[27] But even then, courts appear split on whether the decision to decline coverage marks the shift, or whether a formal demand or threat by the policyholder is required.[28] And to add a final question to the mix is a questionable ruling from the Supreme Court of Ohio that seemingly ignores *Upjohn* in broadly holding "claim file materials that show an insurer's lack of good faith in denying coverage are unworthy of protection."[29]

It therefore appears that the only answers to this mystery wrapped riddle are the enigmas of the facts, jurisdiction, and court. It goes well beyond the scope of this paper to begin to predict where these cases will go.

b. Work-Product Privilege

Adding further complications to the trend of mixed privilege decisions are those dealing with attorney work product. The Federal Rules of Civil Procedure state the general rule that "ordinarily, a party may not discover documents and tangible things that are prepared in anticipation of litigation or for trial by or for another party or its representative."[30] But, the line between documents prepared in the ordinary course of business and those prepared in anticipation of litigation is not always clear.[31] Some courts hold only claim-file documents prepared at the request, or under the direction, of counsel are discoverable.[32] The basis for this rests on the general business nature of adjusting claims.[33] Another group of courts hold that almost all information collected a claim is submitted is immune from disclosure because there is always the chance of litigation in a heavily litigious society.[34]

The only solution to this compounding confusion is to become familiar with the case law in the relevant jurisdiction.[35] For example, where most of the country utilizes a "because of" test that questions whether a document was prepared "because of" litigation, the Fifth Circuit has

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[26] *See Connecticut Indem. Co. v. Carrier Haulers, Inc.*, 197 F.R.D. 564, 570-71 (W.D. N.C. 2000) (collecting authorities).
[27] *Id.*
[28] *Compare id. and St. Paul Reinsurance Co. v. Commercial Fin. Corp.*, 197 F.R.D. 620, 630 (N.D. Iowa 2000) and *Goodyear Tire & Rubber Co. v. Chiles Powers Supply, Inc.*, 190 F.R.D. 532, 535 (S.D. Ind. 1999).
[29] *Boone v. Vanliner Ins. Co.*, 744 N.E.2d 154, 158 (Ohio 2001).
[30] Fed. R. Civ. P. 26(b)(3).
[31] *See Fine v. Bellefonte Underwriters Ins. Co.*, 91 F.R.D. 420, 422 (S.D.N.Y.1981).
[32] *McDougall v. Dunn*, 468 F.2d 468, 473 (4th Cir. 1972); *Allendale Mut. Ins. Co. v. Bull Data Systems, Inc*., 152 F.R.D. 132 (N.D. Ill. 1993); *Lawyers Title Ins. Corp. v. U.S. Fidelity & Guar. Co*., 122 F.R.D. 567 (N.D. Cal. 1988); *Silva v. Fire Ins. Exchange*, 112 F.R.D. 699 (D. Mont. 1986); *In re Bergeson*, 112 F.R.D. 692 (D. Mont. 1986); *Atlanta Coca-Cola Bottling Co. v. Transamerica Ins. Co.*, 61 F.R.D. 115, 118 (N.D. Ga. 1972); *Thomas Organ Co. v. Jadranska Slobodna Plovidba*, 54 F.R.D. 367, 372 (N.D. Ill. 1972).
[33] *See, e.g.*, Jebo, 70 DEF. COUNS. J. 261 at 263.
[34] *Weitzman v. Blazing Pedals, Inc*., 151 F.R.D. 125 (D. Colo. 1993); *Almaguer v. Chicago, R. I. & P. R. Co*., 55 F.R.D. 147, 16 (D. Neb. 1972).
[35] Richmond at 32, Jeffrey M. Cohen, An Update on Top-Down Discovery in Actions Alleging "Institutional Bad Faith," 21 Coverage 29 (July/August 2011).

crafted its own "primary purpose" test that looks to the motivating purpose behind the creation of a document.[36] The various nuances of state work-product doctrines are too numerous to list in this paper.[37] It is sufficient to say that the prudent practitioner is the one that reads the cases; the prudent insurer is the one that documents the legal nature of its communications with counsel.

2. Underwriting File

When the claim file is almost undisputedly relevant to a first-party bad-faith action, requests for the underwriting file are seemingly irrelevant absent a dispute over coverage.[38] Nevertheless, a new trend appears to hold that even though underwriting files may not ultimately be relevant to the bad-faith dispute, they are subject to discovery.[39]

To defense counsel and insurers, the underwriting file represents little more than an electronic history of placing coverage.[40] To policyholders, on the other hand, the underwriting file represents a means of discovering just how the insurer intended its terms to be applied.[41] This is especially relevant when an policyholder argues ambiguity or that the insurer incorrectly interpreted its own policy. And, under those circumstances, the courts are willing to indulge discovery of the underwriting file.[42]

Such a situation recently occurred in *Cummins, Inc. v. ACE American Ins. Co.*[43] There, a policyholder purchased several manuscript policies from a series of insurers over several years.[44] After a massive flood damaged its facilities, a coverage dispute arose over multiple issues one of which was "the meaning and application of the term 'Flood in High Hazard (100 year) Flood Zones."[45] The policyholder requested production of "all documents related" to each Insurer's underwriting files, manuals and guidelines, among other things.[46] The insurers contended that such documents were not relevant because, in several jurisdictions, courts cannot go beyond the strict eight corners of the policy and pleadings.[47] As such, any interpretation guidelines presented in underwriting could not possibly be relevant.[48]

In reviewing the arguments of both parties, the court found itself in a position all too

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[36] *Compare U.S. v. El Paso Co.*, 682 F.2d 530 (5th Cir. 1982) *with United States v. Adlman*, 134 F.3d 1134 (2d. Cir. 1998).
[37] *Compare, e.g., Compton v. Safeway, Inc.*, 169 P.3d 135 (Colo. 2007); *Cotton States Mut. Ins. Co. v. Turtle Reef Assoc.*, 444 So.2d 595 (Fla. Dist. App. 1984); *Nat'l Tank Co. v. Brotherton*, 851 S.W.2d 193 (Tex. 1993).
[38] *See Florida Residential Prop. & Cas. Joint Underwriters Ass'n v Sanchez*, 693 So. 2d 68, 68 (Fla. 3d DCA 1997).
[39] *See, e.g, Cummins, Inc. v. ACE American Ins. Co.*, No. 1:09-cv-00738-JMS-DML, 2011 WL 130158 (S.D. Ind. Jan. 24, 2011).
[40] *Id.* at *5.
[41] *Id.*
[42] *See, e.g., United States Fire Ins Co. v. Bunge*, 244 F.R.D. 638, 646 (D. Kan 2007); *Stonewall Ins. Co. v. Nat'l Gypsum Co.*, 1988 WL 96159 at *3-4 (S.D. N.Y. Sept. 6, 1998); *Michigan Mut. Ins. Co. v. Sports, Inc.*, 698 N.E.2d 838 (Ind. Ct. App. 1998).
[43] *Cummins,* 2011 WL 130158 at *5.
[44] *Id.* at *1.
[45] *Id.*
[46] *Id.* at *4.
[47] *Id.*
[48] *Id.*

familiar to many judges: "Cummins's discovery requests, and motion to compel, give the impression that nearly every word of the Policy is at issue, while the Insurers think none of it is."[49] On the whole, the court could not find that the policy was not unambiguous.[50] As a result, it refused to bar discovery that could "lead to admissible evidence regarding the meaning of the Policy."[51] Several other courts have relied on the same broad interpretation to allow discovery of underwriting files.[52]

These decisions mean that if coverage or policy ambiguity is alleged, then underwriting files will almost certainly be relevant. As explained by one court, "although the interpretation of an insurance policy is a legal question, an policyholder is entitled to explore what risks the insurer expects to cover in the policy."[53] And though counsel for the insurer may bemoan giving up yet more documents, the trend appears to be like that of claim files: production.[54]

3. Personnel Files

Another trend in claim-specific discovery has been repeated requests by policyholder's counsel for the personnel files of the employees involved in the denial or underpayment of coverage. As described by policyholders, there are two general bases for such discovery: (1) to prove a lack of employee credibility, training, or qualifications;[55] or (2) to determine whether through payment or corporate structure, employees were encouraged to deny claims.[56]

While there is a stated "strong public policy against the disclosure of personnel files,"[57] an increasing number of courts are finding that they are relevant for discovery purposes in first-party litigation.[58] These courts balance the need for discovery against the privacy interest inherent in the files, and in another trend discussed in detail below, are increasingly issuing protective orders or ordering in camera inspection of the files.[59]

Still, some courts are decidedly protective over the private nature of the files for a variety of reasons. One court has taken a parallel approach to *Upjohn* in explaining that personnel files

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[49] *Id.* at *5.
[50] *Id.*
[51] *Id.*
[52] *See, e.g, Silgan Containers v. Nat'l Union Fire Ins. Co.*, 2010 WL 5387748 (N.D. Cal. Dec. 21, 2010); *Pentair Water Treatment (OH) Co. v. Continental Ins. Co.,* 2009 WL 3817600, at * 4 (S.D.N.Y. Nov.16, 2009); *1550 Brickell Associates v. QBE Ins. Corp.*, 2008 WL 4279538 (S.D. Fla. July 8, 2008); *Lexington Ins. Co. v. Commonwealth Ins. Co.*, 1999 WL 33292943 (N.D. Cal. Sept. 17, 1999).
[53] *Silgan Containers v. Nat'l Union Fire Ins.*, 2010 WL 5387748 (N.D. Cal. Dec. 21, 2010), *relying on Quan v. Truck Ins. Exchange,* 67 Cal.App.4th 583, 602 (1998).
[54] 2 Dennis Wall, Litig. & Prev. Ins. Bad Faith § 12:4 (3rd ed.).
[55] *See, e.g., Waters v. Continental Gen. Ins. Co.*, 2008 WL 2510039 (N.D. Okla. June 19, 2008).
[56] *See, e.g, White v. Continental Gen. Ins. Co.*, 831 F. Supp. 1545, 1556 (D. Wyo. 1993).
[57] 10 John Kimpflen, et al, Federal Procedure §26:130 (L. Ed. West 2011).
[58] *See, e.g., Porter v. Farmers Ins. Co.*, 2011 WL 1566018, *2 (N.D. Okla. Apr. 25, 2011); *Christensen v. American Family Mut. Ins. Co.*, 2011 WL 3841293, *7 (D. Utah Aug. 29, 2011); *Lyon v. Bankers Life and Cas. Co.*, 2011 WL 124629, *8 (D. S.D. Jan. 14, 2011); *Saldi v. Paul Revere Life Ins. Co.*, 224 F.R.D. 169, 184-86 (E.D. Pa. 2004); *Dahdal v. Thorn Americas, Inc.*, 1997 WL 5999614, *1 (D. Kan. Sept. 15, 1997); *Hamilton Mut. Ins. Co. of Cincinnati v. George*, 2006 WL 1652237 (Ky. June 15, 2006).
[59] *See, e.g., Christensen*, 2011 WL 3841293 (noting general trend); *Regan-Touhy v. Walgreen Co.*, 526 F.3d 641, 648 (10th Cir. 2008).

should encourage candid evaluations of employees.[60] Heavy discovery into those files could stifle such workplace productivity.[61] Another has focused on "raw data, uncorroborated complaints, and other information which may or may not be true but may be embarrassing."[62] And others have relied on the generally private nature of the files to block their production.[63]

Nevertheless, the trend in first-party bad-faith cases appears to be because personnel information related to job performance, pay, or incentives could reveal a systematic issue of bad faith, the files are discoverable.[64] The Kentucky Supreme Court highlights the general trend and the issues for the courts: "many of the items likely to be found in personnel records (e.g, original job application, marital information, tax and dependent data, medical information, health insurance data, worker's compensations claims, and retirement account data) are irrelevant to a bad-faith claim and thus are not discoverable."[65] But, the Court also highlighted: "other information to be found in personnel files (e.g., related to job performance, bonuses, wage and salary data, and disciplinary matters) could help show that the adjusters and their superiors had engaged in bad-faith practices."[66]

Like the Kentucky, many courts have recognized that with relevance comes intrusiveness as explained by the Tenth Circuit:

[P]ersonnel files often contain sensitive personal information,…and it is not unreasonable to be cautious about ordering their entire contents disclosed willy-nilly. Indeed, the Supreme Court has underscored that "the requirement of Rule 26(b)(1) that the material sought in discovery be 'relevant' should be firmly applied, and the district courts should not neglect their power to restrict discovery [to protect] 'a party or person from annoyance, embarrassment, [or] oppression…'"[67]

Many courts have followed and "firmly applied" the need for protection in what appears to be a nationwide trend.[68] Some courts have blocked written requests, but allowed questioning during deposition about the termination of employees because it was a less intrusive measure.[69] Another court narrowed a policyholder's discovery requests by only allowing discovery into the personnel files of the specific employees involved in the handling of the file.[70]

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[60] *See Blount v. Wake Elec. Membership Corp.*, 162 F.R.D. 102, 105 (E.D. N.C. 1993).
[61] *Id.*
[62] *Alterra Healthcare Corp. v. Estate of Shelly*, 827 So.2d 936, 944-45 (Fla. 2002).
[63] *See Royal Bahamian Ass'n v. QBE Ins. Corp.*, 268 F.R.D. 692, 694 (S.D. Fla. 2010); *Regan-Touhy v. Walgreen Co.*, 526 F.3d 641, 648 (10th Cir. 2008); *Pepperwood of Naples Condo Ass'n v. Nationwide Mut. Fire Ins. Co.*, 2011 WL 4596060, *12 (M.D. Fla. Oct. 3, 2011) (due to sensitive nature only files of directly involved personnel could be produced); *Christensen v. Am. Fam. Mut. Ins.* Co., 2011 WL 3841293, *7 (D. Utah Aug. 29, 2011).
[64] Cohen, 21 Coverage at 31.
[65] *Grange Mut. Ins. Co. v. Trude*, 151 S.W.3d 803, 815 (Ken. 2004).
[66] *Id.*
[67] *Regan-Touhy v. Walgreen Co.*, 526 F.3d 641, 648 (10th Cir. 2008), *quoting Herbert v. Lando*, 441 U.S. 153, 177 (1979).
[68] Cohen, 21 Coverage at 31; *Pochat v. State Farm Mut. Auto. Ins. Co.*, 2008 WL 5192427 (D.S.D. Dec. 11, 2008); *Saldi v. Paul Revere Life Ins. Co.*, 224 F.R.D. 169 (E.D. Pa. 2004); *Dahdal v. Thorn Americas, Inc.*, 1997 WL 599614, *1 (D. Kan. Sept. 15, 1997).
[69] *See, e.g., Carlucci v. Maryland Cas. Co.*, 2000 WL 298925 (E.D. Pa. March 14, 2000)*; see also Adams v. Allsate Ins. Co.*, 189 F.R.D. 331, 333 (E.D. Pa. 1999).
[70] *See Pepperwood of Naples Condo. Ass'n*, 2011 WL 4596060 at *12. *See also, Christensen*, 2011 WL 3841293 at

In what appears to be a new trend, most courts are relying on some version of a protective order to protect adjusters' or employees' personal information.[71] Like requests for claim and underwriting files, the general trend in production of personnel files appears to be an increasing finding of relevance with a concomitant recognition of privacy.[72] As arbiters of the ultimate conflict, courts are recognizing the need to protect both parties' rights within litigation.[73] For policyholders, it is the right to develop a case through discovery of an insurer's files and documents. For insurers, it is recognition of their ongoing business concerns, and most importantly, the inherent privacy all employees expect at work. Generally, the courts are attempting to find a workable balance for discovery requests directed solely at a single claim, but the question remains of whether that balance can withstand the fires of even broader allegations with even broader defenses.

C. INSTITUTIONAL DISCOVERY

Moving beyond claim-specific discovery, an ever increasing trend for policyholders is to allege claims of "institutional bad faith."[74] Policyholders frequently rely on institutional bad-faith allegations to prove that the insurer either knew or recklessly disregarded the fact that it had no reasonable basis for its actions.[75] As almost all jurisdictions require some level of culpability beyond mere breach of contract, institutional bad-faith allegations can sometimes provide the policyholders' counsel with the only method to prove bad faith.[76] Nevertheless, these requests serve the double purpose of both discovery and significantly increasing the costs of defense.

1. The Motivation for Institutional Discovery

Institutional bad-faith allegations allow a policyholder's counsel to widen the battlefield from a single, narrow claim to the entire front of how an insurer does business and even its previous successes and failures, essentially putting the insurer itself on trial.[77] Generally, the strategic goal of widening the discovery front is accomplished through two main tactical allegations: (1) as a direct theory of liability; and (2) as a means of enhancing potential punitive damage awards.[78]

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[71] *See, e.g.*, *Fulbright v. State Farm Mut. Ins. Co.*, 2010 WL 300436, *5 (W.D. Okla. Jan. 20, 2010); *Stokes v. Life Ins. Of N. Am.*, 2008 WL 2704564 (D. Idaho July 3, 2008); *Saldi v. Paul Revere Life Ins. Co.*, 224 F.R.D. 169, 184 (E.D. Pa. 2004); *Cesena v. Allstate Ins. Co.*, 2006 WL 3302837 (N.D. Cal. Nov. 9, 2006); *DeKnikker v. Gen. Cas. Co. of Wis.*, 2008 WL 1848144 (D. S.D. April 23, 2008).

[72] *Christensen*, 2011 WL 3841293 at *7, *quoting Porter*, 2011 WL 1566018, at *2 ("Courts have generally permitted discovery of relevant personnel files in insurance bad faith cases. However, sensitive personal information is often contained in such files.").

[73] *Id., see also Lyon v. Bankers Life and Cas. Co.*, 2011 WL 124629 at *8 (D. S.D. Jan. 14, 2011); *Carlucci v. Maryland Cas. Co.*, 2000 WL 298925 (E.D. Pa. March 14, 2000); *Dahdal v. Thorn Americans, Inc.*, 1997 WL 599614 at *1 (D. Kan. Sept. 15, 1997).

[74] Richmond, supra at 1.

[75] Richmond, supra at 7.

[76] Cohen, supra at 29.

[77] Richmond, supra at 1, *citing* Michael R. Nelson et al., Extra-Contractual Litigation Against Insurers §2.11, at 2-59 (2009).

[78] Richmond, supra at 9.

a. The Liability Theory

As a theory of liability, "'[i]nstitutional bad-faith' is the argument that the insurer's corporate structure and policies encourage bad-faith claims handling."[79] Numerous consumer websites, articles, and television vignettes only increase the public perception that insurers do not "like" to pay claims.[80] Policyholders capitalize on these fears and perceptions held by the jury panel by alleging that an insurer has engaged in "institutional bad faith." Two key cases set out the parameters of the current institutional bad-faith trend.

(i) Business Decisions

In the first, in *White v. Continental General Cas. Co.*, a policyholder argued that "post claim underwriting" of his health insurance claim was the product of institutional bad faith and set up the threshold for institutional bad-faith discovery.[81] Though the policyholder had knowingly failed to reveal a history a depression on his medical insurance application, he nevertheless argued that the insurer had committed bad faith by denying his claim for a thyroid cyst.[82] The insurer argued its cancellation of coverage was reasonable because it had investigated his application prior to denying coverage, and because coverage for the treatment was "fairly debatable," (i.e., a *bona fide* dispute).[83]

In denying the insurer's motion for summary judgment, the Wyoming federal district court looked to two salient items of discovery obtained by the policyholder:

- The insurer had suffered serious financial losses (roughly $8.5 million) in the years leading up to the application.
- A "bonus plan" required the adjuster to amass "points" based on denial of claims for pre-existing conditions: 100 points were required to keep the adjuster's job, 2.5 points were awarded for either paying or denying a claim, but 5 points were awarded for denials based on pre-existing conditions.[84]

By "post claim underwriting" the insurer could, theoretically, increase its revenues with new applicants and decrease its expenditures by later denying claim.[85] The "bonus plan" created that motive by encouraging adjusters to deny claims simply to save their own jobs.[86] Thus, the benchmark argument of "institutional bad faith" was seemingly confirmed.

(ii) Causally Connected

In the second case, the Arizona's Supreme Court in *Zilisch v. State Farm Mut. Auto. Ins.*

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[79] Richmond, supra at 2.
[80] William F. Merlin and Leslie Scalley, Trying a Catastrophe Claim in the Court of Public Opinion, The Brief, Vol. 41 No. 2 at 50 (Winter 2012).
[81] 831 F. Supp. 1545 (D. Wyo. 1993).
[82] *Id.* at 1548-49.
[83] *Id.* at 1555.
[84] *Id.* at 1556.
[85] *Id.*
[86] *Id.*

Co., supplies the limit to institutional bad-faith claims: a causal connection.[87] In *Zilisch*, an policyholder sued State Farm for bad-faith for allegedly failing to pay her $100,000 underinsured motorist coverage ("UIM"). Trial proceeded with the general theory that State Farm had a nationwide practice of denying claims.[88] Some evidence suggested that not only did State Farm have a goal of having the "most profitable" claims department in the country, but that that goal had led it to set arbitrary payment amounts and to tie both promotions and salary increases for its adjusters to that goal.[89] Like *White*, State Farm allegedly utilized its own adjusters to affect an ultimate corporate bottom line.

Following trial and a negative verdict, State Farm appealed and won.[90] Nevertheless, the policyholder appealed to the Supreme Court of Arizona.[91] That court's analysis illustrates a nuanced approach that looks directly at the policyholder's *claim*, and the impact of the improper "institutional" action directly on it; not necessarily, the institutional practice itself.[92] The court began its analysis by explaining the error of the Arizona Court of Appeals: "[t]he court of appeals held that as long as the amount the insurer ultimately offers to its policyholder is fairly debatable, nothing else it does in investigating the claim, evaluating the claim, and paying the claim really matters."[93] But, the Arizona Supreme Court clarified this result-oriented inquiry by laying out the "basic rules" of bad faith:

- The carrier is obligated to promptly conduct an adequate investigation;
- The carrier must act reasonably in evaluating the claim;
- The carrier must act promptly in paying a legitimate claim;
- It should not that jeopardizes the policyholder's security under the policy;
- The carrier should not force an policyholder "through needless adversarial hoops;" and
- The carrier should not "lowball" or delay claims to devalue the settlement amount.[94]

Because the record contained sufficient evidence to demonstrate at least one of these factors, the Arizona Supreme Court remanded for further consideration.[95]

As shown here, *White* and *Zilisch* illustrate important parameters for institutional bad-faith allegations. First, because each policyholder utilized institutional evidence, it is clear that courts have allowed discovery of institutional documents that bear on the policyholder's claims. Next, not only is discovery allowed, but the use of discovery items in dispositive motions or at trial has also been allowed. Finally, the ultimate restraint underlying both decisions is the need for a causal connection between the alleged institutional practice and the ultimate handling and result of the policyholder's claim. The *White* court denied summary judgment because there was at least some evidence to support the general institutional allegations, and the *Zilisch* court reaffirmed that the relationship at issue in bad-faith litigation is between the policyholder and the insurer in the context

[87] 995 P.2d 276 (Ariz. 2000).
[88] *Id.*
[89] *Id.*
[90] *Zilisch*, 977 P.2d at 279.
[91] *Id.*
[92] Richmond, supra at 12.
[93] *Zilisch*, 977 P.2d at 279.
[94] *Id.* at 280.
[95] *Id.*

of the claim; not necessarily the institutional practices alone. "If there is no causal link, there can be no liability."[96]

b. The Multiplier Effect

Partly in response to the need for a causal link, some institutional bad-faith allegations are included in a policyholder's petition or complaint simply to "ratchet up" the basis for a potential punitive damages award.[97] But, as explained by the United States Supreme Court, the potential use of institutional documents "in a punitive damage context goes to our understanding of the place of punishment in modern civil law and reasonable standards of process in administering punitive law."[98] At the heart of the institutional bad-faith argument in the punitive damage context is the hoary use of civil penalties "for example's sake."[99] This fits with the modern notion of the punitive nature of punitive damages; rather than the compensatory aspect.[100]

In the bad-faith context, no case has received more attention (for a variety of reasons), than the Supreme Court's decision in *State Farm Mut. Auto. Ins. Co. v. Campbell*.[101] There, the Court emphasized the constitutional basis behind awarding punitive damages.[102] The problem of the underlying decision by the Supreme Court of Utah was not the application of punitive damages – even the court agreed – it was the manner in which they were applied.[103] The Utah jury had only considered State Farm's conduct for the *specific* case; it had viewed the claims handling as part of a "platform to expose, and punish, the perceived deficiencies of State Farm's operations throughout the country."[104]

Despite the irrelevance of legal out-of-state conduct, the policyholder's counsel had argued to the underlying trial court that the conduct was not the primary basis for punitive damages award, "it demonstrated, in a general sense, State Farm's motive against its policyholder."[105] The Supreme Court readily dismissed that argument, and focused instead on the causal connection between the improper conduct and the damages suffered by that particular policyholder.[106] Its ruling forms the benchmark of the insurer's position in institutional bad-faith cases: "[a] defendant should be punished for the conduct that harmed the plaintiff, not for being an unsavory individual or business."[107]

Thus, courts have laid out the arguments and apparent parameters of the theory of

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[96] Richmond, supra at 12, relying on *Sterling v. Provident Life & Acc. Ins. Co.*, 619 F.Supp.2d 1242, 1259 n.15 (M.D. Fal. 2009); *Milhone v. Allstate Ins. Co.*, 289 F.Supp.2d 1089, 1100-02 (D. Ariz. 2003); *Young v. Allstate Ins. Co.*, 296 F.Supp.2d 1111, 1123 n. 21 (D. Ariz. 2001); *Yumukoglu v. Provident Life & Acc. Ins. Co.*, 131 F.Supp.2d 1215, 1227 (D. N.M. 2001); *Kosierowski v. Allstate Ins. Co.*, 51 F.Supp.2d 583, 594-95 (E.D. Pa. 1999).
[97] Richmond, supra at 17.
[98] *Exxon Shipping Co. v. Baker*, 554 U.S. 471, 490 (2008).
[99] *See, e.g, Tullidge v. Wade*, 3 Wils. 18, 19, 95 Eng. Rep. 909 (K.B. 1769).
[100] *See, e.g., Baker*, 554 U.S. at 492, n.9 (collecting authorities).
[101] 538 U.S. 408 (2003).
[102] *Id.* at 421.
[103] *Id.* at 419-420.
[104] *Id.* at 420.
[105] *Id.* at 422.
[106] *Id.*
[107] *Id.* at 423.

institutional bad faith as both a theory of recovery, and as a means of punitive damages. To the policyholder, institutional discovery represents the opportunity to discover just how unsavory an insurer's business practices are.[108] To the insurer, institutional bad faith represents a highwayman's attempt to derail legitimate business concerns by mischaracterizations taken to heart by runaway juries.[109] Nevertheless, all courts seem to agree that at least some causal connection is necessary to demonstrate institutional bad faith.[110]

2. Entity Discovery

As illustrated in *Campbell*, institutional discovery frequently focuses on information specific to the entity's financial status. In the punitive or exemplary damage context, the high net worth of an insurer is frequently argued to be relevant to show the amount of punitive damages necessary to "make it pinch." Though *Campbell* clarifies that policyholders can use total net worth for punitive damage purposes, discovery requests are increasingly being used for other means.

Information about the financial entity can arguably show motivation for engaging in poor institutional practices.[111] In theory, when a policyholder claims bad faith "a comparison between the reserve value of the claim and defendant's actions in processing plaintiff's claim could shed light on defendant's potential liability."[112] For example, in *White*, one frequent allegation used to engage in discovery of the insurance entity's finances is that the company was financially motivated by recent losses and/or market loss to underpay claims.[113] And in *Saldi*, financial losses of an insurer were relevant to showing why post-claim underwriting was necessary.[114] As a result, information regarding the financial status of an policyholder can, and frequently does, prove relevant.[115]

But entity discovery does not stop with the net worth or financial profitability of an insurer, it can extend into the process by which it values and insures against its own losses. The first type of discovery frequently sought related to those allegations are requests for evidence regarding loss reserves.

a. Reserve Information

Reserves are quite simply the insurer's evaluation of how much it will have to pay for a claim.[116] But to policyholders, reserves are relevant to prove just how little an insurer thinks of their claims.[117] Based on similar allegations, similar requests have been increasing over time.[118]

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[108] Richmond, supra at 1.
[109] *Id.*
[110] *Id.*
[111] *See Consugar v. Nationwide Ins. Co. of Am.*, 2011 WL 2360208, *5 (M.D. Pa. June 9, 2011).
[112] *Consugar* at *5.
[113] *White v. Continental Gen. Ins. Co.*, 831 F. Supp. 1545, 1549 (D. Wyo. 1993).
[114] *Saldi v. Paul Revere Life Ins. Co.*, 224 F.R.D. 169, 177 (E.D. Pa. 2004).
[115] Cohen, supra 30.
[116] *See* 17A Couch on Ins. 3d §251:29.
[117] *Id.*
[118] *See* Sukel, TM and Pipkin, MF: Discovery and Admissibility of Reserves, 34 Tort & Ins. Law Journal 191 (Fall 1998).

The inherent problem with reserve information is that reserves are typically required to be set by state statute and do not necessarily reflect anything other than compliance with those commands.[119] As observed by one court: "[t]he setting of reserve amounts may be an accounting decision, made by claims personnel with no knowledge of the particulars of the policyholder's actual policies.[120] Nevertheless, the "widely followed rule" is that reserve information is not only relevant, but it is frequently produced voluntarily.[121]

b. Reinsurance Information

Coupled with requests for reserve information, are requests for reinsurance information. Policyholders argue that reinsurance information could potentially reveal the insurers own assessment of the claims, extrinsic meaning of a policy term, or even when notice was received of a claim.[122] Courts are increasingly struggling with two issues raised by these requests: (1) discovery of the reinsurance agreement itself; and (2) communications between the insurer and its reinsurer.[123]

The first issue typically raised with requests for reinsurance information is the automatic production of potential indemnity agreements under Rule 26 of the Federal Rules of Civil Procedure, and its state counterparts.[124] Some courts have held that the reinsurance agreement automatically falls under the auspices of Rule 26 that requires production of any discoverable indemnity agreements.[125] These courts reason that Rule 26-like requirements are automatic and require no showing of relevance.[126] On the other hand, another cluster of courts reason that while an insurer's communications about a claim may indicate some idea of its position regarding coverage or bad faith, the reinsurance agreement itself does not necessarily have any impact on those claims.[127] According to this group, there is seldom any question of an insurer's ability to pay a judgment, and moreover, reinsurance agreements are "sensitive business matters" that should have some protection.[128] Thus, the increasing trend when it comes to producing reinsurance agreements is confusion, at best.

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[119] 17a Couch on Ins. 3d §251:29.

[120] *Heights at Issaquah Ridge Owners Ass'n. v. Steadfast Ins. Co.*, 2007 WL 4410260 (W.D. Wash. Dec. 13, 2007), *citing Leski v. Federal Ins. Co.,* 129 F.R.D. 99, 106 (D.N.J.1989).

[121] Wall, Litig. & Prev. Ins. Bad Faith § 12:16 (3rd ed.)

[122] Richard C. Mason, et al, Recent Developments in Excess, Surplus Lines, and Reinsurance, 44 Tort Trial & Ins. Prac. J., 437 (Winter 2009).

[123] Richard C. Mason, et al, Recent Developments in Excess, Surplus Lines, and Reinsurance, 44 Tort Trial & Ins. Prac. J., 437 (Winter 2009).

[124] *Heights at Issaquah Ridge Owners Ass'n. v. Steadfast Ins. Co.*, 2007 WL 4410260 (W.D. Wash. Dec. 13, 2007).

[125] *See, e.g., U.S. Fire Ins. Co. v. Bunge N. Am.*, 224 F.R.D. 638, 641 (D. Kan. 2007); *National Union Fire Ins. Co. of Pittsburgh, Pa. v. Continental Ill. Corp.*, 116 F.R.D. 78 (N.D. Ill. 1987); *Stonewall Ins. Co. v. Nat'l Gypsum Co.*, 1988 WL (S.D. N.Y. 1988).

[126] *Heights at Issaquah Ridge Owners Ass'n. v. Steadfast Ins. Co.*, 2007 WL 4410260 (W.D. Wash. Dec. 13, 2007), *relying on United States Fire Ins. Co. v. Bunge N. Am.,* 244 F.R.D. 638, 641 (D.Kan.2007); *citing National Union Fire Ins. Co. of Pittsburgh v. Continental Illinois Corp.,* 116 F.R.D. 78, 83-84 (N.D.Ill.1987).

[127] *Id.; see also* Richard C. Mason, et al, Recent Developments in Excess, Surplus Lines, and Reinsurance, 44 Tort Trial & Ins. Prac. J., 437 (Winter 2009).

[128] *Cummins*, 2011 WL 130158, *11.

The same dichotomy applies to requests for communications between insurer and reinsurer. Some courts have ordered production of such communications because "[t]hey may indeed reveal the Insurers' views on coverage that may lead to evidence admissible on both [the policyholder]'s breach of contract claim and bad faith claim.[129] But, another group of courts explains that communications are irrelevant for discovery because reinsurance involves an insurance company's effort to spread the burden of indemnification.[130] It is a decision based on business decisions and not questions of policy interpretation.[131]

This apparent dichotomous trend in decisions regarding reinsurance is baffling. Courts have relied on the exact same reasoning of business risk management to order production of reinsurance agreements, but use the same logic to block production of communications between insurer and reinsurer.[132] The exact opposite result has been reached using the same logic.[133] Therefore, until some higher precedent is establish, there is no discernible trend and the issue of reinsurance discovery will rest on the whims of whatever court faces the decision.

3. The Practice of Institutional Discovery

Compared to the decisions regarding entity discovery, decisions involving institutional discovery are straightforward. These requests relate to the "institution" of insurance, i.e., the method by which an insurer investigates, adjusts, and makes a coverage determination for a claim.[134] Requests for "institutional documents" can be broken into two broad categories. The first are requests claims manuals, guidebooks, training materials, and the like that reveal *how* the insurer adjusts claim. The next type of request is typically for information regarding other similar claims. Despite these requests, the trend of decisions does not necessarily reflect a similar cluster of success for policyholders.

a. Claims Handling Manuals, Policies, Procedures

Policyholders argue that these documents can show a deliberate institutional practice designed to underpay claims. As seen above, the crux of an institutional bad-faith argument is the causal connection between the alleged institutional practice and the particular policyholder's claims. Necessarily, discovery about institutional bad faith must at least be reasonably calculated to lead to the discovery of admissible evidence of that causal connection.[135]

One line of authority holds that discovery of such institutional documents is relevant in

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[129] *Cummins*, 2011 WL 130158, *11, *citing Stonewall Ins. Co. of Nat'l Gypsum Co.*, 1988 WL 96159, *5 (S.D. N.Y. Sept. 6, 1988); *Hoechst Celanese Corp. v. Nat'l Union Fire Ins. Co.*, 623 A.2d 1099, 1108 (Del. Super. Ct. 1991).
[130] *Heights at Issaquah Ridge Owners Ass'n. v. Steadfast Ins. Co.*, 2007 WL 4410260 (W.D. Wash. Dec. 13, 2007), *citing Leski,* 129 F.R.D. at 106.
[131] *Id.*
[132] *See Heights at Issaquah Ridge Owners Ass'n. v. Steadfast Ins. Co.*, 2007 WL 4410260 (W.D. Wash. Dec. 13, 2007).
[133] *See Cummins*, 2011 WL 130158, *11.
[134] *See* Richmond, supra at 9, citing *Hogan v. Provident Life & Acc. Ins. Co.*, 665 F.Supp.2d 1273, 1281-82 (M.D. Fla. 2009).
[135] Fed. R. Evid. 402.

almost any circumstance, at least for discovery purposes.[136] As explained by one court, it may be probative evidence of bad faith if the design is inherent in the document:

> There may be circumstances when such discovery would be relevant. For example, a claims manual could be relevant if it requires an adjustor to take certain investigative steps before adjusting a claim and plaintiff can show that these steps were deliberately omitted. Although this fact alone would not be enough to establish bad faith, surely it is probative evidence for plaintiff to demonstrate bad faith."[137]

The same analysis has also been applied to pure coverage disputes involving policy interpretation.[138]

On the other hand, at least one court has disallowed similar discovery requests because "the fact that the defendant may have strayed from its internal procedures does not establish bad faith on the part of the defendant in handling the plaintiff's loss."[139] After all, case law "has not reached the point where it is wrong for an insurance company to make a profit, much less follow good business practices."[140]

The junction of these two lines of authority is the causal connection. "Courts have disallowed discovery of an insurance company's claims manuals when a plaintiff alleges a broad corporate policy of bad faith—but not when a plaintiff alleges that a bad faith policy was applied to the specific plaintiff."[141] Thus, if some causal connection is alleged a court will most likely find that the institutional document request is relevant for discovery.[142]

b. Other Claims

(1) Carrier Perpective

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[136] *See, e.g., Saldi v. Paul Revere Life Ins. Co.*, 224 F.R.D. 169, 177 (E.D. Pa. 2004); *U.S. Fire Ins. Co. v. Bunge North America, Inc.,* 244 F.R.D. 638, 645 (D.Kan.2007) (upholding an order requiring an insurance company to produce its claims handling manuals as relevant to whether the claims were properly handled); *Jeffryes v. Hartford Life and Acc. Ins. Co.,* 2006 WL 1186493, *3 (D.Colo.2006) (requiring Defendant to provide "a general description of all claims manuals and training and instructional documents pertaining to the claims review and determination process"); *Cunningham v. Standard Fire Ins. Co.,* 2008 WL 2668301 (D. Colo. July 1, 2008).

[137] *See Kaufman v. Nationwide Mut. Ins. Co.*, 1997 WL 703175, *2 (E.D. P.A. Nov. 12, 1997). *See also, Consugar v. Nationwide Ins. Co. of Am.*, 2011 WL 2360208, *6 (M.D. Pa. June 9, 2011) ("A failure to follow established policy could make it more likely that defendant acted in bad faith in denying plaintiff's UIM claim.").

[138] *See Cummins, Inc. v. ACE American Ins. Co.*, 2011 WL 130158, *5 (S.D. Ind. Jan. 14, 2011), citing *United States Fire Ins. Co. v. Bunge North Amer. Inc.*, 244 F.R.D. 638, 646 (D. Kan. 2007); *Stonewall Ins. Co. v. Nat'l Gypsum Co.*, 1988 WL 96159 at *3-4 (S.D. N.Y. Sept. 6, 1988); *Michigan Mut. Ins. Co. v. Sports, Inc.*, 698 N.E.2d 838 (Ind. Ct. App. 1998).

[139] *Garvey v. Nat'l Grange Mut. Ins. Co.*, 167 F.R.D. 391, 396 (E.D. Pa. 1996).

[140] *Knoell v. Metro. Life Ins. Co.*, 163 F. Supp.2d 1072, 1078 (D. Ariz. 2001).

[141] *Safeco Ins. Co. of Am. v. M.E.S., Inc.*, 2011 WL 6102014 (E.D.N.Y. Dec. 7, 2011).

[142] *Dombach v. Allstate Ins. Co.*, 1998 WL 695998 (E.D. Pa. Oct. 7, 1998) ("[D]iscovery should be aimed at disclosing whether defendant *in this particular case* (1) did not have a reasonable basis for offering $10,000; and (2) knew or recklessly disregarded its lack of a reasonable basis.") (emphasis in original).

Increasingly seen are requests for information about other similarly situated claims.[143] While the stated reason for such requests is proof of pattern and practice for punitive damages purposes, the unstated reason is to demonstrate that the insurer is an "evil institution."[144] Not only do such requests bring the constitutional relevancy concerns of *Campbell*, they necessarily implicate the privacy concerns of the individual non-parties involved in the other claims.[145]

The immediate question raised by requests for other claims is relevance. If institutional bad faith requires proof of a causal connection for *this* policyholder's claim, then other claim files are irrelevant,[146] particularly where they involve claims in other states at remote periods of time.[147] As one commentator explains, these requests can be relevant on the "not unwarranted" theory that an insurer may have paid similar claims at one point, and then changed its position for some financial reason.[148] On that thin line of relevancy some courts have not blocked such requests, but have instead limited the request to "appropriate" or relevant periods of time or locations.[149]

A similar, but stronger defense is based on third-party privacy concerns.[150] Third parties have a legitimate expectation of privacy in dealing with *their* insurer for *their* claim; not an expectation that information about their claim could be shared in other litigation.[151] Still, courts have ordered production of other claims information with protections for privacy.[152] For example, the *Fulbright* court tailored an overly broad request to an incredibly narrow production order of: (1) in-state files, (2) of the last two years, (3) that were adjusted by the same adjusters at issue.[153] Likewise, all personal information was to be redacted from the other claim files.[154] The practicality of such an order is questionable, but it nevertheless demonstrates an increasing willingness by courts to indulge discovery, but to limit the requests as they see fit.[155]

(2) Policyholder's Perspective

Relevance of discovery of other claims is the battlefield. The most obvious targets for making "relevant" discovery requests regarding other claims include the following:

- Pattern, practice or scheme
- Inconsistent coverage positions
    - Shows ambiguity
    - Discrimination

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[143] *See.,e.g.,* 17A Couch on Ins. § 251:31.
[144] *Id.*
[145] Cohen, supra at 32.
[146] *Ex parte Finkbohner*, 682 So.2d 409, 413-14 (Ala. 1996).
[147] *See, e.g., Allstate Ins. Co. v. Scroghan*, 851 N.E.2d 317 (Ind. Ct. App. 2006); *Saldi*, 224 F.R.D. 169.
[148] 17A Couch on Insurance §251:31.
[149] *See, id., Fulbright*, 2010 WL 300436 at *6; *see also Sampathachar v. Federal Kemper Life Assurance Co.*, 2004 WL 2743589 *2 (E.D. Pa. Nov. 24, 2004).
[150] *See, e.g.,* 17A Couch on Ins. § 251:31; *Aztec Life Ins. Co. of Tex. v. Dellana*, 667 S.W.2d 911 (Tex. App. 1981); *Hill v. Troy Sav. Bank*, 185 A.D.2d 423, 585 N.Y.S.2d 636 (3d Dep't 1992).
[151] *Fulbright*, 2010 WL 300436 at *5.
[152] *Id.*
[153] *Id.* at *6.
[154] *Id.*
[155] *See* 17A Couch on Insurance 3d §251:3.

- Improper coverage decisions
    - Use of opinions in other claims to decide the one at hand
- Motive or intent
- Habit
- Bad faith
    - Lack of reasonable basis based on inconsistency
    - PretextUse of experts in other cases
        - Cookie cutter opinions
        - Result-oriented
    - Frequency/Repeated bad acts
    - Carrier acted knowingly
- Punitive damages
    - Standard factors
        - The nature of the wrong
        - The character of the conduct involved.
        - The degree of culpability of the wrongdoer.
        - The situation and sensibilities of the parties concerned.
        - The extent to which such conduct offends a public sense of justice and propriety.
    - Review factors under *BMW of North America, Inc. v. Gore*, 517 U.S. 559, 116 S. Ct. 1589, 134 L.Ed.2d 809 and *State Farm Mut. Auto. Ins. Co. v. Campbell,* 538 U.S. 408, 420, 123 S. Ct. 1513, 155 L.Ed.2d 585 (2003):
        - The degree of reprehensibility of the defendant's misconduct
            - Whether the harm caused was physical as opposed to economic;
            - Whether the tortious conduct evinced an indifference to or a reckless disregard of the health or safety of others;
            - Whether the target of the conduct had financial vulnerability;
            - Whether the conduct involved ***repeated actions*** or was an isolated incident; and
            - Whether the harm was the result of intentional malice, trickery, or deceit, or mere accident.
        - The disparity between the actual or potential harm suffered by the plaintiff and the punitive damages award; and
        - The difference between the punitive damages awarded by the jury and the civil penalties authorized or imposed in comparable cases.

Numerous jurisdictions have clearly permitted discovery of other claims regarding ambiguity and the reasonableness of the policy interpretation. *See Nestle Foods Corp. v. Aetna Cas. & Sur. Co.*, 135 F.R.D. 101, 106–107 (D.N.J. 1990) (evidence of insurer's varying interpretations of policy "could undermine defendants' position that the language in question is clear and unambiguous."), *Rhone-Poulenc Rorer, Inc. v. Home Indem. Co.*, Civ. A. No. 88-9752, 1991 WL 78200, at *3-4 (E.D. Pa. May 7, 1991) (information regarding other insureds with similar claims was "relevant for the purposes of discovery since, 1) it may show that identical language has been afforded various interpretations by the insurer and 2) the interpretations suggested by the insurers may not be the same as those intended by the original drafters"), *modified on other*

grounds, 1991 WL 111040 (E.D. Pa. June 17, 1991); *Westport Ins Co. v. Wilkes & McHugh, P.A.*, 264 F.R.D. 368, 371–74 (W.D. Tenn. 2009); *Polygon Northwest Co. LLC v. Steadfast In. Co.*, 2009 U.S. Dist. LEXIS 130238, 2009 WL 1437565, at *3–6 (W.D. Wash. May 22, 2009) ("The manner in which [the insurer] has handled the claims of other insureds with identical policy language is potentially relevant" to the ambiguity issue.), *National Union Fire Ins. Co. v. Stauffer Chem. Co.*, 558 A.2d 1091, 1095 (Del. Super. Ct. 1989) ("[T]he claim files and the interpretive materials are relevant to the determination of ambiguity and should be the subject of discovery that is structured to lessen the burden on insurers while protecting the confidentiality of other insureds.") *Rhone-Poulenc Rorer, Inc. v. Home Indem. Co.*, 1991 U.S. Dist. LEXIS 6215, at *8 (E.D. Penn. May 7, 1991) (finding that handling of other claims was relevant because it could show that identical language had been interpreted in various ways by the insurer and that the insurer's interpretation may not be similar to that intended by the drafters), *J.C. Assocs. v. Fid. & Guar. Ins. Co.*, 2006 U.S. Dist. LEXIS 32919, 2006 WL 1445173, at *1 (D. D.C. May 25, 2006) ([I]nformation as to how defendant interpreted the [particular exclusion . . . is] relevant to the claim presented by plaintiff if that interpretation is difference from the interpretation that the defendant is asserting in this case."), *Owens-Brockway Glass Container v. Seaboard Sur. Co.*, 1992 U.S. Dist. LEXIS 10337, 1992 WL 696961, at *9 (E.D. Cal. May 28, 1992) ("[S]imilar insurance claims asserted by other insureds against defendant [insurers] may be relevant to the interpretation of the insurance policy language of this case."); *see also Potomac Elec. Power Co. v. Cal. Union Ins. Co.*, 136 F.R.D. 1, 3 (D.D.C. 1990) (ordering insurers to "provide information on third party claims that were either litigated or ultimately paid" where the policies and claims involved were similar to one another); *Champion Int'l Corp. v. Liberty Mut. Ins. Co.*, No. 87 Civ. 1634 (WCC), 1989 WL 299156, at *2 (S.D.N.Y. Oct. 31, 1989) (authorizing depositions of defendant insurers regarding recordkeeping and filing procedures regarding other claim information); *Indep. Petrochemical Corp. v. Aetna Cas. & Sur. Co.*, 117 F.R.D. 283, 287 (D.D.C. 1986) (granting motion to compel production of documents concerning dioxin claims of other policyholders), aff'd, No. Civ. A. 83-3347, 1987 WL 8512, at *2-4 (D.D.C. Mar. 9, 1987); *Carey-Can., Inc. v. Cal. Union Ins. Co.*, 118 F.R.D. 242, 245-46 (D.D.C. 1986) (ruling that insurers must produce certain "policies themselves [of non-party insureds] and all claims and underwriters' files concerning these policies").

Numerous courts have found that evidence regarding other claims is admissible to show bad faith. *See, e.g.*, *Poneris v. Pa. Life Ins. Co.*, No. 1:06-cv-254, 2007 WL 3047232, at *1 (S.D. Ohio Oct. 18, 2007) (discovery regarding other policyholders relevant to claim for bad faith denial of coverage; claims information regarding other insureds "is relevant to establish whether Defendant had a pattern or practice" of improperly denying claims); *Paolo v. AMCO Ins.* Co., No. 02-02367 JW (HRL), 2003 WL 24027877, at *1 (N.D. Cal. Sept. 17, 2003) (ordering production of other policyholder information in bad faith breach of contract action); *Fridkin v. Minn. Mut. Life Ins. Co.*, No. 97 C 0332, 1998 WL 42322 (N.D. Ill. Jan. 29, 1998) (same); *First Fid. Bancorp. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa*, Civ.A. No. 90-1866, 1992 WL 6859 (E.D. Pa. Jan. 13, 1992) (ordering National Union to produce other policyholder files because, "there is no other way for [plaintiffs] to obtain the requested pattern and practice information"); *Colonial Life & Ace. Ins. Co. v. Sup. Ct., 647* P.2d 86, 89-90 (Cal. 1982) (same).

4. Defending Against Entity Discovery

Insurers must pick the battles that they will choose to fight. It is unwise to fight every battle. And, good military tactics dictate that good generals choose the battlefield. Insurers have defended on the bases of costs and burdens, specificity, trade secrets, and staged-discovery limits. Each is discussed in turn below.

a. Costs and Burdens

One of the defenses being raised in response to institutional and entity discovery is the overwhelming cost associated with responding to such requests. "At the very least, institutional bad faith allegations spawn expensive and time-consuming discovery disputes."[156] While the cynic might argue that this is the ultimate goal of institutional bad-faith allegations, the apparent trend among courts is to impose the same requirements for an objection as to the request.

For example, where some courts readily hold that the burden and expense of producing several thousand pages of institutional documents is too much,[157] others reckon that multi-million dollar insurers can easily absorb such costs.[158] The decisions explaining what type of burden is sufficient to outweigh relevance are mixed at best, and frequently determined based on the pleadings and facts of the particular case.[159]

Nevertheless, one maxim appears true across the board: the objection must demonstrate *why* the burden will outweigh the benefit.[160] The evidence necessary to demonstrate the "why" prong varies among the courts. In *Cummins*, the court was satisfied with the affidavit of a senior claims examiner that compliance would require sifting through over 30,000 other claims to adequately respond.[161] In another case, even evidence of 48 claims outweighed the potential relevance associated with discovery.[162] The trend seems to be that the courts are finding the burden is too great for even insurers with "rather sophisticated information systems."[163]

b. Specificity as a Defense

The Achilles heel of widespread institutional attacks is specificity. Widespread requests and general objections serve neither party's purposes and leave courts only the more frustrated:

> I might observe metaphorically that if defendant is indeed trying to put plaintiff's case in a shoe box, then plaintiff is trying through his discovery requests to put it in the hold of a large trans-Atlantic cargo carrying ship. Neither container is representative of the approach to discovery contemplated under federal rules.[164]

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[156] Richmond, supra at 2, *citing Saldi*, 224 F.R.D. at 175-78; *Pincheira v. Allstate Insc. Co.*, 190 P.3d 322, 324-48 (N.M. 2008).
[157] *See Nestle Foods Corp. v. Aetna Cas. and Sur. Co.*, 135 F.R.D. 101 (D. N.J. 1990).
[158] *See Ex parte Asher, Inc.*, 569 So.2d 733 (Ala. 1990).
[159] *See, e.g.,* 17A Couch on Insurance 3d §251:31.
[160] *See, e.g., Leksi, Inc. v. Federal Ins. Co.*, 129 F.R.D. 99 (D. N.J. 1989).
[161] *Cummins*, 2011 WL 130158, *9.
[162] *See Cleveland Constr., Inc. v. Fireman's Fund Ins. Co.*, 2010 WL 2836105 (W.D. N.C. July 19, 2010).
[163] *See Ex parte Asher*, 569 So.2d 733 (Ala. 1990).
[164] *Dombach v. Allstate Ins. Co.*, CIV. A. 98-1652, 1998 WL 695998 (E.D. Pa. Oct. 7, 1998).

It is well recognized that most courts abhor discovery disputes, and the absolute vagueness of some requests and objections only hurts both parties.

As discussed above, some tailoring by the court is possible, and at least one has explained: "[b]ecause Cummins and the Insurers have taken 'all or nothing' approaches to discovery, neither has provided the court with suggestions for paring down any of these discovery requests."[165] Without such suggestions, the parties are necessarily subject to the court's mercy. Therefore, one of the best defenses available to combat institutional discovery is to narrow the widespread front to a single issue.

c. Trade Secret Privilege

Quite frequently, the single issue chosen to fight over by an insurer is whether the documents sought constitute a "trade secret." While courts have struggled to define what exactly constitutes a "trade secret", as of February 2012, 46 states have adopted the Uniform Trade Secrets Act.[166] That act defines "trade secret" as:

> [I]nformation, including a formula, pattern, compilation, program, device, method, technique, or process, that:
>
> > (i) Derives independent economic value, actual or potential, from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from its disclosure or use; and
> > (ii) Is the subject of efforts that are reasonable under the circumstances to maintain its secrecy.

Texas, which has not adopted the act, defines trade secret as "any formula, pattern, device or compilation of information which is used in one's business and presents an opportunity to obtain an advantage over competitors who do not know or use it."[167]

Courts have struggled with these definitions. For example, while several courts have concluded that claims manuals contain trade secrets, others have rejected such arguments because the insurer could sufficiently articulate *why* the information was a secret.[168] Likewise, other courts have disturbingly allowed discovery of arguably trade secret information because of production in other cases.[169] For insurers, production of trade secret documents is of some importance. As observed by one court: "[t]he discovery of State Farm's policy manuals by a competitor would permit them to appropriate State Farm's trade secrets by duplicating or reconstructing its claims handling procedures. This information is of particular value to small insurance companies, which

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[165] *Cummins*, 2011 WL 130158, *7.
[166] http://www.nccusl.org/Act.aspx?title=Trade%20Secrets%20Act. The four non-adopting states are New York, Massachusetts, North Carolina, and Texas.
[167] *In re Cooper Tire & Rubber Co.,* 313 S.W.3d 910, 914 (Tex. App.--Hous. [14th Dist.] 2010, no pet.).
[168] *Compare, e.g., Hamilton v. State Farm Mut. Auto. Ins. Co*., 204 F.R.D. 420 (S.D.Ind.2001), and *McCallum v. Allstate Prop. & Cas. Ins. Co.*, 204 P.3d 944 (2009); *Woo v. Fireman's Fund Ins. Co.*, 154 P.3d 236, 239–42 (2007).
[169] *See, e.g., Jacoby v. Hartford Life & Acc. Ins. Co.*, 254 F.R.D. 477, 479 (S.D.N.Y. 2009).

lack the resources to adopt their own procedures."[170]

Nevertheless, that same holding emphasizes the extent to which an insurer must go to demonstrate that the documents requested, are in fact, a trade secret. The court considered several factors:

> (1) the claims handling procedures and materials were developed with considerable time, effort, and expense, thus possess economic value;
> (2) the materials were developed, created, and maintained for business use and considered confidential and proprietary;
> (3) the documents contain claims handling philosophies and strategies unique to State Farm;
> (4) access of the materials by a competitor would result in economic value to the competitor and place it in a competitive advantage; and
> (5) the materials are in locking file cabinets and/or in areas not open to the public.[171]

In the end, the court also rejected arguments by policyholder's counsel that the same documents had been produced in other litigation.[172] Simply being required to produce documents in response to a discovery order does not constitute a waiver of confidentiality.[173] Indeed, the fact that State Farm routinely contested such orders indicated its desire to keep the information confidential.[174]

From these cases, trade secret privilege appears to provide some protection to insurers seeking to defend against production requests for institutional documents. Nevertheless, the insurer must bear in mind that each of the case discussed above did not outright bar production, but instead utilized protective orders to limit the extent to which the confidential information could be used.

d. Staged Discovery

Given the trends, one of the more practical defenses to institutional and entity discovery may be to lose the discovery battle, but ultimately win the discovery war. Many of the decisions discussed above have not ordered production of sensitive business documents willy-nilly; instead, they recognize that insurers are business, and are entitled to at least some privacy in their dealings.[175] As a result, several courts have utilized a "staged discovery" process to meet the discovery concerns of policyholders while still protecting the business concerns of insurers.[176]

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[170] *Hamilton v. State Farm Mut. Auto. Ins. Co.*, 204 F.R.D. 420, 424 (S.D. Ind. 2001).
[171] *Hamilton*, 204 F.R.D. at 423-24.
[172] *Hamilton*, 204 F.R.D. at 423-24.
[173] *Hamilton*, 204 F.R.D. at 423-24.
[174] *Hamilton*, 204 F.R.D. at 423-24.
[175] *See, e.g., Garvey v. Nat'l Grange Mut. Ins. Co.*, 167 F.R.D. 391, 396 (E.D. Pa. 1996) ("[T]he fact that the defendant may have strayed from its internal procedures does not establish bad faith on the part of the defendant in handling the plaintiff's loss.").
[176] *See, e.g., Pochat v. State Farm Mut. Auto. Ins. Co.*, 2008 WL 5192427 (D.S.D. Dec. 11, 2008); *Dahdal v. Thorn Americas, Inc.,* 1997 WL 599614 at *1(D. Kan. Sept.15, 1997) (court entered limited protective order for personnel files of employees because employees were non-parties to the suit, files commonly contain sensitive, personal information with little or no relevance to the suit, and widespread dissemination of such information could result in economic or emotional harm to the employees); *Williams v. Bd. of County Comm'rs,* 2000 WL 133433 at *1 (D.Kan.

Each of the cases discussed above re-emphasizes that a causal connection is necessary to demonstrate institutional bad faith, or to engage in discovery about it.[177] But to demonstrate a causal connection, massive and expensive discovery is not necessarily needed. Courts can, and do, tailor requests or order only portions of discoverable information to be produced.[178] Once that information is produced and reviewed, if there is need for further evidence, the court can then reconsider the issue.[179]

This discovery two-step then provides the policyholder with an opportunity to prove the grandiose allegations of corporate shenanigans, and at the same time, allows insurers to not invest further expenditures on expensive litigation over relatively minor claims. As a result, requesting a staged discovery process can provide benefits for both parties.

D. THE CATASTROPHE EFFECT

Catastrophes over the last decade offer the opportunity to study massive amounts of discovery in very discrete contexts. For example, the Gulf Hurricane trio of Katrina, Rita, and Ike carried their own unique set of coverage issues and methods of handling them. Likewise, the BP oil spill presents its own unique types of coverage questions. But, "[w]hile most insurance disputes ultimately hinge on dry issues of contract interpretation and valuation of loss, when they occur in the wake of a catastrophe, the battles are intensified on both sides."[180]

Catastrophe situations present not only physical difficulties for insurers and policyholders, but they also present several challenges when dealing with discovery issues. First, the sheer magnitude of potential bad-faith claims and law suits is staggering.[181] Consider the situation following Hurricane Ike where damage was spread across fourteen Texas counties directly and several more indirectly.[182] The same is true of the BP spill where claims ranged from death and personal injury to environmental and property damage, to business interruption, extra expense, and a host of other coverage types.[183] To respond to such unique circumstances, courts have employed and crafted unique systems for handling discovery in first-party bad-faith cases following a catastrophe.

1. Consolidation and Staging Discovery

Perhaps the most unique system for handling large amounts of discovery following a

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Jan.21, 2000) (for the general proposition that "personnel files and records are confidential in nature and that, in most circumstances, they should be protected from wide dissemination").

[177] Richmond, supra at 26.

[178] *See, e.g., Cummins*, 2011 WL 130158, *10 (ordering limited production).

[179] *Cummins*, 2011 WL 130158, *10

[180] William F. Merlin, et al, Trying a Catastrophe Claim in the Court of Public Opinion, 41 The Brief 50, 51 (Winter 2012).

[181] *See, e.g.,* Edward F. Sherman, The BP Oil Spill Litigation and Evolving Supervision of Multidistrict Litigation Judges, 30 Miss. C. L. Rev. 237, 238 (2011).

[182] Div. of Management, Office of the Governor of the State of Texas, Hurricane Ike Impact Report, 1 (2008).

[183] Sherman, *supra* at 238.

catastrophe has arisen in response to Hurricane Ike. Several counties experienced severe damage and correspondingly large numbers of lawsuits. Harris County, Texas (home of Houston), consolidated all residential first-party bad-faith cases into a single court for pre-trial purposes.[184] Presided over by Judge Mike Miller, each first-party bad-faith case was randomly assigned to a district court, per normal Texas procedure; however, was case is then referred to Judge Miller's court for all pre-trial rulings.

Following the lead of Katrina MDL courts, Judge Miller worked with both sides of the bar to craft a unique system for responding to the large numbers of Ike suits. First, both the policyholders and insurers bar worked together to craft not only how the system would work, but also the type of discovery involved. Each case in the "Ike court" was automatically abated until mediation can be completed.[185] Pursuant to the court's master order, both parties had to use "best efforts" to exchange relevant information prior to mediation.[186] For insurers this meant automatic production of claims, underwriting, and agent's files wherever possible.

Mirroring the discussion of claim specific discovery, this process recognized the almost universal relevance and discoverability of the insurer's claim file for the policyholder at issue. The unique aspect of the Master Order was that a request was not needed by a policyholder; instead, both parties had to use their "best efforts" to quickly exchange basic documentation. Such a sweeping recognition of the discoverability of the claim file was groundbreaking, particularly in light of the extraordinary number of claims.

Further mirroring the nationwide trends discussed above was recognition of the relevance of institutional bad-faith allegations. The Harris County Master discovery contained several institutional types of discovery requests. For example:

> 5. Your written procedures or policies (including document(s) maintained in electronic form) that pertain to the handling of windstorm claims in Texas from August 31, 2007 to August 31, 2009.
>
> ***
>
> 7. The Operation Guides which relate to the handling of Hurricane Ike claims in Texas in effect from September 1, 2008 to August 31, 2009.
>
> ***
>
> 10. If you dispute that cause of the loss was related solely ot Hurricane Ike windstorm, produce the engineering reports in your possession regarding Hurricane Ike damage to property within a one-mile radius of the Plaintiff's policyholder property.
>
> ***
>
> 20. The documents, manuals, and training materials, including audio and/or video tapes used in training, overseeing, or supervising your

[184] To be sure, each Texas county affected by Ike has crafted its own discovery response system, but given the swath of damage, an in-depth discussion of each county's procedure is beyond the scope of this paper.
[185] Standing Pretrial Order Concerning Residential Hurricane Ike Cases. A copy of this order is attached to this paper, but is also at http://www.justex.net/courts/civil/CourtSection.aspx?crt=1&sid=344.
[186] *Id.*

personnel employed in adjusting property claims in Texas and in effect from August 31, 2007 to August 31, 2009.

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24. For the past five years, the portions of the personnel file of the adjuster(s) involved in handling Plaintiff's claim that pertain to disciplinary actions associated with claims handling, and performance under a bonus or incentive plan.

25. The bonus or incentive plan for adjusters in effect for the time period January 1, 2008 through August 31, 2009.[187]

As discussed above, these types of inquiries and requests mirrored trends seen nationwide. Although the list above was certainly not intended to be all inclusive, it does reveal that the court allowed discovery of internal procedures; personnel files; other claims; and pay structure.

Recognizing the breadth of the requests, Judge Miller also followed the trend of many courts in issuing a protective order and recognizing the responding to such a large amount of discovery necessarily involves exorbitant costs in production and attorney fees.[188] As a result, each carrier was only required to produce one set of responsive institutional documents and produce only one corporate representative for deposition regarding institutional practices and procedures.

The drawback to Harris County's approach was that the pre-trial court's orders were not binding and the parties could opt-out of the system. In the first Harris County Hurricane Ike case to go to trial, the policyholder immediately sought additional discovery from the trial court that the pre-trial court had not allowed before sending the case to the trial court for trial. The trial court allowed the additional discovery to go forward as sanctions for not providing the discovery initially, even though the pre-trial court had not ordered the discovery.

2. Multidistrict Litigation

The Multidistrict Litigation Device (MDL) has proven itself capable of dealing with catastrophes and discovery situations over an almost fifty year history.[189] The MDL procedure allows for consolidation and handling of potentially endless amounts of cases before a federal judge so long as there are common questions of fact.[190]

One of the more prominent "catastrophes" handled by the MDL procedure was the spread of Vioxx litigation between 1999 and 2004.[191] Although almost exclusively a tort situation, Vioxx

[187] Master Discovery to Insurer and Adjuster Defendants. A copy of these requests is attached to this paper, but is also at the web address indicated above.
[188] Amended Protective Order. A copy of this order is attached to this paper, but is also at the web address indicated above.
[189] *See* 15 Charles Alan Wright, Arthur R. Miller & Edward H. Cooper, Federal Practice & Procedure §386 (3d ed. 1998).
[190] 28 U.S.C. §1407 (2000).
[191] Edward F. Sherman, The MDL Model for Resolving Complex Litigatino if a Class Action is Not Possible, 82 Tul. L. Rev. 2205, 2214 (June 2008).

litigation is instructive in the insurance context. Like natural disasters, the short latency period of Vioxx left a relatively discrete cluster of several thousands of cases.[192] But because bellwether trials and discovery issues could be resolved quickly, the procedure actually provided a fairly efficient means of resolving thousands of cases.[193]

The same relative efficiency was observed directly in the first-party bad-faith scenario following Hurricane Katrina.[194] Given the isolated location of most Katrina claims, several primary issues of coverage were presented across thousands of claims.[195] Chief among these was interpreting how the mixed wind/flood event affected coverage under most homeowners' policies.[196] Because key coverage issues resolved quickly, settlement and resolution of thousands of cases happened much quicker than could be expected in regular litigation.[197]

These two scenarios are particularly appropriate when discovery is considered. Not only can common issues of coverage be resolved fairly quickly, but coordinated discovery has been the goal of the MDL procedure since it was created.[198] Given the speedy resolution of overarching coverage issues, future first-party discovery issues, such as the BP litigation or Hurricane Ike, may also prove uniquely well suited to the MDL procedure.[199]

The inherent problem in first-party bad-faith litigation following a catastrophe is the overwhelming number of claims, necessarily, overwhelming costs of related discovery. Consolidation and MDL both provide relatively efficient, if not entirely perfect, methods of resolution. But the problems discussed in sections I and II are likewise overwhelming. Institutional discovery by itself is inordinately expensive, but discovery requests across entire sections of the country for claims handling procedures, adjuster personnel files, and internal insurer documents are seemingly endless. Indeed, in the heat of discovery battles it is easy to observe that the only gains in catastrophe litigation belong to the policyholder's bar that has become remarkably "well equipped to take on the insurance industry."[200] Ultimately, catastrophes echo all the way into the courtroom and the best observations when it comes to discovery are that some sort of consolidation is an absolute necessity, coordinated discovery saves thousands of costs for all parties involved, and the wisest choice of action is attack early, and attack often.

IV. TRIAL STRATEGY ISSUES

A. Voir Dire

Most bad faith cases are won and lost in voir dire. Voir dire is both an art and a science

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[192] *Id.*
[193] *Id.*
[194] Allan Kanner and M.Ryan Casey, What We Learned from Katrina, 48 Trial 28, 39 (Oct. 2009).
[195] *Id.*
[196] *Id.* at 40.
[197] *Id.*
[198] *See, e.g.,* Stanley A. Weigel, The Judicial Panel on Multidistrict Litigation, Transferor Courts and Transferee Courts, 78 F.R.D. 575, 582-83 (1978); Edward F. Sherman, The BP Oil Spill Litigation and Evolving Supervision of Multidistrict Litigation Judges, 30 Miss. C.L. Rev. 237, 238 (2011).
[199] *See*, Sherman *supra*, 30 Miss. C.L. Rev. 240 (making similar observations).
[200] Kanner, *supra* at 39.

and unfortunately, most trial lawyers give it inadequate pretrial consideration. Even when they think about it, most lawyers are very poor at doing a good voir dire simply because they do not pick enough juries in insurance bad faith cases. First, before voir dire strategy can be developed, counsel has to have a mastery of their case themes and the probable dispositive evidence and testimony expected to be elicited at trial. Once these key factors are known, it becomes possible to start evaluating how different people filter those themes, testimony, and evidence. Men and women filter information differently. Gen Xers and Seniors filter information differently. Millennials and Boomers filter information differently. A great voir dire involves maximizing the number of people on your jury who are predisposed to filter information in the same way you and your client do. Warning: stereotypes can kill you in making this assessment. Lawyers who make jury selection decision solely based upon physical appearance, level of articulation, gender, or occupation are *highly* prone to make disastrous choices.

Because of the complex psychology involved, this is an area where "group think" from experienced professionals can be case dispositive. There are a handful of truly exceptional jury consultants with a tremendous understanding of personal filters that can provide great assistance to lawyers in both identifying the right questions to ask in voir dire and, if appropriate, actually assisting in voir dire. We believe one of the greatest uses of mock jury exercises is to use a jury consultant to help identify unique questions for voir dire that can assist in filter identification of individual panel members. Talented jury consultants can also serve in a valuable role in helping identify those types of individuals with filters that might be more prone to assess information in the same way as the carrier and its counsel. A good jury consultant can also serve a valuable role by providing an extra set of eyes and ears during the actual voir dire in order to pick up on body language and other non-verbal cues that frequently serve as indicators of certain filters. Most good jury consultants also have infinitely greater experience in actually picking juries than most trial lawyers and, in our experience, the added expertise typically pays off in a better jury for the defendant than those voir dires when such an expert is not used.

In voir dire most counsel fear "negative" information. As a result, they run from it. We, on the other hand, embrace it. It is the essence of our voir dire. If a rogue panel member is going to poison the panel, we welcome the opportunity because of the ability it gives us to then explore all of those members on the panel who disagree with the overly vocal jerk. It also gives us the ability to figure out everyone else in the panel who agrees with the verbose bomb-thrower. If the rogue juror is going to say outrageous things, it will create an opportunity for us to strike them "for cause." We then want to give many other jurors a similar opportunity in order to get as many of them off the jury for cause as possible.

The biggest problem with most voir dires is the inability to get some information out of some jurors. Despite a multi-hour of voir dire, there are typically some jurors who simply never say a word. Unless they communicate some information, it is impossible to know what filters that potential juror may or may not have. As such, it is of critical importance that *some* questions be asked of every single member of the venire panel.

The easiest and most time-effective way to ask meaningful filter questions to every member in the venire panel is to use a series of "range questions." Range questions typically make a statement and then ask jurors on a scale of 1to 10 to state whether they agree or disagree with the

statement. An example is:

> "I'm going to make a statement and then ask you for a number to indicate how much you agree or disagree with the statement. The statement is: I have a very positive impression of the insurance companies that insure my property." On a scale of one to ten, please state whether you strongly disagree, strongly agree or have feelings somewhere in the middle. 1 is strongly disagree, 10 is strongly agree, and the other numbers in the middle express feelings in the middle of either extreme. What is your statement?"

You can ask a range questions about the panel's feelings of the insurance industry in general, their feelings about insureds who attempt to profit from insurance claims, the prevalence of insurance fraud, or an infinite number of other topics. By going quickly through each member of the venire panel, counsel receives a number for every single panelist that can then be very helpful in determining a general filter even if no other questions are answered by certain quiet panelists during either party's voir dire.

We would strongly recommend asking two or three diverse range questions so that every single member of the venire panel has at least two or the independent data points from which counsel can make appropriate peremptory strikes. When individual panelist give numbers at the far ends of the spectrum, it may be appropriate to follow up and ask more "why" questions to any individual who gave a particularly high or low number. Interestingly, in some voir dires, we have had individuals attempt to give answers outside the 1 to 10 range that we give them. For example, in one voir dire when we asked the panel to give us their reaction to a positive statement about the insurance industry, one panelist gave us the answer of "negative ten thousand" (while zero or one would have sufficed). That one answer gave us *tremendous* filter information from that panel member even though they never said another word during the entire voir dire. Had we not asked the range question, we never would have received a single piece of information on them and would have made preemptive strike decisions based upon the terribly uninformative general characteristics of appearance, occupation, education and gender.

B. Shadow Juries

Neither of us had used a shadow jury until 2013, but we found it to be surprisingly affordable and unbelievably helpful. Shadow juries are typically administered by the same jury consultants that do mock trials and/or assist with voir dire. A typical shadow jury consists of a gender, racial, age and social economic profile consistent with a seated jury. We had seven for a recent trial and we never communicated directly with any of them during the trial. All communications were done through the jury consultant and the shadow jury was never told who was paying for their time. Each night the shadow jury members were debriefed by a staff member of the jury consultant at a neutral location and gave their feedback to the day's witnesses and the evidence presented. Throughout the trial, they said both good and bad things about all the lawyers and all of the witnesses. It was the single most informative and helpful thing any of us had ever received during the trial of any lawsuit in our lives.

As with any real jury, the shadow jurors filtered information and evidence at trial in a manner consistent with their life experience. Through the entire trial some shadow jurors consistently filtered most of the trial information positively for the insured while others consisted filtered all of the trial information positively for the carrier. The most helpful information consistently came from those shadow jurors with a positive view of the plaintiff's claims because they gave us the greatest insight into how their views might be changed. Each night they were asked what questions they had of the day's witness that were not asked by the lawyers. We then turned around and asked those exact questions to the same witness the same day or, if they were already off the stand, another witness who could answer the questions. Each day we got feedback on what they did not understand so that we could clarify with other witnesses. If they did not like a witness, we knew what to deemphasize and, if they liked a witness, we knew what to emphasize later. Surprisingly, their view of the day's developments frequently differed radically from our views as counsel. As our trial progressed into several weeks, the shadow jury also gave us feedback on what evidence and testimony stuck with them the longest so that we knew where the greatest rhetorical tractions existed. At the end of the trial, prior to closing argument, they also gave us their summary of the best testimony and evidence they heard which were dispositive to them on each question the jury was going to be asked the next day. From this insight, we crafted our closing argument. Their feedback from start to finish through the trial was the single most helpful aid we ever received from a client during trial and we would highly recommend it in any large case.

C. Attorney's Fees

If the attorney's fees consist of an amount significantly larger than the damage claim, then the trial of the case has got to be about attorney's fees from start to finish or the defense counsel is not properly framing the issue for the jury. Most lawyers will be shocked to discover the divergent attitudes about attorney's fees in voir dire if they appropriately dig into them. Because of family law and criminal justice experience with family members, many people that show up for jury duty have experience in paying large amounts of attorney's fees which lawyers might not expect by simply looking at someone and making assumptions based upon their educational and socio-economic profile. Some jurors have paid very high legal fees and still have very favorable opinions about reasonably hourly rates and legal fee claims substantially higher than the real amount in controversy. Others are grossly offended. Counsel has to figure this out in voir dire.

During the trial of the case, attorney's fees should be the trial theme in a case of this nature. This is more easily done if the carrier has properly pled excessive demand as an affirmative defense and is going to have multiple witnesses discussing fees during the trial. It is an issue for the cross of the insureds, for the direct exam with the carrier witnesses, and the sole focus of the testimony of both party's attorney fee experts. We cannot overemphasis enough importance of a good independent attorney fee expert for the carrier who is exceptionally familiar with the nuances of D.R. 1.04, *Arthur Anderson*, *El Apple*, *City of Laredo*, and all related cases.

D. Trial Evidence

In property damage cases the old adage really is true: a picture *is* worth a thousand words. The carrier's exhibit list in property damage cases should have extensive photos of the property

made the basis of the bad faith case. With experts, use power points containing numerous photos (as long as the photos are different). As long as the photos show different aspects of the property or different types of damage, in our experience it takes a great deal to bore a jury, (Conversely, highly repetitive pictures are quickly boring). Counsel should also consider photos of non-related damage in order to show disrepair, lack of maintenance, and the insured's failure to repair.

E. Opening Statements

Our advice: go small. We strongly recommend that the three strongest and least debatable points be the core around which the opening statement is made. Any factual mistakes or highly disputed facts can be used by plaintiff's counsel to attack the credibility of counsel. Some lawyers attempt to use the emotional style of closing argument in their opening, and we believe that is a very serious mistake in most trials. In a trial that lasts more than a week, the jury is highly likely to forget everything said during the opening except for one or two key "nuggets." As such, make them good and as non-debatable as possible. Anything else will be used to harass you by opposing counsel.

F. Cross Examination

1. Policyholder Perspective

Carriers and their counsel are counting on policyholders being emotional and their lawyers being histrionic and bullying at trial. You do not have to bully to show that the corporate morality of what the carrier did is wrong.

First and foremost, keep the questions simple and understandable. Complexity can certainly be shared with the jury, but only a fool uses convoluted, compound questions to claims witnesses and experts.

Good faith is a simply, universally understood concept. Use it. Set the predicate with claims personnel that they are supposed to have a cooperative relationship with insureds, not an adversarial relationship. Were they targeted at denial or delay or did they really objectively analyze the evidence and controlling legal concepts.

A good cross-examination should have pace. Witness who are slow and deliberate and refuse to allow the examiner to pick up speed are the most dangerous witnesses.

Effective cross-examination involves putting together two and three questions packages, at least part of which no one could disagree. By the last question, the conclusion should be ineluctable.

With claims personnel and supervisors, you cannot count on Hollywood examples of corporate arrogance. It is certainly sometimes there. Actions speak louder than words. Ridiculous delays and denials without an objective approach to answering the factual or legal question cannot be swabbed away with corporate apologies and a genial manner at trial. You have to have in your head how things would have been done with someone truly acting objectively and considering the

interests of the insured. Your job is to show that to the jury and then compare it to the conduct actually engaged in by the carrier.

In the end, carriers expect a fire-breathing dragon approach by policyholder counsel. What they fear most is Matlock, a reasonable man.

2. Carrier Perspective

Although cross examination can be the "funnest" part of being in trial for defense counsel, it is also the riskiest. Most lawyers try to get too much on the cross of the plaintiff's fact and expert witnesses and the result simply leads to frustration and ineffective rhetoric. A good cross examination of the plaintiff's witnesses starts with the lawyer being prepped by his or her own expert witnesses. The expert witnesses should outline what <u>they</u> need for their testimony from the cross of the plaintiff, their fact witnesses, and their experts. When this is done, the cross-examinations are effective even if no other rhetoric or emotional points are made.

Most plaintiff lawyers do cross-examination of the carrier's witnesses with finger pointing, name calling, high emotion, voice raising and occasional sleaze. In a short trial, these tactics can be effective. Over a long trial lasting two or more weeks, however, jurors quickly tire of such histrionics. This is one of the many reasons why longer bad faith trials tend to inure to the carrier's benefit in our trial experience. Too often defense counsel is so worried that the jury will despise them for taking the time to put on their case that they rush through it too quickly. We too used to believe this. We have learned through numerous trials that the exact opposite is true. Defense counsel *must* take the time to establish a full record for the jury (and the court of appeals) and cannot afford to rush. Long trials, in our experience, usually work in the carrier's favor.

In a battle of experts, it is always good to go second. If possible, the carrier's experts should watch the plaintiff's experts testify. If not, counsel should order daily trial transcripts and forward those transcripts to the defendant's experts to study before their prep and testimony.

G. The Jury Charge—Questions and Instructions

1. Policyholder Perspective

When it comes to jury questions and instructions, the rule is to get it right, and keep it simple. In Texas, the use of broad form submission favors policyholders. Part of the problem is though that the complexity of the policies, especially personal lines policies, has made getting a correct and understandable submission very tricky, especially when dealing with concurrent and other forms of causation.

Having a charge specialist, usually an appellate lawyer, is helpful to both sides. If charge is wrong, the verdict will get reversed, so getting it right means everything. The involvement of a charge specialist should begin very early. The best approach is to be mindful of the implications of the charge when drafting initial and amended pleadings.

Alternative theories are nice and give a bit of freedom before trial, but submission of

questions and instructions on such theories can create a real mess once the verdict is rendered. Care must be taken to have very precise and connected damages questions that cannot be said to allow a double recovery.

The basic approach to coverage questions and instructions for the jury is to track the language in the policy. As noted in one recent case, caselaw *can* be consulted to flesh out and expand the insutructions. In *Mid-Continent Cas. Co. v. BFH Mining, Ltd.*, 2015 WL 5178118 at *2, Not Reported in F.Supp.3d (S.D. Tex. 2015), the court noted that the jury question would be phrased as, "Were Bellon's injuries expected or intended by the insured (BFH)?" The court fashioned the instruction as to what "expected or intended" meant by looking to controlling caselaw. The court explained:

> The Policy excludes coverage for bodily injury "expected or intended from the standpoint of the insured." Mid–Continent argues that BFH, by and through Harrison, could have expected Bellon's injury to occur. In support of this argument, Mid–Continent asserts that Harrison knew that Gujral did not have a driver's license, knew that the ATV had experienced roll-overs before the day Bellon was injured, and knew that the safety net on the ATV had been removed.
>
> The Court will instruct the jury based on the language in the Fifth Circuit case *Gulf Chem. & Metallurgical Corp.*, 1 F.3d 365, 370 (5th Cir.1993), construing an "expected or intended" exclusion, and *Lamar Homes, Inc. v. Mid–Continent Cas. Co.*, 242 S.W.3d 1, 8 (Tex.2007). Specifically, the Court will instruct the jury as follows:
>
> > The "expected or intended" injury exclusion only excludes an injury which the insured intended, not one which the insured caused, however intentional the injury-producing act. What makes injuries or damages expected or intended are [sic] the knowledge and intent of the insured. It is not enough that an insured was warned that damages might ensue from its actions, or that, once warned, an insured decided to take a calculated risk and proceed as before. *Recovery will be barred only if BFH intended Bellon's injury, or if his injury was expected by BFH because it knew that the injury was highly probable because it was the natural and expected result of BFH's actions.*

Id.

Where the court has construed the meaning of a contract term, the jury should be given an instruction with that interpretation. *See* TEXAS PATTERN JURY CHARGES 101.7. An example of this approach was approved in *International Insurance Co. v. RSR Corp.*, 426 F.3d 281 (5th Cir. 2005). An insured lead smelter sought coverage for environmental cleanup costs. The insurer denied coverage, arguing there was no "claim." The policy provided coverage for damages imposed on the insured "in respect to which a claim has been made against or other due notice has been received by the insured during the Policy Period." The dispute was whether the EPA had asserted a "claim" sufficient to invoke coverage when it issued a press release and then later added the insured to a list of priority cleanup sites and gave notice that it might initiate actions against the responsible parties.

The Fifth Circuit concluded that the district court properly defined "claim," instructed the jury on that definition, and submitted to the jury whether the EPA notice was a "claim." The term was not adequately defined in the policy, so the court applied the meaning that favored the insured. The district court instructed the jury: [T]he term "claim" means an assertion by a third party, that in the opinion of the third party, the insured is liable to it for damages within the risks covered by the policy, whether or not there is reason to believe that there actually is liability. An insured's mere awareness of a potential claim is not a claim. A claim does not require the institution of formal proceedings. 426 F.3d. at 290. The Fifth Circuit held this was an ordinary meaning of the term that was most favorable to the insured. *Id.* at 292.

Jury instructions regarding coverage determinations by the court must steer clear of making any comment on the weight of the evidence. The decision in *Redwine v. AAA Life Insurance Co.,* 852 S.W.2d 10 (Tex. App.– Dallas 1993, no writ), has been used by some defense counsel as a basis for barring any comment or statement to the jury regarding coverage determinations by the court. That is not what *Redwine* holds. In that case, the plaintiff sued her insurer for misrepresenting a travel accident insurance policy. She contended that the advertisements led her to believe the policy covered serious injuries, while the actual policy language only covered death, loss of limb, or loss of sight. The insurer denied the plaintiff's claim when her daughter suffered a spinal cord injury and paralysis of her lower limbs caused by an automobile accident. The plaintiff sued for breach of contract, DTPA and article 21.21 violations, fraud, and breach of the duty of good faith and fair dealing. The trial court held as a matter of law that the policy did not cover the claim and thus granted the insurer a directed verdict on Redwine's breach of contract and duty of good faith and fair dealing causes of action. The trial court instructed the jury as follows:

> You are hereby instructed that AAA Life Insurance Company did not breach its fiduciary duty of good faith and fair dealing, or otherwise act in bad faith, by denying Deanne Redwine's claim under the 365 Travel Accident Policy.
>
> You are hereby instructed that Deanne Redwine's claim pursuant to the injuries received were not covered by the 365 Travel Accident Policy.

Id. at 13. The jury found against the plaintiff on the remainder of her theories. The court of appeals held that the trial court committed reversible error by commenting on the weight of the evidence with these instructions. The court held that these instructions were unnecessary and improperly suggested to the jury the trial judge's opinion about the remaining causes of action. *Id.* at 16.

The instruction in *Redwine* clearly goes too far, especially as a jury instruction. The instruction was clearly unnecessary as to the remaining issues to be considered by the jury. In the case where coverage or a duty to defend previously contested is found, it is impossible to fairly try the case without the fact of the determination being shared with the jury. For the defendant insurer, it is devastating because all of their protestations about being right on the law have been shown wrong, at least in effect. Many defendants will try to obtain additional instructions to the effect that a mere breach of contract is not evidence of bad faith. The law in this area is not well developed.

2. Carrier Perspective

We strongly recommend bringing an appellate lawyer to the jury charge conference. Because they are not trying to prepare for the closing argument at the same time, and because they are not emotionally exhausted from trial, their fresh eyes will catch small items that trial counsel simply won't catch.

Because juries inevitably try to compromise, defense counsel should contemplate where compromise can actually help them. One example is not insisting on conditionality between the breach of contract and the bad faith questions. If a defendant insists on conditioning the breach of contract and the bad faith questions, the jury can figure out the results of their answers. If they are not conditioned, however, in our experience the jury is more times than not willing to find that the insurance policy was fully complied with but that there was some failure to investigate or some other violation of the insurance code. In many instances the "no" answer to the breach of contract question will be dispositive of all of the extra-contractual questions. As such, leaving out the condition actually helps the carrier.

Likewise, we do not recommend granulating the breach of contract question. In our experience a broad form jury question that simply asks if the carrier complied with the policy minimizes the risk of jury compromise. The more granulation that occurs, the greater the opportunity for the jury to compromise and split their answers on the contractual liability question. As such, we recommend a broad form of submission on the breach of contract issue.

Final charge point: do not submit the plaintiff's questions in proper form. If they cannot get it right, let them screw up their own charge. For example, as to plaintiff's extra-contractual questions, we simply submit the *instructions* that we think we need. In terms of the form of the extra-contractual questions, we leave that up to the plaintiff's lawyers to screw up anyway they want (which they typically do). Our submitted charges typically contain more instructions than questions. We also discovered that trial courts are more willing to give us a single instruction or two if they have already given plaintiff the entire question the form they want it. We discovered if we try to submit an entire question with instructions that the real sentence or two of instructions which we really need inevitably get lost in the large submission. So, on the charge, go small.

V. CONCLUSION

A. Carrier Perspective

Not enough parties are willing to try bad faith suits. We understand why they are scared. Unfortunately, the fear has been propagated more by their own lawyers than it has by counsel for the policyholders. If counsel are truly afraid to turn their cases over to a jury it is no surprise that their clients will be as well. Bad faith cases *can* be won in jurisdictions all over America, including Texas. We know because we've done it repeatedly. It takes exceptional planning to win. It takes strategic chess moves from start to finish to win. It takes both analytic sophistication and rhetorical skill to persuade the judge and the jury of those key points upon which victory can be based. Although things can go wrong, in our experience it is far more difficult for plaintiff to get *and keep* a bad faith verdict than it is for the defendant to get a victory in the trial or the appellate courts. We hope that employing some the lessons we've learned in the last two decades of trying insurance

coverage and bad faith cases that other lawyers and their clients can increase their odds of winning their insurance coverage and bad faith trials. We wish you all the best of luck.

B. Policyholder Perspective

The first lesson thirty some-odd years ago upon entering the practice was that juries hate insurance companies. Carriers have a track record, and it is not a good one. Moreover, the duty of good faith is inconsistent with the mindset of many carriers. Playing coverage games has not ended. Claims personnel are very often overworked, underpaid and underappreciated. In fact, they are often no longer even with the company being sued. In liability cases, internal claims operations have significantly changed. Loyalty from employees and defense counsel is at the lowest level seen since I have been in practice. This is a land of opportunity.

More bad faith cases should be tried by policyholders. Experience has shown that bad cases do not get better for carriers. The skill and tactics devoted by defense counsel have certainly increased in some instances and made it more difficult. In the lion's share of cases, however, many carriers continue to try to find bargains, using counsel to defend bad faith cases who have little experience with such cases and conflicts. Losing key coverage rulings still makes it very hard for most carriers to risk the typical juror's inbred view that insurance companies do not act fairly.

Longer bad faith trials I believe work to the advantage of the policyholder in most cases. Jurors have a hard time following tedious, factually and legally intensive coverage fights. There is an old adage among defense lawyers, "The case is too complicated to win." This is still true in many cases. It is clear that the days of filing extreme claims and sending mountains of voluminous and time-consuming discovery to cajole a carrier into settling has likely come to an end. Most jurisdictions are reigning in such discovery. Even the federal rules' scope of discovery has changed to reflect a certain cost-conciousness. While harder, if you develop the skill and work the cases, there is still great potential for success.

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ATTORNEYS FEES IN COVERAGE AND EXTRACONTRACTUAL LITIGATION: WHAT WORKS AND WHAT DOESN'T

American College of Coverage and Extracontractual Counsel
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Parties litigating insurance coverage and bad faith disputes often must factor in the possibility that attorneys fees may be awarded to one side or the other. Fundamentally, attorneys fees can only be awarded if allowed by statute, rule, caselaw or by a contract between the parties. Since most insurance policies do not include attorneys fees provisions, statutes, rules and caselaw are the main sources for recovering attorneys fees in insurance coverage and bad faith litigation.

While this article is written from the perspective of the presenter's home jurisdiction in Texas, much of the strategy, rules and caselaw are similar throughout the United States. For example, Texas state and federal courts utilize the Lodestar method for determining the amount of recoverable attorneys fees, which coincides with the standard method in all United States federal courts. Nonetheless, parties must be careful to heed and comply with the local rules and law of the particular jurisdiction involved.

The most common statutes for recovering attorneys fees in Texas insurance coverage and bad faith litigation are Tex. Civ. Prac. & Rem. Code §37.001 (for breach of contract); Tex. Civ. Prac. & Rem. Code §38.009 (for state court declaratory judgment actions); Tex. Ins. Code §541.152 (for unfair claims handling practices); and Tex. Ins. Code §542.541 (for breaches of the prompt payment of claims statute). Rules that can give rise to awards of attorneys fees in coverage and bad faith litigation include: Tex. R. Civ. P. 91a (for actions not based in law or in fact); and Fed. R. Civ. P. 37(b)(2)(C) (for federal court discovery sanctions).

The courts are currently churning out opinions on awarding attorneys fees. Beginning in earnest with *Arthur Andersen & Co. v. Perry Equip. Corp.,* 945 S.W. 2d 812 (Tex. 1997), the Texas Supreme Court has regularly weighed in on the standards for awarding attorneys fees, leading to significant progeny in the Texas appellate courts. Also, the federal district court Memorandum Orders on attorneys fees are frequently reported on Westlaw and LEXIS, providing a wealth of caselaw and analysis.

I. Standards for Recovering Attorneys' Fees: Lodestar Method

The reasonableness of attorneys fees is generally a fact issue. *See Garcia v. Gomez,* 319 S.W.3d 638, 642 (Tex. 2010). Appellate courts review attorney's fee awards for an abuse of discretion. *Ridge Oil Co. v. Guinn Invs., Inc.,* 148 S.W.3d 143, 163 (Tex. 2004). The basic way to calculate an attorneys fees award is the lodestar method. This method begins by multiplying the number of hours worked by a reasonable hourly rate to obtain a lodestar. The lodestar can be adjusted upward or downward depending on the *Perry Equipment* Factors:

- The time and labor required, the novelty and difficulty of the questions involved, and the skill required to perform the legal services properly;

- The likelihood … that the acceptance of the particular employment will preclude other employment by the lawyer;

- The fee customarily charged in the locality for similar legal services;

- The amount involved and the results obtained;
- The time limitations imposed by the client or by the circumstances;
- The nature and length of the professional relationship with the client;
- The experience, reputation and ability of the lawyer or lawyers performing the services; and
- Whether the fee is fixed or contingent on results obtained or uncertainty of collection before the legal services have been rendered

Arthur Anderson & Co. v. Perry Equip. Corp., 945 S.W.2d 812, 818 (Tex. 1997).

Texas Federal Courts will sometimes utilize the *Perry Equipment* factors and will sometimes utilize what are called the *Johnson* Factors as articulated in *Johnson v. Ga. Highway Express, Inc.*, 488 F.2d 714, 717-19 (5th Cir. 1974). The *Johnson* Factors are basically the same as the *Perry Equipment* Factors; although one *Johnson* Factor not included in the *Perry Equipment* Factors is fee awards in similar cases. *See generally Mid-Continent Cas. Co. v. Chevron Pipe Line Co.*, 205 F.3d 222, 232 (5th Cir. 2000) ("Because Texas courts engage in a similar analysis, it has *not* been necessary for our court to decide whether the *Johnson* factors control in Texas diversity cases").

While the lodestar method is a very common way to recover fees in insurance coverage and bad faith litigation, law exists that a plaintiff seeking to recover for breach of contract or deceptive practices in an insurance case is not limited to the lodestar method. *See United Nat. Ins. Co. v. AMJ Investments*, 447 S.W.3d 1, 13, 16 (Tex. App.—Houston [14th Dist.] 2014, pet. denied) ("a plaintiff seeking to recover for breach of contract or deceptive practices in an insurance case is not subject to the [lodestar] requirement," … [h]aving chosen that method, AMJ was required to introduce sufficient evidence to allow the factfinder to apply it.").

II. Standard for Segregating Attorneys' Fees

Although not an insurance case, in 2006 the Texas Supreme Court analyzed how parties should allocate fees attributable to causes of action permitting the recovery of attorneys' fees (e.g. breach of contract) from the fees attributable to causes of action that do not allow for a prevailing party to recover their fees (e.g. negligence). *Tony Gullo Motors I, L.P. v. Chapa*, 212 S.W.3d 299 (Tex. 2006). In *Chapa*, the Texas Supreme Court held that when a party incurs attorney's fees relating solely to a claim for which such fees are unrecoverable, a claimant must segregate recoverable from unrecoverable fees. *Id*. at 313. Intertwined facts do not convert unrecoverable fees to recoverable. *Id*. at 313-14. In other words, just because recoverable and unrecoverable claims depend upon the same set of facts or circumstances, that does not mean those claims require the same research, discovery, proof, or legal expertise. *Id*. at 313.

Therefore, the Court overruled the previous rule in *Stewart Title Guar. Co. v. Sterling*, 822 S.W.2d 1 (Tex. 1991), stating that *Sterling* went too far in suggesting that a common set of

underlying facts necessarily made all claims arising therefrom "inseparable" and all legal fees recoverable. *Id*. Here, the Texas Supreme Court held that it is only when discrete legal services advance both a recoverable and unrecoverable claim that they are so intertwined that they need not be segregated. *Id*. at 313-14. "But when, as here, it cannot be denied that at least some of the attorneys' fees are attributable to claims for which fees are not recoverable, segregation of fees ought to be required and the jury ought to decide the rest."

III. Standards for Recording the Rendering of Legal Services

Six years after *Chapa*, the Texas Supreme Court analyzed the sufficiency of the evidence required to support an attorneys fees award in *El Apple I, Ltd. v. Olivas,* 370 S.W.3d 757 (Tex. 2012). Here, the Texas Supreme Court found that generalities about tasks performed were insufficient to determine reasonable and necessary fees under the lodestar method. *Id.* at 763. Sufficient evidence includes evidence "of the services performed, who performed them and at what hourly rate, when they were performed, and how much time the work required." *Id.* at 764.

Because the attorneys fees evidence in *El Apple* was limited to the number of hours worked and generalities about discovery and the length of trial, the Texas Supreme Court remanded the case to determine reasonable and necessary attorneys fees. In so doing, the Texas Supreme Court noted that if contemporaneous records are not available, the attorneys must reconstruct their time with information to allow a meaningful review of the fee request. *Id.; see also City of Laredo v. Montano,* 414 S.W.3d 731, 736-37 (Tex. 2013) (case remanded to determine fees when attorney did not provide evidence of the time devoted to specific tasks); and *Long v. Griffin,* 442 S.W.3d 253, 255-56 (Tex. 2014) (general evidence regarding amount of time, hourly rates, that the case involved extensive discovery, several pretrial hearings, multiple summary judgment motions and a four and one-half day trial held: not sufficient to support an attorneys fees award); *United Nat. Ins. Co. v. AMJ Investments, LLC,* 447 S.W.3d 1, 17-18 (Tex. App.—Houston [14th Dist.] 2014, pet. denied) (remanding case for a redetermination of attorneys fees because fee proponent "failed to introduce evidence that was sufficiently specific to permit the determination of a reasonable fee for its attorney's necessary services").

IV. Recovering Attorneys Fees in Texas Courts: What Works

Here are some recent examples of successful attorneys fees applications in interesting situations.

A. Dallas Court of Appeals Affirms a Fee 5.5 Times over the Lodestar

A case that supports the recovery of a substantial fee is *J.C. Penney Co., Inc. v. Ozenne,* 453 S.W.3d 509 (Tex. App.—Dallas 2014, pet. denied). *Ozenne* involved a situation where the Dallas Court of Appeals analyzed a $3.1 million fee request when the lodestar amount was approximately $550,000. The attorneys fee statute involved in *Ozenne* was the Tex. Bus. Org. Code §21.561, which provides that a trial court "may" award fees if the proceeding substantially benefits the corporation. Thus like the Texas Declaratory Judgment statute, Tex. Civ. Prac. & Rem. Code §38.009, an attorney fees award is not mandatory and it is left to the discretion of the trial court.

The key factor in *Ozenne* was a Stipulation that allowed the court to determine fees based on "the results achieved … and the risks of undertaking the prosecution of the Action on a contingent basis." *Id.* at 512. Thus, the court was not constrained by the lodestar and *Perry Equipment* Factors, which would have resulted in a significantly lower fee.

B. Houston 14th Court of Appeals Affirms $85,000 Fee on a $17,000 Jury Award

State Farm Lloyds v. Hanson, 500 S.W.3d 84 (Tex. App.—Houston [14th Dist.] 2016 pet. denied) involves a first party breach of contract action for a hail-damaged roof claim. At first, State Farm denied coverage on the claim and then post-suit, it made a $30,000 settlement offer.

The Plaintiff prevailed on her breach of contract action and was awarded approximately $17,000 in damages for wrongfully denied policy benefits. With respect to Plaintiff's request for fees, she introduced a ten-page Summary with information about the date, the time keeper, tasks performed, hours worked and hourly rate. Along with supporting testimony by the Plaintiff's attorney, the Plaintiff proved up approximately $157,000 in fees and volunteered a 5% reduction for fees exclusively relating to an unsuccessful bad faith claim. Accordingly, the Plaintiff asked the jury to award right at $150,000 for attorneys fees. State Farm's expert countered with a fee range between $30,000 and $40,000. The jury awarded $15,000 in fees from the start to the rejection of the Plaintiff's settlement offer and $70,000 in fees from the settlement rejection through trial (and another $80,000 in conditional appellate attorneys fees).

Upon a comprehensive attack of the attorneys fees award on appeal, the Houston 14th Court of Appeals affirmed the trial court judgment. Here is what worked:

- Plaintiff's counsel presented expert testimony regarding the reasonableness and necessity of the work, experience and quality of the lawyers and their prevailing hourly rates. *Id.* at 11.

- Plaintiff introduced a ten page computer generated summary that included general and block-billing entries. *Id.* at 11-12.

1) Block Billing

In response to the Block Billing attack, the 14th Court of Appeals held that the Summary allowed for "meaningful review" "because they included details about the nature of the work, who did it at what rate, what day the work was performed, and the time worked. [citation omitted] … [T]he entries were detailed enough to provide 'some indication of the time spent on various parts of the case.'" *Id.* at 12.

2) General Time Entries

Plaintiff Hanson also withstood an attack on the fees evidence that the time entries were too general. Here, the 14th court relied on the testimony of the plaintiff's attorney about the grueling nature of litigating jury trials. Also, the court specifically found the description: "Prepare for trial"

was legally sufficient. *Id.* at 13; *citing Med. Disc. Pharmacy, L.P. v. State,* No. 01-13-00963-CV, 2015 WL 4100483 (Tex. App.—Houston [1st Dist.] 2015, pet ___) (concluding that *El Apple* does not require more level of detail for particular category of tasks than, e.g., "attend/appear at hearing").

3) Failure to Segregate

With respect to an attack on the fees evidence because the recoverable fees were not properly segregated from the non-recoverable fees, the 14th Court of Appeals held:

> even when fee segregation is required, attorneys are not required to keep separate records documenting the exact amount of time prosecuting one claim versus another. Rather, segregation is sufficiently established if an attorney testifies that a given percentage of the time worked would have been necessary even if the claim for which attorney's fees are unrecoverable had not been asserted. [Citations omitted].

Id. at 14.

Accordingly, the 14th Court of Appeals relied on the Plaintiff's attorneys testimony that: a) the case involved inextricably intertwined claims; b) much of the discovery for Hanson's contract claim applied to her bad faith claims; c) an estimated five percent of the attorney's time shown on the summary was spent solely on bad faith issues; and d) the Plaintiff's attorney did not include every fee incurred in the course of the trial, particularly for the trial days themselves. *See Sentinel Integrity Sols., Inc. v. Mistras Group, Inc.,* 414 S.W.3d 911, 929-30 (Tex. App.—Houston [1st Dist.] 2013 pet. denied) (considering as part of segregation analysis testimony that bills did not include every fee incurred).

4) Excessive Fee Award

In response to the argument that the jury's fee award was excessive, the 14th Court of Appeals deferred to the jury. For example, the jury had to consider *Perry Equipment* Factor "the amount involved and the results obtained." Also, the 14th Court of Appeals noted that the fees awarded by the jury were less than half sought by Plaintiff Hanson. For supporting authority, the 14th Court of Appeals cited to *Bencon Mgmt. & Gen. Contracting, Inc. v. Boyer, Inc.,* 178 S.W.3d 198, 209-10 (Tex. App.—Houston [14th Dist.] no pet.) (fee award of over $282,000 compared to actual damages of $81,336.83 was not factually insufficient) and *Metroplex Mailing Services, LLC v. RR Donnelley & Sons Co.,* 410 S.W.3d 889, 900 (Tex. App.—Dallas 2013 no pet.) ("[T]here is no rule that fees cannot be more than the actual damages awarded.").

C. $3.2 Million Fee Award: Innovated Segregation

In *Bear Ranch, LLC v. Heartbrand Beef, Inc.,* 2016 WL 3549483 (S.D. Tex. 2016), Judge Gregg Costa reconsidered an application of a $5 million fee upon undergoing a court ordered exercise of segregating fees relating solely to a non-recoverable fraud claim from the recoverable fees attributable to enforcing the agreement between the parties. Specifically, Judge Costas charged the prevailing party with submitting a fee request that: "(1) eliminated those fees related

solely to the damages on the nonrecoverable fraud claims" … and 2) proposed a percentage of the remaining fees that would have been recovered absent the unrecoverable claims."

After agreeing that approximately $600,000 in fees and expenses were specifically attributable to the fraud claim that did not support the recovery of fees, here is what worked for the recovery of a substantial fee.

1) Segregation by Trial Phases

The fee claimant proposed and Judge Costas accepted dividing the litigation into three phases for pre-summary judgment; summary judgment through jury verdict and post-trial. *Citing Eagle Suspensions, Inc. v. Hellman Worldwide Logistics, Inc.,* 2015 WL 252442 at *3-*4 (N.D. Tex. 2015) (dividing case into six phases to determine the "percentage of fees that should be excluded at each stage for work relating solely to claims other than the [recoverable claim]").

- Phase 1 (pre-summary judgment) Judge Costas allocates 80% of $2,623,942.40 in fees and expenses (right at $2.1 million) toward claims that support the recovery of fees. Judge Costas concedes that most of the discovery would have been needed even absent the unrecoverable fraud claims or the unsuccessful contract claim. Judge Costas based this calculation in part on his "familiarity with this complex litigation." *Id.* at *2.

- Phase 2 (summary judgment through jury verdict) Judge Costas accepts the 76% proposed by counsel seeking the recovery of fees. 76% was derived from using trial time as a barometer. Here, the trial time attributable to claims supporting the recovery of fees was calculated at 804 minutes out of 1,057 minutes of total trial time; or 76%. "The Court agrees that trial time is an accurate measure of what amount of fees were recoverable; in fact, minute-by-minute allocation is an even more refined measure than the witness-by-witness allocation the Court suggested." *Id.* Accordingly, Judge Costas awarded approximately $780,000 out of $1.025 million in fees and expenses incurred during this phase.

- Phase 3 (post-trial) Judge Costas accepts the 44% proposed by counsel seeking the recovery of fees. This 44% figure was based on the percentage of the post-trial briefing attributable to claims supporting the recovery of fees. Apparently, there were 304 pages of filed post trial briefing and 133 pages or 44% were attributable to recoverable claims. Judge Costas ruled that "[t]his point of reference reasonably reflects the amount of work post-trial that was expended on recoverable claims." *Id.* at *3. Accordingly, Judge Costas awarded approximately $380,000 of the approximately $865,000 of fees and expenses incurred during this phase.

2) Amount in Controversy/Complexity of Case

After employing this segregation calculus, Judge Costas next evaluated the reasonableness of the remaining $3.2 million in fees. In this regard, Judge Costas acknowledged that the "[r]equested fees must bear a reasonable relationship to the amount in controversy or to the

complexity of the case." *Northwinds Abatement, Inc. v. Emp'rs Ins. of Wausau,* 258 F.3d 345, 354 (5th Cir. 2001) ("[T]he most critical factor in determining an award of fees is the 'degree of success' obtained by the victorious plaintiffs."). Even so, there are instances of attorneys fees awards being held as reasonable "even when the amount of attorneys' fees far surpasses the amount of actual damages." *Id. citing Chaparral Texas, L.P. v. W. Dale Morris, Inc.,* 2009 WL 455282 at *13-*15 (S.D. Tex. 2009) (collecting Texas cases demonstrating that the complexity of litigation can justify a higher fees award even when the amount recovered was minimal in comparison).

"Although HeartBrand may not have achieved a significant financial recovery in the judgment, the equitable relief it obtained has significant economic value." *Bear Ranch,* 2016 WL 3549483 at *4. "[E]ven if HeartBrand's successes were disproportionate to the fees and costs award, 'disproportion alone does not render the award of attorneys' fees excessive.'" *Citing Northwinds Abatement, Inc.* 258 F.3d at 355 (affirming $712,000 in attorneys' fees on recovery of $74,570 in actual damages).

3) Block Billing

In response to an attack on the fees being block-billed, Judge Costas found that "there is more than sufficient detail to determine whether the hours were reasonably expended." *Citing OneBeacon Ins. Co. v. T. Wade Welch & Assc.,* 2015 WL 5021954 at *8 (S.D. Tex. 2015) ("The court is unconcerned with the block billing, given the level of detail on the bills."). *Bear Ranch,* 2016 WL 3549483 at *4 n.5.

4) Hourly Rates

Analyzing the sought-after hourly rates, Judge Costas considered the relevant community to be the Southern District of Texas. In this regard, Judge Costas found hourly rates for partners between $606 and $684 and for associates between $400 and $492 were consistent with the prevailing market rates for attorneys in the Southern District of Texas who handle complex litigation." Judge Costas also found that these rates found support from the State Bar Survey and because the opposing counsel's hourly rates were even higher than the rates sought in the fee application. *Id.* at 5.

V. Recovering Attorneys Fees in Texas Courts: What Doesn't Work

There is no shortage of unsuccessful fee applications as well. A couple of representative examples include:

A. Fifth Circuit Finds $530,000 Attorneys Fee Award in a Simple Coverage Case Excessive.

In *Mid-Continent v. Chevron Pipe Line Co.,* 205 F.3d 222, 232 (5th Cir. 2000), the Fifth Circuit held that in reviewing a fee award, "it must also consider, *inter alia,* 'whether the award is excessive in light of the plaintiff's overall level of success'" and that "the requested fees must bear

a 'reasonable relationship to the amount in controversy or to the complexity' of the circumstances of the case." *Id.* "In deciding whether fees are excessive, we '[are] entitled to look at the entire record and to view the testimony, the amount in controversy, the nature of the case and our common knowledge and experience as lawyers and judges.'" *Id.*

The Fifth Circuit noted that "many of Mid-Continent's complaints appear legitimate, including, for example those about billing record entries regarding clerical work performed by paralegals." *Id.* at 234. The Fifth Circuit concluded that the fee award was excessive and unreasonable. "In sum, the amount of the award was an abuse of discretion." *Id.* The Fifth Circuit's parting advice to the district court was: "[n]eedless to say, on remand, 'the court should exclude *all* time [in the billing records] that is excessive, duplicative, or inadequately documented.'" *Id.*

B. Texarkana Court of Appeals Holds that Awarding Fees under the Declaratory Judgment Act in a Standard UM/UIM Claim is not Equitable or Just

Allstate Ins. Co. v. Jordan, No. 06-15-00042 (Tex. App.—Texarkana 2016) involved an Underinsured Motorists Coverage case where a UIM claimant filed a declaratory judgment actions to resolve the damages phase of the UIM claim and recovered attorneys fees pursuant to Tex. Civ. Prac. & Rem. Code §38.009 . On the one hand, the Texarkana Court of Appeals held that use of the Texas Uniform Declaratory Judgment Act was appropriate. On the other hand, the court held that:

> allowing recovery of attorneys fees in UIM cases under [Tex. Civ. Prac. & Rem. Code §38.009] would create a special category of contract cases where attorneys fees would be recoverable prior to presentment. The Supreme Court has made it clear that a [Uniform Declaratory Judgment Act] claim cannot be used "as a vehicle to obtain otherwise impermissible attorney's fees.

Id. at 10. Accordingly, the Texarkana Court of Appeals modified the judgment to delete the award of attorneys fees.

C. Houston 14th Court of Appeals Refuses Insured's Attempt for a Double Recovery Based on Multiple Insurers Owing Duties to Defend.

In *Coreslab Structures (Texas), Inc. v. Scottsdale Ins. Co.*, 496 S.W.3d 884 (Tex. App.—Houston [14th Dist.] 2016, no pet.), the policyholder, Coreslab, incurred approximately $883,000 in defense costs through the settlement of two property damage cases. Almost all of these defense costs, approximately $825,000, were paid by one of the Coreslab's insurers, Lexington. A coverage dispute involving Coreslab's status under the Scottsdale policy resulted in a declaration that Coreslab was an additional insured and that Scottsdale owed Coreslab a duty to defend. The Summary Judgment evidence showed that Scottsdale paid at least $410,000 toward the defense of Coreslab. As stated by the 14th Court of Appeals, "Coreslab essentially asserts that it is entitled to recover $473,400.39 against Scottsdale based on defense costs that Scottsdale failed to pay under

the Scottsdale policy, even though Coreslab has not paid any of the attorneys fees and even though Lexington has paid $825,642.32 to Coreslab's defense counselin the Underlying Lawsuits." *Id.*

Rejecting Coreslab's arguments that since Scottsdale owed it a "complete defense," and that because Scottsdale not paying for the entire defense had a negative impact on Coreslab's loss history, the 14th Court of Appeals held that "[a]s a matter of law, Coreslab is not entitled to recover any damages based on Coreslab's defense costs in the Underlying Lawsuits because the total amount paid by Lexington and Scottsdale exceeds the sum of Coreslab's defense costs in the Underlying Lawsuits." *Id.*

D. Dallas Federal Judge Halves $1.2 Million Fee Request

Spear Marketing, Inc. v. Bancorpsouth Bank, 2016 WL 193586 (N.D. Tex. 2016), *affirmed* 844 F.3d 464 (5th Cir. 2017) involved a fee application totaling approximately $1.2 million. Judge Jane Boyle held that upon calculating the lodestar amount (number of hours an attorney reasonably spent on the case multiplied by an appropriate hourly rate based on the market rate in the community for this work), "the court should exclude all time that is excessive, duplicative, or inadequately documented." *Id.* at *8. Reducing partner hourly billing rates, which exceeded $600 and associate hourly rates in excess of $400, the court found that attorneys of comparable skill, experience and reputation to range from $100 to $400 an hour and between $60 and $125 an hour for legal assistants. *Id.* at *9. After noting that: "[g]enerally, fee awards for rates above $500 per hour are reserved for 'specialized tasks in complex cases that few attorneys are capable of handling,'" Judge Boyle held that "the Court will adhere to a general rate of $150 to $400 per hour for attorneys and $100 an hour for paralegals." *Id.*

On the one hand, Judge Boyle found that the time spent on the requested fees was reasonable and it was not excessive, duplicative, inadequately documented or inadequately segregated. On the other hand, Judge Boyle recalculated the lodestar amount using the lower hourly rates to obtain an approximately 50% reduction from the sought after fees. *Id.*

VI. Selected Issues

A. Trial over Fees to Judge or Jury

Whether to try attorneys fees to the court or to the jury is a judgment call that depends on the circumstances. If a party has multiple timekeepers seeking a large fee, then it might be tempting to opposing counsel to bring this information to the attention of the jury. Conversely, particularly if the fee application is reasonable, trying fees to the jury allows counsel to testify in front of the jury about what he or she did to prepare for and try the case. This gives counsel the opportunity in the middle of the trial to personalize him or herself and perhaps the client as well.

B. Declaratory Judgments

With respect to the recovery of attorneys fees, Declaratory Judgment Actions are different from breach of contract and the insurance code fees statutes. Tex. Civ. Prac. & Rem. Code §37.009

provides: "[i]n any proceeding under this chapter, the court may award costs and reasonable and necessary attorney's fees as are equitable and just." According to the Texas Supreme Court, "the [Uniform Declaratory Judgment Act] entrusts attorney fees awards to the trial court's sound discretion, subject to the requirements that any fees awarded be reasonable and necessary, which are matters of fact, and to the additional requirements that fees be equitable and just, which are matters of law." *Bocquet v. Herring,* 972 S.W.2d 19, 20 (Tex. 1998). Accordingly, fees awarded under the Declaratory Judgment act are discretionary; giving rise to arguments for and against whether the sought after fees are equitable and just.

Also, it is possible in state court cases for the court to award fees to insurers in pure Declaratory Actions (such as when the insurer is defending under a reservation of rights and seeks a declaration of no duty to defend). Texas federal courts, however, do not award fees in pure declaratory judgement actions. *See Utica Lloyds of Texas v. Mitchell,* 138 F.3d 208, 210 (5th Cir. 1998).

Furthermore, fees will not be awarded under the Texas Uniform Declaratory Judgment Act when they would not otherwise available. *See MBM Fin. Corp. v. Woodlands Operating Co., L.P.,* 292 S.W.3d 660, 669 (Tex. 2009). So, if an insured sues for a breach of contract; the insurer's counterclaim for a declaratory judgment will not support a fee award. Since the insurer cannot recover fees in defending a breach of contract action, that insurer cannot use the Texas Uniform Declaratory Judgment Act as an avenue to recover otherwise nonrecoverable fees.

C. Appellate Counsel Fees

Appellate counsel fees can come into play as appellate counsel attending trial and also for contingent fees in the event of an appeal. Depending on the circumstances, it may be possible to argue that appellate counsel participating at trial is not necessary. Also, there is authority for the proposition that courts should not conditionally award attorneys fees for appeals (rather, they should be addressed on a remand to the court, if necessary). *See, e.g., Great American Ins. Co. v. AFS/IBEX Financial Services, Inc.,* 2009 WL 361956 (N.D. Tex. 2009). If conditional attorneys fees evidence is allowed, it is important for the fee proponent to show a rational basis between the fees sought and the work involved. Conversely, fee opponents should attack the lack of a rational basis, if merited under the circumstances.

D. Contingency Fees

Contingency fees give rise to a host of issues in the recovery of fees in insurance coverage and bad faith litigation. While there is no blanket rule against them, the cases strain to reconcile contingency fees with the *Perry Equipment* Factors. *See OneBeacon Ins. Co. v. T. Wade Welch & Assc.,* 2015 WL 5021954 (S.D. Tex. 2015). An example of a contingency fee being awarded under Tex. Civ. Prac. & Rem. Code §38.001 for breach of an insurance contract is *Mid-Continent Cas. Co. v. Kipp Flores Architects, L.L.C.,* 602 Fed. Appx. 985 (5th Cir. 2015), which in awarding fees pursuant to a contingency fee agreement minus a reduction for time spent outside of the breach of insurance contract claim, the Fifth Circuit held:

> Mid-Continent argues that Texas requires lodestar evidence for attorneys fees. That is not accurate. Texas courts permit otherwise reasonable contingency fee awards under §38.001.
>
> ***
>
> Mid-Continent's argument rests entirely on the proposition that KFA failed to submit lodestar evidence. Because Texas law does not require lodestar evidence for contingency fee arrangements and because Mid-Continent has not shown that the fee is unreasonable, we cannot say that the district court abused its discretion in awarding the fee.

Id. at 999-1000.

VII. Tips for Effective Fee Applications

- Better the task description, the easier the bill is to uphold
- Demonstrate proper and efficient staffing (explain each team member's role)
- Demonstrate that work performed was not duplicative, unnecessary or excessive (avoid obvious overbilling situations)
- Block Billing Beware
- Show reasonable segregation between recoverable fees from nonrecoverable fees
- Show that the hourly rates are in line with the particular market
- Demonstrate that fees for clerical tasks are not being sought
- Allow for some Business Judgment reductions
- Consider Expert Testimony
- Remember Pigs get Fatter; while Hogs get Slaughtered

VIII. Areas Conducive to Challenge

- High hourly rates; especially in routine matters
- Improper delegation of work
- Redundancy and unnecessary duplication of effort
- Excessive time keepers
- Excessive time spent on particular tasks
- Apparent bill padding
- Overly redacted time entries

- Claims that fees attributable to both recoverable and nonrecoverable claims are inextricably intertwined
- Inadequate segregation efforts
- Legal Assistants (and Associates) performing clerical work
- General and vague time entries
- Block-billing
- Billing for traditional overhead expenses
- Remember, be careful what you ask for; you might just get it.

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TABLE OF CONTENTS

I. Introduction

The familiar "American Rule" holds that each party bears its own attorneys' fees in litigation. The only exceptions are a statute or contract authorizing the shifting of legal fees from the prevailing party to the losing party. Any number of federal and state statutes have fee-shifting provisions in them. These generally relate to civil rights, consumer protection, employment and environmental suits. In addition, many contracts have prevailing party provisions, which likewise shift attorneys' fees.[1] In many contexts (class actions, for example), the attorney fee award can be substantial, often representing a large percentage of the overall recovery.

Where the prevailing party is awarded attorney fees, the inevitable question is whether the fees are covered by the losing party's liability insurance. There are two primary avenues by which an attorney fee award may be recovered from the insurer. The first is the indemnity provision in the policy. Here, the question is whether the attorney fee award constitutes "damages" within the particular coverage grant. The second is under the supplementary payments coverage of the policy, which obligates the insurer to pay for expenses, costs of bonds, interest and "costs" taxed against the insured. Here, the question is whether an attorney fee award constitutes a "cost."

II. Attorney Fee Awards as Recoverable "Damages" as Part of the Insurer's Indemnity Obligation

The typical CGL policy provides that the insurer will pay "damages" because of bodily injury, property damage, and personal and advertising injury. For example, the current ISO CGL insuring agreement for bodily injury and property damage liability (Coverage A) provides that:

> We will pay those sums that the insured becomes legally obligated to as damages because of "bodily injury" or "property damage" to which this insurance applies.[2]

[1] In the absence of such a provision, attorneys' fees are typically not awarded in a breach of contract case. Some jurisdictions, however, permit an insured to recover attorneys' fees in establishing coverage where the insurer breaches the defense obligation. *See* Ostrager & Newman, *Handbook on Insurance Coverage Disputes*, §5.06[b] (15th ed. 2011). Such awards are outside of the scope of this article.

[2] Commercial General Liability Coverage Form CG 00 01 04 13, © ISO Properties, Inc., 2012.

The personal and advertising injury liability grant (Coverage B) likewise obligates the insurer to "pay those sums that the insured becomes legally obligated to pay as damages." The policy does not define the word "damages" and neither coverage grant excludes attorneys' fees.

A. Broad Interpretation of the Undefined Word "Damages" Encompasses Attorney Fee Awards.

Because of the historically broad interpretation given to coverage under a CGL policy, a number of courts have held that fee-shifting awards are covered "damages." For example, in *Am. Family Mut. Ins. Co. v. Spectre W. Builders Corp.*[3] the underlying arbitration involved a construction defect claim by a homeowners' association against the contractor relating to a condominium complex in Arizona. As part of the award, the arbitrator found that the association was entitled to $300,000 in attorney's fees pursuant to contract and Arizona fee-shifting statutes.[4] In the coverage litigation, the insurer sought a declaration that there was no coverage under the CGL policy for the construction defect claims and that the policy did not provide coverage for the attorneys' fee award and non-taxable costs. The court rejected both contentions:

> [T]he **insuring language is broad enough to encompass coverage for the Arbitrator's award of attorneys' fees** and costs to the Association. The Court already has held that property damage occurred under the policies, and Spectre became legally obligated to pay attorneys' fees and costs as a result of that property damage. **The Court therefore finds that the attorneys' fees and costs awarded at the arbitration are damages that fall under the insuring clause of the policies**.[5]

The court also rejected the insurer's argument that the attorney fee award was barred by the exclusion for contractual liability. Here, the court concluded that the award was not the result of

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[3] *Am. Family Mut. Ins. Co. v. Spectre W. Builders Corp.*, CV09-968-PHX-JAT, 2011 WL 488891, (D. Ariz. Feb. 4, 2011).

[4] *Spectre W.*, 2011 WL 488891, at *2. *See* Ariz. Rev. Stat. §12-1364 (Dwelling action; attorney fees, costs and expert witness fees: "In any contested dwelling action, the court shall award the successful party reasonable attorney fees, reasonable expert witness fees and taxable costs."); Ariz. Rev. Stat. §12-341-.01(B) (Recovery of attorney fees: "In any contested action arising out of a contract, express or implied, the court may award the successful party reasonable attorney fees.").

[5] *Spectre W.*, 2011 WL 488891, at *9 (emphasis added).

"assumption of liability in a contract or agreement" but rather "because of" covered property damage.[6] Alternatively, the court found that the fees were imposed by statute and thus covered.

In *Neal-Pettit v. Lahman,*[7] the Ohio Supreme Court likewise found that a fee-shifting award was covered as damages under the indemnity provision in an automobile policy.[8] The underlying litigation involved an automobile accident in which the plaintiff alleged that when the policyholder struck plaintiff's vehicle she was intoxicated and fleeing the scene of an earlier collision. The jury awarded both compensatory and punitive damages as well as attorneys' fees based on a finding that the policyholder had acted with malice.

Unlike the traditional CGL policy, the automobile policy at issue contained an exclusion for "punitive or exemplary damages, fines or penalties."[9] The insurer argued that the attorney fee award was derivative of punitive damages and thus not awarded as a result of bodily injury. The court rejected this argument:

> We have recognized that attorney-fee awards and punitive-damages awards are distinct: "In an action to recover damages for a tort which involves ingredients of fraud, malice, or insult, a jury may go beyond the rule of mere compensation to the party aggrieved, and award exemplary or punitive damages …. In such a case, the jury may, in their estimate of *compensatory* damages, take into consideration and include reasonable fees of counsel employed by the plaintiff in the prosecution of his action."[10]

The insurer also argued that attorney fee award was not covered by the policy because it was not "damages." The court again rejected the insurer's argument:

> Although, in this case, attorney fees were awarded as a result of an award of punitive damages, they also stem from the underlying bodily injury. The policy does not limit coverage to damages *solely* because of bodily injury. In addition, insofar as the parties have

[6] *Spectre W.*, 2011 WL 488891, at *8.
[7] *Neal-Pettit v. Lahman*, 125 Ohio St. 3d 327, 928 N.E.2d 421 (2010).
[8] The insuring clause at issue provided: "If a premium is shown on the Policy Declarations for Bodily Injury Liability Coverage and Property Damage Liability Coverage, Allstate will pay damages which an insured person is legally obligated to pay because of: 1. bodily injury sustained by any person, and 2. Damage to, or destruction of, property." *Neal-Pettit*, 928 N.E.2d at 423.
[9] *Neal-Pettit*, at 928 N.E.2d at 424.
[10] *Neal-Pettit*, 928 N.E.2d at 424 (citations omitted; emphasis in original).

> offered their own separate interpretations of the language of the policy, both of them plausible, we must resolve any uncertainty in favor of the insured.
>
> Attorney fees may therefore fall under the insurance policy's general coverage of "damages which an insured person is legally obligated to pay" because of "bodily injury."[11]

Thus, because the award was compensatory in nature, flowed from a covered event and the policy was ambiguous, the court held it to be "damages" within the indemnity portion of the policy.

Similarly, in *Hyatt Corp. v. Occidental Fire & Cas. Co. of N.C.,*[12] the court held that an award of attorney fees as part of a federal class action settlement of claims arising out of the collapse of two skywalks at the Kansas City Hyatt Regency constituted damages under a CGL policy:

> The principal amounts at issue with respect to the federal class action are not the settlements paid to plaintiffs but Columbia's share of attorney's fees awarded in the federal class action as part of the settlement of the case. **Such an award of attorneys' fees is indistinguishable from a damages award for coverage purposes**.[13]

Numerous cases have found that a fee-shifting award is considered "damages" under the indemnity provisions of a liability policy.[14] These cases apply time-honored rules of insurance

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[11] *Neal-Pettit*, 928 N.E.2d at 330 (citation omitted; emphasis in original).

[12] *Hyatt Corp. v. Occidental Fire & Cas. Co. of N.C.*, 801 S.W.2d 382 (Mo. Ct. App. 1990)

[13] *Hyatt Corp.*, 801 S.W.2d, at 393-94 (emphasis added); *see also UnitedHealth Group, Inc. v. Hiscox Dedicated Corporate Member Ltd.,* No. 09-CV-0210 (PSJ/SRN), 2010 WL 550991 (D. Minn. Feb. 9, 2010) (a potential award of plaintiffs' attorneys' fees under a class action settlement qualified as "damages";

[14] *See, e.g. Mid-Continent Cas. Co. v. Petroleum Solutions, Inc.,* Nol. 4:09-0422, 2016 WL 5539895 (S.D. Tex. Sept. 29. 2016) (holding that an attorneys' fee award under the Texas Product Liability Act against an innocent seller qualified as "damages … because of property damage" and thus covered by the manufacturer's CGL policy, but that the seller's attorneys' fees incurred in successfully prosecuting its claim against the manufacturer did not constitute "damages"); *Ass'n of Apartment Owners of the Moorings, Inc. v. Dongbu Ins. Co., Ltd.,* Civ. No. 15-00497, 2016 WL 4424952 (D. Hawai'i Aug. 18, 2016) (holding that an award of attorneys' fees was restitutive payment – damages – to the claimant and therefore the insurer was obligated to pay the fees as "damages … because of property damage"); *APL Co. v. Valley Force Ins. Co.,* 754 F.Supp.2d 1084, 1093 (N.D. Cal. 2010), reversed on other grounds, 541 Fed. Appx. 770 (2013) (award of attorneys' fees awarded in underlying litigation was "a remunerative payment made to an aggrieved party" and thus qualified as "damages"); *Insurance Co. of the State of Pennsylvania v. City of Long Beach*, 342 Fed. Appx. 274 (9th Cir. 2009) (attorneys' fees awarded in the underlying Fair Housing Act constitute "damages" where the statute authorized the court to award "a reasonable attorney's fee and costs"); *Fair Hous. Advocates Assoc. Inc. v. Terrace Plaza Apartments*, 2:03-cv-0563, 2006 WL 23348511, at *5 (S.D. Ohio Aug. 10, 2006) (holding that an attorney fee award under the Fair Housing Act, 42 U.S.C. §3613(c)(2), constitutes "damages"

contract interpretation in concluding that CGL coverage is broad in nature, the word "damages" is broad enough to include an award of attorneys' fees and that, in the absence of a definition, the word "damages" is at least ambiguous and therefore must be construed against the insurer.

B. Coverage for a Fee Award is Consistent with the Reasonable Expectations of the Insured

Some courts have held that an award of attorney fees constitutes "damages" as being consistent with the reasonable expectations of the insured. In *Ypsilanti v. Appalachian Ins. Co.,*[15] for example, the court held that coverage for an award of attorneys' fees is encompassed within the meaning of "damages" on grounds of reasonable expectations. The plaintiffs in the underlying litigation asserted civil rights claims and requested, among other things, attorneys' fees. The defendants tendered the claims to their insurer under a comprehensive professional liability policy. Ultimately, the parties in the underlying civil rights action entered into a consent judgment, after which the court awarded attorneys' fees to the plaintiffs. In the coverage litigation, the court applied the traditional rules of interpretation with respect to the word "damages." Finding that the word "damages" did not include or exclude attorneys' fees, the court concluded that the word was ambiguous and construed that ambiguity against the insurer.[16] Specifically, the court held that "a

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under a CGL policy because the language of the policy was ambiguous and had to be construed in favor of the insured); *Church Mut. Ins. Co. v. Exec. Bd. of the Mo. Baptist Convention,* 03-4224-CV-W-SOW, 2005 WL 1532948, at *10 (W.D. Mo. June 24, 2005) (quoting *Hyatt Corp.* and holding that an award of attorneys' fees and costs "'is indistinguishable from a damages award for [insurance] coverage purposes.'"); *Sylvania Twp. Bd. of Trs. v. Twin City Fire Ins. Co.*, L-03-1075, 2004 WL 226115 (Ohio Ct App. Feb. 6, 2004), *appeal dismissed* 102 Ohio St. 3d 1416, 806 N.E.2d 1005 (2004) (finding that the word "damages" in an errors-and-omissions policy to be ambiguous and holding that attorneys' fees pursuant to state statute to be covered by the policy); *Pacific Ins. Co. v. Burnet Title, Inc.,* 380 F.3d 1061, 1066 (8th Cir. 2004) (holding that a claim for attorneys' fees under the Real Estate Settlement Procedures Act falls within the meaning of "damages" under and errors and omissions policy); *Scottsdale Ins. Co. v. Avol*, No. 91-55773, 1992 WL 170931, at *3 (9th Cir. July 7, 1992) (award of attorney fees under Cal. Civ. Proc. Code §1021.5 is "analogous to money damages and thus fall with the policies' general provision to pay all damages that [insured] is legally obligated to pay."); *Kirtland v. Western World Ins. Co.*, 43 Ohio App. 3d 167, 169-70, 540 N.E.2d 282, 285 (Ohio Ct. App. 1988) (holding that the undefined phrase "money damages" in the policy was ambiguous, attorneys' fees awarded to the claimant under 42 U.S.C. §1988 were "costs" in the "nature of incidental damages" and therefore were money damages covered by the policy).

[15] *Ypsilanti v. Appalachian Ins. Co.*, 547 F. Supp. 823 (E.D. Mich. 1982), *aff'd mem.*, 725 F.2d 682 (6th Cir. 1983).

[16] *Ypsilanti*, 547 F. Supp. at 828.

reasonable person in the position of the insured would believe that the words 'all sums which the Insured shall become legally obligated to pay as damages' would provide coverage for all forms of civil liability, including attorneys' fees."[17]

C. Absence of Exclusion for Attorney Fee Award

As noted above, the typical CGL policy does not expressly exclude fee-shifting awards from indemnity coverage. Where the policy expressly excludes costs or expenses that an insured may become obligated to pay as a result of an adverse judgment, however, an award of attorneys' fees may be barred. For example, in *Scottsdale Ins. Co. v. City of Hazelton,*[18] the claimants in the underlying litigation challenged the validity of certain ordinances adopted by city officials and exclusively sought declaratory and injunctive relief (not damages). The court permanently enjoined the city from enforcing the ordinances. The plaintiffs sought an award of attorneys' fees pursuant to a civil rights statute which allows for an award of attorneys' fees (42 U.S.C. §1988). The public entity policy at issue expressly excluded "any fees, costs or expenses which the insured may become obligated to pay as a result of any adverse judgment for declaratory or injunctive relief." Based on this exclusion, the court held that the award of attorney fees for pursuit of non-monetary claims was a cost expressly excluded by the policy.[19]

D. Fee Award as Compensation to Make the Claimant Whole

Coverage for a fee-shifting award may also be supported by the underlying rationale for the award. Clearly, the purpose of liability insurance is to compensate the injured party. Many

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[17] *Ypsilanti*, 547 F. Supp. at 828. In *Cal. Ins. Co. v. Stimson Lumber Co.*, Civ. No. 01-514-HA, 2005 WL 627624, at *9 (D. Or. Mar. 17, 2005), *aff'd in part; rev'd in part, remanded in part*, *Cal. Ins. Co. v. Stimson Lumber Co.*, 325 Fed. Appx. 496 (9th Cir. 2009) the court cited *Ypsilanti* and *Hyatt Corp.* as persuasive that an insured's obligation to pay attorney fees is equivalent to damages. However, because the underlying claims were not covered by the policy, the court held that neither were the attorney's fees.

[18] *Hazelton*, 3:07-CV-1704, 2009 WL 1507161 (M.D. Pa. May 28, 2009), *aff'd,* 400 Fed. Appx. 626 (2010).

[19] *Hazelton*, 2009 WL 1507161, at *15.

fee-shifting statutes are likewise grounded on the concept of compensating an injured party. As one scholar notes:

> Another argument for fee shifting that has a strong intuitive appeal is that refusing to award fees denies a wronged party full compensation for his injury. . . . Undeniably, the American rule's effect of reducing a successful plaintiff's recovery by the amount of his lawyer's fee conflicts with the make-whole idea underlying much of the law of remedies.[20]

That policy may be implied or expressly indicated in the statute itself. For example, an Arizona statute that permits recovery of attorney fees for breach of contract provides that an "award of reasonable attorney fees … should be made to mitigate the burden of the expense of litigation to establish a just claim or a just defense."[21] Indeed, under many fee-shifting statutes, the award is to the "prevailing party" not the attorney. As the court noted in *Neal-Pettit*,[22] "the jury may, in their estimate of *compensatory* damages, take into consideration and include reasonable fees of counsel employed by the plaintiff in the prosecution of his action."

Insurers, on the other hand, may argue that where an award of attorney fees is penal in nature, such an award should not be covered. Unlike other forms of liability coverage, however, CGL policies do not typically exclude fines, penalties or punitive damages. Moreover, under the law of many jurisdictions, punitive damages may be insurable.[23] Even when a policy contains an exclusion for fines, penalties or punitive damages, there may still be coverage for a fee award. In *Neal-Pettit*,[24] the Ohio Supreme Court held that an exclusion in an automobile policy for "punitive

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[20] *See* Thomas D. Rowe, Jr., *The Legal Theory of Attorney Fee Shifting: A Critical Overview*, 1982 Duke L. J. 651, 657; *see also, Shuette v. Beazer Homes Holdings Corp.*, 121 Nev. 837, 124 P.3d 530, 547 (2005) (holding that recovery of attorney fees is "intended to compensate the claimant for legal fees incurred when he or she is forced to institute a court action to resolve a valid constructional defect claim by shifting the fees to the defendant"); *Penn. v. Del. Valley Citizens' Council for Clean Air*, 478 U.S. 546, 106 S.Ct. 3088, 92 L.Ed. 439 (1986) ("[T]he aim of such statutes was to enable private parties to obtain legal help in seeking redress for injuries resulting from the actual or threatened violation of specific federal laws."); *Delgadillo v. Astrue*, 601 F. Supp. 2d 1241, 1246 (D. Colo. 2007) ("The purpose of fee shifting statutes is to free the litigant from burdensome expenses that might chill assertion of valid claims").
[21] Ariz. Rev. Stat. §12-341.01(B).
[22] *Neal-Pettit*, 928 N.E.2d at 423 (emphasis in original; citation and quotes omitted).
[23] *See* 1 Punitive Damages: Law and Prac. 2d Chap. 7.
[24] *Neal-Pettit*, 928 N.E.2d at 424-25.

or exemplary damages, fines or penalties" did not "clearly and unambiguously encompass an award of attorney fees" and therefore construed the policy in favor of coverage.[25]

Where, however, the policy excludes punitive or exemplary damages and the award of attorney fees is considered penal in nature, recovery may be barred. For example, in *Indian Harbor Ins. Co. v. Bestcomp, Inc.,*[26] the policyholder sought coverage for an award of attorney fees under a professional errors and omissions policy. The underlying litigation involved a putative class action against the policyholder for failure to comply with the notice requirements of a Louisiana statute when applying discounts to workers' compensation bills. The putative class sought statutory damages in the form of "double the fair market value of the medical services provided … together with attorney fees to be determined by the court."[27] Unlike many CGL policies, the E&O policy defined damages as "any compensatory sum and includes a judgment, award or settlement." [28] Significantly, the policy also expressly excluded punitive and exemplary amounts.[29] The insured argued that the policy covered attorney fees because such fees are compensatory in nature and were not expressly excluded from coverage. Since the policy specifically provided coverage for "compensatory sums," the court analyzed whether an award of attorneys' fees under the statute was penal in nature. Because the award of attorneys' fees was predicated upon violation of a penal statute, the court held that the award was likewise penal in nature and thus excluded by the policy.

III. Situations Where Attorney Fees May Not Be Covered As Damages

[25] *Neal-Pettit*, 928 N.W.2d at 425. The court also rejected the argument that the attorney fee award violates public policy.
[26] *Indian Harbor Ins. Co. v. Bestcomp, Inc.*, 2010 WL 5471005, at *5 (E.D. La. Nov. 15, 2010), *aff'd on other grounds*, 432 Fed. Appx. 560 (5th Cir. 2011).
[27] La. Rev. Stat. §40:2203.1(G).
[28] *Bestcomp*, 2010 WL 5471005, at *1.
[29] *Bestcomp*, 2010 WL 5471005, at *1.

Other courts have concluded that attorneys' fees are not damages. These cases generally fall into two narrow categories. The first relates to statutory or common law treatment of certain types of attorney fee awards as "costs." The second relates to whether a boilerplate demand for attorney fees triggers the defense obligation where the underlying claim is not otherwise covered by the policy.

A. Statutory or Common Law Treatment of Certain Types of Fee Awards as "Costs"

Some courts have determined that an attorney fee award does not qualify as damages because the statute on which it is based expressly categorizes the award as a "cost."[30] A number of cases here concern a fee-shifting provision for vindication of civil rights, 42 U.S.C. §1988(b), which provides for an award of attorney fees "as part of the costs." For example, in *Sullivan County v. Home Indem. Co.,*[31] the Sixth Circuit Court of Appeals drew a distinction between attorneys' fees recoverable as "costs" under 42 U.S.C. §1988 and attorney fees recoverable as "damages" under 18 U.S.C. §2520. Based on this statutory categorization, it held that attorney fees awarded under Section 1988 were therefore costs and not recoverable as damages. Similarly, in *Am. Safety Cas. Ins. Co. v. City of Waukegan,*[32] the court held that an award of over $1 million in attorneys' fees to the claimant in the underling litigation under 42 U.S.C. §1988 was better characterized as an award of costs rather than damages. Thus, because the statute expressly

[30] *See Marek v. Chesny*, 473 U.S. 1, 44-51 (1985) (Brennan, J. dissenting) and *Hutto v. Finney*, 437 U.S. 678, 697 n. 28 (1978) (listing those federal provisions which refer to attorney fees as "costs" and those which do not).
[31] *Sullivan County v. Home Indem. Co.*, 925 F.2d 152, 153 (6th Cir. 1991).
[32] *Am. Safety Cas. Ins. Co. v. City of Waukegan*, 776 F. Supp. 2d 670, 725 (N.D. Ill. 2011).

characterized the attorneys' fees as "costs," the court concluded that they were not "damages."[33] In contrast, some statutes provide that a fee award is an element of damages.[34]

In some situations, a fee award may not be considered damages because the common law treats certain types of awards as costs. In *Alea London Ltd. v. Am. Home Servs., Inc.*,[35] the court rejected the policyholder's contention that fees awarded under a Georgia statute concerning expenses of litigation were damages. The underlying litigation involved a class action under the Telephone Consumer Protection Act.[36] In the coverage litigation, the insurer argued, among other things, that its CGL policy did not cover any attorney fees awarded against the insured in the underlying litigation. The attorney fee award at issue in the coverage litigation was based on a Georgia statute permitting the recovery of "expenses of litigation" where "the defendant has acted in bad faith, has been stubbornly litigious, or has caused the plaintiff unnecessary trouble and expense …."[37] The policyholder argued that the insurer's obligation to cover attorneys' fees arose from its contractual duty to indemnify the insured for "damages." The court rejected that argument holding instead that under Georgia law, attorneys' fees are not typically included within the "ordinary species of damages."[38] The rationale for this conclusion appears to be that such an award

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[33] Similarly, in *Cutler-Orosi Unified Sch. Dist. v. Tulare County Sch. Dists. Liability/Property Self-Insurance-Auth.*, 31 Cal. App. 4th 617, 631, 37 Cal. Rptr. 2d 106, 114 (Cal. App. 5th Dist. 1994), the court held that a claim for attorneys' fees under the Voting Rights Act, 42 U.S.C. §1973, was not one for damages. The court noted that the Voting Rights Act permits the court to award "a reasonable attorney fee as part of the costs." *Cutler-Orosi*, 37 Cal. Rptr. 2d at 114 (citing 42 U.S.C. §1973l(e)). Accordingly, the court concluded that "to treat attorney fees as damages in such circumstances would ignore the evident intent of the policies to differentiate between costs and damages and would render the supplementary payments provision superfluous." *Cutler-Orosi*, 37 Cal. Rptr. 2d, at 114.

[34] *See, e.g., Shuette v. Beazer Homes Holdings Corp.*, 121 Nev. 837, 124 P.3d 530, 547 (2005) (holding that in construction defects cases, claimants may recover attorney fees as an item of damages pursuant to Nev. Rev. Stat. §40.655(1)(a)).

[35] *Alea London Ltd. v. Am. Home Servs., Inc.*, 638 F.3d 768 (11th Cir. 2011), *cert. denied* 132 S.Ct. 553, 181 L. Ed. 2d 397 (U.S. 2011).

[36] 47 U.S.C. §227.

[37] *Alea*, 638 F.3d at 772 (quoting O.G.C.A §13-6-11).

[38] *Alea*, 638 F.3d at 780. In support of this finding, the court cited a number of Georgia cases for the proposition that where no damages or other relief are awarded on the underlying claim, attorney fees are not recoverable under O.C.G.A. §13-6-11.

was "ancillary" to the plaintiff's damage claim in that it required additional proof.[39] As noted above, however, other cases have held that attorneys' fees are analogous to money damages and thus fall within coverage.

B. In the Absence of a Covered Claim, the Potential for an Award of Attorney Fees May Not Independently Create a Duty to Defend

Other cases which do not permit recovery of attorneys' fees simply are grounded on the narrow proposition that where that where there is no coverage whatsoever for the underlying claim, a demand for attorney fees does not trigger a duty to defend. For example, *School Dist. of Shorewood v. Wausau Ins. Co.*[40] involved a discrimination action against the district seeking declaratory and injunctive relief. The insurers refused to defend or indemnify the insureds on the grounds that the underlying complaint sought declaratory and injunctive relief and thus did not constitute "damages" under the policies. The school districts defended themselves and ultimately settled with the plaintiffs. In the coverage litigation, the school districts argued, in part, that the insurers were obligated to defend and indemnify them because the complaint in the underlying litigation requested "'an order pursuant to 42 U.S.C. sec. 1988 allowing plaintiffs their costs and reasonable attorneys' fees.'"[41] The Wisconsin Supreme Court held that the insurers had no duty to defend or indemnify the insured for the claims for declaratory and injunctive relief. It further concluded that because attorney fees under 42 U.S.C. §1988 are labeled "costs" they do not constitute "damages."[42] Accordingly, the "insurers did not have a duty to defend the school

[39] *See also, First Specialty Ins. Co. v. Caliber One Indem. Co.*, 988 So. 2d 708, 714 (Fla. Dist. Ct. App. 2d Dist. 2008) (holding that under Florida law, attorneys' fees are "ancillary to damages"). In *Kirtland*, 540 N.E. 2d, at 285, the court appears to have accepted insured's argument that a fee award under 42 U.S.C. §1988 was a form of money damages because it was in the nature of incidental damages. Thus, whether attorney fees are considered "incidental damages" is not necessarily dispositive of the issue.
[40] *Sch. Dist. of Shorewood v. Wausau Ins. Co.*, 170 Wis. 2d 347 488 N.W.2d 82 (Wis. 1992).
[41] *Shorewood*, 170 Wis. 2d at 375.
[42] *Shorewood*, 170 Wis. 2d at 378.

districts in the underlying action based solely on a request for attorney fees under 42 U.S.C. sec. 1988."[43]

Other cases holding that attorney fee awards are not damages are largely duty-to-defend cases where the insured contended that the boilerplate phrase for "costs, attorneys' fees and other and further relief as the court deems just and proper" in the prayer for relief was in reality a claim for damages, thus triggering the defense obligation. The courts have by and large rejected this argument.[44]

IV. Attorney Fee Awards as "Costs" Under the Supplementary Payments Coverage

As an alternative means of recovery, the policyholder may seek to recover an attorney fee award under the policy's supplementary payments coverage. The Supplementary Payments provision in the typical CGL policy provides that the insurer "will pay, with respect to any claim we investigate or settle, or any 'suit' against an insured we defend" certain expenses and costs, including, among other things, "All costs taxed against the insured in the 'suit.'"[45] The 2007 modifications to the ISO standard form added a sentence behind this clause, which now reads

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[43] *Shorewood.*, at 378. This decision was issued following withdrawal of an earlier decision by the Wisconsin Supreme Court, which decided that attorney fees were damages. *Shorewood*, 168 Wis. 2d 390, 484 N.W.2d 314, 423 (Wis. 1992) ("The term 'damages,' according to its ordinary usage, includes all forms of civil liability, including attorney fees. … We conclude that attorney fees paid to an opposing party in a discrimination case … falls under the term 'damages.'"). The final *Shorewood* opinion's treatment of "damages" was subsequently rejected in *Johnson Controls, Inc. v. Emplrs. Ins.*, 264 Wis. 2d 60, 136, 665 N.W.2d 257, 295 (Wis. 2003), *cert. denied* 541 U.S. 1027 (U.S. 2004) ("[W]e … reject the too narrowly stated definition of damages in *Shorewood*."). *Johnson Controls* also calls into question the decision in *United States v. Security Mgmt. Co. Inc.*, 96 F.3d 260, 269 (7th Cir. 1996), which applied Wisconsin law and cited *Shorewood* for the proposition that "[w]here the obtaining of attorneys' fees is expressly provided for by statute, a request for attorneys' fees is not a request for damages."

[44] *See Pa. County Risk Pool v. Northland Ins.*, 1:07-cv-00898, 2009 WL 506369, at *11 (M.D. Pa. Feb. 27, 2009) (holding that there was no duty to defend notwithstanding the inclusion of a prayer for costs and attorneys' fees in the complaint because the underlying lawsuit was an equitable action for declaratory and injunctive relief, which fell outside of the scope of coverage); *City of Sandusky v. Coregis Ins. Co.*, 192 Fed. Appx. 355, 359 (6th Cir. 2006) (holding that where the policy expressly excluded "all forms of injunctive relief and declaratory judgments" an award under 42 U.S.C. §1988 based on the success of the class plaintiffs on equitable claims was not covered, but expressing "no opinion as to whether a §1988 award given to a prevailing party that depended, at least in part, on the success of claims that were affirmatively covered by the insurance agreement, could be considered a claim for 'damages' under the language of this policy").

[45] *See* Commercial General Liability Coverage Form CG 00 01 12 04, © ISO Properties, Inc., 2003; Commercial General Liability Coverage Form CG 00 01 10 01, © ISO Properties, Inc., 2000.

"However, these payments do not include attorneys' fees or attorneys' expenses taxed against the insured."[46] As a result of the 2007 exclusion for attorneys' fees in the supplementary payments coverage, policyholders will more likely look for coverage under the indemnity provisions of the policy. Where, however, the Supplementary Payments provision does not expressly exclude attorneys' fees, a number of courts held that attorneys' fees are recoverable "costs." Indeed, the absence of such an exclusion presents a strong argument that attorney fees can be consider insured costs.

In *St. Paul Fire & Marine Ins. Co. v. Hebert Constr., Inc.*, the underlying action involved alleged construction defects in a 78-unit condominium project.[47] The plaintiff entered into a stipulated judgment against the developer, which included $1.6 million in attorney fees. The insurer brought a declaratory judgment contending, in part, that the attorney fees were not covered by the Additional Payments provision in the policy.[48] This provision provided for payment of, among other things, "all costs taxed against any protected person in a suit."[49] Noting that the phrase "costs taxed" was undefined, the court looked to the plain, ordinary and popular meaning of the words, as defined by dictionaries.[50] Based on those dictionary definitions, the court concluded that "the plain, ordinary meaning of the 'costs taxed' clause in the St. Paul policies includes attorneys' fees."[51] Accordingly, the insured could recover the attorneys' fees as taxable costs.

Similarly, in *Mut. of Enumclaw v. Harvey,*[52] the court analyzed the Supplementary Coverages provision in the insured's homeowner's policy that provided coverage for "all costs

[46] Commercial General Liability Form CG 00 01 12 07, © ISO Properties, Inc., 2006.
[47] *St. Paul Fire & Marine Ins. Co. v. Hebert Constr., Inc.*, 450 F. Supp. 2d 1214 (W.D. Wash. 2006).
[48] *Hebert Construction*, 450 F. Supp. 2d, at 1229.
[49] *Hebert Construction*, 450 F. Supp. 2d, at 1229.
[50] *Hebert Construction*, 450 F. Supp. 2d, at 1229.
[51] *Hebert Construction*, 450 F. Supp. 2d, at 1235.
[52] *Mut.of Enumclaw v. Harvey*, 115 Idaho 1009, 772 P.2d 216 (Idaho 1989).

taxed against the insured in any suit defended by the Company."[53] The court held that the supplementary coverages are separate from and in addition to the basic policy and therefore the insurer's obligation to pay such costs was unaffected by the fact that the policy did not cover the insured's intentionally tortious conduct.[54] The court then turned to the issue of whether attorneys' fees were covered under the supplementary coverage provision. Utilizing *Webster's* definition of costs, the court stated:

> Though the word "costs" as a legal term of art may be ambiguous, it is not so from the perspective of the ordinary person unfamiliar with the jargon of the legal and insurance professions standing in the position of the insured. An insurance policy must be interpreted from that perspective.[55]

Accordingly, the court held that the award of attorney fees in the underlying litigation was recoverable.

In *Employers Mut. Cas. v. Donnelly*, 154 Idaho 499, 300 P.3d 31(2013) the Idaho Supreme Court revisited the issue of whether an award of attorneys' fees in the underlying action was covered even though there was no coverage for the claims themselves. The Court noted that in *Harvey*, the duty to pay emanated from the supplemental coverages, whereas in the present case the obligation to pay emanated from the duty to defend as provided in the supplementary payments section of the policy.

The underlying lawsuit involved claims by homeowners (the "Donnellys") against a construction company, Rimar Construction Company ("RCI"), arising out of allegedly defective repairs and remodeling of their home. Employers Mutual Casualty ("EMC") defended RCI under a reservation of rights. The jury found that RCI breached the implied warranty of workmanship and violated two (2) provisions of the Idaho Consumer Protection Act ("ICPA"). The Donnellys

[53] *Enumclaw*, 772 P.2d, at 218.
[54] *Enumclaw*, 772 P.2d, at 219.
[55] *Enumclaw*, 772 P.2d, at 220.

were awarded roughly $128,000 in damages and almost $300,000 in costs and attorneys' fees. They were also awarded $2,000 in damages on the ICPA claims.

EMC brought a declaratory judgment action against RCI and the Donnellys seeking a determination that there was no coverage the CGL policy for the damages awarded in the underling action. The trial court ruled that the damages awarded for breach of the implied warranty of workmanship sounded in contract and therefore were not covered by the EMC policy. It also held that there was coverage for the $300,000 in costs and attorneys' fees.

The Idaho Supreme Court affirmed the trial court's rulings. The Court held that there was no coverage for damages awarded on the breach of implied warranty of workmanship claim or the ICPA claims. Importantly, the Court held that EMC had a duty to pay the attorneys' fees awarded to the Donnellys even though none of the damages were covered by the policy. The Court based its determination on the supplementary payments provision of the EMC policy, which provided that "We will pay, with respect to any claim we investigate or settle, or any 'suit' against an insured we defend: … [a]ll costs taxed against the insured in the 'suit'." *Id.*, 34. The Court concluded:

> Under the plain language of the contract, RCI's policy states that the damages only need be 'alleged' to trigger coverage, they do not need to be proven. Since the Donnellys clearly alleged damages that implicate the applicable provisions of the policy, EMC is obligated to pay '[a]ll costs taxed against the insured in the 'suit."

Id., 35.

In *Employers Mut. Cas. Co. v. Philadelphia Indem. Ins. Co.,*[56] the underlying action involved claims by residents of a mobile home park under the California Mobile Home Residency law, which provides that that the prevailing party in an action under the statute "shall be entitled to reasonable attorney's fees and costs."[57] The settlement of the underlying action allocated $1.8

[56] *Employers Mut. Cas. Co. v. Philadelphia Indem. Ins. Co.*, 169 Cal. App. 4th 340, 86 Cal. Rptr. 3d 383 (Cal. App. 2d Dist. 2008).
[57] Cal. Civ. Code §798.85.

million of the proceeds to plaintiffs' attorney fees and costs pursuant to this statute. The insurers who paid the settlement then sought contribution from two other insurers. The court held that the $1.8 million was a "taxed" cost which was recoverable under the supplementary payments provision.[58] The court rejected the argument that costs taxed cannot include attorney fees paid in a settlement. Numerous other cases have held that attorney fees are covered "costs" under the supplementary payments provision.[59]

Other courts have held that attorneys' fees do not include costs. These decisions are by and large dependent on state law classifications of attorney fees as something other than taxable costs.[60] Coverage may also be precluded where there is no coverage for the underlying claims.[61] Finally, in some unique circumstances, state law may actually bar coverage for a fee award if the loss is caused by the "willful act of the insured."[62]

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[58] *Employers Mut.*, 169 Cal. App. 4th, at 348.

[59] *See Prichard v. Liberty Mut. Ins. Co.*, 84 Cal. App. 4th 890, 912, 101 Cal. Rptr. 2d 298, 313 (Cal. App. 4th Dist. 2000) (holding that insured was entitled to recover attorneys' fees assessed under a prevailing party clause as part of the insurer's defense obligation); *Insurance Co. of North America v. National American Ins. Co.*, 37 Cal. App. 4th 195, 206-207, 43 Cal. Rptr. 2d 518, 525 (Cal. App. 4th Dist. 1995) (holding that costs awarded against the insured under a prevailing party fee clause applicable in the underlying litigation were covered under the supplementary payments section); *Tri-State Ins. Co. v. Fitzgerald*, 593 So. 2d 1118, 1119 (Fla. Dist. Ct. App. 3d Dist. 1992) (holding that attorneys' fees as part of sanctions award under Fla. R. Civ. Proc. 1.380(a)(4) were covered by the supplementary payments coverage, "[p]articularly since the policy emphasizes that the carriers are required to pay 'all [such] costs'…"); *Littlefield v. McGuffey*, 979 F.2d 101 (7th Cir. 1992) (interpreting a building owner's policy and holding that where the insurer defended the claim, attorneys' fees assessed under 42 U.S.C. §1988(b) were "costs taxed" against the insured); *Argento v. Village of Melrose Park*, 838 F.2d 1483, 1499 (7th Cir. 1988) (holding that fees under 42 U.S.C. §1988 are costs covered by the policy).

[60] *See e.g., Titelfex Corp. v. Liberty Mut. Fire Ins. Co.,* 84 Mass.App.Ct. 1105, 990 N.E.2d 1072 (2013) (Table) (common fund attorneys' fees and administrative costs awarded in class action settlement under the common fund or common benefit approach were not "costs" within the meaning of the supplementary payments provision in CGL policies); *Polygon Nw. Co. v. Am. Nat'l Fire Ins.,*143 Wn. App. 753, 189 P.3d 777, 788 (Wash. Ct. App. 2008) (stating that the Washington cost statute, Wash. Rev. Code §4.84.010, "lists costs that may be taxed in a suit in Washington" and "does not include an award of reasonable attorney fees").

[61] *See Golden Eagle Ins. Corp. v. Cen-Fed, Ltd.*, 148 Cal. App. 4th 976, 56 Cal. Rptr. 3d 279 (Cal. App. 2d Dist. 2007) (holding that an award of attorney fees pursuant to the attorney's fee clause in a lease was not covered under the supplementary payments provision because that provision is a function of the defense obligation, not the indemnity obligation, and where none of the claims were potentially covered, the insurer had no defense obligation and thus was not liable to pay costs and attorney fees).

[62] *See Combs v. State Farm Fire and Cas. Co.*, 143 Cal. App. 4th 1338, 1344 n. 5, 49 Cal. Rptr. 3d 917, 924 (Cal. App. 1st Dist. 2009) (holding that "the reason for which State Farm need not reimburse Combs for attorney fees he was required to pay is not that the explicit terms of the policy do not call for such reimbursement, but that [Cal. Ins. Code] section 533 prohibits it").

Notwithstanding the 2007 modifications to the Supplementary Payments provision to exclude attorneys' fees from taxable costs, there may still be coverage under a different section relating to expenses incurred at the insurer's request. Some courts have allowed for the recovery of attorneys' fees under the provision in the Supplementary Payments clause for "[a]ll reasonable expenses incurred by the insured at our request to assist us in the investigation and defense the claim or 'suit.'" In *Gov't Employees Ins. Co. v. Macedo,*[63] the insurer rejected a settlement offer and thereafter the jury returned a verdict in favor of the plaintiff awarding more than four times the amount of the settlement offer. The trial court taxed fees and costs against the insurer and the insured. In affirming, the court cited the policy language "other reasonable expenses incurred at our request" as including fees and costs associated with the insurer's decision to litigate instead of settling. In doing so, the court noted that the policy gave the insurer the sole right to litigate and settle claims and, as such, choosing to litigate is no different than a request to do so.[64]

V. Conclusion.

Where there is the potential for a fee-shifting award, policyholders need to carefully analyze whether such an award may be covered by their insurance. This necessarily requires a thorough understanding of the basis for a fee-shifting award (statute, rule or contract), the policy terms and conditions, and applicable state law regarding both treatment of attorney fees awards (damages or costs; compensatory or penal) and the interpretation of insurance policies. In light of the 2007 ISO revisions to the standard CGL form excluding attorney fees as "costs" under the supplementary payments coverage, the focus going forward will be on the indemnity coverage. Nevertheless, fitting the pieces together may indeed result in coverage for such awards.

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[63] 190 So.3d 1155 (Fla. 1st DCA 2016), rev. granted Oct. 19, 2016.

[64] *See also New Hampshire Indem. Co. v. Gray*, 177 So.3d 56 (Fla. 1st Dist DCA 2015); *Gieco Gen. Ins. Co. v. Hollingsworth,* 157 so.3d 365 (Fla. 5th DCA 2015); *but see Steele v. Kinsey*, 801 So.2d 229 (Fla. 2nd Dost. DCA 2001) (attorneys' fees and costs incurred under the offer of judgment statute were not incurred at the insurer's request and, thus, were not covered by the supplementary payments provision).

ACCEC
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Allocating the Defense:
Two Perspectives on *Arceneaux* and Beyond

American College of Coverage and Extracontractual Counsel
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This paper is a joint project undertaken by counsel for both insurers and policyholders to provide analysis of the recent *Arceneaux* decision by the Louisiana Supreme Court, which addressed the question of whether defense obligations in long-tail exposure cases may be allocated among insurers – and the insured.

Section I is a summary of the recent *Arceneaux* decision. Section II(A) is an analysis of the case from the perspective of counsel for the insurer, and represents the views of panelists Jay Sever and Laura Foggan. Section II(B) is an analysis from the perspective of counsel for policyholders, and represents the views of panelist Martin Pentz. (Of course, the views expressed do not necessarily reflect those of the panelists' firms or any of their clients!)

I. The *Arceneaux* Decision

In 2016, in *Arceneaux v. Amstar Corp.*,[1] the Supreme Court of Louisiana became the latest court to address the issue of whether and how the cost of defense ought to be allocated among multiple insurers in long-tail exposure claim scenarios covered by commercial general liability ("CGL") insurance. *Arceneaux* arose out of an underlying action in which the insured, American Sugar Refining, Inc. ("American Sugar"), was sued by approximately 100 former employees. The former employees alleged that they were exposed to loud noise while working for American Sugar and suffered resulting hearing loss.[2] The exposures allegedly occurred during various years from 1941 until 2006.[3] The insurer, Continental Casualty Company ("Continental") had insured American Sugar from 1963 to 1978, although bodily injury to employees was excluded for most of this period, excepting only some 26 months during the period 1975 to 1978.[4] Continental thus was on the relevant risk for about 26 months out of more than 60 years of exposure, and American Sugar evidently had no coverage for a substantial portion of the remaining time.[5]

The Continental policy employed widely-used wording for the pertinent definitions. "Bodily injury" was defined as "bodily injury, sickness or disease sustained by any person which occurs during the policy period, including death at any time resulting therefrom."[6] "Occurrence" was defined as "an accident, including continuous or repeated exposure to conditions, which

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[1] *Arceneaux v. Amstar Corp.*, 200 So. 3d 277 (La. 2016).

[2] *Id.* at 279-80.

[3] *Id.* at 280.

[4] *Id.*

[5] *See id.*

[6] *Id.*

results in bodily injury or property damage neither expected nor intended from the standpoint of the insured."[7]

In 2007, American Sugar brought a third-party demand against Continental alleging breach of the duty to defend the underlying action.[8] American Sugar sought full coverage of its past defense costs and asked Continental to provide a complete defense going forward. Continental agreed to pay only 25% of the defense (subject to a full reservation of rights) on a theory that responsibility for defense costs should be prorated across the full period of exposure.[9] The trial and intermediate appellate courts both rejected Continental's position, and ruled instead that American Sugar was entitled to a complete defense from Continental (at least prospectively) without proration of defense costs.[10] Continental sought further review of this question by the Supreme Court of Louisiana, which was granted.[11]

In an opinion reversing the trial court's order, the Supreme Court of Louisiana noted that "there appears to be no Louisiana precedent on the precise issue the court is presented with in this case, which is whether an insurer's duty to defend may be prorated among insurers and the insured during periods of self-insurance in long latency disease cases."[12] It considered, therefore, "two general approaches" that have emerged nationwide: "the pro rata allocation method and the joint and several allocation method."[13] For analysis favoring joint and several allocation, the Court looked to the seminal *Keene Corp. v. Insurance Co. of North America* decision from the U.S. Court of Appeals for the District of Columbia.[14] For analysis favoring pro rata allocation, it looked primarily to the equally seminal *Insurance Co. of North America v. Forty-Eight Insulations, Inc.* decision from the U.S. Court of Appeals for the Sixth Circuit.[15]

Ultimately, the Court adopted the pro rata allocation method.[16] Among other reasons, it observed that the policy language limited coverage to bodily injury occurring during the policy

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[7] *Id.*

[8] *Id.*

[9] *Id.* at 280-81.

[10] *Id.* at 281.

[11] *Id.*

[12] *Id.* at 282.

[13] *Id.* at 282-83.

[14] *Id.* at 283 (citing *Keene Corp. v. Ins. Co. of N. Am.*, 667 F.2d 1034 (D.C. Cir. 1981)).

[15] *Id.* at 285 (citing *Ins. Co. of N. Am. v. Forty-Eight Insulations, Inc.*, 633 F.2d 1212 (6th Cir. 1980), *clarified on reh'g*, 657 F.2d 814 (6th Cir. 1981), *cert denied*, 454 U.S. 1109, 102 S. Ct. 686, 70 L. Ed. 2d 650 (1981)).

[16] *Id.* at 286.

period, that Louisiana tort law does not include the concept of joint and several liability, and that adopting joint and several liability for defense costs could inappropriately reduce incentives for policyholders to maintain continuous coverage.[17] Accordingly, the Court held that Continental would only be liable for its pro rata share of American Sugar's defense, based strictly on Continental's time on the risk, which Continental asserted to be about 3.3% and 3.7% in the two cases addressed by the appeal.[18] Two Justices filed concurring opinions expressing somewhat different rationales for reaching the same result.[19]

II. Significance of *Arceneaux*

A. Insurer Perspective[20]

1. Why Courts Increasingly Favor Pro Rata Allocation for Defense

The Louisiana Supreme Court is part of a trend by courts across the country toward a more equitable system of allocating defense costs in long latency injury claims. Within the last few decades a growing number of courts in other jurisdictions have adopted the pro rata allocation approach, which limits any one insurer's responsibility for defense and indemnity costs based on the proportionate responsibility of the insured or other insurers.[21]

Courts use various formulas to apply pro rata allocation. Some courts take into account policy limits, as well as time on the risk.[22] Other courts multiply the policy limits and the years of coverage.[23] Still other courts simply look to the amount of time an insurer is on the risk.[24] In applying such a formula, courts typically will look to all years that may be triggered for the

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[17] *Id.* at 286-88.

[18] *Id.* at 289.

[19] *Id.* at 289-91 (Knoll, J., concurring in the result, and Crichton, J., separately concurring).

[20] This section is authored by Jay Sever and Alexis Joachim of Phelps Dunbar LLP.

[21] *See*, *Towns v. Northern Sec. Ins. Co.,* 184 Vt. 322 (2008); *EnergyNorth Natural Gas, Inc. v. Certain Underwriters at Lloyd's,* 156 N.H. 333 (2007); *Sec. Ins. Co. of Hartford v. Lumbermens Mut. Cas. Co.,* 264 Conn. 688 (2003); *Sharon Steel Corp. v. Aetna Cas. and Sur. Co.,* 931 P.2d 127 (Utah 1997); *Owens-Illinois Inc. v. United Ins. Co.,* 138 N.J. 437 (1994); *Ins. Co. North America v. Forty-Eight Insulations, Inc.,* 633 F.2d 1212 (6th Cir. 1980); *Certain Underwriters at Lloyds, London v. Arch Specialty Ins. Co.,* 246 Cal.App.4th 418 (3rd Dist. 2016); *Radiator Specialty Co. v. Fireman's Fund Ins. Co.,* No. 13 CVS 2271 (N.C. Super. Ct. Jan. 28, 2016). *See also, Boston Gas Co. v. Century Indemnity Co.,* 454 Mass. 337 (2009) (holding that indemnity should be determined based on a pro rata allocation, but left open the question of defense costs).

[22] *See, Owens-Illinois,* 138 N.J. at 479.

[23] *Sharon Steel Corp.,* 931 P.2d 127.

[24] *Arceneaux v. Amstar Corp.,* 200 So.3d, 277, 289.

claim, regardless of whether the insured is self-insured or uninsured and regardless of whether policies are lost/destroyed or whether coverage is denied for a particular year.[25]

In reaching the conclusion that pro rata is more appropriate than the joint and several allocation method for defense, these courts tend to focus on the following factors: (1) policy language/contract interpretation; (2) reasonable expectations; (3) equity/public policy; and (4) judicial economy. Each factor is discussed more fully below:

a. Policy Language

Pro rata courts start with language of the policy itself, applying basic contract interpretation rules. An insurance policy is a contract that must be analyzed using the general rules of contract interpretation and it is the "responsibility of the judiciary to determine the common intent of the parties."[26]

Generally, pursuant to the terms of an insurance policy, an insurer is obligated to defend an insured for suits seeking damages for "bodily injury" or "property damage," but only if such "bodily injury" or "property damage" "occurs during the policy period." Other versions provide that an insurer has "the right and duty to defend any suit against the insured seeking damages on account of … 'bodily injury.'" "Bodily injury" is defined as "bodily injury, sickness or disease sustained by any person which occurs *during the policy period,* including death at any time resulting therefrom." (emphasis added).

The *Arceneaux* court recognized that the policy language itself limited "coverage for bodily injury to that which occurs during the policy period."[27] In fact, Justice Knoll's concurring opinion focused solely on this approach.[28] According to Justice Knoll, the case is a simple contract dispute and based on the language of the policy, the bodily injury must occur during the policy period for coverage to be triggered.[29]

Moreover, the courts have discounted the "all sums which the insured shall become legally obligated to pay as damages" language — *i.e.,* the language courts cite to support application of the joint and several allocation method. This language, according to the courts, does not bear the interpretation that the insurer should be liable for injuries that do not occur

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[25] *See, Forty-Eight Insulations,* 633 F.2d at 1215 n. 4 (treating an insured which has lost or otherwise destroyed policies as self-insured); *Sec. Ins. Co. of Hartford,* 264 Conn. at 720 (finding that for purposes of allocating costs to the insured periods during which it was uninsured or lost or destroyed policies will be considered).

[26] *Arceneaux,* 200 So.3d at 286.

[27] *Arceneaux,* 200 So.3d at 286.

[28] *Arceneaux,* 200 So.3d at 290.

[29] *Id.*

during the policy period and, consequently, that the insurer should be liable for all defense costs relating to such injuries.[30]

b. Reasonable Expectations

Next, based on the policy language analysis above, the courts explain that "neither the insurers nor the insured could reasonably have expected that the insurers would be liable for losses occurring in periods outside of their respective policy coverage periods."[31] More specifically, "[n]o 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."[32] According to *Boston Gas*, "[a]ny 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."[33] Further, as explained in *Arceneaux*, although the duty to defend is broader than the duty to indemnify, "neither obligation is broader than the policy's coverage period in the context of long latency disease cases that trigger occurrence-based policies."[34]

c. Equity and Public Policy

Courts have increasingly recognized that a significant public policy benefit exists in requiring the policyholder to bear the risk of uninsured years, as a pro rata allocation system produces a more equitable result than joint and several allocation.[35] In *Arceneaux*, the court explained that a pro rata allocation is "reasonable" because the joint and several scheme "would treat an insured who had uninterrupted policies for twenty years the same as an insured who had a triggered policy for one year."[36] To hold otherwise, would entitle an insured to receive coverage for a period in which it did not pay a premium.[37]

The court in *Owens-Illinois, Inc.* explained:

> The theory of insurance is that of transferring risks. Insurance companies accept risks from manufacturers and either retain the risks or spread the risks through reinsurance.... Because insurance companies can spread costs throughout an industry and thus achieve cost efficiency, the law should, at a minimum, not

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30 *Sec. Ins. Co. of Hartford,* 264 Conn. at 710.

31 *Id*.

32 *Boston Gas Co.,* 454 Mass. at 363.

33 *Id*.

34 *Arceneaux,* 200 So.3d at 286.

35 *Boston Gas Co.,* 454 Mass. at 365 and *Arceneaux,* 200 So.3d at 287.

36 *Arceneaux,* 200 So.3d at 287.

37 *Id*.

provide disincentives to parties to acquire insurance when available to cover their risks. Spreading the risk is conceptually more efficient. (Citation omitted.)[38]

The joint and several liability approach provides a disincentive to insureds to obtain uninterrupted insurance coverage and would result in a windfall to those companies that had broken chains of insurance.[39] Moreover, the joint and several method "'creates a false equivalence between an insured who has purchased insurance coverage continually for many years and an insured who has purchased only one year of insurance coverage.' … This false equivalence would tend to 'reduce the incentive of ... property owners to insure against future risks.'"[40]

d. Judicial Efficiency

The *Boston Gas* court also focused on the aspect of judicial efficiency.[41] The joint and several allocation approach, according to the court, is inefficient in that it does not ultimately resolve the allocation issue.[42] Instead, the issue is postponed and divided into two parts — the policyholder first chooses the triggered insurer to pursue and second, the triggered insurer then sues other insurers for contribution.[43] As a result, the joint and several approach increases litigation costs, which are then passed on to policyholders via higher premiums, whereas the pro rata approach resolves all coverage and allocation issues in a single proceeding.[44]

2. The Pro Rata Allocation Method Supports Reimbursement of Defense Costs

Based on the pro rata allocation method, an insurer that is providing a complete defense to an insured is entitled to reimbursement of defense costs for uncovered claims, including those claims that are not triggered for that policy period or those claims that otherwise are not covered

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38 *Owens-Illinois, Inc.*, 650 A.2d at 992.

39 *Id*.

40 *Boston Gas Co.*, 454 Mass. at 365-66.

41 *Boston Gas Co.*, 454 Mass. at 364-65 *citing to EnergyNorth Natural Gas, Inc.*, 156 N.H. at 345.

42 *Boston Gas Co.*, 454 Mass. at 364-65.

43 *Boston Gas Co.*, 454 Mass. at 365.

44 *Id*.

under the terms and conditions of a policy.[45] Still other courts have held that an insurer has a right to reimbursement of defense costs when no ultimate duty to defend exists.[46]

In support of reimbursement, courts similarly look to the policy language, as well as equity and public policy. As explained by the Connecticut Supreme Court:

> A cause of action for reimbursement is cognizable to the extent required to ensure that the insured not reap a benefit for which it has not paid and thus be unjustly enriched. Where the insurer defends the insured against an action that includes claims not even potentially covered by the insurance policy, a court will order reimbursement for the cost of defending the uncovered claims in order to prevent the insured from receiving a windfall. Consistent with the pro rata method of allocation, we have concluded that time on the risk is a reasonable means of prorating defense costs for periods of self-insurance. Those costs allocable to periods of self-insurance are not even potentially covered by the insurer's policies. The insured has not paid premiums to the insurer for the cost of defending periods of self-insurance, and the insurer has not bargained to bear these costs. Thus, the insured would be unjustly enriched were we to conclude that there is no claim for reimbursement for the cost expended by the insurers in defending periods of self-insurance. Accordingly, we conclude that, where the pro rata method of apportionment applies, there is a cause of action for reimbursement by an insurer against its insured.[47]

3. The Pro Rata Allocation of Defense Costs and its Application to Other Case Types

Pro rata allocation of defense costs should not be limited to long-tail environmental cases, as the logic underlying it should be extended to apply to any claim involving multiple years of coverage, multiple policies, or gaps in coverage. Examples of such case types include construction defect claims, products liability claims, the non-environmental aspect of oil and gas claims, and continuous bodily injury claims (sexual molestation or abuse). The essential issues in these cases mimic those of long-tail environmental claims in that multiple policies are triggered for damages that occur over a span of several years. The same four factors (discussed above) supporting pro rata allocation can be applied just as persuasively to them, proving that a pro rata allocation method should not be limited to long-tail environmental cases.

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[45] *Buss v. Superior Court,* 939 P.2d 766 (Cal. 1997); *Sec. Ins. Co. of Hartford,* 264 Conn. 717; *Travelers Property Cas. Co. v. R.L. Polk & Co.,* 2008 WL 786678 (E.D. Mich. 2016); *Hebela v. Healthcare Ins. Co.,* 851 A.2d 75 (N.J. Super. 2004); *Travelers Prop. Cas. Co. v. Hillerich & Bradsby Co.,* 598 F.3d 257 (6th Cir. 2010); *Nationwide Mut. Ins. Co. v. Flagg,* 789 A.2d 586 (Del. Super. 2001); *E.E.O.C. v. Southern Pub. Co., Inc.,* 894 F.2d 785 (5th Cir. 1990).

[46] *Hecla Mining Co. v. New Hampshire Ins. Co.,* 811 P.2d 1083 (Colo. 1991); *Horace Mann Ins. Co. v. Hanke,* 312 P.3d 429 (Mon. 2013); *Resure, Inc. v. Chemical Distributors, Inc.,* 927 F. Supp. 190 (M.D. La. 1996) (applying Nevada law); *Cincinnati Ins. Co. v. Grand Pointe, LLC,* 501 F. Supp.2d 1145 (E.D. Tenn. 2007).

[47] *Sec. Ins. Co. of Hartford,* 264 Conn. 716-17.

Construction defect may be the most obvious area ripe for extension of *Areceneaux*. In fact, the South Carolina Supreme Court recently held that for construction defect cases indemnity should be determined based on a pro rata allocation.[48] In *Crossmann*, the South Carolina Supreme Court overruled *Golden Hills Builders, Inc.* finding in favor of a joint and several approach and adopting a time on the risk approach. The court focused on the language of the policy at issue:

> [W]e construe the standard CGL policy to require that each insurer cover only that portion of a loss attributable to property damage that occurred during its policy period. In light of the difficulty in proving the exact amount of damage incurred during each policy period, we adopt the [time on risk] formula . . . as the default method for allocating shares of the loss. . . .[T]he premise [is] that each insurer is responsible only for a pro rata portion of the total loss, and each pro rata portion must be defined by the insurer's time on the risk.[49]

Applying the pro rata allocation method for defense is a natural extension of this ruling.

For example, in applying the factors noted to a construction defect claim: The insurance policies at issue generally involve similar policy language requiring that the property damage occur during the policy period. Such language, as discussed in *Arceneaux* and *Crossmann,* provides that coverage is limited to property damage that occurs *during the policy period*. As far as reasonable expectations, the same can be said for contractors as for the insureds involved in long latency claims, in that no reasonable contractor would expect to have a single-year policy provide coverage for losses that span years of damage; and thus, the application of the pro rata method is supported by a contractor's reasonable expectations. Equity and public policy also favor the pro rata allocation method for construction defect claims. Under a joint and several allocation approach a contractor could obtain insurance every other year and likely have adequate coverage to provide continuous protection, essentially allowing the insured to receive coverage for a period of time in which it did not pay a premium. On the other hand, under a pro rata method, the contractor has an incentive to obtain uninterrupted insurance coverage to obtain complete protection. Finally, for the same reasons discussed in *Boston Gas,* the pro rata method supports judicial economy in resolving all disputes once, rather than resolving the disputes in two parts with an increased litigation cost.

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48 *Crossmann Cmtys. of N.C. v. Harleysville Mut. Ins. Co.*, 395 S.C. 40 (S.C. 2011).

49 *Crossmann,* 395 S.C. at 66.

4. The Absence of Coverage Has No Impact on a Pro Rata Allocation

Under the pro rata allocation approach, an insured's lack of coverage vis-à-vis a coverage denial, uninsured years or a self-insured retention has no bearing on the method of allocation for defense costs. To accurately formulate an insurer's pro rata share, the court must take into account **all** years of damage regardless of whether coverage is available to the insured. Such a formulation is the only fair and equitable means of applying this approach.

If the insured chose not to obtain insurance, the insured should bear the responsibility of contributing to its defense, as the absence of coverage was at the insured's own doing. If the insured chose an insurance program with a self-insured retention, the insured again should bear the responsibility of contributing to its defense, as the insured is essentially acting as an insurer. Moreover, if coverage is denied by another carrier, other carriers defending should not be penalized for that denial and required to absorb the cost of an insured's defense. The insured should bear the responsibility of contributing to its defense, as a denial of coverage is premised on the insured's failure to obtain and procure the proper coverage.

As noted in *Arceneaux* and *Forty-Eight Insulations,* this result is "reasonable as the joint and several scheme would treat an insured who had uninterrupted policies for twenty years the same as an insured who had a triggered policy for one year." To hold otherwise would entitle an insured to receive coverage for a period in which it did not pay a premium.

B. Policyholder Perspective[50]

1. The Indivisible Right and Duty to Defend

From the perspective of the insured, *Arceneaux* is conceptually flawed because it confuses an insurer's right and duty to *provide* a defense with mere reimbursement of defense expenses (or some portion thereof). The fundamental problem with the court's analysis is that it ignores not only the insured's right to *be defended* – and not just reimbursed, but also the insurer's *right* to control the defense to ensure its interests are adequately protected – a right the insurer in *Arceneaux* may have been content to jettison, but which nevertheless forms a part of the parties' bargain. At least in the narrow circumstances there presented, *Arceneaux* undercuts the rights of both parties by treating as divisible that which is not.

CGL policies do not typically address defense obligations in terms of defense expense payments (or partial payments), but rather by providing the insurer a right and duty to *conduct* the defense – and a reciprocal right of the insured to receive such performance. "It is common – almost universal – for liability insurance policies to give the insurer both the *right* to control the defense of any claim covered by the policy and the *duty* to provide that defense."[51] The insurer's

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[50] This section is authored by Martin Pentz and Daniel McFadden of Foley Hoag LLP.

[51] *Sherwood Brands v. Hartford Accident & Indem. Co.*, 698 A.2d 1078, 1083 (Md. 1997) (emphasis in original); *see Pilkington N. Am., Inc. v. Travelers Cas. & Sur. Co.*, 861 N.E.2d 121, 127 (Ohio 2006) (explaining that such language "gives the insurer the right to control the conduct of the litigation in order to safeguard its interests").

right of control "is important to the insurer as a mechanism for protecting and minimizing its duty of indemnification," such that the insurer can "make certain that a proper defense is made to the claim and that unwarranted, overstated, and collusive claims are exposed and defeated."[52] While assuming this right, the insurer also assumes a duty to defend the insured, including "hiring competent counsel" and "keeping abreast of the progress and status of litigation in order that it may act intelligently and in good faith on settlement offers."[53] The arrangement is one of mutual benefit. Putting aside the financial incentives created by the high-stakes phenomenon of long-tail tort liability, one can readily imagine an insurer on the risk for most, though not all, of the period during which injury was occurring *insisting* on a right to conduct (and thus control) the defense, in spite of the existence of a relatively brief uninsured period.

Because the defense of a lawsuit is necessarily a coordinated exercise, the right and duty to defend are generally held to be indivisible within any given lawsuit. For example, courts typically have held that if any one claim in an action triggers a duty to defend, then the duty extends to *every* other claim in the action, whether covered or not.[54] In other words, "the duty to defend one claim creates a duty to defend all claims."[55] "If any of the claims against the insured arguably arise from covered events, the insurer is required to defend the entire action."[56] Indeed, what would be the alternative? Uncovered but factually related claims are likely to bear on the outcome of any covered allegations. If the "right and duty" to defend were divisible, then the insured would lose a complete defense of the covered subject matter, and the insurer would lose an important safeguard against incompetence or collusion that bears on its indemnity obligations.

The indivisibility of the defense duty is consistent with the CGL wordings typically at issue in cases addressing coverage for long-tail liabilities. For example, in *Arceneaux*, which dealt with wording derived from the 1973 standard provisions, while the policy defined "bodily injury" as injury, sickness or disease which occurs during the policy period, it then stated that the insurer had "the right and duty to defend any suit against the insured seeking damages on account of such bodily injury . . .."[57] In other words, if the suit involved covered (*i.e.*, policy-period) injury, then the insurer would be entitled and obligated to *defend the suit*, not to chip in some allocated share of defense costs. Had the policy drafters intended the defense obligation to be parsed and shared with the insured where some injury took place outside of the covered period, they were capable of crafting a defense sharing provision suitable for such circumstances.

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[52] *Sherwood*, 698 A.2d at 1083.

[53] *R.C. Wegman Constr. Co. v. Admiral Ins. Co.*, 629 F.3d 724, 728 (7th Cir. 2011) (quoting 4 Couch on Insurance § 202:17 (3d ed. 2007)).

[54] *E.g.*, *AMCO Ins. Co. v. Inspired Techs., Inc.*, 648 F.3d 875, 880 (8th Cir. 2011).

[55] *AMCO*, 648 F.3d at 880.

[56] *Frontier Insulation Contrs., v. Merchants Mut. Ins. Co.*, 91 N.Y.2d 169, 175 (N.Y. 1997).

[57] *Arceneaux*, 200 So.3d at 280.

2. Courts Have Rejected Allocation of the Defense In Long-Tail Liability Cases

Consistent with these principles and wordings, many courts have concluded that, even in long-tail liability cases, every triggered insurer independently bears a complete defense obligation for the entire case, so long as some portion of the claimed injury occurred during its policy period. The progenitor of this approach is generally acknowledged to be the U.S. Court of Appeals for the D.C. Circuit's decision in 1981 in *Keene*. In that case, Keene, the insured, had manufactured asbestos-containing insulation from 1948 to 1972, resulting in thousands of underlying claims against it for asbestos-related injuries.[58] It was insured by four separate insurers beginning in 1961.[59] The policies typically provided for "all sums" coverage for damages "because of bodily injury . . . caused by an occurrence," where an occurrence was defined as "an accident, including injurious exposure to conditions, which results, during the policy period, in bodily injury."[60] The court adopted essentially a continuous trigger of coverage, in which "inhalation exposure, exposure in residence [in the body], and manifestation [of disease]" all constitute "bodily injury."[61] To the extent such injury spanned multiple policy periods and, therefore, triggered multiple policies, the court held that each "insurer must defend Keene" and "is fully liable for defense costs."[62]

Since *Keene*, courts in various states have reached similar conclusions. For example, in 2015, in *Peabody Essex Museum, Inc. v. United States First Insurance Co.*, environmental contamination had occurred between 1960 and 1986, and the defendant insurer had been on the risk from 1983 to 1985.[63] The U.S. Court of Appeals for First Circuit held as a matter of Massachusetts law that, in light of the "all-encompassing" and "in for one, in for all" nature of the duty to defend, the triggered insurer was responsible for a complete defense, not merely a prorated share, notwithstanding that indemnity might be subject to *pro rata* allocation.[64]

Similarly, in 2009, in *Plastics Engineering Co. v. Liberty Mutual Insurance Co.*, the Supreme Court of Wisconsin held, in a case involving several decades of underlying asbestos

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[58] 667 F.2d. at 1038.

[59] *Id.* at 1038-39.

[60] *Id.* at 1039.

[61] *Id.* at 1042-47.

[62] *Id.* at 1050.

[63] *Peabody Essex Museum, Inc. v. United States Fire Ins. Co.*, 802 F.3d 39, 42 (1st Cir. 2015).

[64] *Id.* at 53; *see also Narragansett Elec. Co. v. Am. Home Assur. Co.*, 999 F. Supp. 2d 511, 519-21 (S.D.N.Y. 2014) (holding under Massachusetts law that defense costs in pollution case could not be prorated), *rev'd on other grounds*, 2016 U.S. App. LEXIS 11647 (2d Cir. Jun. 23, 2016).

exposures, that "there can be no pro rata approach to the duty to defend."[65] The court based this ruling on the unitary nature of defense obligations, explaining that "[w]e do not base the scope of a duty to defend upon whether some allegations fall outside of the complaint or whether some of the damages fall party within and partly outside a policy period," and, therefore, "[i]f a duty to defend arises, the insurer must defend the lawsuit in its entirety."[66]

3. The Impact of *Arceneaux* Will Likely Be Limited

In *Arceneaux*, the Supreme Court of Louisiana recognized many of the principles articulated above. The court began its analysis by correctly noting that "an insurer's duty to defend is distinct from its duty to indemnify," and that law requiring the proration of indemnity does not necessarily require allocation of the defense.[67] The court also correctly noted that some courts have rejected *pro rata* allocation of the defense and cited *Keene* as a "leading decision" representing that approach.[68] Unfortunately, the court then chose to follow the reasoning of *Forty-Eight Insulations* and its progeny, which conflate the duty to *provide a defense* with a "contract[] . . . to pay defense costs."[69]

Ultimately, however, it appears that *Arceneaux* is unlikely to wield great influence in future analyses of defense obligations. In part, this is due to the fact that the *Arceneaux* court's analysis is tied to the somewhat idiosyncratic law of Louisiana.[70] "[T]he concept of 'joint and several' is not a concept that is currently part of Louisiana's tort law,"[71] and in such circumstances the court seemed to find it hard to believe that the parties would reasonably anticipate such an outcome as a matter of contract.

Further, future courts are likely to distinguish *Arceneaux* based on that fact that its holding was expressly tied to the specific policy language at issue.[72] That policy language defined "bodily injury" as "bodily injury, sickness or disease sustained by any person which

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[65] *Plastics Eng. Co. v. Liberty Mut. Ins. Co.*, 759 N.W.2d 613, 627 (Wis. 2009).

[66] *Id.* As other examples, courts applying Rhode Island and Illinois law have likewise reject pro rata allocation of the defense. *See Emhart Indus. v. Home Ins. Co.*, 515 F. Supp. 2d 228 (D.R.I. 2007); *Chicago Bridge & Iron Co. v. Certain Underwriters at Lloyd's*, 797 N.E.2d 434, 444 (Mass. App. Ct. 2003).

[67] *Arceneaux*, 200 So. 3d at 282.

[68] *Id.* at 283.

[69] *Arceneaux*, 200 So. 3d at 285, *quoting Forty-Eight Insulations*, 633 F.2d at 1224-25.

[70] *Arceneaux*, 200 So. 3d at 286.

[71] *Id.*

[72] *Id.* ("We . . . adopt the pro rata allocation method for defense costs in this case before us based on the policy language.")

occurs during the policy period."[73] The court indicated that this specific wording created a "reasonable expectation[]" that the insurer would not be liable for "losses" that occurred outside of the policy period.[74] And, notably, the court stressed that courts in future cases would be required to examine the "precise language of the insurance contract at issue" to reach an outcome on a "case by case basis."[75] Accordingly, even the Louisiana courts might reach a different conclusion if the policy included different language, or additional provisions supporting coverage for out-of-period harm, such as a non-cumulation clause.

Future courts may also distinguish *Arceneaux* for its focus on discontinuities in coverage. For most, but not all, of the triggered insurer's time on the risk, its policies contained an exclusion for employee injury during the course of employment, which suggested a purpose to exclude claims (like the underlying plaintiffs') for hearing loss arising from employment-related industrial exposure.[76] The court seemed to conclude that, if proration were not required in this circumstance, then the insured would receive an unfair windfall for periods of time when it had purchased a policy that expressly excluded the asserted claim.[77]

Finally, it is notable that the two concurrences in *Arceneaux* reinforce the narrowness of its holding. Justice Knoll concurred specifically to explain that the case provides no "bright-line rule" for future courts, but rather that such courts must undertake their analysis of defense proration "on a case-by-case basis, according to the terms of the contract for insurance."[78] And Justice Crichton concurred to add that the holding was limited to "long latency occupational disease cases."[79]

In conclusion, allocation of defense is fundamentally inconsistent with the right and duty to defend agreed by the parties for their mutual benefit. And while *Arceneaux* regrettably held otherwise, it appears that its prospective applicability will be limited, and the debate on this issue will continue.

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[73] *Id.* at 280.

[74] *See id.* at 286.

[75] *Id.* at 286.

[76] *Id.* at 280.

[77] *Id.* at 287.

[78] *Id.* at 290 (Knoll, J., concurring in the result).

[79] *Id.* (Crichton, J., concurring).

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Reasonable Settlement Decisions
Will The ALI Restatement Change Common Law Standards for Failure to Settle Claims?

American College of Coverage and Extracontractual Counsel
5th Annual Meeting

Chicago, IL
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I. INTRODUCTION

Law suits against insurers based upon claimed negligence in failing to settle claims represent one of the largest sources of coverage litigation between insurers and policyholders. As a result, there is an extensive body of case law of state and federal precedent in most states defining when insurers have a duty to settle. As will be seen in Section II of this paper, these rules differ from state to state.

The *Restatement of the Law of Liability Insurance*, which is expected to receive final approval from the American Law Institute on May 23, 2017 will create a national standard against which these claims may be tested. Although Restatements are generally viewed by lawyers as an amalgamation of accepted principles of law, this one departs from traditional insurance law in a number of significant respects. In particular, Section 24 sets forth a number of new proposals that will challenge courts and litigants going forward in divining when insurers are liable for failing to settle and what defenses may be raised against such claims. Among the issues that may arise going forward are:

- Are failure to settle claims distinct from "bad faith" claims?
- Should an objective or subjective standard govern whether an insurer should have settled the claims against its insured?
- Do insurers have an affirmative duty to make settlement offers in serious cases, even if the underlying plaintiff has not yet made a demand to settle?

In this article, we will discuss the common law governing the duty to settle, the evolution of Section 24 over the past few years and consider the potential for Section 24 to shape the future shape of the common law in this area.

II. Common Law Rules Governing The Duty to Settle

Most "failure to settle" cases concern three issues: (1) what standard should be applied to assessing the insurer's decision not to settle; (2) may insurers consider coverage defenses in declining to settle and (3) do insurers have an affirmative obligation to make settlement offers or seek out a settlement within policy limits even if the plaintiff has not made a demand?

A. Origins of Failure to Settle Claims

Claims based upon an insurer's failure to protect its insured against an excess verdict have their origin in the explicit and implicit contractual duties arising out of the insurer's right to defend, including the right to "make such investigation, negotiation, and settlement of any claim or suit as it deems expedient."

Most courts have found the duty to defend encompasses a duty on the part of insurers to exercise due care in the conduct of that defense, including a duty to act reasonably in response to settlement offers. Kooyman v. Farm Bureau Mutual Ins. Co., 315 N.W.2d 30, 32-34 (Iowa 1982); Short v. Dairyland Ins. Co., 334 N.W.2d 384, 387 (Minn. 1983); Allstate Ins. Co. v. Reserve Insurance 116 N.H. 806, 808 (1977).

As explained by the Wisconsin Supreme Court in Mowry v. Badger State Mut. Cas. Co., 129 Wis. 2d 496, 510, 385 N.W.2d 171 (1986), this duty is implied from the terms of the contract that give the insurer the absolute control of the defense of the action against the insured. Because the insured has given up something of value to the insurer-namely, the right to defend and settle a claim-the insurer is said to be in the position of a fiduciary with respect to the insured's interest in settlement of a claim. The insurer has the right to exercise its own judgment in determining whether a claim should be settled or contested; but in order to be made in good faith, a decision not to settle a claim must be based on a thorough evaluation of the underlying circumstances of the claim and on informed interaction with the insured.

Other courts have gone further, holding that these rights give rise to a fiduciary obligation "to act in the best interests of its insureds in order to protect the insured from excess liability" and to refrain from conduct that demonstrates "greater concern for the insurer's monetary interest than the financial risk attendant to the insured's situation. See, e.g. Asermely v. Allstate Ins. Co., 728 A.2d 461, 464 (R.I. 1999)("the duty of good faith and fair dealing includes an affirmative duty to engage in timely and meaningful settlement negotiations and to make and consider offers of settlement consistent with an insurer's fiduciary duty to protect its insured from excess liability").

Where an insurer places its interests before those of its policyholder and negligently fails to accept an opportunity to settle a claim within the available policy limits, the rule in most states is that it will be liable for any excess verdict that results. Hartford Acc. & Ind. Co. v. Aetna Cas. & Sur. Co., 792 P.2d 749 (Ariz. 1990); Hadenfeldt v. State Farm Mutual Auto Ins. Co., 239 N.W.2d 499, 502 (Neb. 1976); Dairyland Ins. Co. v. Herman, 954 P.2d 56, 61 (N.M. 1997); Trotter v State Farm Mut. Auto. Ins. Co 377 S.E.2d 343 (S.C. App. 1988); State Auto Ins. v. Rowland, 427 S.W.2d 30, 32 (Tenn. 1968); Stowers Furniture Co. v. American Ind. Co., 15 S.W.2d 544, 547 (Tex. 1929) and Western Cas. & Sur. Co. v. Fowler, 390 P.2d 602 (Wyo. 1964).

B. Elements of a Failure to Settle Claim

In general, five elements must be present to give rise to a claim against an insurer for negligent failing to settle a claim within policy limits: (1) the case was one that the insurer was defending; (2) the insured's liability was such that an ordinarily prudent insurer would have concluded that the case should settle; (3) the insurer had the opportunity to settle within policy limit; (4) the claims were covered and (5) due to the insurer's failure to settle, a judgment in excess of policy limits entered against the insured.

1. Insurer Must Have Been Defending

As the insurer's liability flows from its conduct of the insured's defense, an insurer that simply denies coverage and refuses to defend cannot be sued on this basis (although it may certainly face other types of bad faith claims). Mesmer v. Maryland Automobile Ins. Fund, 725 A.2d 1053 (Md. 1999)("Since the source of the duties to defend and to indemnify are entirely contractual, a liability insurer breaches no tort duty when, upon learning of a claim, it erroneously denies coverage and refuses to undertake any defense against the claim").

In Mutual Insurance Company v. Murphy, 630 F. Supp. 2d 158 (D Mass. 2009), a federal district court ruled that a media E&O insurer was not liable for its claimed failure to settle in violation of G.L. 176 D § 3 (9)(f) as it did not have language in its policy creating a duty to defend.

Judge Saris focused on the fact that the policy in question was issued over a retention and that, as it was the excess insurer, it did not control the defense of the underlying action such that it could have such an obligation.

2. The Insurer's Refusal to Settle Was Unreasonable

An insurer is not obligated to settle every claim when an offer is made within policy limits. However, it must evaluate such settlement possibilities in good faith taking into account the probability of the insured's liability, the extent of damages claimed, the amount of the policy limits, the adequacy of the insurer's investigation and the openness of communications between the insurer and the insured. Smith v. Audubon Ins. Co., 679 So.2d 372 (La. 1996).

An insurer is only obligated to accept a settlement if it's insured's liability is clear and the amount demanded is not excessive in light of the facts. Short v. Dairyland Ins. Co., 334 N.W.2d 384, 387 (Minn. 1983). Thus, liability does not exist merely because the insurer refused an offer within the policy limits, however; the refusal must be unreasonable. Crisci v. Security Ins. Co., 66 Cal.2d 425, 58 Cal. Rptr. 13, 426 P.2d 173 (1967). See also Allstate Ins. Co. v. Campbell, 639 A.2d 652, 659 (Md. 1994)(insurer does not have an absolute duty to settle a claim within policy limits but fails to do so at its own peril).

There is little uniformity in the standards that courts around the country have evolved in assessing whether the insurer's decision not to settle was unreasonable. For the most part, however, courts have adopted an objective standard, concluding that the test for determining liability is whether an "ordinarily prudent insurer" standing in the shoes of the defendant created an unreasonable risk by choosing to try the case. Shearer v. Reed, 428 A.2d 635 (Pa. Super. 1981)(insurer's actions must be "intelligent and objective") and Physician Ins. Exchange v. Garcia, 876 S.W.2d 842 (Tx. 1994).

States such as Massachusetts and New Hampshire have applied a "negligence" rule, however. See Hartford Cas. Ins. Co. v. New Hampshire Ins. Co., 417 Mass. 115, 628 N.E.2d 14 (1994) and Dumas v. State Mutual Auto Ins. Co., 111 N.H. 43, 274 A.2d 781 (1971). See also Carrier Express, Inc. v. Home Indemnity Co., 860 F.Supp. 1465, 1479 (N.D. Ala. 1994)(decision not to settle must be "thoroughly honest, intelligent and objective...it must also be a realistic one when tested by the necessarily assumed expertise of the insurance company").

The Wyoming Supreme Court has declared that "bad faith in this context would occur if an excess judgment were obtained under circumstances when the insurer failed to exercise intelligence, good faith and honest and conscientious fidelity to the common interest of the insured as well as the insurer and to give at least equal consideration to the interests of the insurer." Herrig v. Herrig, 844 P.2d 487, 490 (Wyo. 1992).

Among the more elaborate set of factors are those that Illinois courts have identified, including (1) whether the insurer ignored the advice of its own adjusters; (2) whether the insurer refused to negotiate; (3) whether the insurer followed the advice of defense counsel; (4) whether the insurer kept its policyholder aware of ongoing offers to settle; (5) whether the insurer conducted an adequate investigation and defense; (6) whether there was a substantial prospect of an adverse verdict; and (7) whether there was a potential for damages to exceed the policy limit. See O'Neill v. Gallant Ins. Co., 769 N.E.2d 100 (Ill. App. 2002).

An insurer is not liable just because the defense that it provided results in an excess verdict, nor is it absolved merely because its claims handler acted "sincerely." The Birth Center v. St. Paul Companies, 787 A.2d 376 (Pa. 2001), "Where there is little possibility of a verdict within the policy limits, the insurer's decision to litigate must be based on a reasonable assessment of the circumstances of the case and a real and substantial chance of a verdict in favor of the insured."

As the New Jersey Supreme Court noted in Rova Farms Resort, Inc. v. Investor's Ins. Co., 65 N.J. 474, 323 A.2d 495 (1974):

> [A] decision not to settle must be a thoroughly honest, intelligent and objective one. It must be a realistic one when tested by the necessarily assumed expertise of the [insurance] company." This expertise must be applied, in a given case, to a consideration of all the factors bearing upon the advisability of a settlement for the protection of the insured. While the view of the carrier or its attorney as to liability is one important factor, a good faith evaluation requires more. It includes consideration of the anticipated range of a verdict, should it be adverse; the strengths and weaknesses of all of the evidence to be presented on either side so far as known; the history of the particular geographic area in cases of similar nature; and the relative appearance, persuasiveness, and likely appeal of the claimant, the insured, and the witnesses at trial.

Apart from these general descriptions of the sort of conduct that may give rise to extracontractual liability, courts have focused on a few specific types of misconduct, notably failing to advise insureds of settlement opportunities. The insurer's failure to advise its insured of the risk of an excess verdict or of an opportunity to settle within policy limits has often been cited as a basis for imposing extracontractual liability for excess verdicts. See OK Lumber Co. v. Providence Washington Ins. Co., 759 P.2d 523 (Ala. 1988); Hawkins v. Dennis, 905 P.2d 678 (Kan. 1995) and Alt v. American Family Mutual Ins. Co., 237 N.W.2d 706, 712 (Wis. 1976)(in all cases where a likelihood of liability in excess of policy limits exists, the insurer must inform the insured so that it may protect its own interests).

3. Claims Must Have Been Covered

Courts are divided with respect to whether an insurer may consider the partial or total absence of coverage in responding to an opportunity to settle a claim against its policyholder. In short, in addition to determining the likelihood of its insured's liability to the plaintiff, may the insurer consider the likelihood of its potential duty to indemnify the insured for that judgment?

Courts declaring that an insurer need not accept a reasonable offer of settlement where a bona fide coverage dispute exists include Robinson v. State Farm Fire & Casualty Co., 583 So.2d 1063, 1068 (Fla. App. 1991); Stephenson v. State Farm Fire & Casualty Co., 628 N.E.2d 810, 813 (Ill. App. 1993); Snodgrass v. State Farm Mutual Auto Ins. Co., 804 P.2d 1012, 1022 (Kan. App. 1991); Dawn Frosted Meats, Inc. v. INA, 99 A.D.2d 448 (N.Y. App. 1984); National Service Fire Ins. Co. v. Williams, 454 S.W.2d 362, 365 (Tenn. 1970) and Mowry v. Badger State Mut. Cas. Co., 129 Wis. 2d 496, 510, 385 N.W.2d 171 (1986).

In a few states, an insurer may be liable for failure to settle within policy limits, notwithstanding the existence of a coverage issue. State Farm Auto Ins. Co. v. Civil Employees Ins. Co., 509 P.2d 725, 733 (Ariz. App. 1973); Johansen v. California State Auto Association Inter-Insurance Bureau, 15 Cal. 3d 9, 123 Cal. Rptr. 288, 538 P.2d 744 (1975); Trahan v. Central Mutual Ins. Co., 219 So.2d 187, 194 (La. App. 1969). In such circumstances, an insurer acts at its peril in rejecting a reasonable settlement offer and will be found to have an obligation to indemnify the insured for this amount if it is subsequently found to have wrongfully refused to defend. The insurer's coverage questions are not an obstacle to its liability for failing to settle.

The seeming harshness of this rule may be ameliorated by the corollary rule that the insurer may subsequently bring a claim against the insured to recoup the uninsured portion of the settlement. In Blue Ridge Ins. Co. v. Jacobsen, 25 Cal.4th 489, 22 P.3d 313, 106 Cal. Rptr.2d 535 (2001), the California Supreme Court ruled that where an insurer has defended a lawsuit under a reservation of rights, it is entitled to full reimbursement for all reasonable settlement payments in the event that it is later determined that the claims were not covered under its policy, even if it settled over the objections of its insured.

Notwithstanding Blue Ridge, the California Supreme Court has also ruled, however, that an insurer may not be held liable for an excess award resulting from its negligence where the "excess" aspect of the award constitutes punitive damages for which coverage is not otherwise permitted under the policy. In PPG Industries, Inc. v. Transamerica Ins. Co., 20 Cal.4th 310, 975 P.2d 652 (1999), the California Supreme Court ruled that a liability insurer does not owe coverage for an award of punitive damages awarded against its insured as a consequential aspect of the insurer's claimed negligence in failing to settle the claim within policy limits. As coverage for punitive damages is barred both by statute and public policy in California, the Supreme Court ruled that an insurer could not be forced to bear responsibility for such awards, even if it was otherwise negligent in failing to settle In such circumstances, the insurer's failure to settle the third party lawsuit is a cause in fact of the punitive damages awarded against the insured but was not the proximate cause of those damages. Accord Lira v. Shelter Ins. Co., 913 P.2d 514 (Colo. 1996) and St. Paul Fire & Marine Ins. Co. v. Convalescent Services, Inc., 193 F.3d 340 (5th Cir. 1999)(Texas law).

4. Insurer Could Have Settled Within Policy Limits

Traditionally, an insurer's duty to settle was only triggered if a concrete opportunity to settle within policy limits is presented to it; it had no duty to solicit such an offer or to affirmatively engage in settlement discussions with an eye towards generating such an opportunity. Commercial Union Ins. Co. v. Mission Ins. Co., 835 F.2d 587, 588 (5th Cir. 1988); Ranger Ins. Co. v. Home Indemnity Co., 741 F.Supp. 716, 718 (N.D. Ill. 1990); Short v. Dairyland Ins. Co., 334 N.W.2d 384, 387 (Minn. 1983) and Birmingham Fire Ins. Co. v. American Nat. Fire Ins. Co., 947 S.W.2d 592 (Tex. App. 1997).

Some opinions have suggested that the resolution of this issue is not clear cut and will depend on the particular circumstances of a case. Thus, whereas the Illinois Supreme Court has ruled that insurers generally are not required to initiate settlement negotiations, the court declared in Haddick v. Valor Ins. Co., 763 N.E.2d 299 (Ill. 2001) that a duty to settle also arises in any case where the probability of an adverse finding on liability is great and the amount of probable damages would greatly exceed the primary coverage. Likewise, the Wisconsin Supreme Court ruled in Alt

v. American Family Mutual Ins. Co., 237 N.W.2d 706, 710 (Wis. 1976) that the absence of an actual offer to settle within limits was not an absolute defense to liability; under appropriate circumstances the insurer may have an affirmative obligation to seek out such an offer.

Indeed, a growing number of courts have concluded that a primary insurer cannot ignore its obligation to explore a settlement within policy limits merely because the plaintiff has failed to explicitly make such a demand. See New Hampshire Ins. Co. v. United States, No. 95-55245 (9th Cir. August 2, 1996)(California law), Westchester Fire Ins. Co. v. General Star Indemnity Company, 183 F.3d 578 (7th Cir. 1999)(Illinois law); California Union Ins. Co. v. Liberty Mutual Ins. Co., 920 F.Supp. 908 (N.D. Ill. 1996); Hartford Ins. Co. v. Methodist Hospital, 785 F.Supp. 38 (E.D.N.Y. 1992); Fulton v. Woodford, 545 P.2d 979, 984 (Ariz. 1976); Rova Farms Resort, Inc. v. Investor's Ins. Co., 65 N.J. 474, 323 A.2d 495 (1974); Maine Bonding & Casualty Co. v. Centennial Ins. Co., 693 P.2d 1296, 1299 (Ore. 1985) and State Auto Ins. Co. v. Rowland, 427 S.W.2d 30, 32 (Tenn. 1968).

There remains consider controversy, however, as to whether insurers have an affirmative duty to make offers or initiate settlement discussions in cases where the plaintiff has, for whatever reason, failed to make a demand. A few courts have taken an expansive view of this duty, declaring that if the insurer's pre-trial assessment is that its insured faces a significant likelihood of an excess verdict if the case goes to trial, the absence of an offer from the plaintiff to settle within policy limits does not excuse the insurer from its obligation to try to settle the case within limits before trial. Berglund v. St. Farm Mutual Automobile Ins. Co., 121 F.3d 1225 (8th Cir. 1997)(Iowa law). Accord Hopkins v. Liberty Mut. Ins. Co., 434 Mass. 556, 561, 750 A.2d 943 (2001)(claimant did not have to show that the plaintiff would have accepted the insurer's offer).

Whether presented or solicited, the offer must be one that the insurer can accept. As a result, the insurer should not be liable if the inability to settle results from circumstances over it which it had no control. Thus, an insurer may not be held liable if it in fact offered to settle but was refused for no reason. Brocato v. Prairie State Farmers Insurance Association, 520 N.E. 2d 1200 (Ill. App. 1988). See also. Wierck v. Grinnell Mutual Ins. Co., 456 N.W.2d 191, 193 (Iowa 1990)(insurer unable to settle claim despite offer to tender full policy limits).

But what happens if the demand exceeds the primary insurer's limits? Such limited law as presently exists suggests that a primary insurer still has a duty to make its limits available to settle even if the successful consummation of a settlement would require contribution from an excess insurer or the policyholder.

In Cotton States Mutual Insurance Company v. Brightman, 580 S.E.2d 519 (Ga. 2003), the Georgia Supreme Court held that an insurer is not protected from liability merely because the plaintiff's demand against it was conditional on a second insurer also making an offer of settlement. In such circumstances, the court ruled that even though the insurer had no control over the involvement of the second carrier, it was nonetheless obligated to give equal consideration to its policyholder's financial interests by offering its limits. The Supreme Court ruled that it was "unwilling to ascribe a duty to insurers to make a counter-offer to every settlement demand that involves a condition beyond their control. Instead, we conclude 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."

5. A Judgment Must Enter Exceeding the Policy Limits

Finally, a cause of action for failing to settle may only be successfully prosecuted if the insured has suffered injury as a result of the insurer's acts or omissions. In most cases, that means that an insurer may only be sued if an actual excess judgment has entered against its policyholder. State Farm Mutual Automobile Ins. Co. v. Hollis, 554 So.2d 387 (Ala. 1989); Allstate Ins. Co. v. Campbell, 639 A.2d 652 (Md. 1994) and Jarvis v. Farmers Ins. Exch., 948 P.2d 898, 901 (Wyo. 1997). Thus, the mere prospect of an excess verdict or potential liability to the insured is not sufficient to warrant the imposition of extracontractual liability on the insurer.

On the other hand, most courts have not required that this judgment have been satisfied by the insured as a pre-condition to suing the insurer or even that the insured face any personal liability for the judgment (as many of these cases result in consent judgments wherein the tort claimant agrees to a covenant not to execute against the insured's personal assets). Economy Fire & Cas. Co. v. Collins, 643 N.E.2d 382 (Ind. Ct. App. 1994); Dumas v. State Mutual Auto Ins. Co., 111 N.H. 43 (1971) and Campbell v. State Farm Mut. Auto Ins. Co., 840 P.2d 130 (Utah App. 1992). But see Evans v. Mutual Assurance Company, Inc., 727 So.2d 66 (Ala. 1999)(insurer cannot be sued it its insured faces no personal liability for the excess judgment).

C. What Damages Are Recoverable?

The measure of damages in "failure to settle" cases is not the insurer's policy limit. Rather, most courts have held that an insurer may be liable for damages in excess of its policy limits if it is found to have denied coverage in bad faith or if it has negligently rejected a settlement offer within policy limits. Purdy v. Pacific Automobile Ins. Co., 157 Cal. App. 3d 59, 74, 203 Cal. Rptr. 524 (1984); Mid-America Bank & Trust Co. v. Commercial Union Insurance Co., 224 Ill. App. 3d 1083, 1087 (1992); Associated Wholesale Grocers, Inc. v. Americold Corp., 934 P.2d 65 (Kan. 1997). Accord, Short v. Dairyland Ins. Co., 334 N.W.2d 384, 387-89 (Minn. 1983); Dairyland Ins. Co. v. Herman, 954 P.2d 56, 61 (N.M. 1997) and Besel v. Viking Insurance of Wisconsin, 146 Wash. 730, 49 P.3d 887 (2002).

A divided Pennsylvania Supreme Court has declared that a professional liability insurer could still be sued for consequential damages suffered by its insured due to the carrier's failure to settle within policy limits even though the insurer ultimately agreed to pay the verdict in full. In The Birth Center v. St. Paul Companies, Inc., 787 A.2d 376 (Pa. 2001), the majority severely criticized the insurer's failure to heed repeated warnings that the case had an excess potential and found that an insurer could not wipe the slate clean by later paying the excess verdict if its claims conduct had caused the insured to suffer other consequential damages.

III. The *Restatement* Approach to Failure to Settle Claims

A. Section 24: *The Duty to Make Reasonable Settlement Discussions*

As presently drafted, Section 24 states in its black letter rule that:

> (1) When an insurer has the authority to settle a legal action brought against the insured, or the authority to settle the action rests with the insured but the insurer's prior consent is required for any

> settlement to be payable by the insurer, and there is a potential for a judgment in excess of the applicable policy limit, the insurer has a duty to the insured to make reasonable settlement decisions.
>
> (2) A reasonable settlement decision is one that would be made by a reasonable insurer who bears the sole financial responsibility for the full amount of the potential judgment.
>
> (3) An insurer's duty to make reasonable settlement decisions includes the duty to make its policy limits available to the insured for the settlement of a covered legal action that exceeds those policy limits if a reasonable insurer would do so in the circumstances.

B. The Origins of Section 24

The ALI's treatment of the duty to settle has evolved over the past five years as this project progressed from a *Principles* to a *Restatement* and moved through numerous different iterated drafts.

1. The Principles Phase (2010-2014)

The *Ur* ancestor of Section 24 first appeared in the Reporter's Preliminary Draft No. 3 on February 28, 2012 as part of the proposed Chapter 3 of the *Principles of Liability Insurance*. After discussions with the Advisers and MCG, this precursor language was revised in Council Draft No. 3, released on December 21, 2012, to state:

> **§ 35. The Liability Insurer's Duty to Make Reasonable Settlement Decisions**
>
> (1)When a liability insurer has the authority to settle a claim against the insured, or the authority to withhold prior consent from an insured's proposed settlement, the insurer has a duty to the insured to make reasonable settlement decisions. This duty includes a duty to accept reasonable settlement demands made by claimants. The duty to make reasonable settlement decisions is owed only with respect to liability in excess of the policy limits.
>
> (2) A reasonable settlement decision is one that would be made by a reasonable person that bears the sole financial responsibility for the full amount of potential judgment and the costs of defending the claim. The amount, if any, that an insurer must contribute to a settlement is subject to the policy limits.
>
> (3) Unless otherwise stated in a policy issued to a large commercial policyholder, an insurer's duty to make reasonable settlement decisions includes the duty to contribute its policy limits to a

reasonable settlement of a covered claim if that settlement exceeds those policy limits.

Although the language of this Section has changed in various respects since 2012, the core concepts underlying this Section have not. It was—and remains—the view of the Reporters that:

- The obligations of insurers to settle should be set forth as a positive obligation ("the duty to make reasonable settlement decisions") rather than in the traditional negative statement of the insurer's negligent failure to settle.

- The liability of an insurer for failing to make a reasonable settlement decision is not necessarily bad faith and is therefore dealt with in Chapter 3 and not in Chapter 4.

- While an insurer's failure to settle may give rise to bad faith under Sections 51 and 52, the insurer's liability is subject to entirely different standards of fault and damages.

- An insurer must "disregard the limits" in determining whether to settle or not.

- An insurer's liability for failing to make reasonable settlement decision reflects a "reasonableness" analysis rather than strict liability for any suit that results in an excess verdict.

- "Reasonableness" is a range, not a point.

A streamlined version of language resurfaced as Section 27 of the new Chapter Two as Section 27 in Council Draft No. 4 that was released by the Reporters after further Adviser/MCG debate and deliberation on September 3, 2013:

§ 27. The Liability Insurer's Duty to Make Reasonable Settlement Decisions

Unless otherwise stated in a policy issued to a large commercial policyholder:

(1)When a liability insurer has the authority to settle a claim against the insured, or when the authority to settle a claim rests with the insured but the insurer's prior consent is required for any settlement to be payable by the insurer, the insurer has a duty to the insured to make reasonable settlement decisions. The duty to make reasonable settlement decisions is owed only with respect to liability in excess of the policy limits.

(2) A reasonable settlement decision is one that would be made by a reasonable person that bears the sole financial responsibility for the full amount of the potential judgment and the costs of defending the claim.

(3) An insurer's duty to make reasonable settlement decisions includes a duty to accept reasonable settlement demands by claimants, subject to the following limitation: the amount, if any,

> that an insurer must contribute to a settlement is never greater than the policy limits.
>
> (4) An insurer's duty to make reasonable settlement decisions includes the duty to contribute its policy limits to a reasonable settlement of a covered claim if that settlement exceeds those policy limits.

The principal change in this draft was the elimination of the language in Section 27(2) that had included anticipated defense costs within the calculus for determining the settlement value of a case.

The Reporter's Comments to these *Principles* precursors to Section 24 are revealing.

Comment a. describes the rationale for these rules as follows:

> The objective is to encourage liability insurers to make efficient and equitable settlement decisions. In addition, because insureds are generally more risk adverse than insurers, this rule maximizes the joint well-being of the parties by shifting the risk of excess judgments from insureds to insurers.
>
> The purpose of the duty to make reasonable settlement decisions is to align the interest of insurer and insured in cases that expose the insured to damages in excess of the policy limits. Therefore, the duty is owed only with respect to cases that expose the insured to such damages.

Comment b. observed that the Reporters use the term "duty to make reasonable settlement decisions" instead of the more common term "duty to settle," to emphasize their view that insurers do not have a duty to settle every claim but, rather, "to make reasonable settlement decisions." It emphasized that insurers "may reject unreasonable settlement demands," as defined in Section 27(2) of the black-letter rule. The reasonableness standard is "flexible," permitting the finder of fact "to take into account the whole range of reasonable settlement values." This range includes consideration of whether an insurer made reasonable offers and counteroffers.

Comment f. specifically distinguished between an insurer's rejection of a reasonable settlement demand and its failure to make a reasonable offer at all:

> A rejection of a reasonable settlement demand automatically subjects the insurer to liability for any excess judgment. By contrast, the insurer's decision not to make a reasonable offer, or counter-offer, is merely evidence of unreasonableness on the part of the insurer from which a trier of fact may or may not conclude that the insurer is subject to liability for an excess judgment.

Comment f. also made plain that this difference rises from differences in proof of causation. When an insurer rejects a reasonable settlement demand leading to an excess judgment against the

policyholder, causation is plain. It is less clear when an insurer fails to make any offer or counter-offer. This rule applies to both duty to defend and defense costs indemnification policies.

Comment g. acknowledges the argument that these rules may "hamper negotiation strategies by liability insurers in settlement discussions, to the detriment of policyholders as a whole." The Reporters stated, however, that "minimization of liability insurance premiums is not the primary objective of the duty to make reasonable settlement decisions. Rather, the primary objective is to protect insureds from the conflict of interest inherent in the standard less-than-full-coverage case where the insurer has the sole settlement discretion." In any event, insurers remain free to reject settlement offers. "Rather, the rule simply imposes on insurers (and, thus, the insurance pool) the risk of being wrong in making that determination in individual cases."

Finally, Comment m. observed that the issue of whether an insurer has failed to make a reasonable settlement decision is not the same as whether an insurer has acted in bad faith or breached the implied duty of good faith and fair dealing as liability for failing to make a reasonable settlement decision does not require proof of bad intent. The Reporters observed, therefore, that the issue is one of "reasonableness" and not a question of "good faith."

2. The Restatement Phase (2014-2017)

Section 27 was among the provisions of the *Principles* that the membership of the American Law Institute approved at their Annual Meeting in May 2014. A few months later, however, the ALI leadership elected to change the status of this project to a *Restatement* of the law, which obliged the Reporters to go back to the drawing board on the numerous topics that had already been debated and accepted as *Principles* provisions.

A revised Section 27 was released by the Reporters in Preliminary Draft No. 1 of the new Restatement that was issued on March 2, 2015. In contrast to many other sections, the earlier *Principles* language was relatively unaffected by this transition to *Restatement* status. Other than the elimination of the "commercial policyholder" concept that had pervaded the *Principles* drafts but was eliminated in the *Restatement*, the text and Comments for Section 27 were unchanged.

This language was submitted to the 2015 ALI Annual Meeting on April 30, 2015 as a new Discussion Draft with this text:

§ 24. The Liability Insurer's Duty to Make Reasonable Settlement Decisions

> (1)When a liability insurer has the authority to settle a claim against the insured, or when the authority to settle a claim rests with the insured but the insurer's prior consent is required for any settlement to be payable by the insurer, the insurer has a duty to the insured to make reasonable settlement decisions. The duty to make reasonable settlement decisions is owed only with respect to liability in excess of the policy limits.
>
> (2) A reasonable settlement decision is one that would be made by a reasonable person that bears the sole financial responsibility for the full amount of the potential judgment.

> (3) An insurer's duty to make reasonable settlement decisions includes a duty to accept reasonable settlement demands by claimants, subject to the following limitation: the amount, if any, that an insurer must contribute to a settlement is never greater than the policy limits.
>
> (4) An insurer's duty to make reasonable settlement decisions includes the duty to contribute its policy limits to a reasonable settlement of a covered claim if that settlement exceeds those policy limits.

Earlier drafts had also imposed an affirmative obligation on the part of insurers to make reasonable settlement offers even if the underlying plaintiff had had, for some reason, failed to assert a demand within policy limits. Comment e. in earlier drafts stated:

> If the claimant does not make a demand that is within the range of reasonableness, the insurer can satisfy its duty by making an offer at the low end of the reasonableness range, even if that offer is rejected.

Comment f observed that a different causation standard applied with respect to this affirmative duty in light of the fact that an insurer's rejection of a reasonable settlement demand automatically subjected it to liability for any excess judgment whereas an insurer's failure to make an affirmative offer was merely evidence of unreasonableness on the part of the insurer from which a trier of fact might or might not conclude that the insurer is subject to liability for an excess judgment. As originally drafted, a comment to this section stated that defense costs should be included within the calculus of assessing when the insurer has a duty to settle as "the duty to settle should include the obligation to accept a settlement offer that is equal to or less than the expected value of the claim plus the costs of taking the claim to trial." The reporters ultimately concluded, that introducing such a requirement would be a "substantial departure from current practice" and would add a due complexity to the analysis.

3. 2016 ALI Debate on Section 24

This revised text of Section 24 was debated and approved at the May 2016 ALI Annual Meeting.

Prior to the meeting, Bob Cusamano of Crowell & Moring (former general counsel to ACE) submitted a lengthy letter to the Reporters urging them to delete language holding insurers liable for excess judgments in any case where they fail to accept a reasonable offer of settlement. As Cusamano observed, Comment d. did not reflect the reality of how cases settle and would impose unrealistic and costly obligations on insurers:

> In tort actions, one can say that ranges of reasonable are often several hundred percent of each other or more. Indeed, in many cases where liability itself is questionable, or where the law is disputed, that ratio may rise to infinity as a perfectly reasonable defendant concludes

> that a given action has no merit at all. Once again, to force an outcome at the highest point in such a wide range is incompatible with the mandate to negotiate as if one "bears sole financial responsibility" for a potential judgment. And, once again, "reasonableness" is very much in the eye of the beholder and there are beholders (plaintiff, defendant, mediator, judge, jury and the main tort case, appellate bench, jury in the second case against the insurer for failure to settle) and they all have different cognitive apparatus, wants, needs and exigencies.

Cusamano criticized the treatment of this issue in Comment d. as representing "an existential change in the nature of settlement talks, and entail a dramatic, perhaps virtually total, shift in bargaining power among litigants" and as supplanting the existing framework of settlement negotiations "with a system that requires payment of any reasonable amount requested."

As Cusamano observed, "the current approach, while reflected in the black letter text of Section 24, certainly encourages a dialogue structure around policy limits and the duties of good faith, as it centers on the insurer's duty to act carefully and reasonably." By contrast, the new regime set forth in Comment d. "will center not on good faith, and will not even center on the insurer's course of conduct. Rather, it will center on predictions about how a later adjudicator will assess the reasonableness of a plaintiff's unilaterally selected settlement demand" based on valuation factors that are "hardly knowable and probably not even roughly predictable."

Comment d. was also attacked by William Barker of Dentons. Barker suggested striking the final sentence of Comment d., which states that an insurer is liable "even if the rejected settlement was at the high end of the reasonable range" and substituting in its place the following text:

> While reasonableness may be seen as a range, a reasonable person evaluating a demand will look towards the center of that range to evaluate the probable verdict value of the case, which would reflect the average result if the case were tried many times. Hypothetical verdicts at the high and low end of the range of reasonableness would average out.

While neither proposal was adopted at the meeting, they had an effect on the Reporters. In particular, in advance of the meeting, the Reporters had softened earlier language in Comment d. suggesting that insurers were liable if they rejected "any" reasonable settlement demand. As revised, Comment d. now stated that liability only arises if the insurer rejected "a settlement offer that a reasonable insurer would accept …"

Furthermore, Council Draft No. 3 that the Reporters issued on December 13, 2016 stated that the Reporters were amending the Comments to Section 24 to adopt the standard of a "reasonable insurer" that Cusamano had argued for in his remarks to the Annual Meeting the prior May.

IV. The Insurance Industry's Critique of Section 24

For the most part, insurers responded have wary caution to the revised text of Section 24 that the American Law Institute has adopted for this *Restatement.* While the amelioration of the standards of liability have been welcome by insurer advocates, concerns remain that insurers will face increased liability for failing to accept a "reasonable" settlement offer even where their efforts to settle have otherwise been reasonable. Additionally, although the Reporters are at pains to distinguish such claims from bad faith litigation, the inclusion of "procedural factors" as a basis for imposing liability muddies the waters and certainly introduces bad faith evidentiary elements into failure to settle litigation. Finally, while the revised text of Section 24 omits prior language imposing an affirmative duty to make settlement offers, echoes of this earlier language continue to resonate in the Comments to this Section.

When May Insurers Be Held Liable For Failing to Settle?

As set forth in Section 24, the insurer's duty is to make reasonable settlement decisions without regards to the policy limits. As defined in Comment b., a "reasonable settlement offer is one that would be accepted or made by a reasonable insurer that bears the sole financial responsibility for the full amount of the potential judgment."

This is not a duty that exists in every case, nor does liability result in every case where a verdict in excess of the available limits is handed down. The Reporters state somewhat grudgingly that insurer's do not face strict liability in such cases "despite the good arguments in favor of a strict liability rule for the duty to settle, this Section does not endorse such a rule, because such a rule has not been adopted in the courts. Instead, this Section follows and clarifies the prevailing reasonableness rule."

From an insurer's perspective, Section 24 is significantly less onerous than originally envisioned. Gone is the language in Subsection (1) requiring insurers to include the costs of defense along with the risk of a jury verdict in assessing the settlement value of a case. Gone too is more recent language that would have impose liability on insurers that refused to accept "any" offer of settlement within the "range of reasonableness."

Subsection (1) of Section 24 originally imposed liability so long as there was a "potential for a judgment in excess of the applicable policy limit." This language has been moved to the end of Subsection (1) and is now phrased in the sense of the duty of the insurer "to make reasonable settlement decisions to protect the insured from a judgment in excess of the applicable policy limit." Arguably, the change is simply stylistic and no greater liability was intended to be created by it since the definition of a "reasonable settlement" necessarily reflects a reasoned analysis of the likelihood of an excess verdict. At the same time, it is curious that that the black letter rule now states an affirmative duty to protect insureds from excess judgments without expressly limiting that duty to cases that are likely to yield such judgments.

The key provision in this Section is Comment d. There, the Reporters observe that

> The duty to make reasonable settlement decisions includes the duty to accept a settlement offer that a reasonable insurer would accept to make an offer to settle when a reasonable insurer would do so, if that reasonable insurer had sold an insurance policy with limits that were sufficient to cover any likely outcome of the legal action.

…

> A reasonable insurer reasonable insurer is expected, at the time of the settlement negotiations, to take into account the realistically possible outcomes of a trial and, to the extent possible, to weigh those outcomes according to their likelihood….The insurer will be liable for any excess judgment against the insured in the underlying litigation if the trier of fact finds that the insurer rejected a settlement offer that a reasonable insurer would have accepted (or failed to consent to a settlement to which a reasonable insurer would have consented).

There are several important observations to be made concerning Section 24. First and foremost, its focus is on the actions of "reasonable insurers." This is stated to be an objective standard, having its roots in the redoubtable "reasonable man" of tort law, and reflects the general approach that most insurers would have taken under the circumstances.

Second, the "reasonable insurer" standard replaces earlier language that would have imposed liability for situations in which insurers make reasonable efforts to settle and, in fact, make settlement offers within the lower end of the so-called "range of reasonableness" but decline to accept a demand that was in the upper end of this range. As the Reporters accurately observe in Section 24, few claims have a specific "point" of reasonable value and "reasonable" generally reflects a range of values. The problem with the Reporters' prior approach was that it automatically imposed liability so long as a demand was presented anywhere within the range of reasonableness without regard to the reasonableness of the insurer's own settlement efforts. As Bob Cusamano observed during the May 2016 debate, this approach precludes the ability of insurers to make reasonable offers at the low end of the range in the hope of negotiating some compromise in the middle.

As revised, Comment d. correctly places the *Restatement*'s focus on the overall conduct of the insurer and rejects a mechanistic approach that looked solely to the amount of the plaintiff's demand.

A. Is This A Bad Faith Claim By Another Name?

The Reporters are at pains to state that liability of an insurer for failing to make reasonable settlement decisions is not bad faith and is not subject to the criteria for bad faith claims set forth in Section 51 of this *Restatement*. Thus, they assert in Comment a. that these claims are subject to an objective test of "commercial reasonableness as distinct from a standard that requires proof of bad intent."

Even so, the suggestion in Comment e. that courts should also look to "procedural factors…that might have affected the "quality of the insurer's decision making," including whether the insurer failed to conduct a reasonable investigation or to conduct negotiations in a reasonable manner and whether the insurer failed to follow the recommendations of its adjusters or defense counsel, threatens to blur any doctrinal distinction between Section 24 claims and other bad faith actions under Section 51 and, at a minimum, creates a factual overlap in which "bad faith" evidence will be used in Section 24 litigation.

The Reporters concede that such factors cannot transform a "plainly unreasonable settlement offer into a reasonable offer" but state that they can make the difference in a "close case by allowing the jury to draw a negative inference from the lack of information that reasonably should have been available or from the low quality of the insurer's decision making and fact-gathering processes." In short, such external factors may prove to be a "tie breaker" in favor of the insured in cases where the court or jury is otherwise unable to determine whether the insurer acted unreasonably.

The other problem with introducing such evidence in a Section 24 claim is that these kind of subjective considerations are entirely at odds with standard of objective liability that is stated to apply in these cases.

B. Do Insurers Have a Duty to Make Settlement Offers?

The final text of Section 24 eliminates the earlier affirmative statement that insurers are obligated to make offers even in the absence of a settlement demand. However, the Comments have not entirely eliminated this requirement but rather have made it more of an implicit obligation. Thus, Comment d. now states that:

> The duty to make reasonable settlement decisions includes the duty to accept a settlement offer that a reasonable insurer would accept *and to make an offer to settle when a reasonable insurer would do so.* (Emphasis supplied)

Comment f. expands on this reasoning:

> There is no hard and fast rule regarding the insurer's obligation to make offers. It is a question of what a reasonable insurer would do in the circumstances. In the absence of a reasonable offer by the plaintiff, there can be circumstances in which an insurer has a duty to make a settlement offer, such as, for example, a suit in which the policy limits are significantly less than the reasonable settlement value of the case. In such circumstances, the insurer is obligated to attempt to protect its insured from an excess judgment. By making a reasonable settlement offer, the insurer can avoid potential liability for an excess judgment, even if that offer is rejected. *It is important to emphasize, however, that the insurer has no obligation to make an offer unless a reasonable insurer that bore the sole financial responsibility for the full amount of the judgment would do so, and there may be good reasons not to.* (Emphasis supplied.)

As a result, even though this language has been considerably softened from earlier drafts, considerable wiggle-room has been left for policyholders to argue that, in particular circumstances, insurers may face liability for failing to make offers.

This lack of clarity and vague phrasing may prove problematic over time. In many cases, insurers may well want to make settlement offers even if no demand has been received, if only to

get the ball rolling towards a final settlement. In those circumstances, however, no prudent insurer would lead with their best offer. The reality is that settlements result from a process of negotiation. As the Supreme Judicial Court observed in Bobick v. USF&G, 439 Mass. 652, 662 (2003):

> Negotiating a settlement, particularly when the damages are unliquidated is, to an extent, a legitimate bargaining process. The statute [G. L. c. 176D, § 3 (9)] does not call for [a] defendant's final offer, but only one within the scope of reasonableness. Experienced negotiators do not make their final offer first off, and experienced negotiators do not expect it, or take seriously a representation that it is.

While the Reporters posit a lesser standard of liability and greater proof of causation in cases involving the failure of an insurer's settlement offer, the fact remains that such offers will almost always be at the lower end of the so-called "range of reasonableness" because they are generally intended to be the starting point of a negotiation that will end somewhere closer to the middle of the range. Focusing solely on the starting point of the negotiation ignores the broader context of the negotiation process.

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Reflections on a Paradigm Shift for Extra-Contractual Liability
In the Restatement of the Law, Liability Insurance

American College of Coverage and Extracontractual Counsel
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Introduction

In 2010, the American Law Institute ("ALI") initiated a project on Liability Insurance Law. Initially, it was a "Principles" project to identify Principles of the Law of Liability Insurance. Professor Tom Baker of the University of Pennsylvania was recruited to be the Reporter for the project, and Kyle Logue of the University of Michigan agreed to be the Associate Reporter. After several years of work on the project, in 2015 it was changed from a "principles" project to the Restatement of the Law, Liability Insurance. This moved from a more aspirational statement of principles to a restatement of current common law concerning liability insurance. The final draft of the Restatement is schedule for final vote at the ALI's Annual Meeting in May 2017.

The restatements produced by the ALI often are significantly persuasive authority for the courts. The ALI process tends to produce restatements that are thoughtful and well-researched, and the ALI membership and processes add legitimacy. The ALI is an independent organization of prominent judges, lawyers and professors. The organization is governed by a Council of its members. The initiation of the Liability Insurance project and the appointment of the Reporter and Associate Reporter was approved by the Council. The Reporter and Associate Reporter are responsible for the drafting of the Restatement. They present drafts to a group of Advisers and to a Members Consultative Committee. Advisers are experts in the field invited by the Council to participate. Members of the Members Consultative Committee are members of the ALI who volunteer to participate in the project.

Drafts are revised by the reporters based on feedback from those presentations. In addition, drafts are presented to the Council for approval before being placed on the agenda for review by the general membership. Approval by the general membership includes procedures for discussion and amendment by motion.

With the considerable work that has gone into the production of the Restatement of the Law, Liability Insurance, and with the leadership of Tom Baker and Kyle Logue, it is likely that the Restatement will have considerable influence on the understanding and development of the law of liability insurance. This paper focuses on the Restatement's treatment of an insurer's duty to settle and of insurance bad faith. With the permission of the ALI, the current drafts of sections 24, 51 and 52 of the Restatement have been reprinted as part of the materials for our presentation, along with this written commentary.

The Reporters, after discussion with the Advisers and the Members Consultative Committee, and with approval of the Council and the general membership, have framed the duty to settle as an objective "duty to the insured to make reasonable settlement decisions."[1] At the same time, however, the Reporters have retained a separate claim for an insurer's "bad faith" breach of its duties (including the duty to settle). The Reporters adopted a subjective element for the bad faith standard. To be liable for "bad faith," an insurer must act "without a reasonable basis for its conduct" and must also act with "knowledge of its obligation to perform or in reckless disregard of whether it had an obligation to perform."[2] I suggest that this use of the objective and subjective standards creates a new paradigm, one that distinguishes between the duty to settle and other "bad faith" conduct and applies different standards for liability. These reflections on that paradigm begin with a general description of the

[1] RESTATEMENT OF THE LAW, LIABILITY INSURANCE § 24(1) (Council Draft No. 3, December 12, 2016) [hereinafter RESTATEMENT LIABILITY INSURANCE]. All citations to the Restatement will be to the Council Draft No. 3 dated December 12, 2016, unless otherwise indicated.
[2] RESTATEMENT LIABILITY INSURANCE § 51.

standards and the case law in support of them. The paper then turns to the implications of the new paradigm, both in terms of the damages available to insureds and the application of that standard to insurer conduct at the margins of reasonableness.

The Restatement Adopts an Objective Standard for the Duty to Settle

The Restatement's adoption of an objective standard for the duty to settle endorses the current trend in the law and helps to clarify the standard that should be applied. The comments explain that the duty to accept reasonable settlements arises out of "a special application of the general contract-law duty of good faith and fair dealing."[3] The courts recognize that a liability insurer "may have an incentive to undervalue the possibility of a loss at trial" because of its policy limits, and therefore it may not accept an otherwise reasonable settlement offer.[4] The objective duty to accept reasonable settlement offers addresses this problem by creating "an incentive for insurers to take into account" the insured's interest in avoiding a judgment in excess of the policy limits.[5]

The comments recognize, however, that "courts in some jurisdictions refer to the standard for breach of the duty in the settlement context as one of 'bad faith,'" which "suggests the need to prove some bad intent on the part of the insurer that goes beyond the reasonableness standard stated in this Section."[6] The Restatement rejects approach. It intentionally chooses not to use the term "bad faith" because "an insurer's duty is grounded in commercial reasonableness."[7] It suggests that in most breach-of-the-duty-to-settle cases, "even those that invoke the language of bad faith, the ultimate test of

[3] RESTATEMENT LIABILITY INSURANCE § 24, comment a.
[4] *Id.*
[5] *Id*.
[6] *Id*., comment c. A classic example of this is found in the Missouri Supreme Court case of Zumwalt v. Utilities Ins. Co., 228 S.W.2d 750 (Mo. 1950), where the court quoted with approval the statement that "bad faith, of course, is a state of mind indicated by acts and circumstances." 228 S.W2d at 753 (quoting Johnson v. Hardware Mut. Casualty Co. 1 A.3d 817, 822 (Vt. 1938). For a detailed doctrinal and normative analysis of this bad faith standard, see Jeffrey E. Thomas, *A Case Study of Bad Faith Refusal to Settle: A Doctrinal, Normative and Practical Analysis of Missouri Law*, 64 UMKC L. REV. 695 (1996)
[7] RESTATEMENT LIABILITY INSURANCE § 24, comment c.

liability is whether the insurer's conduct was reasonable under the circumstances."[8] It submits that the objective reasonableness standard "is more closely tailored to the conflict of interest that underlies the legal duty."[9] The restatement's approach is consistent with the general trend in the case law. As William Barker and Ronald Kent note, "[s]tates requiring subjective culpability are now a small and dwindling minority."[10]

An example of this evolution can be seen in the way the way the standard has developed in California. The early (1957) articulation of the standard in *Brown v. Guarantee Ins. Co.*[11] provided that liability was based on "bad faith" that was a "substantial culpability" beyond "mere negligence."[12] The California Supreme Court moved away from this notion of subjective bad faith in *Crisci v. Security Ins. Co.*[13] in 1967. Although the court noted that "[s]everal cases, in considering the liability of the insurer, contain language to the effect that bad faith is the equivalent of dishonesty, fraud, and concealment,"[14] such language was not to be understood "as meaning that in the absence of [such] evidence . . . no recovery may be had for a judgment in excess of the policy limits."[15] The court held that prior case law made it "clear . . . that liability may exist when the insurer unwarrantedly refuses an offered settlement where the most reasonable manner of disposing of the claim is by accepting the settlement."[16]

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[8] *Id*.

[9] RESTATEMENT LIABILITY INSURANCE § 24, comment a. For a criticism of the subjective state-of-mind standard, see Thomas, *supra* note 6, at 711-717.

[10] WILLIAM T. BARKER & RONALD D. KENT, NEW APPLEMAN INSURANCE BAD FAITH LITIGATION § 2.03[2][a][iii] (2nd ed. 2017). The two most notable exceptions explored by Barker and Kent are Missouri and New York. *See id.* § 2.03[2][a][i]-[ii]. Others also conclude that the objective test is the predominant test. *See*, *e.g.*, Ellen S. Pryor & Charles Silver, *Defense Lawyers' Professional Responsibilities: Part I – Excess Exposure Cases*, 78 TEX. L. REV. 599, 656-657 (2000) (finding that "all jurisdictions require carriers to make reasonable settlement decisions").

[11] 319 P.2d 69 (Cal. 1957).

[12] 319 P.2d at 74. The California Supreme Court recognized that some cases had "indicated a coalescence of the bad faith and negligence tests," yet while recognizing some overlap between the two, the court concluded that "bad faith should be the basis of the insured's cause of action." *Id*. at 75.

[13] 426 P.2d 173 (Cal. 1967).

[14] 426 P.2d at 176.

[15] *Id*.

[16] *Id*. at 176-177. A Federal District Court opinion makes this point even more bluntly: "When there is a great risk of recovery beyond the policy limits so that the most reasonable manner of disposing of the claim is a settlement, a

The California Supreme Court's most recent articulation of the test, while still giving some lip service to "bad faith," uses language of the objective test similar to that in the Restatement. In 2000, the California Supreme Court articulated the standard this way in the case of *Kransco v. American Empire Surplus Lines Ins. Co.*:[17]

> [T]he insurer must settle within policy limits when there is substantial likelihood of recovery in excess of those limits. The duty to settle is implied in law to protect the insured form exposure to liability in excess of coverage . . . . An insurer breaches its implied duty . . . by unreasonably refusing to accept a settlement offer within policy limits.[18]

The Restatement Adopts a Subjective Test for Other Bad Faith

Notwithstanding the clear movement away from a subjective standard for the duty to settle, which is consistent with the general trend in the case law, the Restatement adopts a ***subjective*** test for other acts of bad faith outside of the duty to settle. This distinction is noted in the comments to section 24: "an insurer is subject to liability for insurance ***bad faith*** only when it fails to perform its duties under a liability insurance policy without a reasonable basis for its conduct ***and*** with knowledge or in reckless disregard of its obligation to perform."[19] Thus, a liability insurer can be liable for an excess of limits judgment by failing to make reasonable settlement decisions, "but is not thereby subject to liability for insurance bad faith" unless the insured can prove subjective intent (knowledge or reckless disregard).[20]

The standard identified in the comments of section 24 is the black-letter for section 51:

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consideration of the insured's interest requires the insurer to settle the claim. Crisci v. Security Ins. Co. 426 P.2d 173 (1967). . . . 'Liability is imposed not for a bad faith breach of the contract but for failure to meet the duty to accept reasonable settlement decisions.' Johansen, 15 Cal.3d at 16 n.7 [additional citations omitted]." McDaniel v. GEICO Gen. Ins. Co., 55 F. Supp. 3d 1244, 1262 (E.D. Cal. 2014).

[17] 2 P.3d 1 (Cal. 2000).

[18] 2 P.3d at 9 (citations omitted).

[19] RESTATEMENT LIABILITY INSURANCE § 24, comment c (emphasis supplied).

[20] *Id*. The comments include a cross-reference to § 51, discussed *infra*.

§ 51. Liability for Insurance Bad Faith

An insurer is subject to the insured for insurance bad faith when it fails to perform its duties under a liability insurance policy:

(a) Without a reasonable basis for its conduct; and

(b) With knowledge of its obligation to perform or in reckless disregard of whether it had an obligation to perform.

This is a novel approach; reasonableness for the breach of the duty to settle, but subjective knowledge or reckless disregard for "other" bad faith conduct. While the reporters' notes suggest that this distinction is drawn by the case law, I am not convinced. In the course of my review of a large body of bad faith cases to study the use and application of the equal consideration test and the disregard the limits test for breach of the duty to settle,[21] I found that in the context of liability insurance bad faith conduct such as the failure to investigate or the failure to communicate is often considered along with the failure to accept a reasonable settlement offer. These cases generally do not impose different requirements for the duty to settle from the duty to otherwise act in good faith in connection with liability insurance. Let us consider the authority relied upon in support of the Restatement's adoption of the subjective standard for bad faith.

Judicial Authority Does not Support the Subjective Requirement

The Reporters notes assert that "The majority approach to determine whether an insurer acted in bad faith requires courts to evaluate the insurer's conduct with both an objective and subjective test."[22] Three cases are cited in support of this proposition, *Nardelli v. Metro. Group Property & Casualty*

[21] This work was done in connection with a Symposium sponsored by Rutgers and resulted in the publication of an article about the standard to be applied for the duty to settle. *See* Jeffrey E. Thomas, *The Standard for Breach of a Liability Insurer's Duty to Make Reasonable Settlement Decisions: Exploring the Alternatives*, 68 RUTGERS U. L. REV. 229 (2015).

[22] RESTATEMENT LIABILITY INSURANCE § 51, Reporters Note b.

Ins. Co.,[23] decided by the Arizona Court of Appeals; *Adamski v. Allstate Ins. Co.*,[24] decided by a Pennsylvania Superior Court; and *Republic Ins. Co. v. Stoker*,[25] decided by the Texas Supreme Court. The notes also indicate that other courts have adopted "a purely objective standard," citing to the Supreme Courts of California, Ohio and Washington. We now turn to consideration of the cases purportedly supporting the majority rule.

Nardelli v. Metro. Group Property & Casualty Ins. Co.,[26] applied both the objective reasonableness test and the subjective knowledge or reckless disregard test, but it was in the context of a first-party insurance claim, not a third-party liability claim. The case involved a dispute over whether a car damaged by thieves was a total loss or could be repaired.[27] Under Arizona law, the subjective knowledge or reckless disregard requirement does not apply to third-party bad faith claims. In *Clearwater v. State Farm Mutual Automobile Ins. Co.*[28] the Arizona Supreme Court rejected the use of a first-party bad faith standard in third party cases. After stating the same test as in *Nardelli* for first-party bad faith claims,[29] the court held that "because the risk to the insured and the responsibilities of the insurer are distinguishable in first- and third-party claims, the applicable standard of conduct is necessarily different."[30] For third-party bad faith claims, the court held that the standard was "equal consideration of the comparative hazards,"[31] a "standard of reasonableness [that] requires that the insurer consider various factors."[32]

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[23] 277 P.3d 789 (Ariz. Ct. App. 2012).
[24] 738 A.2d 1033 (Pa. Super. Ct. 1999).
[25] 903 S.W.2d 338 (Tex. 1995).
[26] 277 P.3d 789 (Ariz. Ct. App. 2012).
[27] 277 P.3d at 793-794.
[28] 792 P.2d 719 (Ariz. 1990).
[29] "In a first-party situation the insurer breaches the implied duty of good faith and fair dealing if it (1) acts unreasonably towards its insured, and (2) acts knowingly or with reckless disregard as to the reasonableness of its actions." 792 P.2d at 723.
[30] 792 P.2d at 723
[31] *Id*. (quoting General Acc. Fire & Life Assur. Corp. v. Little, 443 P.2d 690, 698 (Ariz. 1968)).
[32] 792 P.2d at 723. The factors to be considered are: "(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 induce the insured to contribute to a settlement; (4) the insurer's rejection of advice of its own

Adamski v. Allstate Ins. Co.,[33] concerned a third-party claim against a driver of a motor vehicle, but the standard applied was a ***statutory*** standard, not the common law standard for breach of the duty to make reasonable settlement decisions. The statute, section 8371 of the Pennsylvania Code, "was passed by the legislature in 1990 to rectify the lack of a common law remedy for bad faith conduct in denying an insured's claim."[34] The statute provides that "if the court finds that the insurer acted in bad faith toward the insured," the court may award interest, award punitive damages and assess court costs and attorney fees.[35] While the statute does not define "bad faith," the court cited to Black's Law Dictionary[36] and to *Terletsky v. Prudential Property & Casualty Ins. Co.*,[37] which used a two-part test very similar to the black-letter of § 51 with the subjective requirement that "the insurer knew or recklessly disregarded its lack of a reasonable basis."[38] The two-part test from the *Terletsky* case, which involved a statutory claim alleging first-party bad faith for uninsured motorist benefits,[39] originated in *Anderson v.*

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." 792 P.2d at 722 (citing General Acc. Fire & Life Assur. Corp. v. Little, 443 P.2d 690, 698 (Ariz. 1968) (quoting Brown v. Guarantee Ins. Co., 319 P.2d 69, 75 (Cal. 1957)). An insurer's knowledge of its misconduct or reckless disregard is not a required element, though it could have bearing on a determination of bad faith through factors 4 (rejecting advice of its own counsel) or 8 (other evidence of bad faith). The insurer in *Clearwater* had proposed a jury instruction that it was not acting in bad faith if the position it took was fairly debatable. 792 P.2d at 722. The fairly debatable instruction is tied to the subjective element of the bad faith standard: "Discussing the standard of care in first-party cases, we stated that 'an insurance company may still challenge [first party] claims which are fairly debatable. The tort of bad faith arises when the insurance company intentionally denies, fails to process or pay a claim without a reasonable basis for such action." *Id.* (quoting Noble v. National Am. Life Ins. Co., 624 P.2d 866, 868 (Ariz. 1981)).

[33] 738 A.2d 1033 (Pa. Super. Ct. 1999).

[34] 739 A.2d at 1036 (citing Romano v. Nationwide, 646 A.2d 1228 (Pa. Super. 1994)).

[35] 42 Pa. C.S.A. § 8371. *See* 739 A.2d at 1035 n.2.

[36] 739 A.2d at 1036. The definition from Black's was: "'Bad faith' on the part of insurer is any frivolous or unfounded refusal to pay proceeds of policy; it is not necessary that such refusal be fraudulent. For purposes of an action against an insurer for failure to pay a claim, such conduct imports a dishonest purpose and means a breach of a known duty (i.e., good faith and fair dealing), though some motive of self-interest or ill will; mere negligence or bad judgment is not bad faith." *Id.*

[37] 649 A.2d 680 (Pa. Super. 1994).

[38] 739 A.2d at 1036. The first element of the test is that "the insurer lacked a reasonable basis for denying coverage." *Id*. The test from *Terletsky* also required that bad faith be established by "clear and convincing evidence." *Id.*

[39] 649 A.2d at 681-684.

Continental Ins. Co.,[40] a Wisconsin Supreme Court case addressing a first-party bad faith claim arising out of a coverage dispute for a furnace fire or explosion under a homeowners policy.[41] Thus, the requirement for subjective knowledge or reckless disregard in Pennsylvania originally came from a Wisconsin first-party bad faith, and was applied to a third-party claim through a Pennsylvania statute.

Pennsylvania common law recognizes a claim for an insurer's breach of the duty to settle, and that claim does not require knowledge or reckless disregard. The Pennsylvania Supreme Court recognized the bad faith claim for breach of the duty to settle in *Cowden v. Aetna Casualty & Surety Co.*[42] That case concerned a third-party claim under an automobile liability policy.[43] The court recognized the right of the insured to recover for the excess verdict beyond a limits of a liability policy "if the insurer's handling of the claim, including a failure to accept a proffered settlement, was done in such a manner as to evidence bad faith on the part of the insurer."[44] The court then adopted a standard very close to the Restatement's objective test. The insurer, consistent with the "predominant majority rule," must "accord the interest of its insured the same faithful consideration it gives its own interest, [and] the fairest method of balancing the interests is for the insurer to treat the claim as if it were alone liable for the entire amount."[45]

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[40] 271 N.W.2d 368 (Wis. 1978). The court stated that "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 a claim." *Id*. at 376. The only authority for this statement was a citation to American Heritage Dictionary of the English Language defining "bad faith," and an interpretation of Hilker v. Western Auto. Ins. Co., 231 N.W.257 (Wis. 1931). This two-part test from *Anderson* was cited by the Pennsylvania Supreme Court as dicta in D'Ambrosio v. Pennsylvania Nat'l Mut. Cas. Ins. Co., 431 A.2d 966, 971 (Penn. 1981). *Terletsky*, the authority relied upon by *Adamski*, cited to American Franklin Life Ins. Co. v. Galati, 776 F. Supp. 1054 (E.D. Pa. 1991) and *D'Ambrosio.* 649 A.2d at 688. *Galati* cited to *D'Ambrosio* quoting *Anderson*. 776 F. Supp. at 1064.

[41] 271 N.W.2d at 371-372.

[42] 134 A.2d 223 (Penn. 1955).

[43] The claimant was injured when the automobile in which he was a passenger was driven into a truck stopped on the highway because of an apparent fire. The truck driver, who was the insured involved in the bad faith claim, was under the truck with a fire extinguisher trying to put out the fire at the time of the accident. *Id.* at 225. The insurer did not settle the claim because it believed the truck driver was not liable. *Id*. at 231.

[44] *Id.* at 227.

[45] *Id.* at 228 (citations omitted).

While this articulation of the standard does not include the subjective element of knowledge or reckless disregard, the court's analysis and application of the rule may support a subjective consideration of the insurer's state of mind, though more in the form of an affirmative defense than a prima facie requirement. The court held that the insured's refusal to accept the settlement within policy limits was not bad faith because it "was the result of the honest, considered judgment its trial lawyer, claims manager and associate counsel."[46] On one hand, this is evidence that the insurer acted reasonably, especially because "[t]heir judgment coincided with the opinion of the trial court written after the second trial."[47] On the other hand, this could suggest that even if another reasonable insurer would have settled, an insurer that makes an "honest mistake," that is, has an honest state of mind, should not be liable. This same evidence, of course, would show that the insurer did not have knowledge that it was acting unreasonably in refusing the settlement and that it did not act with reckless disregard for its duty to settle. Nevertheless, the court did not require a showing the knowledge or reckless disregard as part of the test for bad faith, though perhaps one could imply such a requirement from the court's holding.

The Texas case relied upon for the subjective standard in the Notes, *Republic Ins. Co. v. Stoker*,[48] is another case involving first-party bad faith. In addition, the standard cited in that case does not require the subjective element of knowledge or recklessness. *Stoker* concerned uninsured motorist benefits sought by the insured after a collision caused by furniture that fell off an unidentified pickup truck. The insurer originally denied the claim on the ground that the accident was the insured's fault, but

[46] *Id.* 231.
[47] *Id.* The case was tried three times. The first trial resulted in a mistrial. The second trial resulted in a verdict for the plaintiff for $100,000, but the trial court granted a motion for a new trial because it found the judgment against the weight of the evidence showing that the insured truck driver was not negligent. The new trial order was affirmed on appeal. *Id.* at 225-226. The third trial resulted in a verdict of $90,000. *Id.* at 227. The liability policy had limits of $25,000. *Id.* at 225.
[48] 903 S.W.2d 338 (Tex. 1995).

later denied because the hit-and-run vehicle (the pickup) did not come into physical contact with the insured's vehicle.[49] In the course of deciding the issue of first impression whether a bad faith claim could be based on the insurer's denial of coverage for an incorrect reason, the court cited the standard for bad faith. "A breach of the duty of good faith and fair dealing is established when: (1) there is an absence of a reasonable basis for denying or delaying payment of benefits under the policy and (2) the carrier knew or should have known that there was not a reasonable basis for denying the claim or delaying payment of the claim."[50] As with *Adamski*, this statement of the standard can be traced back to the Wisconsin first-party bad faith case of *Anderson v. Continental Ins. Co.*[51] However, unlike *Anderson* and *Adamski*, the second element of the standard under Texas law is that the insurer "knew or ***should have known*** that there was not a reasonable basis for the denial."[52] The requirement that an insurer "should have known" that its conduct was unreasonable is an objective standard that can satisfy the second element. Therefore, if the insurer did not know the conduct was unreasonable, but a reasonable insurer would have known, the insurer is liable.

The Majority of States do not Require Subjective Intent

Although I believe there is some room for debate whether the majority of states follow the standard that requires insurers to give equal consideration to the interests of the insured,[53] the standard

[49] 903 S.W.2d at 339-340.
[50] *Id.* at 340 (citing Aranda v. Insurance Co. of N. Am., 748 S.W.2fd 210, 213 (Tex. 1988)).
[51] 271 N.W.2d 368 (Wis. 1978). The *Stoker* case relied upon Aranda v. Insurance Co. of N. Am., 748 S.W.2d 210, 213 (Tex. 1988). 903 S.W.2d at 340. The *Aranda* case cited to *Anderson* and a Colorado case, Travelers Ins. Co. v. Savio, 706 P.2d 1258, 1272 (Colo. 1985). It should be noted, however, that the second element in *Anderson* was "knowledge or reckless disregard of a reasonable basis for the denial," 271 N.W.2d at 693, while the standard here is the more objective standard that the insurer "knew or ***should have known*** that there was not a reasonable basis," 903 S.W.2d at 340 (emphasis supplied). For additional analysis of *Anderson*, see *supra* n. 40.
[52] 903 S.W.2d at 340 (emphasis supplied).
[53] *See*, *e.g.*, STEPHEN S. ASHLEY, BAD FAITH ACTIONS: LIABILITY AND DAMAGES § 3:18 (2d ed. 1997) (noting that the equal consideration standard "has garnered by far the largest share of support among the states); Barker & Kent, *supra* n. 10, § 2.03[2][b] ("one of the most common formulation of the duty is as one to give equal consideration to the insured's interest with the insurer's own interests"); Kent D. Syverud, *The Duty to Settle*, 76 VA. L. REV. 1113, 1122 (The majority of states today require the insurance company to give 'equal consideration' to the interest of the insured").

that requires insurers to act as a reasonable insurer that disregards the policy limits,[54] or some combination of the two, there should be no dispute that the majority of states follow one or both of these standards.[55] Neither the equal consideration standard nor the disregard the limits standard require knowledge of the unreasonableness or reckless disregard.[56] This is consistent with section 24 of the Restatement, which adopts the disregard the policy limits standard[57] as "implementation" of the equal consideration standard.[58] There is no dispute that this standard is an objective one.[59]

So why does the Restatement adopt the subjective requirement? For two related reasons. First, the Restatement needed a different standard than the one adopted for the duty to settle. The Restatement's standard for the duty to settle requires insurers to act as a reasonable insurer without policy limits. While this standard is elegant,[60] it cannot be applied to non-settlement bad faith actions. For example, a third-part bad faith claim may allege that the insurer failed to adequately investigate the claim,[61] or that the insurer failed to properly communicate the settlement offer to the insurer.[62] These behaviors are not "settlement decision" and cannot be evaluated in a meaningful way by a standard that asks whether a reasonable insurer without limits would have accepted the settlement offer; the

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[54] *See*, *e.g.*, KENNETH S. ABRAHAM, INSURANCE LAW AND REGULATION 664-665 (5th ed. 2010) (The *Crisci* rule is standard law in most jurisdictions); 3 PAUL E.B. GLAD, WILLIAM T. BARKER, MICHAEL BARNES, NEW APPLEMAN ON INSURANCE LIBRARY EDITION § 16.06[4][a] (2012)("The most widely used test is typically formulated as 'whether a prudent insurer without policy limits would have accepted the settlement offer'").

[55] *See* Thomas, *supra* note 21, at 260-273 (classifying thirty states as following equal consideration standard, disregard the limits standard, or a combination of both).

[56] *See* Barker & Kent, *supra* n. 10 § 2.03[2][b]-[d]. Barker and Kent also point out that "[s]tates requiring subjective culpability are now a small and dwindling minority." *Id.* § 2.03[2][a][iii].

[57] RESTATEMENT LIABILITY INSURANCE § 24 (2).

[58] *Id.* § 24, comment b.

[59] *See id.* § 52, comment d (the standard for bad faith under § 51 "is more demanding than the ***purely objective standard*** stated for breach of the duty to make reasonable settlement decisions stated in § 24") (emphasis supplied).

[60] What I mean by an "elegant" standard is that it provides a simple, easy to understand and apply, algorithm to determine whether an insurer has made an unreasonable settlement decision. The primary competing standard, that an insurer should give equal consideration to the interests of the insured, has been justly criticized as "providing no guidance at all." Barker & Kent, *supra* n. 10, § 2.03[2][b].

[61] This is one of the examples I use to illustrate the difference between the disregard-the-limits standard and the equal consideration standard. *See* Thomas, *supra* n. 21, at 249-252.

[62] *See* Thomas, *supra* n. 21, at 243-249.

standard simply asks the wrong question.[63] (I believe that the equal consideration standard is flexible enough to include such behavior in its bad faith assessment.)[64]

Second, the Restatement, in large part because it has primarily considered the duty to settle from the standpoint of the disregard-the-limits standard, presumed that duty to settle cases were a discrete set of bad faith cases that were being (or could be) treated differently than other third-party bad faith cases. This assumption fails to account for the historical evolution of third-party bad faith and for the case law that often combines a failure to settle with other bad faith conduct.

Historically, the Restatement correctly notes that the basis for the duty to settle was the conflict of interest between the insurer and the insured when dealing with the tripartite relationship that exists with liability insurance and a third-party claimant.[65] But what the Restatement fails to point out is that the duty to settle cases historically ***are the basis for all third-party bad faith liability***. One unfamiliar with insurance bad faith law, in reading the Restatement, might think that there were separate bodies of law that developed around the duty to settle and the duty to otherwise act in good faith. Indeed, the comments to section 51 indicated that "[m]uch of the law governing insurance bad faith has developed in the first-party insurance context because successful, true liability insurance bad-faith actions are uncommon."[66] This statement is only true if duty to settle cases are excluded, or if "true" bad faith actions are those that apply the subjective element. In fact, the earliest cases to rely

[63] I propose that the equal consideration standard can be used, and is being used, to evaluate this kind of insurer behavior. *See id.* at 243-252.
[64] *See generally*, Thomas, *supra* n. 21.
[65] *See* RESTATEMENT LIABILITY INSURANCE § 24, comment a.
[66] *Id.* § 51, comment b. The comment goes on to note that "An action for breach of the duty to make reasonable settlement decisions that is framed as a "bad faith" action is not a true liability insurance bad faith action under the rules followed in this Restatement, unless the more demanding standard followed in this section is met. See Comment *d* and § 24, Comment *c*." This appears to be a tautology; the breach of the duty to settle is not bad faith because the standard adopted by the Restatement says it is not bad faith. While the term "bad faith" may be considered a misnomer, it is the term commonly associated with the breach of the duty to settle in the case law. *See* Barker & Kent, *supra* n.10, § 2.03[2][b] ("In the majority of American jurisdictions liability [for breach of the duty to make reasonable settlement decisions] is predicated on bad faith.").

upon the implied covenant of good faith and fair dealing in the insurance context were failure to settle cases starting in the 1930s.[67] It was not until some forty years later, in 1970s, that bad faith liability was extended to first-part cases.[68]

Because third-party bad faith evolved from the duty to settle, cases addressing non-settlement bad faith commonly include failure to settle claims.[69] Not only is this true historically, but it makes sense from a practical standpoint. The failure to settle claim has more easily measurable damages (the excess of limits verdict) than non-settlement bad faith claims. Therefore, claimants (which often end up in control of the claim through an assignment by the insured) have an incentive to include the failure-to-settle claim with other bad faith claims. At the same time, claimants who seek recovery beyond the policy limits have an incentive to include non-settlement bad faith claims as a means to bolster the unreasonableness and bad faith conduct of the insurer in handling of the settlement. In addition, to the extent that there are additional damages for bad faith besides the excess of limits judgment (such as emotional distress damages), the availability of such damages to the insured can create an incentive for cooperation with the claimant.

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[67] *See*, *e.g.*, Auto. Mutual Indem. Co. v. Shaw, 184 So. 852 (Fla. 1938); Tiger River Pine Co. v. Maryland Cas. Co., 161 S.E.491 (S.C. 1931); Hilker v. Western Auto. Co, 231 N.W. 413 (Wis. 1930), *aff'd on reh'g*, 235 N.S. 413 (1931).

[68] *See*, *e.g.*, Gruenberg v. Aetna Ins. Co., 510 P.2d 1032, 1038 (Cal. 1973) (en banc); Anderson v. Continental Ins. Co., 271 N.W.2d 368 (Wis. 1978).

[69] In Arizona and California, the jury instructions for third party bad faith include consideration of the reasonableness of the settlement decision along with other behaviors of the insured. *See* Clearwater v. State Farm Mut. Auto. Ins. Co., 792 P.2d 719, 722 (Ariz. 1990) (including attempts to induce insured to contribute to the settlement, failure to properly investigate, and failure to inform insured of the settlement offer as factors to be considered along with the strength of the claimant's case, the advice of counsel to settle, and the amount of financial risk); Brown v. Guarantee ins. Co., 319 P.2d 69, 75 (same). For examples of cases addressing failure to settle along with non-settlement behavior, see Allstate Ins. Co. v. Miller, 212 P.3d 318, 324 (Nev. 2009) (failure to communicate the settlement offer along with failure to settle); Betts v. Allstate Ins. Co., 201 Cal. Rptr. 528, 533-534 (Cal. App. 1984) (insurance investigation unreasonably sought to support the theory that insured was not at fault, along with failure to settle). These cases are discussed in Thomas, *supra* n. 21, at 247-249 (*Miller*) and at 250-252 (*Betts*).

Implications of the Paradigm Shift

Implications for Damages

What are the implications of this paradigm shift? Because the Restatement adopts the reasonableness standard for the duty to settle, as a general proposition it makes it easier for insureds (and claimants who stand in the shoes of the insureds via assignment or through garnishment) to recover excess verdicts.[70] While I disagree with the suggestion that adopting the reasonableness standard covers substantially all of the third party bad faith claims,[71] I agree that most of the third party bad faith claims involve the breach of the duty to settle (along with other bad faith allegations). Consequently, by adopting a reasonableness standard, the Restatement addresses the biggest part of the great majority of third-party bad faith cases.

What is left of third-party bad faith after the adoption of the reasonableness standard for the duty to settle? It is hard to tell. Section 51 does not provide any examples of non-settlement bad faith. Presumably, such conduct would give rise to potential bad faith liability,[72] though it is unclear what the

[70] While this is true as a general proposition, I contend that the use of the disregard-the-limits standard for the reasonableness standard provides less protection to the insured than the equal consideration standard. *See* Thomas, *supra* n. 21, at 235-257.

[71] In the comments to § 51, the Reporters suggest that "true liability insurance bad-faith actions are uncommon" because "other liability insurance rules provide an incentive for insurers to behave reasonably." RESTATEMENT LIABILITY INSURANCE § 51, comment b. This assumes, as noted above, that duty to settle cases are not "true liability bad-faith actions." In addition, while the other rules create incentives, those incentives are not always enough. More important than incentives, I think, is the availability of easily proven damages. Judgments in excess of liability limits are easy to calculate, and claimants whose counsel are aware of bad faith potential, have learned how to capitalize on the prospect of a bad faith judgment to recover the excess verdict. Other bad faith damages are much harder to prove and to quantify. The most common is emotional distress, which, while real, is difficult to evaluate especially in light of the likelihood of some emotional distress from the tort claim regardless of how the insurer handles it.

[72] The treatment of non-settlement misconduct by insurers is uncertain in part because it may be included in the duty-to-settle as a "procedural factor that affected the quality of the insured's decisionmaking or that deprived the insured of evidence that would have been available if the insurer had behaved reasonably." RESTATEMENT LIABILITY INSURANCE § 24, comment e. The Restatement does not explain how these factors are to be included in the evaluation, except to say that "they can make the difference in a close case by allowing the jury to draw a negative inference." *Id*. Thus, a settlement offer that is not clearly a reasonable one, may become reasonable in a close case because the insurer's non-settlement behavior (such as investigation or communication). But this same conduct

damages would be independent of the failure to settle. The only example of bad faith included with § 51 is a failure-to-settle scenario with limits of $25,000, an offer to settle for that amount, and judgment of $135,000. The bad faith aspect of the example is that the insurer's investigator "reported to her supervisor that the Driver was at fault," that the supervisor "directed investigator to change her report," that jury verdicts in the jurisdiction "had all been greatly in excess of $25,000," and that the "supervisor was under pressure to meet claim-payment-reduction goals."[73] This is clearly bad faith and the failure to make a reasonable settlement decision. The insurer would be liable for $110,000 excess of policy limits without bad faith liability. So what does bad faith add to the recovery?

Under § 52, upon proof of bad faith, the insurer would be liable for "attorneys' fees and other costs incurred by the insured in the legal action establishing the insurer's breach," any "other loss to the insured proximately caused by the bad faith conduct" and, if the state standards are met, "punitive damages."[74] The Restatement does not provide any guidance on these "other losses" except to say that they include any consequential losses under the rule of proximate cause (for tort claims) rather than under the foreseeable loss rule under contract law.[75] The Reporters' notes, however, suggest that "emotional-distress damages" would be included as consequential damages.[76]

While emotional distress damages are available as bad faith damages, they are also available as foreseeable damages for the failure to make a reasonable settlement decision. Section 27, the section addressing damages for breach of the provides that, in addition to the portion of the judgment in excess of policy limits, the insurer also is liable for "any other foreseeable harm caused by the insurer's

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could also be bad faith if done with knowledge or recklessness, and where the conduct is without any justification, it seems likely that knowledge, or at least recklessness, could be inferred by the jury.

[73] RESTATEMENT LIABILITY INSURANCE § 51, comment d, illustration 4.

[74] *Id*. § 52.

[75] *Id*. § 52, comment a.

[76] *Id*. § 52, Reporters Note a.

breach of duty."[77] While the comments simply focus on the notion of "foreseeable" losses, illustration 1 includes emotional distress damages in the award because "the obviously fragile emotional state of the insured" made it "foreseeable that the insured [would] suffer significant emotional distress as a result of an excess verdict."[78] So the only difference that a bad faith finding makes for emotional distress damages is that applicability of a somewhat looser standard of proximate cause instead of contractual foreseeability. It is hard to gauge how much difference, if any, this will make in the adjudication of claims. In addition, it seems odd, to say the least, to use the contract standard of foreseeability for what is widely recognized as a tort claim,[79] and therefore would normally be subject to the more liberal tort standard.[80]

Making attorneys' fees damages available as damages could be more meaningful, but the case law does not support drawing a distinction between awarding attorneys' fees for bad faith and not awarding them in failure to settle cases. The case law is highly variable for the awarding of attorneys' fees. While the courts sometimes allow attorneys' fees as consequential damages in bad faith cases,[81] this case law does not predicate recovery on a subjective state of mind. In addition, attorneys' fees could be warranted as foreseeable damages even under the more stringent contract rule. Some states even award attorneys' fees without any unreasonableness on the part of the insurer by making them available in declaratory relief actions.[82] The variable case law is further complicated by statutes in a number of states that provide for awarding attorneys' fees in insurance cases.[83]

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[77] RESTATEMENT OF THE LAW, LIABILITY INSURANCE § 27 (Tentative Draft No. 1, April 11, 2016). Section 27 was not included in the Council Draft No. 3, so citation is to the Tentative Draft No. 1 as the next most recent available version.
[78] *Id*., comment b, illustration 1.
[79] *See*, *e.g.*, Douglas R. Richmond, *An Overview of Insurance Bad Faith Litigation*, 25 SETON Hall L. Rev. 74, 80 & n. 33 (citing cases from 45 states).
[80] *See id*. at 79-80.
[81] *See* Barker & Kent, *supra* n. 10, at § 9.05[2].
[82] *Id*. at § 9.05[1].
[83] *See id.*

The third type of damages mentioned in section 51 is punitive damages. However, the availability of punitive damages under the Restatement is not meaningful because it is predicated on satisfying state law punitive damages standards. While the mention of punitive damages in section 51[84] might create the impression that a bad faith claim is more likely to give rise to punitive damages, in reality the award of punitive damages will turn on the application of the state law standard for punitive damages, not bad faith law.

Implications for Insurer Settlement Conduct

While the distinction between a reasonableness standard for the duty to settle and a subjective requirement of knowledge or recklessness may not make a significant difference for insureds asserting such claims, the shift away from "bad faith" terminology (as opposed to the subjective requirement which has not really been applied in third-party cases) could require more affirmative conduct from insurers in marginal cases. Two such cases are briefly considered here: 1) the duty to accept any reasonable settlement, and 2) the duty to offer policy limits even though the claimant has not asked for them.

If we embrace the reasonableness standard from the Restatement—that an insurer should behave as reasonable insurer with full responsibility for the entire judgment—an insurer's liability is an open question in the case where a reasonable settlement offer is rejected but countered with a lesser but still reasonable offer. On one hand, the failure to accept the first reasonable offer could be unreasonable. On the other hand, if the insurer honestly believes that a lower counter offer, which is objectively reasonable, has a good chance of being accepted, the decision to make such a counter offer could be reasonable as well. The question is one for the jury.[85]

[84] RESTATEMENT LIABILITY INSURANCE § 52(3). This is the Council Draft No. 3.
[85] *See id.* § 24, comment d, illustration 2.

The use of the terminology of "bad faith" could make a difference in such a case. The terminology connotes some kind affirmative misconduct, not a mere failure to act. While one could characterize the insurer's failure to accept the initial reasonable settlement offer as unreasonable, it is slightly more difficult to characterize that conduct as "bad faith." After all, the insurer did in fact make an objectively reasonable settlement offer (albeit a lower one) and it honestly believed that such an offer was likely to be accepted. If, instead of using the standard of an insurer without limits we were to use the equal consideration standard, we could argue that by giving an objectively reasonable counteroffer, the insurer was sufficiently protecting the insured's interest to satisfy the test. Moreover, achieving a lower settlement could be beneficial for the insured by reducing the incentive for others to file similar suits and by reducing the insured's loss history.

This same distinction between an unreasonable failure to act and a bad faith response could be used for the affirmative duty to propose a settlement within limits. While a reasonable insurer facing the entire exposure might initiate a settlement, it is more difficult to say that the failure to initiate the settlement was bad faith. It is customary for insurers to request that the claimant make the first settlement offer; after all, the claimant is the one asserting the claim and so could be expected to put a value on that claim. This example also shows a possible difference between the disregard the limits standard and equal consideration. While one might expect a reasonable insurer to initiate settlement discussions, an insurer that waits for the claimant to initiate settlement discussions may be giving equal consideration to the interests of the insured because a settlement offer from the insurer could create expectations on the part of the claimant that the policy limits were the floor of the negotiations and that the insured would contribute more to obtain a settlement.

Conclusion

The Restatement of the Law, Liability Insurance, represents a paradigm shift to an objective standard of reasonableness for insurers' settlement decisions. This shift was consistent with a general trend towards an objective evaluation of settlement decisions, and the Restatement makes the test clearer and easier to apply. As a general matter, this probably favors insureds somewhat more than insurers, but by making the standard that of a reasonable insurer, the Reporters have given a small concession to the insurers.

The Restatement's treatment of third-party bad faith, however, is a much more radical paradigm shift. By adopting a subjective requirement of knowledge or recklessness, the Restatement has followed the approach used by some courts for first-party bad faith. This imposes a subjective requirement that is not reflected in third-party bad faith case law.

Whether this will make any difference (assuming the courts decide to follow this novel approach) remains to be seen. The damages that seem most likely to be associated with bad faith claims independent of an excess of policy limits judgment are for emotional distress. Those damages, however, are also available for failure to settle, though under the more limited standard for contractual foreseeability rather than tort proximate cause. Whether this distinction is meaningful, and whether courts will adopt it, is debatable. Availability of attorneys' fees may be a more meaningful addition to damages, though the current rules for attorneys' fees are quite variable and include a number of statutory provisions that may apply. The reference to punitive damages in connection with bad faith is not meaningful because the availability of punitive damages turns on meeting state law standards, which are independent of bad faith or duty to settle standards.

For insurer settlement behavior, the move to the objective reasonableness standard, and one operationalized by reference to a reasonable insurer without policy limits, could at the margins increase

insurer liability. The terminology of "bad faith," even when it does not require a subjective bad state of mind, connotes some affirmative misconduct by an insurer rather than a failure to act. The equal consideration standard to some extent captures this connotation as it recognizes the insurer's right to act in its own interest so long as it gives equal consideration to the interests of the insured. As a consequence of the standard requiring an insurer to act as a reasonable insurer without policy limits, insurers are at risk of being held liable for the failure to accept the first reasonable offer or for the failure to initiate settlement discussions.

f. The "suit" requirement. See Mark Bradford, *What Constitutes a Suit*, in DRI, INSURER'S DUTY TO DEFEND: A COMPENDIUM OF STATE LAW 59 (2005), which provides a useful explanation of the different understandings of suit. Compare, e.g., Foster-Gardner, Inc. v. National Union & Fire Ins. Co. of Pittsburgh, 959 P.2d 265, 282 (Cal. 1998) (declining to require insurer to defend based on a governmental demand letter); Lapham-Hickey Steel Corp. v. Protection Mutual Ins. Co., 655 N.E.2d 842, 847-848 (Ill. 1995) (same) with Compass Ins. Co. v. City of Littleton, 984 P.2d 606, 622 (Colo. 1999) (holding that coercive actions begun by government demand letters are "suits"); Hazen Paper v. USF&G, 555 N.E.2d 576, 570-580 (Mass. 1998) (same). See also STEVEN PLITT & JORDAN ROSS PLITT, 1 PRACTICAL TOOLS FOR HANDLING INSURANCE CASES § 2:8 (2012) (stating that the broader interpretation of suit is the significant majority view).

§ 24. The Insurer's Duty to Make Reasonable Settlement Decisions*

(1) When an insurer has the authority to settle a legal action brought against the insured, or the authority to settle the action rests with the insured but the insurer's prior consent is required for any settlement to be payable by the insurer, and there is a potential for a judgment in excess of the applicable policy limit, the insurer has a duty to the insured to make reasonable settlement decisions.

(2) A reasonable settlement decision is one that would be made by a reasonable insurer who bears the sole financial responsibility for the full amount of the potential judgment.

(3) An insurer's duty to make reasonable settlement decisions includes the duty to make its policy limits available to the insured for the settlement of a covered legal action that exceeds those policy limits if a reasonable insurer would do so in the circumstances.

Comment:

a. A duty to make reasonable settlement decisions rather than the "duty to settle." The duty set forth in this Section is a longstanding rule of insurance law that is frequently referred to in shorthand by commentators and some courts as the "duty to settle." This Section uses a more accurate term, the "duty to make reasonable settlement decisions," to emphasize that the

*This Section was approved at the 2016 Annual Meeting with amendments to certain Comments in response to a motion from William Barker. This draft differs from that in T.D. No. 1 in the Comments regarding the reasonableness standard. The black letter is identical to T.D. No. 1 except for the replacement of the word "insurer" for "person" in subsection (2) and a slight revision of subsection (3).

insurer's duty is not to settle every legal action, but rather to protect the insured from unreasonable exposure to a judgment in excess of the limits of the liability insurance policy. Although a strict-liability standard of the sort that might be suggested by the label "duty to settle" would eliminate the need for the reasonableness evaluation, a strict-liability standard has not found favor in the courts. Moreover, the reasonableness standard followed in this Section is more closely tailored to the conflict of interest that underlies the legal duty.

The insurer's duty to make reasonable settlement decisions arose as a special application of the general contract-law duty of good faith and fair dealing in the context of insurance policies that granted the insurer discretion over the settlement of an insured liability action. As courts early recognized, when the insured faces a potential judgment in excess of the policy limit (an "excess judgment"), the insurer may have an incentive to undervalue the possibility of a loss at trial, since a portion of that loss will be borne by the insured rather than by the insurer, absent a legal rule assigning the risk of excess judgment to the insurer. For example, if an insurer receives a settlement offer that is equal to or just under the policy limits, the insurer has little financial incentive, other than reduction in defense costs, to accept that offer as long as there is some chance of a judgment at trial in favor of the defense. By going to trial in such cases, the insurer maintains the possibility of eliminating its own liability by winning the case against the claimant. Moreover, as long as the insurer's liability is bounded by the policy limit, taking the case to trial imposes no added risk on the insurer, beyond the additional defense costs required to try the case. As courts have described this conflict-of-interest problem, an insurer that rejects a reasonable settlement offer in favor of going to trial is effectively "gambling with the insured's money," or gambling with the excess insurer's money, since the insured or the insured's excess insurer will have to pay any verdict in excess of the policy limit.

The duty to make reasonable settlement decisions creates an incentive for insurers to take into account this risk to insureds and excess insurers. Because the purpose of the duty to make reasonable settlement decisions is to align the interests of insurer and insured in cases that expose the insured to damages in excess of the policy limits, the duty is owed only with respect to the exposure to such excess damages. With respect to liability for damages within the policy limits, the insurer's contractual liability for those damages already provides an incentive for the insurer to make reasonable settlement decisions.

b. Equal consideration and the "disregard the limits" rule. In the insurance context, the general duty of good faith and fair dealing is often described as requiring the insurer to give equal consideration to the interests of its insured. The duty to make reasonable settlement decisions can be similarly described as requiring the insurer to give equal consideration to the insured's exposure in excess of the policy limits. When there is the potential for a judgment in excess of the policy limit, equal consideration requires managing the litigation and settlement process in a manner that neutralizes, to the extent possible, the conflict of interest described in Comment *a*. Courts and commentators use a variety of verbal formulas to articulate that requirement more precisely. The standard stated in subsection (2) implements the equal-consideration requirement in actionable terms. A reasonable settlement offer is one that would be accepted or made by a reasonable insurer that bears the sole financial responsibility for the full amount of the potential judgment. Courts and commentators sometimes refer to this formulation of the standard as the "disregard the limits" rule, because it requires the insurer to evaluate the reasonableness of a settlement offer without regard to the policy limits, or, to put it another way, in a manner that "disregards the limits" of the policy.

c. Relationship to the duty of good faith and fair dealing. Because of its origins in the duty of good faith and fair dealing, courts in some jurisdictions refer to the standard for breach of the duty in the settlement context as one of "bad faith." That formulation suggests the need to prove some bad intent on the part of the insurer that goes beyond the reasonableness standard stated in this Section, and some courts do require such a showing. In most breach-of-settlement-duty cases, however, even those that invoke the language of bad faith, the ultimate test of liability is whether the insurer's conduct was reasonable under the circumstances. To make clear that an insurer's settlement duty is grounded in commercial reasonableness, this Section does not use the term "bad faith" to describe the insurer's breach of the duty to make reasonable settlement decisions. Under the rule followed in this Restatement, an insurer is subject to liability for insurance bad faith only when it fails to perform its duties under a liability insurance policy without a reasonable basis for its conduct and with knowledge or in reckless disregard of its obligation to perform. See § 51. A liability insurer that breaches the duty to make reasonable settlement decisions is subject to liability for damages under § 27, but it is not thereby subject to liability for insurance bad faith unless the insured also satisfies the requirements of § 51. See Comment *d* to § 51. If the insured does satisfy the requirements of § 51, the insurer will be liable

not only for the excess verdict and other damages under § 27 but also for the damages set forth in § 52 (including attorneys' fees, any other loss proximately caused by the insurer's bad-faith conduct, and, if the insurer's conduct meets the applicable state-law standard, punitive damages).

d. Applying the reasonableness standard. The "reasonable insurer" referred to here is a legal construct, similar to that of the "reasonable person" in tort law. As such, it can be understood as an average or ordinary insurer that sells liability insurance of the kind and in the amounts of the liability insurance policy at issue. The duty to make reasonable settlement decisions includes the duty to accept a settlement offer that a reasonable insurer would accept and to make an offer to settle when a reasonable insurer would do so, if that reasonable insurer had sold an insurance policy with limits that were sufficient to cover any likely outcome of the legal action. See also Comment *f* (on the insurer's failure to make settlement offers).

In determining whether a settlement decision was reasonable, the factfinder should view the settlement decision from the perspective of the parties at the time the settlement decision was made. A reasonable insurer is expected, at the time of the settlement negotiations, to take into account the realistically possible outcomes of a trial and, to the extent possible, to weigh those outcomes according to their likelihood. In a complex case, these evaluations are difficult, both for the insurer making the settlement decision and for the trier of fact in a subsequent suit challenging the reasonableness of the insurer's settlement decision. This difficulty, however, cannot be avoided. If a reasonableness standard is to be applied, such qualitative evaluations are inevitable. The insurer will be liable for any excess judgment against the insured in the underlying litigation if the trier of fact finds that the insurer rejected a settlement offer that a reasonable insurer would have accepted (or failed to consent to a settlement to which a reasonable insurer would have consented).

In evaluating the reasonableness of an insurer's settlement decisions, the trier of fact may consider, among other evidence, expert testimony as well as testimony from the lawyers and others involved in the underlying insured liability claim. The reasonableness of settlement offers may also take into account other facts, such as the amount of time that is given to evaluate an offer and the jurisdiction in which the case would be tried. It is also appropriate for the trier of fact to consider the procedural factors addressed in Comment *e*. It is important to note that this standard takes into account only the interests of the parties in relation to the legal action at issue,

not the insurer's interest in minimizing the overall size of the losses in its portfolio of claims. Otherwise, the insurer would not be giving equal consideration to the interests of the insured.

The effect of this rule is that, once a claimant has made a settlement offer in the underlying litigation that a reasonable insurer would have accepted, an insurer that rejects that offer thereafter bears the risk of an excess judgment against the insured at trial. One practical effect of this rule is to give claimants an incentive during the pretrial phase to make reasonable settlement offers within the policy limits, since the insurer's rejection of such an offer sets the stage for a subsequent breach-of-settlement-duty lawsuit in the event of a verdict that produces an excess judgment that is covered by the policy. In that subsequent lawsuit, it will not be sufficient for the policyholder to simply demonstrate that the amount of the offer was reasonable; the policyholder must also demonstrate that a reasonable insurer would have accepted the offer. Nevertheless, evidence that the amount of the offer was reasonable would ordinarily be enough to make the reasonableness of the insurer's decision to reject the offer a question of fact.

Illustrations:

1. A claimant files a personal-injury lawsuit against the insured seeking damages. The insured has a duty-to-defend liability insurance policy that assigns settlement discretion to the insurer. The policy contains a policy limit of $75,000 and no deductible. The claimant offers to settle for $45,000. The insurer rejects the offer. The case proceeds to trial and a judgment of $175,000 is entered against the insured. In a subsequent action for breach of the duty to make reasonable settlement decisions, the insured introduces evidence supporting the conclusion that, at the time of the settlement negotiations, $45,000 was a reasonable settlement value of the case, based on the judgment that it was reasonable to conclude that the plaintiff had a 30 percent chance of success and likely damages of $150,000. Based on this evidence a trier of fact could conclude that a reasonable insurer would have accepted the offer and, thus, the insurer breached its duty.

2. Same facts as Illustration 1, except that the insurer makes a counteroffer of $35,000 and, in the subsequent breach-of-settlement-duty case, the adjuster managing the claim for the insurer testifies that, based on her extensive experience managing similar claims, she believed that the claimant would eventually accept the counteroffer. The parties offer conflicting expert testimony regarding the reasonableness of the adjuster's decision to reject an offer that represented a reasonable settlement value of the suit in

these circumstances. Even if the trier of fact concludes that the adjuster had made every reasonable effort to become informed about the suit and honestly held the opinion to which she testified and, accordingly, that the rejection of the settlement offer was in good faith, the trier of fact could nevertheless conclude that a reasonable insurer would have accepted the initial offer, and, thus, the insurer breached its duty. Based on this evidence, the trier of fact could also conclude, however, that the insurer did not breach its duty.

e. Procedural factors may be considered. The reasonableness standard requires the trier of fact in the breach-of-settlement-duty suit to evaluate the expected value of the underlying legal action at the time of the failed settlement negotiations. That inquiry may be complex and difficult in some cases. Because of the difficulty of determining, in hindsight, whether a settlement offer was reasonable, it is appropriate for the trier of fact to consider procedural factors that affected the quality of the insurer's decisionmaking or that deprived the insured of evidence that would have been available if the insurer had behaved reasonably. Factors that may affect the quality of the insurer's decisionmaking include: a failure to conduct a reasonable investigation, a failure to conduct negotiations in a reasonable manner, a failure to follow the recommendation of its adjuster or chosen defense lawyer, and a failure to seek the defense lawyer's assessment of the settlement value of the case. Factors that may deprive the insured of evidence include: a failure to conduct a reasonable investigation, a failure to follow the insurer's claims-handling procedures, a failure to keep the insured informed of within-limits offers or the risk of excess judgment, and the provision of misleading information to the insured.

Such factors are not enough to transform a plainly unreasonable settlement offer into a reasonable offer, but they can make the difference in a close case by allowing the jury to draw a negative inference from the lack of information that reasonably should have been available or from the low quality of the insurer's decisionmaking and fact-gathering processes. Just as reasonable investigation and settlement procedures cannot guarantee that an insurer will make a decision that is substantively reasonable, however, the failure to employ reasonable procedures does not necessarily mean that the insurer's decision was substantively unreasonable. In breach-of-settlement-duty cases in which the facts do not make clear that the insurer's settlement decision was substantively reasonable, however, the factfinder may decide based on these other procedural factors that the settlement decision was unreasonable. In an extreme case, the insurer may be subject to liability for bad-faith breach. See § 51.

Illustration:

3. A claimant files a tort suit against the insured seeking compensatory damages of $500,000. The insured has a duty-to-defend liability insurance policy that assigns settlement discretion to the insurer, with a policy limit of $100,000. Early in the litigation the claimant makes a time-limited settlement offer for the policy limits directly to the insurance claims manager, giving the insurer 60 days to investigate and either accept or reject the offer. The insurer immediately rejects the offer without conducting a reasonable investigation. The claim goes to trial and results in a jury verdict against the insured of $500,000. In the subsequent breach-of-settlement-duty lawsuit brought by the insured against the insurer, the trier of fact may, but need not, properly conclude from the insurer's failure to investigate and failure to inform the insured of the offer that the insurer's settlement decisions were unreasonable. If the trier of fact concludes that the $100,000 offer was above the range of reasonableness and that the claimant was unwilling to accept any reasonable settlement offer from the insurer or insured, the insurer will not be held liable for the excess judgment.

f. The insurer's failure to make settlement offers and counteroffers. There is no hard and fast rule regarding the insurer's obligation to make offers. It is a question of what a reasonable insurer would do in the circumstances. In the absence of a reasonable offer by the plaintiff, there can be circumstances in which an insurer has a duty to make a settlement offer, such as, for example, a suit in which the policy limits are significantly less than the reasonable settlement value of the case. In such circumstances, the insurer is obligated to attempt to protect its insured from an excess judgment. By making a reasonable settlement offer, the insurer can avoid potential liability for an excess judgment, even if that offer is rejected. It is important to emphasize, however, that the insurer has no obligation to make an offer unless a reasonable insurer that bore the sole financial responsibility for the full amount of the judgment would do so, and there may be good reasons not to.

g. The causation difference between rejecting a settlement offer and choosing not to make an offer. An insurer's decision to reject a reasonable settlement offer made by a claimant potentially has different consequences than an insurer's decision not to make its own reasonable settlement offer, even in those situations in which a reasonable insurer would have made such an

offer. The difference comes from the causation requirement in an action for breach of the duty. When an insurer breaches the duty by failing to accept a settlement offer (in situations in which failing to accept such an offer constitutes a breach of the duty), and the case goes to trial resulting in an excess judgment against the insured, the causation requirement is satisfied: had the insurer accepted the settlement offer, there would have been no trial and no possibility of an excess judgment. By contrast, when the insurer breaches the duty by failing to make its own settlement offer (in situations in which failing to make its own settlement offer constitutes a breach of the duty), and the case goes to trial and an excess judgment ensues, causation remains in question. The insurer's failure to make an offer caused the excess judgment only if the claimant would have accepted a reasonable offer from the insurer. Proving causation is difficult. Before the trial, the claimant would have been in the best position to answer the question whether he or she would have accepted the settlement offer, but after the trial the claimant's interests will often be too closely aligned with those of the insured defendant to be objective. Other good sources of objective evidence on the matter will be scarce. Nevertheless, a trier of fact may conclude that an insurer's decision not to make a settlement offer or counteroffer constitutes an unreasonable settlement decision.

Illustrations:

4. A claimant files a personal-injury lawsuit against the insured seeking damages. The insured has a duty-to-defend liability insurance policy that assigns settlement discretion to the insurer. The policy contains a policy limit of $100,000 and no deductible. As found by the trier of fact in a subsequent action for breach of the duty to make reasonable settlement decisions, reasonable estimates of the value of the underlying claim range between $30,000 and $45,000. The claimant makes no settlement offers during the period leading up to the trial. The insurer, however, makes a settlement offer of $35,000, which is rejected by the claimant. The jury in the personal-injury lawsuit finds for the claimant and awards damages of $150,000. The insurer is not subject to liability for the amount of the judgment in excess of the policy limits. By making a reasonable settlement offer in a circumstance in which the claimant did not make a reasonable settlement offer, the insurer satisfied its duty to make reasonable settlement decisions.

5. Same facts as Illustration 4, except that the insurer, rather than making a $35,000 settlement offer, makes a $5000 settlement offer, well below the minimum reasonable offer. The claimant rejects the offer. The insurer makes no other settlement offers. The case then goes to trial, resulting in a jury verdict of $150,000 for the claimant, which includes an excess judgment of $50,000. The trier of fact in a subsequent action alleging breach of the duty to make reasonable settlement decisions may take into account that the insurer, having received no reasonable settlement offer from the insured, failed to make a reasonable settlement offer of its own. Indeed, the trier of fact may conclude from this fact, in the absence of compelling reasons to the contrary, that the insurer acted unreasonably and thus breached its settlement duty. Whether the insurer is subject to liability for the amount in excess of the policy limits for any breach, however, will depend on whether the trier of fact determines that the claimant would have accepted a reasonable offer.

6. Same facts as Illustration 4, except that the claimant makes a settlement offer of $45,000, which is at the high end of the reasonableness range. The insurer rejects that offer and makes a counteroffer of $35,000 in circumstances in which a reasonable insurer would have accepted the $45,000 offer. The claimant rejects the insurer's offer, and the settlement negotiations break down. The case goes to trial, resulting in a $150,000 judgment against the insured, which is $50,000 more than the policy limits. In the subsequent breach-of-settlement-duty case against the insurer, the insurer is subject to liability for the full amount of the judgment, because the insurer rejected a settlement offer in the underlying litigation that a reasonable insurer would have accepted.

h. Settlement offers in excess of policy limits. In some cases the expected value of the underlying legal action is greater than the limits on coverage contained in the policy. In such cases a reasonable insurer that bore the risk of the entire liability would settle the case for an amount in excess of the policy limits. The duty to make reasonable settlement decisions, however, does not obligate the insurer to accept or make such settlement offers in excess of its policy limits. In such cases the insurer may satisfy the duty by informing the insured that the insurer is prepared to offer the policy limits toward a reasonable settlement. The insurer may also make the insured aware of the option to pay the amount of the settlement in excess of the policy limits and explain why the insurer has concluded that settlement would be reasonable (for

example, by pointing out the high likelihood of an excess judgment in the event of a trial). If the insured opts not to pay to settle in excess of the policy limits, the insurer is not thereby excused from its obligation to defend the claim. See § 18 (terminating the duty to defend). This duty to make the policy limits available to the insured in response to reasonable settlement offers in excess of the policy limits is sometimes referred to as the "duty to contribute." The duty to contribute does not apply to settlement offers that are unreasonable.

Illustration:

7. A claimant files a tort suit against the insured seeking compensatory damages of $500,000 and punitive damages of $700,000. The insured has a duty-to-defend liability insurance policy that gives settlement discretion to the insurer and provides coverage for punitive damages, which are insurable in the jurisdiction. The policy also contains a policy limit of $500,000 and no deductible. At the time of settlement negotiations in the underlying tort action, the reasonable settlement value of the case ranges between $525,000 and $600,000. The claimant makes a settlement offer of $545,000. A reasonable insurer—a rational insurer who is the sole holder of the full $1.2 million potential liability—would accept the offer. The insurer satisfies its obligations under the duty to make reasonable settlement decisions by notifying the insured of the offer and by offering to contribute the policy limits in support of the settlement. The insurer has no obligation to pay more than the policy limits to settle the claim.

i. No direct duty owed to excess insurers. The duty stated in this Section is owed to insureds, not to excess insurers. Excess insurers nevertheless may recover through equitable subrogation for damages incurred as a result of a breach of the duty to make reasonable settlement decisions. Excess insurers' subrogation rights are addressed in § 28.

j. No duty owed to third parties. The duty to make reasonable settlement decisions is owed to insureds, not to the third-party claimants that bring tort suits against insured defendants. A claimant has no independent common-law right to recover against the insurer for breach of the duty to make reasonable settlement decisions. The courts in a few states have interpreted state insurance consumer-protection statutes to grant tort claimants an implied statutory private right of action against insurers for unfair settlement practices in individual cases. The majority of states that have addressed this question have found no such implied right of action in individual

cases. This Section follows the majority rule. Imposing a direct duty to tort claimants in individual cases could distort the market for liability insurance, because insurers would be subject to liability for conduct that would be permissible for an uninsured defendant. An insured may assign its rights under a liability insurance policy, including for breach of the duty to make reasonable settlement decisions, to a third-party claimant. See § 37.

k. Mandatory rules. Insurers may avoid the rules stated in this Section by structuring insurance policies that do not give the insurer the kind of control over settlement that leads to the conflict of interest that these rules address. As long as insurance policies grant insurers that control, however, the duty to make reasonable settlement decisions is a mandatory rule that is properly understood as an application of the general contract-law duty of good faith and fair dealing.

REPORTERS' NOTE

a. A duty to make reasonable settlement decisions rather than the "duty to settle." See Robert Keeton, *Liability Insurance and Responsibility for Settlement*, 67 HARV. L. REV. 1136, 1160-1161 (1954); Kent D. Syverud, *The Duty to Settle*, 76 VA. L. REV. 1113, 1116 (1990) ("For [a century], courts have invoked a doctrine known as 'the duty to settle' to impose liability on insurance companies who fail to settle lawsuits against the people they insure."). For an explanation of the advantages of insurer control over settlement decisions, see Syverud, 76 VA. L. REV. at 1138-1139. The duty to make reasonable settlement decisions not only benefits individual insureds, but also encourages efficient settlement decisionmaking by insurance companies. The doctrine requires that insurers internalize "all of the costs of going to trial before rejecting a settlement." Syverud, 76 VA. L. REV. at 1164. For support that the standard stated in this Section is the most common, see 3 JEFFREY E. THOMAS, NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION § 16.06[4][a] (Lexis 2012) ("The most widely used test is typically formulated as 'whether a prudent insurer without policy limits would have accepted the settlement offer'."). See also Ellen S. Pryor & Charles Silver, *Defense Lawyers' Professional Responsibilities: Part I—Excess Exposure Cases*, 78 TEX. L. REV. 599, 656-657 (2000) (concluding that "all jurisdictions require carriers to make reasonable settlement decisions"); 16 WILLISTON ON CONTRACTS § 49:105 (4th ed. 2014) ("Most courts require that an insurer act reasonably when deciding whether to settle a claim . . . "); Cindie Keegan McMahon, Annotation, *Duty of liability insurer to initiate settlement negotiations*, 51 A.L.R.5th 701 (originally published in 1997) ("When the claimant makes an offer to settle within the policy limits, courts generally agree that the insurer's good-faith duty requires the insurer to accept the offer if it would be reasonably prudent to do so.").

The reasonableness standard stated in this Section is analogous to the negligence standard in tort law. Some commentators have suggested a strict-liability standard pursuant to which any insurer that rejects a settlement offer within the policy limits would be subject to liability for a judgment against the insured in excess of the policy limits, without regard to whether the offer was reasonable. See, e.g., Bruce

L. Hay, *A No-Fault Approach to the Duty to Settle*, 68 RUTGERS U. L. REV. 321 (2015) (arguing that making insurers liable for excess judgment following any rejected within-limits settlement offer would actually work to the benefit of insurers and policyholders); and Philip L. Deaver, Note, *Insurer's Liability for Refusal to Settle: Beyond Strict Liability*, 50 S. CAL. L. REV. 751, 752 n.11 (1977) (listing numerous articles from the 1970s urging strict liability for the insurer when a within-limits settlement offer is rejected). By eliminating the need to undertake a reasonableness analysis, a strict-liability standard would eliminate some of the complexity and costs of breach-of-settlement-duty suits. Thus, there would be no need for the trier of fact in the settlement-duty case to gather evidence on the range of reasonable settlement values. In addition, an argument can be made that, when policyholders purchase liability insurance coverage, they are in a sense paying insurers to make lawsuits "go away," which usually means by settlement. Thus, despite the language in liability insurance policies giving settlement discretion to the insurer, insureds are often surprised to learn, after the fact, that their insurers can refuse to accept settlement offers that are within the policy limits and can thereby expose the insureds to the risk of an excess judgment. A strict-liability rule, therefore, might be more consistent with the reasonable expectations of policyholders.

The primary criticism of the strict-liability approach, however, is that under such a rule any tort claimant could eliminate the binding effect of the policy limit simply by making a settlement offer within the limit through a "set up" letter. This effect would in turn lead to an increase in premiums. An argument can be made that both of these effects of the strict-liability rule are desirable, insofar as they encourage insurers to provide coverage that includes adequate policy limits. Moreover, given the hindsight bias that might be present in settlement-duty cases that apply a reasonableness standard (that is, the tendency of triers of fact, faced with an excess judgment against the insured, to overestimate the ex ante likelihood of that judgment occurring and thus to overestimate the reasonableness of some settlement offers), the effects of a strict-liability duty-to-settle rule might not be substantially different from the effects of the reasonableness/disregard-the-limits rule followed in this Section and that is already applied in many jurisdictions. Some appellate courts have gone so far as to encourage such hindsight bias by requiring that juries in settlement-duty cases be specifically instructed to consider the actual excess tort judgment in the underlying case as evidence of the expected value of the tort suit at the time the settlement offer was made and rejected. Despite the good arguments in favor of a strict-liability rule for the duty to settle, this Section does not endorse such a rule, because such a rule has not been adopted in the courts. Instead the Section follows and clarifies the prevailing reasonableness rule. The majority of jurisdictions impose on the insurer a general duty to make reasonable settlement decisions.

b. Equal consideration and the "disregard the limits" rule. See, e.g., Syverud, 76 VA. L. REV. at 1122; see also Cowden v. Aetna Cas. & Sur. Co., 134 A.2d 223, 228 (Pa. 1957) ("The requirement is that the insurer consider in good faith the interest of the insured as a factor in coming to a decision as to whether to settle or litigate a claim against the insured. . . . the predominant majority rule is that the insurer must accord the interest of its insured the same faithful consideration it gives its own interest"). The most straightforward and utilized application of the "equal consideration" standard is the disregard-the-limits test. The disregard-the-limits standard was first articulated by Professor Keeton in 1954: "With respect to the decision whether to settle or try the case, the insurer, acting through its representatives,

must use such care as would have been used by an ordinarily prudent insurer with no policy limit applicable to the claim." Robert E. Keeton, *Liability Insurance and Responsibility for Settlement*, 67 HARV. L. REV. 1136, 1147 (1954). The Supreme Court of California adopted Keeton's articulation in Crisci v. Security Ins. Co., 426 P.2d 173 (Cal. 1967), and the disregard-the-limits rule has since become the most common test for determining whether an insurer gave "equal consideration" to its insured's interests in duty-to-settle cases. Id. at 176 ("In determining whether an insurer has given consideration to the interests of the insured, the test is whether a prudent insurer without policy limits would have accepted the settlement offer."); Bollinger v. Nuss, 449 P.2d 502, 511 (Kan. 1969) ("As Professor Keeton suggests, equal consideration of the conflicting interests of the company and the insured means consideration of each portion of the total risk without regard to who is bearing that portion of the risk . . . [t]his undoubtedly is the meaning intended by courts which have said the insurer must accord the interests of its insured the same faithful consideration it gives its own interests."); Cowden v. Aetna Cas. & Sur. Co., 134 A.2d 223, 228 (Pa. 1957) ("[T]he fairest method of balancing the interests is for the insurer to treat the claim as if it were alone liable for the entire amount."); see also KENNETH S. ABRAHAM, INSURANCE LAW AND REGULATION 664-665 (5th ed. 2010) ("The *Crisci* rule is standard law in most jurisdictions . . ."); 3 JEFFREY E. THOMAS, NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION § 16.06[4][a] (Lexis 2012) ("The most widely used test is typically formulated as 'whether a prudent insurer without policy limits would have accepted the settlement offer.'" [quoting *Crisci*, 426 P.2d at 176]).

For courts applying the disregard-the-limits approach to discern whether "equal consideration" was given to the insured's interests by the insurer, see, e.g., Herges v. Western Cas. & Sur. Co., 408 F.2d 1157, 1163-1164 (8th Cir. 1969) (applying Minnesota law) (using Keeton's "no policy limits approach" to determine if the insurer had given equal consideration to the insured's interests); Koppie v. Allied Mut. Ins. Co., 210 N.W.2d 844, 848 (Iowa 1973) ("Modern decisions require the insurer . . . to view the settlement situation as if there were no policy limit applicable to the claim. When it does so, it views the claim objectively and renders equal consideration to the interests of itself and of the insured."); Bowers v. Camden Fire Ins. Ass'n, 237 A.2d 857, 862 (N.J. 1968) (holding that the insurer acts in good faith "only if the insurer treats any settlement offer as if it had full coverage for whatever verdict might be recovered, regardless of policy limits.").

Some courts have held that the "equal consideration" standard imposes a stricter obligation on insurers to defer to the individual insured's greater pecuniary interests in the outcome of a single case, even when it would be reasonable for an insurer properly disregarding the limit to reject the settlement offer, see, e.g., Loudon v. State Farm Mut. Auto. Ins. Co., 360 N.W.2d 575, 581-582 (Iowa Ct. App. 1984) (reasoning that even when an insurer fairly evaluates a settlement offer and claim without regard to policy limits, equal consideration mandates giving greater weight to the catastrophic effect of a judgment over the policy limits on a single insured's financial status in comparison to the nominal effect that settling a single claim has on the insurer); Clearwater v. State Farm Mut. Auto Ins. Co., 792 P.2d 719, 723 (Ariz. 1990) ("[T]he debatability of the claim is not determinative; the insurer must also weigh other considerations, such as the financial risk to the insured in the event of a judgment in excess of the policy limits."); Dumas v. State Farm Mut. Auto Ins. Co., 274 A.2d 781, 784 (N.H. 1971) ("The unlimited

coverage approach has a superficial appearance of fairness to the insured but in fact does not give proper consideration to the insured's interest. An unlimited risk to an insurance company with thousands of claims may in fact be minimal on the average but catastrophic to an underinsured individual with a single claim."). For two authors suggesting that the equal-consideration and disregard-the-limits standards may function differently in some circumstances, see ABRAHAM at p. 665 ("Under the reasonable offer test, however, equal consideration is not the norm. Rather, in certain cases the insured's interests carry more weight."); Michael Sean Quinn, *The Defending Liability Insurer's Duty to Settle: A Meditation upon Some First Principles*, 35 TORT & INS. L.J. 929, 960-963 (2000).

c. Relationship to the duty of good faith and fair dealing. For an explanation of how the duty to settle evolved from the duty of good faith and fair dealing, see generally 3 JEFFREY E. THOMAS, NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION § 23.01[d] (Lexis 2012). As a result of this historical development of the doctrine, some courts have expressed a breach of the duty to settle as a bad-faith failure to settle and have hinged their rulings on whether actual bad faith could be ascribed to the insurer. See, e.g., National Farmers Union Prop. & Cas. Co. v. O'Daniel, 329 F.2d 60, 65 (9th Cir. 1964) (applying Montana law) ("We think it clear that, if Lucas's knowledge and conduct are imputed to [the insurer] under recognized agency principles, there is ample evidence to sustain the finding of bad faith on the part of [the insurer] in failing to consider the interests of its insured."); David Novak, Comment, *Insurance Carrier's Duty to Settle: Strict Liability in Excess Liability Cases?*, 6 SETON HALL L. REV. 662, 671 n.58 (1972) ("Under the bad faith standard, the plaintiff in an excess case has the burden of producing evidence which demonstrates either an intent on the part of the insurance company to commit fraud or that the insurer is guilty of willful misconduct."). However, other courts focus only on whether the insurer declined a reasonable settlement offer, as this Section does. See, e.g., LensCrafters, Inc. v. Liberty Mut. Fire Ins. Co., No. C 07-2853 SBA, 2008 WL 410243, at *3 (N.D. Cal. Feb. 12, 2008) ("The duty to settle arises from the implied covenant of good faith and fair dealing, which is inherent in every contract of insurance. . . . Both primary and excess insurers have an obligation to accept a reasonable settlement."); Hartford Acc. & Indem. Co. v. Foster, 528 So. 2d 255, 282 (Miss. 1988) ("The insurer has a duty to accept an objectively reasonable settlement demand . . . The proper execution of this implied duty is one example of good faith.").

A number of sources have noted that "[w]hether the respective court examining the matter applies a bad faith or negligence standard . . . a test often applied . . . is whether a prudent insurer without policy limits would have accepted the settlement offer." 14 LEE R. RUSS & THOMAS F. SEGALLA, COUCH ON INSURANCE § 203:25 (3d ed. 2012). See also James Martin Truss, Case Note, *Insurance – Stowers Doctrine – A Settlement Offer Above Policy Limits Does Not Trigger an Insurer's Stowers Duty to Act Reasonably*, 26 ST. MARY'S L.J. 673, 691 (1995) ("Although bad faith entails a nominally greater burden than negligence, many courts coalesce the bad faith and negligence standards in practice and focus upon the amount of consideration given to the insured's interests."); Bollinger v. Nuss, 449 P.2d 502, 509 (Kan. 1969) ("[T]he divergency between the good faith test and the negligence test may be more a difference in verbiage than results. While the terms . . . are not synonymous or interchangeable in a strict legal sense, they share common hues in the insurer's spectrum of duty."); Syverud, 76 VA. L. REV. at 1123 ("The practical distinction between a negligent failure to settle and a bad faith failure to settle

remains elusive"); Robert E. Keeton, *Liability Insurance and Responsibility for Settlement*, 67 HARV. L. REV. 1136, 1140-1142 (1954) (noting that "[t]he distinction between the 'bad faith rule' and the 'negligence rule' is less marked than these terms would suggest.").

d. Applying the reasonableness standard. For examples and explanations regarding what constitutes a reasonable settlement offer, see, e.g., Transport Ins. Co. v. Post Express Co., 138 F.3d 1189, 1190-1193 (7th Cir. 1998); Buntin v. Continental Ins. Co., 525 F. Supp. 1077, 1083 (D.V.I. 1981) ("We hold that an insurer's honest but erroneous belief that there is no coverage under its policy of insurance in no way lessens the insurer's obligation to view a settlement offer as if it alone were liable for any eventual judgment, nor does it diminish the insurer's liability in the event it breaches its settlement obligations."); Hartford Cas. Ins. Co. v. N.H. Ins. Co., 628 N.E.2d 14 (Mass. 1994); Eskridge v. Educator & Executive Insurers, Inc., 677 S.W.2d 887, 889-890 (Ky. 1984); Parsons v. Continental Nat'l Am. Group, 550 P.2d 94, 100 (Ariz. 1976); Johansen v. Cal. State Auto. Ass'n. Inter-Ins. Bureau, 538 P.2d 744, 745-751 (Cal. 1975).

For cases holding that the failure to accept a reasonable settlement offer leads to liability for the excess verdict, see, e.g., McNally v. Nationwide Ins. Co., 815 F.2d 254, 259 (3d Cir. 1987) (affirming judgment for insured in case in which insurer had failed to accept a reasonable settlement); Rupp v. Transcon. Ins. Co., 627 F. Supp. 2d 1304, 1320 (D. Utah 2008) (deciding that, although "the Utah Supreme Court has not addressed whether breach of the duty to accept reasonable settlement offers releases the insured from complying with a legal action limitation provision," that the Court likely would find the insured released); Escambia Treating Co. v. Aetna Cas. & Sur. Co., 421 F. Supp. 1367, 1370 (N.D. Fla. 1976) ("Florida courts have clearly recognized the insurer's duty to act in good faith and accept reasonable settlements."); Hamilton v. Maryland Cas. Co., 41 P.3d 128, 132 (Cal. 2002) (citing Kransco v. Am. Empire Surplus Lines Ins. Co., 2 P.3d 1, 9 (Cal. 2000), as modified (July 26, 2000)) ("the covenant of good faith and fair dealing implied by law in all contracts" combines with the "duty to defend and indemnify covered claims" to imply a "duty on the part of the insurer to accept reasonable settlement demands on [] claims within the policy limits."); Whitney v. State Farm Mut. Auto. Ins. Co., 258 P.3d 113, 2011 Alaska LEXIS 83 (Alaska 2011) (the implied covenant of good faith and fair dealing obligates insurers to "accept reasonable offers of settlement in a prompt fashion.") (quoting Guin v. Ha, 591 P.2d 1281, 1291 (Alaska 1979) (allowing insured to recoup prejudgment interest attributable to the bad faith of the insurer, regardless of policy limits); Am. Physicians Ins. Exch. v. Garcia, 876 S.W.2d 842, 848-849 (Tex. 1994) (Texas courts require insurers "to accept reasonable settlement demands within policy limits."). See also Tran v. State Farm Mut. Auto. Ins. Co., 999 F. Supp. 1369, 1372 (D. Haw. 1998) (stating in a first-party case that "an insurer who does not accept a reasonable settlement offer within policy limits is also liable for violation of its duty to act in good faith regarding the interests of the insured."). But see Pavia v. State Farm Mut. Auto. Ins. Co., 626 N.E.2d 24, 28 (N.Y. 1993) (New York law requires that a plaintiff in a bad-faith action show that "the insured lost an actual opportunity to settle the . . . claim . . . at a time when all serious doubts about the insured's liability were removed.").

An insurer has not breached its duty to settle by rejecting a settlement offer well above the range of reasonable settlement amounts. See, e.g., Christian Builders, Inc. v. Cincinnati Ins. Co., 501 F. Supp. 2d 1224, 1237 (D. Minn. 2007) (holding that the insurer had not unreasonably refused to settle when the

plaintiff refused to lower its $2 million offer and the insurer had accurately assessed the reasonable settlement value between $400,000 and $600,000). As with any liability standard, the reasonableness standard stated in this Section does not require the insurer to do anything. Rather, the standard simply assigns to the insurer the legal responsibility for excess judgments that result from a breach of the standard. Moreover, the standard imposes no consequences on the insurer for rejecting a settlement offer that is unreasonable.

e. Procedural factors may be considered. For a general discussion of the multiple factors that courts take into account in the duty-to-settle analysis, see Kenneth S. Abraham, *The Natural History of the Insurer's Liability for Bad Faith*, 72 TEX. L. REV. 1295, 1302-1306 (1994) (describing factors that courts take into account in duty-to-settle analysis); Douglas R. Richmond, *Bad Insurance Bad Faith Law*, 39 TORT TRIAL & INS. PRAC. L.J. 1, 5 (2003) (listing factors). For instances of these factors being relied upon in case law, see Smith v. Gen. Accident Ins. Co., 697 N.E.2d 168, 170-171 (N.Y. 1998); Truck Ins. Exch. v. Bishara, 916 P.2d 1275, 1279-1280 (Idaho 1996); O'Neill v. Gallant Ins. Co., 769 N.E.2d 100, 106-109 (Ill. App. Ct. 2002).

f. The insurer's failure to make settlement offers and counteroffers. There is a split of authority on the question whether the duty to make reasonable settlement decisions can obligate the insurer to explore settlement negotiations should the claimant or claimants not come forward with a settlement offer. See WILLIAM T. BARKER & RONALD D. KENT, NEW APPLEMAN INSURANCE BAD FAITH LITIGATION § 2.03[6][d][iii] (discussing the split of authority) (Lexis 2012). At least one leading treatise has suggested that the view stated in this Section is a minority rule. See JERRY & RICHMOND, UNDERSTANDING INSURANCE LAW 840 (5th ed. 2012) ("In most jurisdictions, the insurer cannot be liable for breaching the duty to settle unless a settlement offer within policy limits is made by the plaintiff. Without a settlement offer, it is not possible for the insurer to have breached its duty."). Nonetheless, a number of scholars have argued that such an affirmative obligation should be imposed. See, e.g., ROBERT KEETON & ALAN I. WIDISS, INSURANCE LAW, § 7.8(c), at 889-890 (1988) ("In most circumstances the insurer, having reserved to itself the right to control the defense and the decision whether to agree to a settlement, should be obligated to explore the possibility of a settlement even in the absence of actions by the third-party or an express request by the insured"). For cases holding that the insurer has a duty to make an offer in certain circumstances, see, e.g., SRM, Inc. v. Great Am. Ins. Co., 798 F.3d 1322, 1323 (10th Cir. 2015) (Oklahoma law) ("a primary insurer owes its insured a duty to initiate settlement negotiations with a third-party claimant if the insured's liability to the claimant is clear and the insured likely will be held liable for more than its insurance will cover"); Boicourt v. Amex Assurance Co., 78 Cal. App. 4th 1390, 1394 (Cal. App. 2000); Powell v. Prudential Property Cas. Ins. Co., 584 So. 2d 12, 14 (Fla. Dist. Ct. App. 1991) ("insurer has an affirmative duty to initiate settlement negotiations," citing cases from Kansas, New Jersey, Wisconsin, and Oregon); Gutierrez v. Yochim, 23 So. 3d 1221, 1226 (Fla. Dist. Ct. App. 2009); Rova Farms Resort, Inc. v. Investors Ins. Co., 323 A.2d 495, 505 (N.J. 1974) (the "better view is that the insurer has an affirmative duty to explore settlement possibilities").

g. The causation difference between rejecting a settlement offer and choosing not to make an offer. See, e.g., Gibbs v. State Farm Mutual Insurance Co., 544 F.2d 423, 427 (9th Cir. 1976) (applying California law) (insurer may be found to have "neglect[ed] its good faith duty when it fails to take

affirmative action in settling claim"); Boicourt v. Amex Assurance Co., 78 Cal. App. 4th 1390, 93 Cal. Rptr. 2d 763, 768 (2000) ("[A] formal settlement offer is not an absolute prerequisite to a bad faith action. . . .").

h. Settlement offers in excess of policy limits. The term "duty to contribute" comes from Richard Squire. In the context in which courts and commentators refer to the "duty to settle," the duty to contribute nicely distinguishes cases that the insurer can settle unilaterally from those in which the insurer cannot do so because the limits of the insurance policy are insufficient. See Richard Squire, *How Collective Settlements Camouflage the Costs of Shareholder Lawsuits*, 62 DUKE L.J. 1 (2012) (arguing that the duty to contribute leads to a collective-action problem among insurers in the securities-class-action settlement context). Some jurisdictions have held that an insurer's failure to offer its policy limits in response to a reasonable above-limits settlement offer can constitute a breach of the duty to settle. See, e.g., Fireman's Fund Ins. Co. v. Sec. Ins. Co. of Hartford, 367 A.2d 864, 869 (N.J. 1976). Some commentators have even characterized this as the majority position. According to some commentators, however, a majority of jurisdictions hold that an insurer does not breach any settlement obligation if it rejects an offer that exceeds the limits in the policy. See, e.g., JERRY & RICHMOND, UNDERSTANDING INSURANCE LAW 874 (4th ed. 2007) ("In most jurisdictions, the insurer cannot be liable for breaching the duty to settle unless a settlement offer within policy limits is made by the plaintiff.") (footnote omitted). Other commentators stop short of characterizing this as the majority position. See, e.g., 14 LEE R. RUSS & THOMAS F. SEGALLA, COUCH ON INSURANCE § 203:20 (3d ed. 2012) ("Some authority states that an insurer's duty to make reasonable settlements is only triggered when a claimant makes an offer to settle within policy limits. Under this view an offer in excess of policy limits does not give rise to the duty, even where the offer is reasonable."). For cases holding that an insurer has no duty to accept a settlement offer in excess of policy limits, see, e.g., Rocor Intern., Inc. v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA, 77 S.W.3d 253, 262 (Tex. 2002) ("[A]n insurer's settlement duty is not activated until a settlement demand within policy limits is made, and the terms of the demand are such that an ordinarily prudent insurer would accept it."); Haddick ex rel. Griffth v. Valor Ins., 763 N.E.2d 299, 305 (Ill. 2001) (noting that the duty to settle "does not arise until a third party demands settlement within policy limits.").

i. No direct duty owed to excess insurers. See § 28.

j. No duty owed to third parties. Because insurers lack a preexisting relationship with third-party tort plaintiffs, the majority of courts and commentators agree that insurers have no common-law tort or contractual duty to tort plaintiffs to settle. See, e.g., WILLIAM T. BARKER & RONALD D. KENT, NEW APPLEMAN INSURANCE BAD FAITH LITIGATION § 2.07[1] (Lexis 2011) ("An insurer has no 'special relationship' with a third party claiming against its insured and owes such a third party no unusual duties. . . . absent a contrary statute, neither [the insurer nor the defendant] owes the third party any duty to settle."). For cases rejecting a common-law duty because of the lack of a preexisting relationship, see, e.g., Bean v. Allstate Ins. Co., 403 A.2d 793, 795 (Md. 1979) ("[T]he insurer owes no duty to a claimant to settle a claim, and . . . . [a]ny obligation to deal with settlement offers in good faith runs only to the insured. . . . [T]he claimant is a stranger to the relationship between the insurer and the insured and is not in privity with them."); Kranzush v. Badger State Mut. Cas. Co., 307 N.W.2d 256, 265 (Wis. 1981) ("The insurer's duty of good faith and fair dealing arises from the insurance contract and runs to the insured. No

such duty can be implied in favor of the claimant from the contract since the claimant is a stranger to the contract and to the fiduciary relationship it signifies."). Courts have similarly rejected the argument that accident victims are third-party beneficiaries to the tortfeasor's insurance policy. See, e.g., Leal v. Allstate Ins. Co., 17 P.3d 95, 100 (Ariz. Ct. App. 2000) ("Although accident victims may be intended beneficiaries of state-mandated insurance, this does not mean that they are intended beneficiaries of every insurance contract."); Long v. McAllister, 319 N.W.2d 256, 262 (Iowa 1982) ("Because plaintiff relies only on the fact that he will benefit if the contract is carried out in accordance with its terms, he has alleged only a basis for finding he is an incidental beneficiary. . . . We refuse to extend the third party beneficiary concept to the limits advocated by the plaintiff.").

Although most states have enacted some version of an Unfair Settlement Practices Act, the vast majority of courts have declined to read the provision to give third-party plaintiffs a private right of action against the insurer for failing to settle. See, e.g., *Leal*, 17 P.3d at 100 (finding that the statute explicitly denies any private remedy); Moradi-Shalal v. Fireman's Fund Ins. Co., 46 Cal. 3d 287 (Cal. 1988) (overturning a prior ruling granting a statutory cause of action).

Only a handful of states have interpreted their Unfair Settlement Practices statute to provide a private right of action to third-party claimants. Montana's statute specifies that third-party claimants have an independent cause of action, and courts have therefore allowed claimants to proceed directly against insurers for a bad-faith failure to settle. Holmgren v. State Farm Mut. Auto Ins. Co., 976 F.2d 573 (9th Cir. 1992) (applying Montana law). A few other states have enacted statutes granting a private right of action to "anyone" injured by a fair-practice violation, and some courts have interpreted this language to include third-party claimants. See, e.g., Auto-Owners Ins. Co. v. Conquest, 658 So. 2d 928, 929 (Fla. 1995); Hovet v. Allstate Ins. Co., 89 P.3d 69, 76 (N.M. 2004); Van Dyke v. St. Paul Fire & Marine Ins. Co., 448 N.E.2d 357, 360 (Mass. 1983).

e. Other loss. See, e.g., Bainbridge, Inc. v. Travelers Cas. Co. of Conn., 159 P.3d 748, 756 (Colo. App. 2006), as modified on denial of reh'g (Nov. 30, 2006) ("[An] insured may recover consequential damages for [a] breach which, if based on contract principles, include those damages that arose naturally from the breach and were reasonably foreseeable at the time of contract.") (citations omitted). Cf. Bi-Economy Mkt., Inc. v. Harleysville Ins. Co. of N.Y., 886 N.E.2d 127, 132 (N.Y. 2008) (consequential damages allowed for breach of business-interruption policy).

§ 51. Liability for Insurance Bad Faith

An insurer is subject to liability to the insured for insurance bad faith when it fails to perform its duties under a liability insurance policy:

(a) Without a reasonable basis for its conduct; and

(b) With knowledge of its obligation to perform or in reckless disregard of whether it had an obligation to perform.

Comment:

a. The tort of insurance bad faith. Most states classify insurance bad faith as a tort-law cause of action. That approach is consistent with the Restatement Second of Contracts, which recognizes an award of punitive damages in an action on a contract only when there is a tort-law cause of action that authorizes the punitive damages. See Restatement Second, Contracts § 355. This tort-law classification has other consequences for the damages that are potentially available, primarily because of differences in the timing of when a harm caused by the breach must be foreseeable for the harm to be compensable under contract- and tort-law rules. Under the contract-law approach followed in § 50, a consequential harm must have been foreseeable at the time of contracting in order to be compensable; while under the tort-law approach, the extent of the harm that is compensable is subject only to rules regarding proximate cause (or, as referred to in the Restatement Third, Torts: Liability for Physical and Emotional Harm, the scope of liability). See § 51 (following the tort-law approach to damages for insurance bad faith).

b. The standard for liability insurance bad faith. Much of the law governing insurance bad faith has been developed in the first-party insurance context because successful, true liability insurance bad-faith actions are uncommon. (An action for breach of the duty to make reasonable settlement decisions that is framed as a "bad faith" action is not a true liability insurance bad-faith action under the rules followed in this Restatement, unless the more demanding standard

followed in this Section is met. See Comment *d* and § 24, Comment *c.*) The relative dearth of true liability insurance bad-faith actions likely results from the fact that other liability insurance rules provide an incentive for insurers to behave reasonably. Because there are no corresponding rules that create similar incentives in the first-party insurance context, insurance bad-faith actions have a larger role in first-party insurance.

Although jurisdictions differ widely in the verbal formulations used to describe the legal standard for insurance bad faith, the majority rule followed in this Section requires both an objective and a subjective element. This Section follows that approach, rather than the purely objective approach, for three reasons. First, the purely objective approach is already embodied in other liability insurance law rules that provide additional remedies when an insurer behaves unreasonably: the rule in § 19(2), pursuant to which an insurer that breaches the duty to defend without a reasonable basis loses its other coverage defenses; the rule in § 24 regarding insurers' duty to make reasonable settlement decisions; and the rule in § 27 setting out the damages for breach of that duty. Second, the insured's right to attorneys' fees under the rules stated in § 49(4) and § 50(3) means that insureds already are entitled to receive their attorneys' fees when their rights to a defense are denied or threatened, without a finding of bad faith. Third, the rule followed in this Section is the clear majority rule, especially once it is recognized that many of the published opinions applying a purely objective standard for bad faith do so in the service of awarding the remedies available under the rules just mentioned: § 19(2), § 27, § 49(4), and § 50(3). If a jurisdiction does require a finding of bad faith as a prerequisite to awarding the remedies provided in those Sections, the appropriate standard for bad faith in those contexts is the purely objective standard, but otherwise the stigma associated with a finding of liability insurance bad faith is appropriately limited to cases in which the insurer's culpability extends beyond negligence.

The objective element is most commonly stated as the lack of a "reasonable" or a "fairly debatable" basis for the failure to perform. What these and other similar expressions of the objective element have in common is that the insurer must have a sufficient basis for any refusal to perform. An insurer has a sufficient basis if it takes a legal position that a reasonable insurer might take, or acts in a manner that a reasonable insurer might act in the circumstances. See also § 19, Comment *g.* Because a reasonable insurer is knowledgeable about and follows liability

insurance law, a coverage position that has no basis in the law of the jurisdiction—a determination that can be made by the court as a matter of law—would not be fairly debatable.

The subjective element is most commonly stated as "with knowledge or in reckless disregard of" the obligation to perform. This means that the insurer failed to perform (a) when it knew it was obligated to perform or (b) without regard to whether it had a reasonable basis for not performing, whether because of lack of investigation of the relevant facts, a failure to conduct the necessary state-specific legal research to evaluate the coverage position, or some other circumstance that placed the insurer on notice that it had not done what it needed to do in order to evaluate whether it had a reasonable basis for its position.

c. Liability insurance bad faith in the duty-to-defend context. Because the standard for insurance bad faith includes both a subjective and an objective element, it is more demanding than the purely objective standard stated for loss of coverage defenses in § 19(2). An insurer that breaches the duty to defend without a reasonable basis is subject to the rule in § 19(2), pursuant to which it loses the ability to assert any coverage defenses that it could have asserted had it defended the insured under a reservation of rights, but it is not subject to liability for insurance bad faith unless it did so "with knowledge or in reckless disregard of its obligation to perform."

d. Liability insurance bad faith in the settlement context. Because the standard for liability insurance bad faith includes both a subjective and an objective element, it is more demanding than the purely objective standard stated for breach of the duty to make reasonable settlement decisions stated in § 24. An insurer that breaches the duty to make reasonable settlement decisions is subject to liability for the damages stated in § 27, but it is not subject to additional liability for insurance bad faith unless it breached that duty "with knowledge or in reckless disregard of its obligation to perform." For example, when an insurer adequately investigates a suit and appropriately trains its claims personnel, an honest mistake about the likelihood or size of an excess verdict would be very unlikely to satisfy the "with knowledge or in reckless disregard" standard in this Section even if the insurer is liable for excess verdict under § 27. Similarly, when an insurer refuses to settle a suit in order to retain the right to contest coverage for the claim, it will be subject to liability under § 27 for breach of the duty to make reasonable settlement decisions if a reasonable insurer that accepted coverage would have settled the suit. See § 25(1) ("A reservation of the right to contest coverage does not relieve an insurer

of the duty to make reasonable settlement decisions stated in § 24"). But, as long as the insurer had a fairly debatable basis for contesting coverage or did not act with knowledge or in reckless disregard of the absence of a fairly debatable basis, the insurer will not be subject to additional liability, beyond that available under § 24 and § 27, for insurance bad faith. If the insured proves that the insurer's conduct did meet the standard stated in this Section, the additional remedies that the insured will receive are the fees and other costs the insured's attorneys incurred in establishing liability, any harm proximately caused by the bad-faith breach that were not already part of the damages for breach of the duty to make reasonable settlement decisions and, if the insurer's conduct meets the applicable state-law standard, punitive damages. See § 52.

Illustrations:

1. A claimant files a personal-injury lawsuit against the insured seeking damages. The insured has a duty-to-defend liability insurance policy that assigns settlement discretion to the insurer. The policy contains a policy limit of $75,000 and no deductible. The claimant offers to settle for $45,000, which is a reasonable settlement value of the case, based on the judgment that the plaintiff has a 30 percent chance of success and likely damages of $150,000. The insurer rejects the offer because it concludes, based on discussion with defense counsel, that the chances of prevailing at trial are sufficiently strong that the risk is worth taking, even accepting the likelihood that it will be held liable for failure to settle if the claimant prevails at trial. The case proceeds to trial and a verdict of $175,000 is entered against the insured. The insurer is subject to liability under the rule in § 24 for the full amount of the verdict because the insurer failed to accept a reasonable settlement offer. The insurer is not subject to liability for insurance bad faith because there was a strong possibility of success at trial and the insurer honestly believed that the risk was worth taking, even accepting the potential liability for an excess verdict under § 24.

2. A claimant files a tort suit against the insured seeking damages of $500,000. The insured has a duty-to-defend liability insurance policy that has policy limits of $100,000 and that assigns settlement discretion to the insurer. The insured tenders the defense of the suit to the insurer, which agrees to defend under a reservation of rights. The insurer reasonably believes that it has a ground for contesting coverage that relieves

it from any duty to indemnify the insured for the suit. As the case approaches trial, the claimant makes a settlement demand of $80,000, which a reasonable insurer that accepted coverage for the suit would have accepted. The insurer rejects the settlement demand. The suit then goes to trial, resulting in a $500,000 verdict against the insured. If the coverage dispute is resolved in the insurer's favor, the insurer is not liable to the insured for any damages. If the coverage dispute is resolved in the insured's favor, the insurer is subject to liability under the rule in § 24 for the full amount of the verdict because it failed to accept the reasonable settlement offer, but the insurer is not subject to liability for insurance bad faith because it had a fairly debatable ground for contesting coverage.

3. A claimant files a tort suit against the insured seeking damages of $500,000. The insured has a duty-to-defend liability insurance policy that has policy limits of $100,000 and that assigns settlement discretion to the insurer. The insured tenders the defense of the suit to the insurer, which agrees to defend. The claimant makes a reasonable settlement demand for the full policy limits of $100,000. After discussions with defense counsel, the insurer rejects the settlement demand, based on the reasonable belief that the plaintiff's lawyer is not prepared to hold out until trial and that there will be an opportunity to achieve a lower settlement later. The plaintiff gets a new attorney, who refuses to settle. The suit then goes to trial, resulting in a $500,000 verdict against the insured. The insurer is subject to liability under the rule in § 24 for the full amount of the verdict because it failed to accept a reasonable settlement offer. The insurer is not subject to liability for insurance bad faith because it reasonably believed that it would be able to settle the case for a lower amount in the future.

4. Following a fatal automobile accident, the estate of the decedent filed a suit against Driver, who was insured under a policy issued by Insurer with policy limits of $25,000. Insurer agreed to defend. The estate offered to settle for the policy limits. Insurer refused. The case went to trial resulting in a verdict against driver in the amount of $135,000. Driver brought an action against Insurer for breach of the duty to make reasonable settlement decisions and for insurance bad faith. Evidence produced in discovery showed that Insurer's investigator reported to her supervisor that Driver was at fault; the supervisor directed investigator to change her report so that it did not indicate that Driver was at fault; prior verdicts in death claims in the jurisdiction had all been

greatly in excess of $25,000; and supervisor was under pressure to meet claim-payment-reduction goals. Insurer is subject to liability under the rule in § 24 for the full amount of the verdict because it failed to accept a reasonable settlement offer. In addition, a jury may find that Insurer is subject to liability for bad faith because it did not have a reasonable basis for the failure to settle, and it knew or recklessly disregarded its obligation to settle the claim.

e. Liability insurance bad faith in other contexts. Most of the, relatively limited, case law involving true liability insurance bad faith arises in the context of a breach of the duty to defend or the duty to make reasonable settlement decisions. Nevertheless, there are a variety of other actions that can constitute liability insurance bad faith. Drawing from published opinions, those actions can include but are not limited to: misrepresentations by the insurer of the coverage provided by the policy, improper destruction of evidence, obtaining from insurance defense counsel confidential information that the insurer could use to avoid coverage for the claim, negotiating with the claimant to plead the policyholder out of coverage, and overpaying on claims to accelerate exhaustion of policy limits.

REPORTERS' NOTE

a. The tort of insurance bad faith. See Restatement Second, Torts § 917, Comment *d* (AM. LAW INST. 1979) ("The limitation in actions for breach of contract that the harm must be such as the contract breaker should reasonably foresee at the time of making the contract to be within the risk of occurrence as a result of his breach (see Restatement, Second, Contracts, Chapter 16 (Tent.Draft)), does not ordinarily apply to the extent of liability for a tort.") In a majority of states an insured may bring a bad-faith tort-law cause of action against its insurer. See, e.g., Allstate Ins. Co. v. Miller, 212 P.3d 318, 324 (Nev. 2009) ("A violation of the covenant gives rise to a bad-faith tort claim") (citing United States Fidelity v. Peterson, 540 P.2d 1070, 1071 (Nev. 1975)); Goodson v. Am. Standard Ins. Co. of Wisconsin, 89 P.3d 409, 414 (Colo. 2004) (explaining that since insurance contracts are "unlike ordinary bilateral contracts," an insurer's bad faith gives rise to a tort-law cause of action); Anderson v. Cont'l Ins. Co., 271 N.W.2d 368, 374 (Wis. 1978) (same); Comunale v. Traders & General Ins. Co., 328 P.2d 198 (Cal. 1958) (recognizing a cause of action for the tort of insurance bad faith); see also Kransco v. Am. Empire Surplus Lines Ins. Co., 2 P.3d 1, 8-9 (Cal. 2000) (holding an insurance company does not have a tort-law cause of action against its policyholder when the insured breaches its good-faith obligation under the policy); State Farm Fire & Cas. Co. v. Nicholson, 777 P.2d 1152, 1155 (Alaska 1989) ("Courts first recognized the tort of bad faith in third-party cases"). Very few jurisdictions do not recognize the tort and thereby limit insureds to bringing a contract action against their insurer. See, e.g., Gebretsadike v. Travelers Home & Marine Ins. Co., 103 F. Supp. 3d 78, 83 (D.D.C. 2015) ("District of Columbia law does not recognize a

tort of bad faith by insurance companies in the handling of policy claims."); Associated Wholesale Grocers, Inc. v. Americold Corp., 934 P.2d 65, 89-90 (Kan. 1997) (stating Kansas does not recognize the tort of insurance bad faith; an insurer's obligation under the contract is "to act in good faith and without negligence"). On the application of tort-law-damages rules in a liability insurance bad-faith case, see, e.g., Polito v. Cont'l Cas. Co., 689 F.2d 457, 461 (3d Cir. 1982) (the tort for failing to settle in good faith "supports a claim for consequential damages"); Chavers v. Nat'l Sec. Fire & Cas. Co., 405 So. 2d 1, 5 (Ala. 1981) (insureds' recovery of excess judgments is allowed when the insurer's failure to settle a claim was "negligent[]," but that damages may also "include mental distress and economic loss" when the insurer's failure to settle constituted the tort of bad faith).

b. The standard for liability insurance bad faith. The majority approach to determine whether an insurer acted in bad faith requires courts to evaluate the insurer's conduct with both an objective and subjective test. See, e.g., Nardelli v. Metro. Grp. Prop. & Cas. Ins. Co., 277 P.3d 789, 794-795 (Ariz. Ct. App. 2012) ("An insurer acts in bad faith when it unreasonably investigates, evaluates, or processes a claim (an 'objective' test), and either knows it is acting unreasonably or acts with such reckless disregard that such knowledge may be imputed to it (a 'subjective' test)"); Adamski v. Allstate Ins. Co., 738 A.2d 1033, 1036 (Pa. Super. Ct. 1999) (applying a two-part, objective and subjective, test for insurance bad faith); Republic Ins. Co. v. Stoker, 903 S.W.2d 338, 340 (Tex. 1995) (same). For courts adopting a purely objective standard, see, e.g., Gruenberg v. Aetna Ins. Co., 510 P.2d 1032 (Cal. 1973); Kirk v. Mt. Airy Ins. Co., 951 P.2d 1124, 1125 (Wash. 1998) ("In order to establish bad faith, an insured is required to show the breach was unreasonable, frivolous, or unfounded"); Zoppo v. Homestead Ins. Co., 644 N.E.2d 397 (Ohio 1994) (applying an objective "reasonable justification" standard for bad-faith cases and not requiring proof of subjective bad faith).

Most courts define the objective prong of the test as the insurer lacking a "reasonable" or "fairly debatable" basis for its failure to perform. See, e.g., Anderson v. Cont'l Ins. Co., 271 N.W.2d 368, 376 (Wis. 1978) (adopting a two-prong test and defining the objective prong as the "absence of a reasonable basis for denying benefits of the policy"); Reliance Ins. Co. v. Barile Excavating & Pipeline Co., 685 F. Supp. 839, 840 (M.D. Fla. 1988) (defining the objective prong as when "the insurance claim is determined not to be 'fairly debatable.'").

Courts define the subjective test as the insurer acting "with knowledge or in reckless disregard" of its obligation to perform under the policy. See, e.g., Ruwe v. Farmers Mut. United Ins. Co., 469 N.W.2d 129, 133-135 (Neb. 1991) (first-party case) (explaining an insured may meet the "knowledge or reckless disregard" standard by submitting proof of its insurer's reckless indifference to facts such as a failure to investigate the covered loss); Anderson v. Cont'l Ins. Co., 271 N.W.2d 368 (Wis. 1978) (same subjective test); Dolan v. Aid Ins. Co., 431 N.W.2d 790, 794 (Iowa 1988) (applying the *Anderson* test); Pickett v. Lloyd's, 621 A.2d 445 (N.J. 1993) (same); Travelers Ins. Co. v. Savio, 706 P.2d 1258, 1274 (Colo. 1985) (same). But see Nat'l Sec. Fire & Cas. Co. v. Bowen, 417 So. 2d 179, 183 (Ala. 1982) (requiring an insurer's actual knowledge that there was no lawful basis for its action). Cf. Pavia v. State Farm Mut. Auto. Ins. Co., 626 N.E.2d 24 (N.Y. 1993) (first-party case) (holding that an insured must prove the insurer's conduct constituted a "gross disregard" of the insured's interests).

c. Liability insurance bad faith in the duty-to-defend context. This Comment distinguishes the heightened standard for proving insurance bad faith from § 19(2)'s "reasonable basis" standard. See, e.g., Adamski v. Allstate Ins. Co., 738 A.2d 1033 (Pa. Super. Ct. 1999) ("[t]o establish bad faith under section 8371, our Court has utilized a two-part test, both elements of which must be established by clear and convincing evidence: (1) the insurer lacked a reasonable basis for denying coverage; and (2) the insurer knew or recklessly disregarded its lack of a reasonable basis. See Terletsky v. Prudential Property & Casualty Ins. Co., 437 Pa.Super. 108, 649 A.2d 680 (1994)."). Cf. Freidline v. Shelby Ins. Co., 774 N.E.2d 37 (Ind. 2002) ("To prove bad faith, the plaintiff must establish, with clear and convincing evidence, that the insurer had knowledge that there was no legitimate basis for denying liability." (citations omitted; emphasis added). Note that courts that award the § 19(2) remedy solely as a consequence of a finding of bad faith often use a purely objective standard for bad faith that is identical to that required to recover the § 19(2) remedy. See § 19, Reporters' Note to Comments *c* and *g*.

d. Liability insurance bad faith in the settlement context. See, e.g., Gruenberg v. Aetna Ins. Co., 510 P.2d 1032 (Cal. 1973) (distinguishing *Comunale* and *Crisci*, cases in which an insurer was held liable for a failure to meet the duty to make reasonable settlement decisions, from the present bad-faith tort case). An insurer that rejects a reasonable settlement offer has not necessarily acted in bad faith. See, e.g., McDaniel v. GEICO General Ins. Co., 55 F. Supp. 3d 1244 (E.D. Cal. 2014) ("When there is a great risk of a recovery beyond the policy limits so that the most reasonable manner of disposing of the claim is a settlement, a consideration of the insured's interest requires the insurer to settle the claim . . . Liability is imposed not for a bad faith breach of the contract but for failure to meet the duty to accept reasonable settlements"); Davis v. Cincinnati Ins. Co., 288 S.E.2d 233, 237-238 (Ga. 1982) (affirming judgment against insurer for failure to make reasonable settlement decision because that claim does not require a showing of bad faith); Crisci v. Sec. Ins. Co. of New Haven, Conn., 426 P.2d 173, 177 (Cal. 1967) ("Liability is imposed not for a bad faith breach of the contract but for failure to meet the duty to accept reasonable settlements, a duty included within the implied covenant of good faith and fair dealing."); Howard v. Am. Nat. Fire Ins. Co., 115 Cal. Rptr. 3d 42, 69-71 (Cal. Ct. App. 2010) (evaluating independently whether insurer breached its duty to make reasonable settlement decisions and acted in bad faith; holding that insurer breached its duty to make a reasonable settlement decision and then holding insurer acted in bad faith because it did not make "an honest mistake or [a] bad judgment" but acted based on "an unfair and selective reading of . . . deposition testimony that distorted . . . [and] ignored powerful indications that a multimillion-dollar judgment was likely."). Cf. Mowry v. Badger State Mut. Casualty Co., 129 Wis. 2d 496, 517 (Wis. 1986) (applying a true bad-faith standard to liability for an excess judgment and holding that, under that standard, an insurer that relies upon a fairly debatable coverage position as justification for not accepting a reasonable settlement offer is not acting in bad faith). See generally COUCH ON INSURANCE § 206:54 (3d ed. 2011) (explaining differences between standards for unreasonably refusing to accept a settlement, leading to liability for damages in excess of the policy limits, and for punitive damages, which requires, in addition, "malice, fraud or oppression"). See also ALLAN D. WINDT, 1 INSURANCE CLAIMS AND DISPUTES: REPRESENTATION OF INSURANCE COMPANIES & INSUREDS §§ 5:12-5:13 (6th ed. 2013) (collecting cases) ("[A]n insurance company can breach its duty to settle without having acted in bad faith. The only prerequisite is that the company fails

to settle a case that it would have settled had it treated the claim as if the company alone would be liable for the entire potential verdict. . . . There is, therefore, no theoretical justification for the bad faith requirement.").

For cases regarding an insurer's honest mistake, see, e.g., Abernethy v. Utica Mut. Ins. Co., 373 F.2d 565, 568 (4th Cir. 1967) (applying North Carolina law) ("[A]n insurer may not be held liable for an honest mistake in judgment, even if unreasonable; it may be held liable only if it acts with wrongful or fraudulent purpose or with lack of good faith"); Henke v. Iowa Home Mut. Cas. Co., 97 N.W.2d 168, 173 (Iowa 1959) ("Bad faith requires more than a showing of inadvertence or honest mistake of judgment."); City of Wakefield v. Globe Indem. Co., 225 N.W. 643, 645 (Mich. 1929) ("It is not bad faith if counsel for the insurer refuse settlement under the bona fide belief that they might defeat the action . . . A mistake of judgment is not bad faith."); Howard v. Am. Nat. Fire Ins. Co., 115 Cal. Rptr. 3d 42, 69-71 (Cal. Ct. App. 2010) (holding insurer acted in bad faith because it did not make an honest mistake). Illustration 4 is a simplified variation on the facts in State Farm Mut. Auto. Ins. Co. v. Campbell, 538 U.S. 408 (2003).

e. Liability insurance bad faith in other contexts. See, e.g., Ellwein v. Hartford Accident & Indemnity Co., 15 P.3d 640 (Wash. 2001) (holding that insurer committed bad-faith breach by misappropriating insured's expert); Lockwood Int'l, B.V. v. Volm Bag Co., 273 F.3d 741 (7th Cir. 2001) (applying Wisconsin law) (holding that insurer committed bad-faith breach by negotiating directly with the claimant without disclosure to insured and paying the claimant to amend the complaint so that it did not include a potentially covered claim).

§ 52. Damages for Liability Insurance Bad Faith

Damages for insurance bad faith include:

(1) The attorneys' fees and other costs incurred by the insured in the legal action establishing the insurer's breach;

(2) Any other loss to the insured proximately caused by the insurer's bad-faith conduct; and

(3) If the insurer's conduct meets the applicable state-law standard, punitive damages.

Comment:

a. Tort-damages rules in the insurance bad-faith context. Except in an unusual circumstance in which the insurer's bad-faith conduct does not constitute a breach of contract, an insured who prevails in a bad-faith case will also receive an award of damages for breach of the liability insurance policy. This Section identifies the additional damages that are available for liability insurance bad faith. These additional damages include: compensation for consequential harm that was not foreseeable at the time of the sale of the policy as probable result of a breach

but that does satisfy the less demanding tort-law requirement of proximate cause (referred to as "scope of liability" in the Restatement Third, Torts: Liability for Physical and Emotional Harm); any attorneys' fees incurred by the insured that were not already included in the damages for breach of contract; and, in an appropriate case, punitive damages.

b. Attorneys' fees. In nearly all jurisdictions, an insured who prevails in a bad-faith action will receive an award of attorneys' fees. In many jurisdictions, the insured will be entitled to a fees award even without a showing of bad faith. All but a few of the remaining jurisdictions award fees upon a showing of insurance bad faith, reasoning that the bad-faith nature of the insurer's conduct eliminates the ordinary justifications for the American rule. This is particularly appropriate in the liability insurance context, because the purpose of liability insurance is to protect the insured from litigation.

c. Punitive damages. There are no special liability insurance law rules governing the standard for or the amount of punitive damages in an insurance bad-faith case. As with punitive damages generally, the purpose of awarding punitive damages for liability insurance bad faith is primarily to punish the insurer for its wrongful conduct and also to deter this and other insurers from engaging in similar conduct in the future. Bad-faith conduct that has the potential to evade detection is particularly deserving of punishment on deterrence grounds, among other reasons to provide a level playing field for insurers that do not engage in such conduct. Bad-faith conduct that denies the dignity of the people that the insurer promised to protect is deserving of punishment on retributive grounds.

The legal standard for awarding punitive damages is worded differently in almost every state. In many, if not most states there is a statute that provides the legal standard for awarding punitive damages. With very few exceptions, every state requires proof of something more than the evidence required to prove bad faith to award punitive damages. Typically, this includes two distinct aspects: the mental state of the people acting for the insurer and the nature of the conduct. In most cases, the minimum necessary mental state is "reckless disregard." In addition, the insurer's conduct must either be "outrageous," reflecting the law's concern that insureds be treated with dignity, or "repeated," reflecting the law's concern with preventing insurers from profiting from multiple infractions. Courts generally require the insured to provide clear and convincing evidence of the wrongful conduct. This is a more demanding evidentiary standard that reflects the understanding that a bad-faith case is an instrument of public punishment and, as

such, is subject to the more demanding procedural requirements that commonly attend to matters of punishment.

Courts have awarded punitive damages in the liability insurance context when presented with adequate proof of: unreasonable delay, failing to investigate, failing to assist in presenting the claim, incorrectly denying the claim, breaching the duty to indemnify, and failing to settle, among other circumstances. An insurance company is not acting in bad faith when it employs a rigorous claims-handling process, but only when its actions evince a conscious or reckless disregard of a policyholder's rights to promote the insurance company's interests at the policyholder's expense.

Appellate courts generally apply an abuse-of-discretion standard in reviewing the trier of fact's decision that the bad-faith conduct warranted a punitive-damages award, but review the amount of the award de novo. The amount of punitive damages is subject to federal constitutional rules as well as state-law rules. The United States Supreme Court has directed courts to apply a three-part test, which state courts have adopted or aligned with their state's requirements. The three elements, or guideposts, of this test are (1) the degree of the insurance company's reprehensibility; (2) the disparity between the harm or potential harm suffered by the policyholder and the punitive-damages award; and (3) a comparison to the civil and/or criminal penalties authorized or imposed in similar cases. Although there are no liability insurance law specific rules governing any of these factors, the mass-market nature of liability insurance for consumers and small businesses means that bad-faith conduct embedded in an insurer's manner of doing business will have impact that extends well beyond any individual insured.

REPORTERS' NOTE

a. Tort-damages rules in the insurance bad-faith context. An insured that prevails in a bad-faith case may recover non-contractual damages including compensation for consequential harm that was not foreseeable at the time of the sale of the policy, as long as the damages satisfy the requirement of proximate cause or scope of liability. See 1-1 NEW APPLEMAN INSURANCE BAD FAITH LITIGATION § 1.06, note 22 (2d ed. 2015) (collecting cases from Florida, New York, and Pennsylvania); Goodson v. Am. Standard Ins. Co. of Wisconsin, 89 P.3d 409, 415 (Colo. 2004) ("An insured can recover damages for bad faith breach of insurance contract based on traditional tort principles. . . . Compensatory damages for economic and non-economic losses are available to make the insured whole and, where appropriate, punitive damages are available to punish the insurer and deter wrongful conduct by other insurers. . . . Non-economic losses recognized under the rubric of compensatory damages include emotional distress; pain and suffering; inconvenience; fear and anxiety; and impairment of the quality of life."); State Farm

Mut. Auto. Ins. Co. v. Freyer, 312 P.3d 403, 417 (Mont. 2013) ("[A]n insurer's wrongful refusal to indemnify entitles its insured to recover consequential damages"; providing examples of consequential damages such as "administrative costs," and lost profits).

Consequential damages include emotional-distress damages. See, e.g., Crisci v. Security Ins. Co. of New Haven, Conn., 426 P.2d 173, 178 (Cal. 1967) ("it is settled in this state that mental suffering constitutes an aggravation of damages when it naturally ensues from the act complained of, and in this connection mental suffering includes nervousness, grief, anxiety, worry, shock, humiliation and indignity as well as physical pain"). See also Goodson v. Am. Standard Ins. Co. of Wisconsin, 89 P.3d 409, 412 (Colo. 2004) (first-party case) (holding insureds may recover damages for emotional distress without proving substantial property or economic loss); Miller v. Hartford Life Ins. Co., 268 P.3d 418 (Haw. 2011) (same). Consequential damages also include harm to an insured's business and/or reputation. See, e.g., Magnum Foods, Inc. v. Cont'l Cas. Co., 36 F.3d 1491, 1507 (10th Cir. 1994) (reversing and remanding for a new trial so that insured could seek compensatory damages for harm to its business and reputation "proximately caused" by insurer's bad faith); Moore v. Am. Family Mut. Ins. Co., 576 F.3d 781, 789 (first-party case) (8th Cir. 2009) (finding testimony that insured's family "looked at her differently" and "she wondered what other members of the community thought about her" was sufficient for alleging emotional distress and loss of reputation).

b. Attorneys' fees. See STEVEN PLITT, ET. AL., 14 COUCH ON INSURANCE § 205:96-97 (June 2016) ("To the extent that an insurer's bad faith has caused an insured to engage counsel to defend against a claim that the policy requires the insurer defend against [or to engage counsel to obtain benefits provided by the policy], the fees incurred by the insured for such purposes are recoverable as damages in a later action based on the carrier's bad faith.") (collecting cases). Many jurisdictions award the insured the fees incurred in establishing coverage even without a showing of bad faith. See, e.g., Shell Oil Co. v. AC&S, Inc., 649 N.E.2d 946 (Ill. App. Ct. 1995) (holding insurer liable for insured's attorney fees to establish coverage through a declaratory judgment). But see O'Keefe v. Allstate Ins. Co., 934 N.Y.S.2d 481 (N.Y. App. Div. 2011).

c. Punitive damages. See Pac. Mut. Life Ins. Co. v. Haslip, 499 U.S. 1, 19 (1991) ("[U]nder the law of most States punitive damages are imposed for purposes of retribution and deterrence."); Mitchell, Jr. v. Fortis Ins. Co., 686 N.E.2d 176, 188 (S.C. 2009) ("[An] award will adequately vindicate the twin purposes of punishment and deterrence that support the imposition of punitive damages"). For cases supporting the proposition that to warrant the award of punitive damages, the defendant's mental state must be at least "reckless," see, e.g., Liberty Mut. Fire Ins. Co. v. JT Walker Indus., Inc., 554 F. App'x 176, 189 (4th Cir. 2014) (applying South Carolina law) ("A court may award punitive damages in bad faith tort actions for conduct willful, wanton, or reckless in disregarding a plaintiff's rights."); Sims v. Great Am. Life Ins. Co., 469 F.3d 870, 893-894 (10th Cir. 2006) (applying Oklahoma law) ("[An] insurer must 'recklessly disregard' or 'intentionally and with malice breach[] its duty to deal fairly and act in good faith with its insured.'"); Ace v. Aetna Life Ins. Co., 139 F.3d 1241 (9th Cir. 1998) (applying Alaska law) ("[A] plaintiff must prove . . . that the wrongdoer's conduct 'was . . . [with] reckless indifference to the interests of another person.'") (citing Alaska Stat. § 09.17.020; State Farm Fire & Cas. Co. v. Nicholson, 777 P.2d 1152, 1158 (Alaska 1989)); Uberti v. Lincoln Nat. Life Ins. Co., 144 F. Supp.

2d 90, 107 (D. Conn. 2001) ("[W]here the insurer's conduct is found to be malicious or outrageous, that is, done with bad motive or reckless disregard of, or indifference to, the plaintiff's rights"); McLendon v. Wal-Mart Stores, Inc., 521 F. Supp. 2d 561, 565 (S.D. Miss. 2007) (stating the minimum mental state for punitive damages under Mississippi law is reckless disregard); Forrest Constr., Inc. v. Cincinnati Ins. Co., 728 F. Supp. 2d 955, 967 (M.D. Tenn. 2010) (same); Goodson v. Am. Standard Ins. Co. of Wisconsin, 89 P.3d 409, 415 (Colo. 2004) ("[T]he insurer either knowingly or recklessly disregarded the validity of the insured's claim. . . .") (citing Colo. Rev. Stat. § 13-21-102 ("'[W]illful and wanton conduct' means conduct purposefully committed which the actor must have realized as dangerous, done heedlessly and recklessly, without regard to consequences, or of the rights and safety of others, particularly the plaintiff.")); Sloan v. State Farm Mut. Auto. Ins. Co., 85 P.3d 230, 232 (N.M. 2004) ("An insurer's frivolous or unfounded refusal to pay is the equivalent of a reckless disregard for the interests of the insured . . . which has historically justified an award of punitive damages. To ensure the jury has found a culpable mental state before awarding punitive damages, we modify UJI 13–1718 to reflect that punitive damages may only be awarded when the insurer's conduct was in reckless disregard for the interests of the plaintiff."); O'Neill v. Gallant Ins. Co., 769 N.E.2d 100, 109 (Ill. 2002) ("[W]here the insurer's conduct exceeds mere negligence and, like here, demonstrates to a jury's satisfaction that the refusal to settle within policy limits was engaged in with utter indifference and reckless disregard for its policyholder's financial welfare, punitive damages can be awarded."); Majorowicz v. Allied Mut. Ins. Co., 569 N.W.2d 472 (Wis. Ct. App. 1997) ("It is no longer necessary to show malice or vindictiveness in order to recover punitive damages; it is enough that the wrongdoer acted in wanton, willful, or reckless disregard . . ."); Tackett v. State Farm Fire & Cas. Ins. Co., 653 A.2d 254, 265 (Del. 1995) ("The penal aspect and public policy considerations which justify the imposition of punitive damages require that they be imposed only after a close examination of whether the defendant's conduct is 'outrageous,' because of 'evil motive' or 'reckless indifference to the rights of others.'"); see also Fla. Stat. Ann. § 624.155 ("No punitive damages shall be awarded under this section unless the acts giving rise to the violation . . . are . . . (b) In reckless disregard for the rights of any insured."); Miss. Code Ann. § 11-1-65 (" . . . which evidences a willful, wanton or reckless disregard for the safety of others.").

For cases regarding the requirement that the insurer's conduct must have been outrageous, see, e.g., Ace v. Aetna Life Ins. Co., 139 F.3d 1241 (9th Cir. 1998) (applying Alaska law) (requiring the insurer's conduct to be outrageous); Nardelli v. Metro. Grp. Prop. & Cas. Ins. Co., 277 P.3d 789 (Ariz. 2012) (same); see also Trinity Evangelical Lutheran Church & Sch.-Freistadt v. Tower Ins. Co., 661 N.W.2d 789 (Wis. 2003) (stating the rule in Wisconsin that an insurer may be liable for punitive damages for "gross or outrageous conduct."); Egan v. Mut. of Omaha Ins. Co., 620 P.2d 141 (Cal. 1979) (first-party case) (insurer's claim representative reduced insured to tears in the presence of his wife and child, also called insured a fraud and incorrectly advised him on his bona fide claim, thereby showing outrageous conduct).

Examples of factual situations where courts have awarded punitive damages against an insurer include: (a) unreasonable delay, see, e.g., Atchafalaya Marine, LLC v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA, 959 F. Supp. 2d 1313, 1329 (S.D. Ala. 2013) (finding clear and convincing evidence the insurance company acted with "unreasonable delay" constituting a reckless disregard for its insured's

rights); (b) failing to investigate, see, e.g., Ace v. Aetna Life Ins. Co., 139 F.3d 1241 (9th Cir. 1998) (applying Alaska law) (listing failure to investigate as one of eight factors supporting an award of punitive damages); Zoppo v. Homestead Ins. Co., 644 N.E.2d 397 (Ohio 1994) (finding an award of punitive damages was justified when the record revealed a "one-sided inquiry" and the insurer breached its affirmative duty to conduct an adequate investigation); (c) failing to assist in presenting the claim, Ace v. Aetna Life Ins. Co., 139 F.3d 1241 (9th Cir. 1998) (listing failure to assist in presenting the claim as one of eight factors supporting an award of punitive damages), (d) incorrectly denying the claim, id. (same); and (e) when it fails to uphold its settlement duties, see, e.g., O'Neill v. Gallant Ins. Co., 769 N.E.2d 100, 109, 112-113 (Ill. App. Ct. 2002) (awarding punitive damages after finding an insurer "pursu[ed] a possible settlement of the claim in a way that kept its interests paramount, and it gambled its insured's interest in a policy-limits settlement on a preposterous strategy designed to shift its responsibilities onto another insurance company," evincing "utter indifference and reckless disregard for its policyholder's financial welfare."); Neal v. Farmers Ins. Exch., 582 P.2d 980 (Cal. 1978) (same); Campbell v. Government Employees Ins. Co., 306 So. 2d 525, 532 (Fla. 1975) (insurer withheld information regarding settlement opportunities from insured, including offer from plaintiff posttrial to enter into a settlement pursuant to which it would agree not to execute against the insured in return for an assignment of the insured's rights against the insurer). See also Coors v. Sec. Life of Denver Ins. Co., 112 P.3d 59 (Colo. 2005) (finding an internal company memo stating that the insurer's actions "may turn out to be a very bad idea" and potentially viewed as "bad faith" supported a finding that the company acted unreasonably or in reckless disregard for the insured's rights); Goodson v. Am. Standard Ins. Co. of Wisconsin, 89 P.3d 409, 412 (Colo. 2004) (awarding punitive damages for failing to provide peace of mind when an insurer took over a year and a half to pay an obviously valid claim); Allied Processors, Inc. v. W. Nat. Mut. Ins. Co., 629 N.W.2d 329 (Wis. Ct. App. 2001); Newport v. USAA, 11 P.3d 190 (Okla. 2000).

For authority regarding the clear and convincing evidence requirement, see, e.g., Minn. Stat. Ann. § 549.20 ("Punitive damages shall be allowed in civil actions only upon clear and convincing evidence"); Grossi v. Travelers Pers. Ins. Co., 79 A.3d 1141 (Pa. Super. Ct. 2013) (applying a clear and convincing evidence burden when reviewing a punitive-damages award); Atchafalaya Marine, LLC v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA, 959 F. Supp. 2d 1313 (S.D. Ala. 2013) (citing Ala. Code § 6-11-20) (same); Nardelli v. Metro. Grp. Prop. & Cas. Ins. Co., 277 P.3d 789 (Ariz. 2012) (same); see also Tex. Civ. Prac. & Rem. Code Ann. § 41.003 (requiring, in addition to the clear and convincing evidence burden, that the jury be instructed it must actually return a unanimous verdict). But see Colo. Rev. Stat. Ann. § 13-25-127(2); Coors v. Sec. Life of Denver Ins. Co., 112 P.3d 59 (Colo. 2005) (requiring proof beyond a reasonable doubt).

On the amount of punitive damages, see, e.g., State Farm Mut. Auto. Ins. Co. v. Campbell, 538 U.S. 408 (2003) (holding a punitive-damage award of $145 million "was an irrational and arbitrary deprivation of the property of the defendant" thereby violating its due-process rights); Deters v. USF Ins. Co., 797 N.W.2d 621 (Iowa Ct. App. 2011) (finding a $1 million punitive-damages award constitutionally permissible where the potential harm was also approximately $1 million; 1:1 ratio); Mitchell, Jr. v. Fortis Ins. Co., 686 S.E.2d 176, 184-185 (S.C. 2009) (aligning South Carolina's eight-step test to match the

Supreme Court's three-part test, finding a ratio of 13.9:1 was grossly excessive and reducing the award to 9.2:1).

Courts usually afford triers of fact the abuse-of-discretion standard for determining whether the bad-faith conduct warranted a punitive-damages award, but are required to review the amount of the award de novo. See Kimble v. Land Concepts, Inc., 845 N.W.2d 395, 405 (Wis. 2014) ("[O]nce the issue of punitive damages is properly before the jury, its decision to award punitive damages is accorded deference. The size of the award, however, is subject to de novo review to ensure it accords with the constitutional limits of due process.") (citing Cooper Indus., Inc. v. Leatherman Tool Grp., Inc., 532 U.S. 424, 436 (2001)); Allstate Ins. Co. v. Dodson, 376 S.W.3d 414, 432 (Ark. 2011) (same).

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American College of Coverage and Extracontractual Counsel
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A. Introduction

1. Under New York law, an all-risks policy "covers all losses which are fortuitous" and not otherwise excluded by the policy. *David Danzeisen Realty Corp. v. Cont'l Ins. Co.*, 565 N.Y.S. 2d 223, 224 (N.Y. App. Div. 1991); *see Consolidated Edison Co. v. Allstate Ins. Co.*, 774 N.E.2d 687, 692 (N.Y. 2002) ("Insurance policies generally require 'fortuity' and thus implicitly exclude coverage for intended or expected harms.").

2. When presented with substantial claims arising from a catastrophic event, insurers may contend that the event was caused by the insured's failure to adhere to industry standards or its own procedures, and that these failures render non-fortuitous all loss resulting from the event, including property damage and business interruption.

3. Under New York law, the test for fortuity, in circumstances in which the conduct of the insured is alleged to be the cause of the loss, is whether the insured intended the loss, or whether the insured acted, or failed to act, with knowledge that the loss was substantially certain to result (sometimes expressed as knowing that the loss "would flow directly and immediately from the insured's intentional act"). We will discuss whether certain hypothetical scenarios present these circumstances.

B. The Meaning of Fortuity Under New York Law

4. Under New York law, a loss is fortuitous unless the insured intended the loss, or unless the insured acted, or failed to act, with knowledge that the loss was substantially certain to result.

5. In *National Union Fire Ins. Co. of Pittsburgh, PA v. Stroh Cos.*, 265 F.3d 97 (2d Cir. 2001), the Second Circuit, applying New York law, explained the scope of the "fortuity" and "known loss" doctrines that exist independently of the language in insurance policies. *Id*. at 106.

   5.1. The Second Circuit held that a loss is "fortuitous" unless the insured either intended the loss or knew that the loss would flow directly and immediately from the insured's intentional acts. *National Union*, 265 F.3d at 111. The insurer

argued that the loss at issue was not "fortuitous" because it was not "beyond the control of either party" within the meaning of N.Y. Ins. Law § 1101(a)(2). In rejecting the insurer's argument and interpreting Section 1101(a)(2), the Second Circuit held that the loss was fortuitous unless the insured had knowledge that "damages . . . [would] 'flow directly and immediately from [the insured's] intentional act' and thus could not "be considered 'accidental' or fortuitous." *Id.* (citing *City of Johnstown v. Bankers Standard Ins. Co.*, 877 F.2d 1146, 1150 (2d Cir. 1989).

5.2. In the cited passage from *City of Johnstown*, the Second Circuit held that in defining what constitutes "accidental" loss:

> the distinction is drawn between damages which flow directly and immediately from an intended act, thereby precluding coverage, and damages which accidentally arise out of a chain of unintended though *expected or foreseeable* events that occurred after an intentional act . . . . *It is not enough that an insured was warned that damages might ensue from its actions, or that, once warned, an insured decided to take a calculated risk and proceed as before* . . . Recovery will only be barred if the insured intended the damages . . . or if it can be said that the damages were, in a broader sense, 'intended' by the insured because the insured knew that the damages would flow directly and immediately from its intentional act . . . .

877 F.2d at 1150 (emphasis added; citations omitted).

5.3. The Second Circuit also held that under one "variation on the fortuity theme" – the so-called "known loss" defense – a loss is fortuitous unless "the inevitability of [the] loss was . . . *known to the insured* before coverage took effect . . . ." *National Union*, 265 F.3d at 109 (emphasis added).

5.4. The Second Circuit rejected the insurer's argument "that the fortuity doctrine bars coverage not only for known losses, but for *likely* losses, i.e., known enhanced risks. We have expressly rejected the existence of such a 'known risk' doctrine under New York law.'" *Id.* at 108 (citing *City of Johnstown*, 877 F.2d at 1152-1153 (emphasis in original).

6. This definition of fortuitous loss is consistent with decisions of the New York Court of Appeals.

6.1. In *Consolidated Edison Co. v. Allstate Ins. Co.*, 774 N.E.2d 687 (N.Y. 2002), the New York Court of Appeals held that "[i]nsurance policies generally require 'fortuity' and thus implicitly exclude coverage for intended or expected harms." *Id.* at 692.

6.2. In an earlier decision, the Court of Appeals defined "intended or expected" as simply meaning "intended." *See* ¶ 6.4, *infra*. And by "intended," that earlier decision meant that the insured either intended the loss or knew that the loss would occur as a direct and immediate result of the insured's intentional acts.

6.3. *Consolidated Edison* involved policies of general liability insurance that did not, as such policies normally do, expressly provide that there was no coverage for harms intended or expected by the insured. Instead, the policies simply provided either that there was coverage for an "accident" or coverage for an "occurrence." *See Consolidated Edison*, 774 N.E.2d at 690-91 ("[E]ach of the policies speaks of damages caused by or arising from either an 'accident' or an 'occurrence.' None of the policies contains an exclusion for intended or expected harm."). Nonetheless, the Court of Appeals held that the policies must therefore be read as though they expressly barred coverage for "intended or expected" harms. *Consolidated Edison*, 774 N.E.2d at 692.

6.4. Nine years earlier, the Court of Appeals had held that where general liability policies expressly provide that "[f]or an occurrence to be covered . . . the injury must be unexpected and unintentional, [w]e have read such policy terms narrowly, barring recovery only when the insured intended the damages." *Continental Cas. Co. v. Rapid-American Corp.*, 609 N.E.2d 506, 510 (N.Y. 1993). *Continental Casualty* specifically cited *City of Johnstown*, *supra*, to illustrate what kinds of losses are covered. *Id.* at 510 (citing *City of Johnstown*, 877 F.2d at 1150).

7. In fact, under New York law, because the question is whether the insured had knowledge that its actions would cause damage, even damage from an intentional or willful act is "fortuitous" if the insured did not intend the harm or know it was substantially certain to occur.

7.1. In *Continental Casualty, supra*, 609 N.E.2d at 510, the New York Court of Appeals held that "[r]esulting damage can be unintended even though the act leading to the damage was intentional . . . ." (citations omitted).

7.2. In *Allegany Co-Op Ins. Co. v. Kohorst*, 678 N.Y.S.2d 424 (N.Y. App. Div. 1998), an insured intentionally set fire to a property that he owned and was convicted of attempted arson. *Id*. at 425. Nonetheless, the court held that in an action brought by a person injured as a result of the fire, the insured could still be covered under his policy of liability insurance, which required that the injury be "accidental," because the insured "did not intend to hurt [the third party] when he intentionally set the fire" and "accidental results may flow from intentional acts." *Id.*

8. Damages resulting from negligence are, of course, fortuitous. *See*, *e.g.*, *David Danzeisen Realty*, *supra*, 565 N.Y.S.2d at 224 ("Mere negligence of an insured is not a defense to coverage under an 'all risk' policy.") (citations omitted). In *David Danzeisen Realty*, where the insured lacked the expertise to repair its own roof and hired a roofing company to do the repairs, the court held that the subsequent sliding of the roof, which the insurer alleged was caused by the inadequacy of the repairs, constituted negligence and was "to a substantial extent beyond [the insured's] control" and therefore fortuitous. 565 N.Y.S.2d at 224.

C. Certainty, "Control" and New York Insurance Code Section 1101

9. Some courts applying New York law have relied on the New York Insurance Law in determining whether losses are fortuitous. *See*, *e.g.*, *National Union*, *supra*; *David Danzeisen Realty*, *supra*; *Petroterminal De Panama, S.A. v. QBE Marine & Specialty Syndicate 1036*, No. 14-8614; 2017 U.S. Dist. LEXIS 7638 (S.D.N.Y. Jan. 19, 2017). Section 1101(a) of that statute defines a "fortuitous event" as "any occurrence or failure

to occur which is, or is assumed by the parties to be, to a substantial extent beyond the control of either party." See N.Y. INS. LAW § 1101(a).

10. Professor Edwin Patterson, one of the drafters of that statute, wrote a treatise on insurance law. Patterson discussed fortuity and the concept of the insured's "control" in these terms:

> *The Designing Act of the Insured*. An insurance enterprise would soon fail if the insurer were liable for losses designedly caused by the persons insured and if those persons should take advantage of the opportunity this offered to impose liability on the insurer. . . Hence it is implied in every insurance contract that the insured event is a fortuitous one, *i.e*., one not designedly brought about by the insured. . . But to say that the insurer is not liable if the happening of the insured event was within the control of the insured would be erroneous or at least likely to mislead. Unless control means only designedly causing the insured event, a meaning narrower than the ordinary sense of the word, it includes a great many situations in which the insurer is undoubtedly liable. Thus, a defective chimney is "within the control" of the insured, since it can be repaired; yet fires due to defective flues are covered by the ordinary fire policy. Even if control is narrowed to include only situations of which the insured has knowledge, it is still too broad, since an insured who carelessly put off repairing a known defect in his chimney would not thereby be barred from recovering on his fire-insurance policy.

Edwin W. Patterson, ESSENTIALS OF INSURANCE LAW 257-58 (2d ed. 1957).

11. Thus, (and even accepting for purposes of argument that Section 1101 applies to questions of coverage as opposed to licensure), the analysis of fortuity is not properly centered around the degree of control that an insured exercises over the risk, and reliance on Section 1101 to support such an argument is misplaced. Non-fortuity requires certainty, and neither the insured's control of risk, nor even courting of risk, is sufficient to show non-fortuity.

12. The fortuity doctrine does not bar coverage for risks – even very sizable risks – about which the insured knew.

12.1. *See National Union*, *supra*, 265 F.3d at 108 (under New York law, "the fortuity doctrine [does not] bar[] coverage . . . for *likely* losses, i.e., known enhanced risks.") (emphasis in original); *id.* ("Even if the risk [of the loss that occurred] was known [by the insured], and known to be high," when the coverage at issue was added to the policy, that would not bar coverage).

12.2. *See Wal-Mart Stores, Inc. v. United States Fid. & Guar. Co.*, No. 06-4417/2002, 2005 BL 323, *aff'd in relevant part*, 816 N.Y.S.2d 17, 18 (N.Y. App. Div. 2006) (a rockslide, "while a known risk at the time the [all-risks] policies took effect, was not 'substantially certain to occur,'" and was therefore fortuitous, even though (a) it involved a sixty-ton boulder falling from a hillside above the insured's store, (b) there had been numerous rockslides before the inception of coverage, including another sixty-ton boulder falling on the store, and (c) the insured was aware of the geologic instability of the hillside) (citing *National Union*, *supra*).

13. A loss resulting from the taking of a "calculated risk" is "accidental" and thus fortuitous. *See Continental Casualty*, *supra*, 609 N.E.2d at 510 ("A person may engage in behavior that involves a calculated risk without expecting that an accident will occur – in fact, people often seek insurance for just such circumstances . . . .") (citing, *inter alia*, *City of Johnstown*, *supra*).

D. <u>The Burden of Proof On The Issue Of Fortuity</u>

14. Under New York law, the insured under an all-risks policy has a "relatively light" burden of showing that its loss was fortuitous. *Petroterminal De Panama, supra,* 2017 U.S. Dist. LEXIS 7638 (quoting *Int'l Multifoods Corp. v. Commercial Union Ins. Co.*, 309 F.3d 76, 83 (2d Cir. 2002)). Once the insured meets that burden, the burden then shifts to the insurer to prove otherwise.

15. In *National Union*, *supra*, the Second Circuit held that "[t]he initial burden of showing that the loss in question was fortuitous – here meaning that the inevitability of such loss was not known to the insured before coverage took effect – is on the insured party . . .

Once that burden is met, the insurer must come forward with evidence showing that 'an exception to coverage applies,' including exceptions based on the non-fortuity or known loss doctrines." *National Union*, 265 F.3d at 109 (citations omitted).

16. In *Union Carbide Corp. v. Affiliated FM Ins. Co.*, 955 N.Y.S.2d 572, 757 (N.Y. App. Div. 2012), a New York appellate court held that where the policy covered damages resulting from an "occurrence," and also contained an express exclusion for damages intended by the insured, the insured met its burden of establishing coverage by providing evidence that it did not intend to harm third parties. Once the insured did that, "the burden shifted to defendant [insurer]s to show that, pursuant to the policy's exclusion, [the insured] intended the damages." *Id.*

17. The insured's initial burden of proof is also "fairly light" in that the insured "does not have to prove the precise cause of the loss." *Fleet Business Credit, L.L.C. v. Global Aerospace Underwriting*, 812 F. Supp. 2d 342, 354 (S.D.N.Y. 2011).

E. <u>Conclusion</u>

18. The relevant standard under New law is whether the evidence presented shows that, at the time of the catastrophic event, the insured intended the event, or knew that the event was substantially certain to occur. If the evidence does not meet this standard, under New York law, the loss was fortuitous.

18.1. If the insured believed that it was operating in a manner consistent with relevant industry standards relevant to the prevention of the root cause of the event, the loss is fortuitous.

18.2. Even accepting for the sake of argument that, with the benefit of hindsight, an insured could have discovered the root cause of, and thus prevented, the event, that does not lead to the conclusion that the insured intended the event to occur, or knew that it was substantially certain to occur, which is the standard under New York law.

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THE INSURER'S PERSPECTIVE

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Introduction

This paper is written in the format utilized for written submissions in London arbitration. The consecutively numbered paragraphs provide a quick and efficient point of reference for the issues addressed.

At the outset, it should be noted that this paper is written with a view towards the fortuity discussion that will take place based upon the involved case study. The analysis is from the perspective of insurer's counsel, who is tasked with evaluating and defending a large commercial first-party property insurance claim based upon non-fortuity. The thoughts and analysis provided are intended to be thought provoking on the issue of fortuity, and to provide some advocacy insight to the insurance practitioner.

Fortuity – Case Study Concepts

1. In recent years, property insurers have often been reluctant to base a denial of coverage upon lack of fortuity. Courts, brokers, and insurance professionals all seem to frown to varying degrees upon the fortuity defense, as if it is a relic of the past that no longer has application to modern claims. But there are certain scenarios where the defense has merit and should be considered – and perhaps asserted. The case study that we will be discussing provides such a scenario. Without getting into specific factual detail, the general foundation for the potential application of the fortuity doctrine to decline coverage involves an old piece of plant equipment that is being operated by the insured in contravention of industry standards, as well as its own internal operating procedures. Operational deficiencies were known, yet use of the equipment continued. This "reckless optimism" culminates in a fire and explosion, thus leading to a 100 plus million dollar claim for time element losses.

2. Against this backdrop, one should understand that the doctrine of fortuity is a basic concept of property insurance. Historically, issues of fortuity were familiar in cases where the insured intended to harm his own property. Some classic examples are arson of warehouses by impecunious owners and scuttling of ships on behalf of fraudulent ship owners. However, many instances where the doctrine could arguably come into play from the insurer's perspective are not extreme cases of that kind. In general, it can be assumed with some confidence that an insured does not maliciously cause, for example, its plant to explode intending to cause harm. But when an insured continually fails to take precautions against known risks and a loss results, an insurer is faced with the pivotal question of determining the dividing line between cover and no cover under the fortuity doctrine.

3. In evaluating this question for an insurer, it should be recognized that the intent of first-party property insurance is to insure against accidental risks – not risks which are substantially within the control of the insured. It is one thing for the insured to make a mistake, even if it involves some degree of negligence, resulting in a fortuitous occurrence

of damage.[1] But it is quite another thing to follow a course of conduct which falls well below applicable internal and industry standards, which ultimately results in the property's failure and loss. Damages resulting from such conduct should arguably fall outside the risk assumed by an insurer, particularly when the course of conduct followed is a course the insured knows is not the ordinary prudent way to proceed and substantially increases the likelihood of loss.

4. In the "reckless optimism" scenario offered by the case study, an insurer may take the position that the insured engaged in the deliberate courting of a known risk by, among other things, operating equipment in a manner that was knowingly contrary to acceptable safe operating procedures, which directly caused the loss. Thus, denial of the claim based upon the fortuity doctrine may be warranted.

Fortuity – The Law

5. All common-law jurisdictions recognize the proposition that insurance policies provide cover only for fortuities. However, common-law courts do not all draw the dividing line between what is and what is not a fortuitous loss in precisely the same place. Rather, different jurisdictions rely on at least four justifications to varying extents to support the fortuity proposition, namely:

    A. As a matter of contractual interpretation, cover is not intended to be provided for losses resulting from misconduct of the insured, which may include deliberate conduct attended by elevated risk;

    B. It is in the very nature of insurance that it covers risks, not certainties;

    C. There is a public policy against allowing an insured to recover under an insurance policy for the consequences of misconduct; and

    D. Conventional insurance practice is that certain matters are not regarded as fortuitous (for example, inherent vice is not conventionally covered by an "all risks" policy).

6. One result of the varying justifications given by courts to support the fortuity proposition is that a range of phrases and terminology is used to express the rule in different contexts. To that end, while courts will naturally tend to choose language apt to the decision of the case being decided, it is important not to mistake a particular expression of the rule for an exhaustive definition of fortuity.

7. In *National Union Fire Insurance Co. of Pittsburgh, Pa. v. Stroh Cos., Inc.*, 265 F. 3d 97, 106 (2d Cir. 2001), the United States Court of Appeals for the Second Circuit described fortuity as a doctrine that holds "insurance is not available for losses that the policyholder knows of, planned, intended, or is aware are substantially certain to occur." *Id*. This generic

[1] "Mere negligence of an insured is not a defense to coverage under an 'all risk' policy." *See David Danzeisen Realty Corp. v. Continental Ins. Co.*, 170 A.D.2d 432 (N.Y. App. Div. 1991).

statement sets out the foundational analysis employed by many courts when considering fortuity.

8. The policy involved in the case study requires the application of New York law. Therefore, the fortuity doctrine and its application must be analyzed primarily under New York law as it has been established by the New York Court of Appeals and/or applicable federal courts.

9. New York's fortuity rule is based primarily on the grounds that insurance is not intended to cover misconduct of the insured, nor is it intended to cover certainties. The three most authoritative guides to New York law on fortuity are:

    A. *Newtown Creek Towing Co. v. Aetna Insurance Co.*, 57 N.E. 302 (N.Y. 1900), where the Court of Appeals determined the limit on the type of causative conduct by the insured that the parties intended to cover;

    B. The provisions of New York Insurance Law § 1101 (McKinney 2011); and

    C. *Consolidated Edison Co. of N.Y. v. Allstate Insurance Co.*, 98 N.Y.2d 208 (N.Y. 2002), where the Court of Appeals determined that the insured had the initial burden of proving a loss was fortuitous.

10. In *Newtown Creek*, the question was whether the loss was within liability cover for accidents caused by collision. The cause of loss was reckless optimism on the part of the insured. The court approached the issue of coverage for such a loss as a question of the proper interpretation of the policy, and decided that coverage was not intended:

> A tug was towing a boat (the McMahon), lashed beside it, at night on a river where there were ice cakes all around. A collision with the ice caused the McMahon to sink. The critical evidence was testimony of the master of the tug:
>
> A. If we find the ice too heavy or dangerous then we stop.
>
> Q. Was the ice so dangerous on this occasion that you should stop?
>
> A. Well, I couldn't see.

Newtown Creek, 57 N.E. at 303.

11. The court in *Newtown Creek* stated:

> [T]he testimony showed that the master of the tugboat, heedless of the risk incident to an attempt to take a tow through the ice when it was 'too heavy or dangerous,' took the chances of forcing the McMahon through in the nighttime, when he could not see, with full knowledge that the ice was all around the boat, ahead of it and behind it, and as the injury came

> while the boat was being thus rammed through the ice, it was not caused by a collision within the meaning of the contract in suit.
>
> ***
>
> [W]hen the master of the vessel insured designedly takes the chance of running into a perfectly apparent obstruction, although with the hope and expectation that the vessel will successfully meet the encounter, the contact is not a collision within the meaning of the term as employed in this contract.
>
> ***
>
> Emerigon . . . states the rule as follows: '(1) When a vessel on which I have effected insurance has been damaged by collision with another vessel, or by an anchor, or by a stake, or net, or such like, the insurers are bound to indemnify me for the damage suffered if the action has happened through mere chance (*cas fortuit*). . . . This rule we conceive to be correct, and, applying it to the facts of this case, we find that the accident did not happen by mere chance . . . .

Id. at 302-03 (emphasis added).

12. The provisions of New York Insurance Law § 1101 provide a codified definition of insurance contracts, for the purpose of the State licensing of insurance companies. Section 1101 provides:

> (a) In this article: (1) "Insurance contract" means any agreement or other transaction whereby one party, the "insurer", is obligated to confer a benefit of pecuniary value upon another party, the "insured" or "beneficiary", 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.
>
> (2) "Fortuitous event" means any occurrence or failure to occur which is, or is assumed by the parties to be, to a substantial extent beyond the control of either party.

N.Y. INS. LAW § 1101(a) (McKinney 2011) (emphasis added).

13. While the definition under Section 1101 is provided for a particular statutory and regulatory purpose, it is clearly consistent with the *Newtown Creek* decision. A loss resulting from (for example) a recklessly optimistic course of conduct by the insured is not a fortuitous event within the statutory definition, because such a loss is properly judged not to be substantially beyond the control of the insured.

14. In *Consolidated Edison Company*, the question that arose in relation to the wording of a number of public liability policies was:

> whether the insured (or the insurers) should have the burden of proving that the damage was (or was not) the result of an "accident" or "occurrence" within the meaning of the policies . . . .[2]

98 N.Y.2d at 215 (N.Y. 2002).

15. In deciding that the burden of proof was on the insured, the court stated:

> Insurance policies generally require "fortuity" and thus implicitly exclude coverage for intended or expected harms.[3]

Id. at 220.

16. The court then recited the provisions of New York Insurance Law § 1101(a)(1) and (2), and continued:

> Thus, the requirement of a fortuitous loss is a necessary element of insurance policies based on either an "accident" or "occurrence." The insured has the initial burden of proving that the damage was the result of an "accident" or "occurrence" to establish coverage where it would not otherwise exist . . . . Once coverage is established, the insurer bears the burden of proving that an exclusion applies.

Id.[4]

17. The significance of *Consolidated Edison Company* in relation to the fortuity issue is threefold:

    A. The court regarded the provisions of New York Insurance Law § 1101 as a guide to understanding the scope of the policies' coverage;

    B. The court stated that the requirement of a fortuitous loss is a necessary element of insurance policies that are based on accident (as in *Newtown Creek*) or occurrence (as in the case study); and

[2] The policies used the express terms "accident" or "occurrence."

[3] The court stated that none of the policies contained an exclusion for intended or expected harm. *Consol. Edison Co.*, 98 N.Y.2d at 218.

[4] *See also Catalano v. State Farm Ins. Cas. Co.*, No. 04-CV-452A, 2007 WL 295321, at *4-5 (W.D.N.Y. 2007) (where insured sought coverage for mold damage under property policy covering "accidental" loss, insured had burden of proof to "demonstrate that the loss was fortuitous, or beyond its control," and insured could not establish coverage because evidence was "uncontroverted that the mold contamination was not caused by a fortuitous event, but was the result of 'long term moisture problems;' 'long-standing moisture migration;' and a 'long-standing ventilation problem' caused by inadequate maintenance").

C. The court decided that the burden of proof of fortuity was on the insured.

18. It should be noted that the phrase "intended or expected harms" was not stated by the court to be an exhaustive exposition of the boundaries of fortuity, but rather deployed by way of introduction to the definition in the New York Insurance Law. The meaning of that phrase needs to be understood in the light of the *Newtown Creek* decision and the express language of Section 1101. The insured's intent is only one aspect of the concept of fortuity.

19. The concept of "control" appears in the wider jurisprudence on the fortuity doctrine. This is conveniently illustrated by reference to *Cincinnati Insurance Co. v. Motorists Mutual Insurance Co.*, 306 S.W.3d 69 (Ky. 2010), where the Supreme Court of Kentucky, in a review of the fortuity doctrine, stated:

> In short, fortuity consists of two central aspects: intent, which we have discussed in earlier opinions, and control, which we have not previously discussed.

Id. at 74.

20. Because of the centrality of "control," the *Motorists Mutual* court decided that faulty workmanship by the insured, although unintended, was under the insured's control and was not an insured occurrence under a commercial general liability policy. With respect to this concept, it is important to note that in New York, the concept of control has been expressly incorporated into the fortuity doctrine, qualified by the phrase "to a substantial extent."[5] This concept is readily understood by comparison with the expression "mere chance" adopted in *Newtown Creek*. An event, which is to a substantial extent within the control of the insured, is not an occurrence that happens by mere chance.

21. In *Northwestern Mutual Life Insurance Co. v. Linard*, 498 F.2d 556 (2nd Cir. 1974), the United States Court of Appeals for the Second Circuit properly stated:

> In all contracts of insurance, there is an implied understanding or agreement that the risks insured against are such as the thing insured, whether it is property, or health, or life, is usually subject to, and the assured cannot voluntarily and intentionally vary them.

Id. at 564 (emphasis added).

22. This rationale, as explained in *Northwestern Mutual*, provides additional reasoning for interpreting the intent of the parties to a contract of insurance in the manner indicated in *Newtown Creek* and New York Insurance Law § 1101. Where the assured knowingly adopts a course of conduct which increases the risk of loss beyond the risks which the insured property is usually subject to, that constitutes a voluntary and intentional varying of the risk. A loss resulting from such conduct is substantially within the control of the insured, and is therefore outside the intended cover of the policy.

[5] *See Petro, Inc. v. Serio*, 804 N.Y.S.2d 598 (N.Y. Sup. Ct. 2005) for a case applying the "substantial control test." Under the test, "an event is deemed fortuitous if its occurrence is beyond the substantial control of either party." *Id.* at 608.

23. In most instances, an insured's contention as to fortuity under New York law will differ considerably from the above concepts. For example, an insured will likely assert that a loss – such as the equipment failure in the case study – is fortuitous unless the insured: (a) knew, before the policy went into effect, the loss event was inevitable;[6] or (b) intended the loss event to occur;[7] or (c) knew the loss event would occur as a direct and immediate result of the insured's intentional acts.[8] While these expressions of what is required to prove non-fortuity may be valid examples, they do not exhaustively define the situations where a loss is regarded as non-fortuitous under New York law. Indeed, these expressions have a narrow focus upon the state of mind of the insured without considering the broader question whether the loss is, to a substantial extent, beyond the control of the insured.

24. Further, insureds often contend that New York law imposes a "fairly light" burden on the insured of showing that losses were fortuitous, and that, in the event of such a showing, the burden shifts to the insurer to overcome that showing by producing sufficient evidence the losses were not fortuitous. The United States Court of Appeals for the Second Circuit used the expression "relatively light" in *International Multifoods Corp. v. Commercial Union Insurance Co.*, 309 F.3d 76, 83 (2nd Cir. 2002).[9] The point being made by the use of the expression "relatively light" was that under an "all-risks" policy the insured "*needs only to show a fortuitous loss; it need not explain the precise cause of the loss.*" *Id.* at 84.

25. It is correct that an insured, in order to obtain cover under an all risks policy, need not explain the precise cause of the loss. However, the insured does have to show that the loss is fortuitous.[10] There is no burden on an insurer to disprove fortuity. Nevertheless, in practice, as well as in the case study, the insurer should be prepared to present substantial evidence of non-fortuity.[11]

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[6] *See 40 Gardenville, LLC v. Travelers Prop. Cas. of Am.*, 387 F. Supp. 2d 205 (W.D.N.Y. 2005) (rejecting insurer's fortuity defense because evidence did not show insureds "knew when they procured the policy that mold contamination existed or was substantially certain to occur.")

[7] *See Highland Capital Mgmt., L.P. v. Global Aerospace Managers Ltd.*, 488 Fed. App'x 473, 475-76 (2d Cir. 2012) (finding all risks policy covering "direct and *accidental* physical loss" to aircraft did not cover co-insureds' claims because "airframe and engine losses . . . were caused by the intentional misconduct of plaintiffs' coinsured" and thus "the damage was not fortuitous").

[8] *See In re Margulies*, No. 16 Civ. 2643 (KPF), 2017 WL 1049548 (S.D.N.Y. Mar. 20, 2017) ("[T]he incident was not 'to a substantial extent beyond the control of either party.' [Insured] was in control of his car, had the capacity to use his brakes, and chose not to do so. The situation was well within his capacity to avoid.").

[9] This "fairly light" language comes from *Fleet Business Credit, L.L.C. v. Global Aerospace Underwriting Managers LTD,* 812 F. Supp. 2d 342, 354 (S.D.N.Y. 2011), where the court apparently misquoted the "relatively light" burden set forth in *International Multifoods*.

[10] *National Union Fire Ins. Co. of Pittsburgh, PA v. Turner Construction Co.*, 986 N.Y.S.2d 74 (N.Y. App. Div. 2014) ("[T]he addition of 'event' or 'happening' to the definition of 'occurrence' [does] not alter the legal requirement that the 'occurrence' triggering the coverage must be fortuitous . . . [but] was developed by the insurance industry 'to provide clearly for coverage of gradual, continuous, and prolonged events that might have been excluded by the instantaneous connotation of 'accident.' Thus the addition . . . does not change the fact that fortuity is still an essential consideration.").

[11] *See Union Carbide Corp. v. Affiliated FM Ins. Co.*, No. 600804/04, 2010 WL 3748410, at *2-3 (N.Y. Sup. Ct. Sept. 9, 2010) (court incorrectly assigning insurer the burden to disprove fortuity and applying the doctrine as a policy exclusion, instead of initial coverage limit).

Fortuity – Conclusion

26. An insurer receives premiums for insuring the insured's property against fortuitous "occurrences," not from deliberately reckless acts or operations performed at the behest of the insured. If the insured cannot credibly demonstrate that the loss happened through "mere chance" or that the loss was "to a substantial extent beyond the control" of the insured, an insurer may reasonably deny the claim under the fortuity doctrine.

27. In the case study, the loss in question was arguably not fortuitous. Rather, it was an incident that could and should have been foreseen by the insured as likely to occur due to the reckless manner in which the plant operations were being carried out. The event leading to the loss was to a substantial extent within the control of the insured – and did not result by mere chance.

28. We are hopeful that the issues and discussion presented provide some practical insight into establishing a meaningful and compelling fortuity defense. Ultimately, each case will turn upon the unique facts and circumstances involved, and how they are developed – and more importantly – presented by counsel.

INDEPENDENT DEFENSE COUNSEL: A 50-STATE (AND D.C.) SURVEY

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TABLE OF CONTENTS

[1] First presented by the Original Authors at the ABA Section of Litigation Insurance Coverage Litigation Committee CLE Seminar ("ICLC"), Tucson, Arizona, March 4-6, 2010: "Independent Defense Counsel: When can the Policyholder Select its Own Defense Lawyer and How Much Does the Insurer Have to Pay? A 50-State Survey." The topic was re-presented by Mr. Posner, with panelists, at the 2013 and 2014 ICLC Seminars.

For additional commentary on this topic, s*ee also*, *Duty of insurer to pay for independent counsel when conflict of interest exists between insured and insurer*, 50 A.L.R.4TH 932 (originally published 1986, updated through 2017); John E. Zulkey, *Contesting the Costs of Independent Counsel: Using Regional Fee Scales as Evidence of Reasonable Rates*, 58 DRI FOR THE DEFENSE 46 (2016); Jeffrey W. Stempel, *Policyholder Rights to Independent Counsel: Issues Remain Regarding Compensation, Supervision of Counsel*, 23 NEV. L. 12 (Dec. 2015); Douglas R. Richmond, *Reconnoitering Reservations of Rights in Liability Insurance*, 51 TORT TRIAL & INS. PRAC. L.J. 1 (Fall 2015); Gary L. Gassman, Seth D. Lamden, Le G. Trieu, *Potential Consequences of Breaching the Duty to Defend: Key Considerations for Insurers and their Attorneys*, 45 BRIEF 30 (Fall 2015); Gary L. Gassman, *Reservation of Rights Letters: A Primer*, 43 BRIEF 51 (Summer 2014).

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ALABAMA

In Alabama, the mere fact that an insurer is defending under a reservation of rights does not entitle a policyholder to independent counsel, nor is the insurer obligated to pay for policyholder's independent counsel. *L & S Roofing Supply Co., Inc. v. St. Paul Fire & Marine Ins. Co.*, 521 So. 2d 1298, 1303 (Ala. 1987).

A policyholder *is* entitled to control the litigation through his or her own counsel with the insurer paying reasonable attorney's fees *only if* the insurer breaches certain specific conditions set out by the court. *Strength v. Alabama Dept. of Finance, Div. of Risk Management*, 622 So. 2d 1283, 1291 (Ala. 1993). The Alabama Supreme Court describes these conditions as an "enhanced obligation" and also mentions "other specific criteria" to be met by the defense counsel in a reservation-of-rights case. *L & S Roofing Supply Co., Inc.*, 521 So. 2d at 1303.

The "enhanced obligation" includes thoroughly investigating the cause of the insured's accident and the plaintiff's injuries, retaining competent defense counsel for the insured, making sure both counsel and the insured know that the insured is the client, fully informing the insured with respect to all coverage issues, disclosing all settlement offers made by the company, and refraining from engaging in any action that would demonstrate a greater concern for the insurer's monetary interest than for the insured's financial risk. *Id.*

Even though the insured is not entitled to independent counsel, the insured may pay for his or her own defense, and the insurance company must reimburse for defense costs if an adverse final judgment establishes the company's liability. *See, e.g., L&S Roofing Supply Co., Inc.,* 521 So. 2d at 1304, citing to *Waite v. Aetna Cas. & Sur. Co.*, 77 Wash. 2d 850, 467 P.2d 847 (1970). However, if the insured chooses to hire its own counsel and does not allow the carrier's counsel to participate, the insured risks losing the insurer's "enhanced obligation of good faith." *Aetna Cas. & Sur. Co. v. Mitchell Bros., Inc.*, 814 So. 2d 191, 197 (Ala. 2001).

The case law concerning independent counsel and "enhanced obligation of good faith" was most recently affirmed in 2009 by a federal district court applying Alabama law. *State Farm and Cas. Co. v. Myrick,* 611 F. Supp. 2d 1287, 1299 (M.D. Ala. 2009). In this case, the court found that the mere refusal to settle *for* the insured was precisely what a reservation of rights permits and not a breach of its enhanced obligation of good faith.

But see MetLife Auto & Home Ins. Co. v. Reid, Civil Action No. CV-09-S-01762-NE, 2013 WL 6844109 (N.D. Ala. Dec. 23, 2013), which followed the holding of *L & S Roofing*, but nevertheless found that the insurer was not obligated to provide a defense in the first instance.

For one commentator's analysis, *see* William E. Shreve, Jr., *Determining An Insurer's Duty to Defend*, 74 ALA. LAW. 238 (July 2013).

ALASKA

A. Parameters of Insured's Right to Independent Counsel

The right to independent counsel was originally a creature of case law. *CHI of Alaska, Inc. v. Employers Reinsurance Corp*., 844 P.2d 1113, 1118 (Alaska 1993); a*ccord Attorneys Liability Protection Soc., Inc. v. Ingaldson & Fitzgerald, P.C.*, No. 3:11-cv-00187-SLG, 2012 WL 6675167 (D. Alaska Dec. 21, 2012) (following *CHI of Alaska, Inc.*, and finding the insurer's position in this case in conflict with AS § 21.96.100).

The District Court case was reversed in party by *Attorneys Liability Protection Soc., Inc. v. Ingaldson Fitzgerald, P.C. f/k/a Ingaldson, Maassen & Fitzgerald, P.C.*, 838 F.3d 976, 980 (9th Cir. 2016), which held that the Liability Risk Retention Act ("LRRA"), 15 U.S.C. § 3902(a)(1) preempts subsection (d) of Alaska Statute ("AS") § 21.96.100. Section 3902(a)(1) broadly preempts "any State law, rule, regulation,

or order to the extent that such law, rule, regulation, or order would . . . make unlawful, or regulate, directly or indirectly, the operation of a risk retention group." 838 F.3d at 980 n.2.

In connection with its consideration of the *Ingaldson* case, the Ninth Circuit had certified two questions to the Alaska Supreme Court:

1. Does Alaska law prohibit enforcement of a policy provision entitling an insurer to reimbursement of fees and costs incurred by the insurer defending claims under a reservation of rights, where (1) the insurer explicitly reserved the right to seek such reimbursement in its offer to tender a defense provided by independent counsel, (2) the insured accepted the defense subject to the reservation of rights, and (3) the claims are later determined to be excluded from coverage under the policy?

2. If the answer to Question 1 is "Yes," does Alaska law prohibit enforcement of a policy provision entitling an insurer to reimbursement of fees and costs incurred by the insurer defending claims under a reservation of rights, where (1) the insurer explicitly reserved the right to seek such reimbursement in its offer to tender a defense provided by independent counsel, (2) the insured accepted the defense subject to the reservation of rights, and (3) it is later determined that the duty to defend never arose under the policy because there was no possibility of coverage?

Ingaldson, 838 F.3d at 979-80. The Alaska Supreme Court answered "yes" to each question. *Attorneys Liability Protection Society, Inc. v. Ingaldson Fitzgerald, P.C.*, 370 P.3d 1101, 1112 (Alaska 2016). Accordingly, any provision entitling insurers to reimbursement—even if the duty to defend never arises—is unenforceable under Alaska law. *Id.*

When and under what circumstances, however, an insurer must provide independent counsel to its insured is governed by statute in Alaska (*see* AS § 21.96.100[2]), subject to the Ninth Circuit's holding in *Ingaldson*, *supra*, which appears limited on its facts to risk-retention groups.

This statute came into effect on July 1, 1995, and provides:

> (a) If an insurer has a duty to defend an insured under a policy of insurance and a conflict of interest arises that imposes a duty on the insurer to provide independent counsel to the insured, the insurer shall provide independent counsel to the insured unless the insured in writing waives the right to independent counsel.…

The statute then specifies the parameters of this obligation. In particular, it explains that claims for punitive damages; claims for damages in excess of the policy limits; and claims or facts in a civil action for which the insurer denies coverage, do not constitute a conflict of interest. (*Id.* subsection (b)). If, however, an insurer reserves rights on an issue for which coverage is denied, then the insurer must provide independent counsel to the insured.

Whether the statute in any way limits the right to independent counsel established in the prior case law has not yet been tested in the courts, but it appears that the statute was essentially enacted to codify the existing case law. *See Great Divide Ins. Co. v. Carpenter ex rel. Reed*, 79 P.3d 599, 604 (Alaska 2003). Although the statute has been in existence for nearly a decade and a half, there has been very little interpretation in published case law. However, there are cases which further illuminate the right to independent counsel.

For example, a case that postdates the statute, but does not directly address it, further explains the duties of an insurer in this context. The court in *Lloyd's & Institute of London Underwriting Co. v. Fulton*, 2 P.3d 1199 (Alaska 2000), explained that an insurer has a duty to advise its insured that a potential conflict exists as soon as its investigation reveals that grounds to dispute coverage exist, not on "the insurer's final decision

[2] Formerly AS § 21.89.100. As noted *supra*, subsection (d) of AS § 21.96.100 has been preempted by 838 F.3d 976 (9th Cir. 2016).

on coverage." Moreover, the insured need not continue to provide information to the insurer once the insurer has a reason to believe that there are coverage issues: "to allow the insurer to attempt to obtain information from the insured in order to bolster an undisclosed policy defense would, in effect, allow the company to take advantage of its fiduciary relationship with the insured in order to strengthen its position against the insured." *Id.* at 1205.

As noted, although the insured has an automatic right to independent counsel under the circumstances specified, the insured may waive its right to independent counsel by signing a statement which describes this intention (an exemplar of such a statement exists in the statute at subsection (f)).

B. Additional Requirements and Duties Under Statute[3]

In addition to explaining when an insured has a right to independent counsel, AS § 21.96.100[4] sets forth other requirements to which the insured and insurer must both adhere. In particular, subsection (d) discusses the minimum qualifications of the independent counsel, and the rates that an insurer may be obligated to pay when such counsel is retained.[5]

The statute also explains the obligations the insured and insurer have vis-à-vis one another if independent counsel is retained: "the independent counsel and the insured shall consult with the insurer on all matters relating to the civil action and shall disclose to the insurer in a timely manner all information relevant to the civil action, except information that is privileged and relevant to disputed coverage." The statute also explains that it does not eliminate the insured's duty to cooperate as required by the terms of an insurance policy. (*Id.* subsection (g)).

Finally, the statute provides that when an insured is represented by independent counsel, the insurer may settle directly with the plaintiff if the settlement includes all claims based upon the allegations for which the insurer previously reserved its position as to coverage or accepted coverage, regardless of whether the settlement extinguishes all claims against the insured. (*Id.* subsection (h)).

Interestingly, this statute is almost identical to California *Civil Code* § 2860. Case law interpreting and applying the California statute may serve as possible guidance for questions not answered by or yet decided under the Alaska statute. (Indeed the *CHI* court cited heavily to California cases that predated the California statute).

C. Statute:

Alaska Stat. § 21.96.100. Appointment of independent counsel; conflicts of interest; settlement[6]

(a) If an insurer has a duty to defend an insured under a policy of insurance and a conflict of interest arises that imposes a duty on the insurer to provide independent counsel to the insured, the insurer shall provide independent counsel to the insured unless the insured in writing waives the right to independent counsel. An insurance policy may contain a provision that provides a method of selecting independent counsel if the provision complies with this section.

(b) For purposes of this section, the following do not constitute a conflict of interest:

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[3] See Appendix.

[4] Formerly AS § 21.89.100.

[5] Note, however, that subsection (d) has been preempted, apparently with respect to risk-retention groups, by *Attorneys Liability Protection Soc., Inc. v. Ingaldson Fitzgerald, P.C. f/k/a Ingaldson, Maassen & Fitzgerald, P.C.*, 838 F.3d 976, 980 (9th Cir. 2016).

[6] Formerly AS § 21.89.100.

(1) a claim of punitive damages;

(2) a claim of damages in excess of the policy limits;

(3) claims or facts in a civil action for which the insurer denies coverage.

(c) Notwithstanding (b) of this section, if the insurer reserves the insurer's rights on an issue for which coverage is denied, the insurer shall provide independent counsel to the insured as provided under (a) of this section.

(d) If the insured selects independent counsel at the insurer's expense, the insurer may require that the independent counsel have at least four years of experience in civil litigation, including defense experience in the general subject area at issue in the civil action, and malpractice insurance. Unless otherwise provided in the insurance policy, the obligation of the insurer to pay the fee charged by the independent counsel is limited to the rate that is actually paid by the insurer to an attorney in the ordinary course of business in the defense of a similar civil action in the community in which the claim arose or is being defended. In providing independent counsel, the insurer is not responsible for the fees and costs of defending an allegation for which coverage is properly denied and shall be responsible only for the fees and costs to defend those allegations for which the insurer either reserves its position as to coverage or accepts coverage. The independent counsel shall keep detailed records allocating fees and costs accordingly. A dispute between the insurer and insured regarding attorney fees that is not resolved by the insurance policy or this section shall be resolved by arbitration under AS 09.43.

(e) If the insured selects independent counsel at the insurer's expense, the independent counsel and the insured shall consult with the insurer on all matters relating to the civil action and shall disclose to the insurer in a timely manner all information relevant to the civil action, except information that is privileged and relevant to disputed coverage. A claim of privilege is subject to review in the appropriate court. Information disclosed by the independent counsel or the insured does not waive another party's right to assert privilege.

(f) An insured may waive the right to select independent counsel by signing a statement that reads substantially as follows:

> I have been advised of my right to select independent counsel to represent me in this lawsuit and of my right under state law to have all reasonable expenses of an independent counsel paid by my insurer. I have also been advised that the Alaska Supreme Court has ruled that when an insurer defends an insured under a reservation of rights provision in an insurance policy, there are various conflicts of interest that arise between an insurer and an insured. I have considered this matter fully and at this time I am waiving my right to select independent counsel. I have authorized my insurer to select a defense counsel to represent me in this lawsuit.

(g) If an insured selects independent counsel under this section, both the counsel representing the insurer and independent counsel representing the insured shall be allowed to participate in all aspects of the civil action. Counsel for the insurer and insured shall cooperate fully in exchanging information that is consistent with ethical and legal obligations to the insured. Nothing in this section relieves the insured of the duty to cooperate fully with the insurer as required by the terms of the insurance policy.

(h) When an insured is represented by independent counsel, the insurer may settle directly with the plaintiff if the settlement includes all claims based upon the allegations for which the insurer previously reserved its position as to coverage or accepted coverage, regardless of whether the settlement extinguishes all claims against the insured.

ARIZONA

Whether an insured has a right to independent counsel is determined by reference to case law in Arizona. Although the first case addressing this issue was in 1976, there has been little significant development on the principals governing the question in the years since, and the specific requirements and process that must be followed remain unresolved.

A. Parameters of Insured's Right to Independent Counsel

Arizona appears to have first addressed whether an insured has a right to independent counsel in *Joseph v. Markovitz,* 551 P.2d 571 (Ariz. App. 1976), in which the Arizona Court of Appeal explained that when a conflict of interest exists between an insurer and its insured, "public policy" demands that the insured be able to "choose his own attorney without relieving [the insurer] of its contractual obligation under the policy to pay for the defense." *Id.* at 577. However, the *Markovitz* court did not elaborate on this obligation beyond this general statement. In a case decided that same year, *Fulton v. Woodford*, 545 P.2d 979 (Ariz. App. 1976), an Arizona Court of Appeal explained that an insurer's reservation of rights to seek reimbursement of payments created a conflict of interest.

Three decades later, however, the Arizona courts provided additional guidance. In *Pueblo Santa Fe Townhomes Owners' Ass'n v. Transcontinental Ins. Co.,* 178 P.3d 485 (Ariz. App. 2008), the Court of Appeal explained that a conflict of interest is created when an insurer "reserves rights to contest indemnification liability." When this happens, the court explained, "[a]n insured … is on notice of the conflict of interest and is free, upon proper notice to the insurer, to act to protect its rights in the litigation with the claimant." *Id.* at 491. The court further warned that, if an insurer fails to advise the insured that it is reserving rights to contest coverage, an insurer may be estopped from asserting its coverage defenses.

But see Nucor Corp. v. Employers Ins. Co. of Wausau, 975 F. Supp. 2d 1048, 1055, (D. Ariz. 2013), holding that "there is no support in Arizona case [law] for the blanket proposition that an insurer defending under a reservation of rights loses its right to appoint defense counsel for its insured. Although the courts in *Morris* and *Pueblo Santa Fe* indicated that an insurer defending under a reservation of rights loses some of its contractual rights to control the defense of an insured, neither of those opinions, nor any other Arizona case that the Court has found, addressed the specific issue of whether an insurer loses its right to appoint defense counsel." [¶] Thus, in the absence of any authority in support of Nucor's claim that it has a right to appoint its own defense counsel, the Court finds that Wausau has a contractual right under the insurance policies to appoint defense counsel in the underlying RID action."

In *Navigators Specialty Ins. Co. v. Nationwide Mut. Ins. Co.*, 50 F. Supp. 3d 1186, 1198 (D. Ariz. 2014), the federal district court held that, under Arizona law, an insurer's retained lawyer for an insured cannot be used as an agent of the company to supply information detrimental to the insured, such as information designed to deny coverage (citing to *Parsons v. Cont'l Nat'l Am. Group*, 113 Ariz. 223, 227, 550 P.2d 94, 98 (1976) (a lawyer retained by an insurer to defend an insured owes an undeviating and singular allegiance to the insured).

B. Additional Requirements and Duties?

Thus, it appears the basic principle in Arizona is that an insured is entitled to seek independent counsel when a conflict of interest exists with the insurer, and that a conflict exists whenever an insurer reserves rights to contest coverage. Beyond this, there is no Arizona authority defining what happens when independent counsel is selected.[7]

[7] There is Arizona case law explaining that when a liability insurer assigns an attorney to represent an insured, the lawyer owes a duty to the insurer arising from the understanding that the lawyer's services are intended to benefit both insurer and insured when their interests coincide, even if the insurer is a nonclient. *See Paradigm Ins. Co. v.*

It is important to note, however, that the issue of right to independent counsel may be subsumed by *Morris* (*United Services Automobile Ass'n v. Morris*, 154 Ariz. 113, 741 P.2d 246 (1987)), and *Damron* (*Damron v. Sledge*, 105 Ariz. 151, 460 P.2d 997 (1969)) in which the Supreme Court held that where there is a reservation of rights, "an insured may protect itself … by assigning the claimant the insured's coverage rights under the policy." *Pueblo Santa Fe*, 178 P.3d at 491. Such protection can include a stipulated judgment and covenant not to execute.

For further commentary on *Damron* and its progeny, *see*, *e.g.*, Myles P. Hassett & Jamie A. Glasser, *Damron Agreements in the 21st Century: Sword or Shield?*, ARIZ. ATTY. 20 (March 2016); Wm. Sandweg III & John Ager, *A Primer on the Cooperation Clause:* Damron v. Sledge *and Its Progeny*, ARIZ. ATTY. 11 (March 2016).

ARKANSAS

No Arkansas state court has directly addressed the issue of whether a policyholder has a right to choose its own counsel under circumstances in which its insurer has reserved its rights. However, numerous federal courts applying Arkansas law have recognized the right of a policyholder to choose its own counsel and be reimbursed *reasonable* fees when the insurer has accepted the defense under a reservation of rights. *Northland Ins. Co. v. Heck's Service Co., Inc.*, 620 F. Supp. 107 (E.D. Ark. 1985), *Union Ins. Co. v. Knife Co., Inc.*, 902 F. Supp. 877, 879 (W.D. Ark. 1995) (includes a lengthy discussion on "relevant data" and the majority rule among the states on this issue).

A United States District Court applying Arkansas law also held that the insurer must either provide an independent attorney to represent the insured *or* pay the costs incurred by the insured in hiring counsel of its own choice, not both. *Bituminous Cas. Corp. v. Zadeck Energy Group, Inc.*, 416 F. Supp. 2d 654, 660 - 61 (W.D. Ark. 2005).

But the Eighth Circuit appears to have limited that holding to situations where the appointed lawyer's conflict of interest is more apparent.

> PNC argues Hortica *assigned* Cross Gunter to represent PNC, despite PNC's "absolute right" to choose its own counsel. Appellant/Cross-Appellee's Br. 35. Hortica counters it had no prior relationship with Cross Gunter and the firm was well qualified to represent PNC. Arkansas law does not directly address this question, but two federal courts have held the insured has a right to select is own counsel in cases where an insurer-appointed counsel would face a conflict of interest. *Union Ins. Co. v. The Knife Co.*, 902 F. Supp. 877, 881 (W.D. Ark. 1995); *Northland Ins. Co. v. Heck's Serv. Co.*, 620 F. Supp. 107, 108 (E.D. Ark. 1985). But even assuming Arkansas law provides PNC the right to choose its own counsel, PNC presents no evidence Hortica chose Cross Gunter out of malice or dishonesty. Nor does PNC explain how its inability to choose proximately caused its harm. We are not anxious to infer bad faith or negligence in such speculative circumstances. *See Wheeler v. Bennett*, 312 Ark. 411, 849 S.W.2d 952, 958 (1993) (declining to award recovery where cause of damages was conjectural).

Hortica-Florists' Mut. Ins. Co. v. Pittman Nursery Corp., 729 F.3d 846, 855 (8th Cir. 2013) (emphasis in original).

Langerman Law Offices P.A., 24 P.3d 593 (Ariz. 2001). Because the ruling rests on the premise that the parties' "interests coincide," it does not speak to the situation of when independent counsel is retained for an insured because its interests diverge from the insurer's.

CALIFORNIA

A. Parameters of Insured's Right to Independent Counsel

In *Executive Aviation, Inc. v. National Insurance Underwriters*, 16 Cal. App. 3d 799, 810 (1971), the court held that in a conflict-of-interest situation, "[t]he insurer's desire to exclusively control the defense must yield to its obligation to defend its policyholder," allowing the insured to control the defense. Subsequently, *San Diego Federal Credit Union v. Cumis Ins. Soc'y, Inc.*, 162 Cal. App. 3d 358 (1984), confirmed that when an insurer reserves rights on issues critical to the defense of the case, a conflict of interest arises for the attorney appointed by the insurer to defend and gives rise to the right of an insured to hire independent counsel at the insurer's expense. The right to independent counsel set forth in *Cumis* was codified in 1987 by California *Civil Code* § 2860,[8] which now sets forth the basic ground rules for rights and obligations with respect to independent counsel. And, although the statute sets forth those basic ground rules, there also is case law that guides the parties' conduct.

To summarize, *Civil Code* § 2860 provides:

(a) If a conflict of interest arises which creates a duty on the part of the insurer to provide the independent counsel, the insurer shall *provide* independent counsel to represent the insured unless the insured is informed and expressly waives in writing its rights to independent counsel or the insurance contract itself provides a different method of selecting counsel consistent with § 2860.

(b) A conflict of interest does not arise under all circumstances; it arises when the outcome of a coverage issue upon which a reservation of rights is based can be controlled by the defending counsel. No conflict of interest exists by reason of claims for punitive damages or the potential for a judgment in excess of policy limits.

(c) The insurer has the right to require certain "minimum qualifications" of the independent counsel. The insurer's obligation to pay fees for the independent counsel is limited "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." Again, the policy can provide other methods for setting fees. Any dispute concerning attorneys' fees is to be resolved by "final and binding arbitration by a single neutral arbitrator selected by the parties to the dispute."

(d) When independent counsel has been selected by the insured, that counsel and the insured must disclose "all information concerning the action except privileged materials relevant to coverage disputes" to the insurer and keep the insurer informed and "consult" in a timely manner on "all matters relating to the action." Privilege claims are subject to an *in camera* review and information disclosed by the insured or independent counsel to the carrier does not create a waiver of any privilege.

(e) The insured may waive its rights to independent counsel by a signed writing in conformance with the Code.

(f) If independent counsel is selected, the insurer may also provide counsel and such counsel "shall be allowed to participate in all aspects of the litigation."

[8] See Appendix.

B. Additional Requirements and Duties

Not every conflict of interest requires independent counsel. According to case law, the conflict must be "significant, not merely theoretical, actual, not merely potential." *Dynamic Concepts. Inc. v. Truck Insurance Exchange*, 61 Cal. App. 4th 999 (1998). A reservation of rights itself is not the trigger of independent counsel. The outcome of the coverage issue upon which the reservation is based must be such as can be controlled by counsel first retained by the insurer. Thus, where the reservation of rights is based on coverage disputes that have nothing to do with the issues being litigated in the underlying case, there is no right to independent counsel. *See, e.g., McGee v. Superior Court*, 176 Cal. App. 3d 221 (1985) (reservation of rights regarding resident relative exclusion does not give rise to rights to independent counsel); *James 3 Corp. v. Truck Ins. Exchange*, 91 Cal. App. 4th 1093 (2001) (insurer's refusal to fund prosecution of affirmative claims does not give rise to right to independent counsel); *Blanchard v. State Farm Fire & Casualty Co.*, 2 Cal. App. 4th 345, 347 (1991) (reservation of rights that certain types of construction-related damages were not covered by the insurance policy does not give rise to right to independent counsel). *Accord with Dynamic Concepts and Blanchard*, *Fed. Ins. Co. v. MBL, Inc.*, 219 Cal. App. 4th 29, 42, (6th Dist. 2013). *Accord with James 3 Corp.*, *Park Townsend, LLC v. Clarendon Am. Ins. Co.*, 916 F. Supp. 2d 1045 (N.D. Cal. 2013).

See also, e.g., Bank of America, N.A. v. Superior Court of Orange County, 212 Cal. App. 4th 1076 (4th Dist. 2013); *Park Townsend, LLC v. Clarendon Am. Ins. Co.*, 916 F. Supp. 2d 1045 (N.D. Cal. 2013).

California courts have made clear that the arbitration provision of *Civil Code* § 2860 applies only to fee-related disputes and no other disputes. Issues relating to the duty to defend and the right to independent counsel are not properly arbitrable. *See, e.g., Handy v. First Interstate Bank*, 13 Cal. App. 4th 917, 927 (1993). Further, for example, *Gray Cary Ware & Freidenrich v. Vigilant Ins. Co.*, 114 Cal. App. 4th 1185 (2004) held that *Civil Code* § 2860 did not require arbitration of a dispute concerning "defense expenses" (*e.g.*, investigative computer litigation support, travel expenses, meals, etc.). In *Compulink Management Center, Inc. v. St. Paul Fire & Marine Ins. Co.*, 169 Cal. App. 4th 289 (2008), however, the court held that *Civil Code* § 2860 required arbitration of "any issues concerning the amount of *Cumis* fees allegedly owed by [the insurer] including any disputed issues regarding independent counsel's hourly rate or number of hours billed." 169 Cal. App. 4th at 301. *Accord with Gray Cary Ware & Freidenrich*, *Wallis v. Centennial Ins. Co.*, 982 F. Supp. 2d 1114 (E.D. Cal. 2013). *Accord with Compulink*, *Arrowood Indem. Co. v. Bel Air Mart*, No. 2:11-CV-00976-JAM-DAD, 2013 WL 2434830 (E.D. Cal. June 4, 2013); *Swanson v. State Farm Gen'l Ins. Co.*, 219 Cal. App. 4th 1153, 1163-66 (2d Dist. 2013).

See also Behnke v. State Farm Gen'l Ins. Co., 196 Cal. App. 4th 1443 (4th Dist. 2011) (where insurer was not a party to a fee agreement between the insured and independent counsel, insurer was not contractually obligated to pay the full amount of independent counsel's fees billed under that agreement).

The insurer's obligation to pay the independent counsel rates is limited to the rate the insurer pays counsel it retains (*i.e.*, panel counsel) to defend similar cases in the relevant community. Importantly, the rate is not a rate to be paid for each individual insurer which may be defending. California courts have held that when multiple insurers are obligated to provide *Cumis* counsel, the statute limits the attorney to a single fee based on billing rates paid by one of the insurers (who must thereafter share such costs). Also *Civil Code* § 2860 applies to policies issued before its enactment. *See, San Gabriel Valley Water Co. v. Hartford Accident & Indemnity Co.*, 82 Cal. App. 4th 1230 (2000).

Although *Civil Code* § 2860 references a conflict of interest created for counsel "first retained by the insurer," in *Long v. Century Indem. Co.*, 163 Cal. App. 4th 1460 (2008), the court made clear that the duty arises "when the potential conflict arises, whether or not the insurer has—or will—retain its own counsel."

New cases:

- *Hartford Cas. Ins. Co. v. J.R. Marketing, LLC*, 61 Cal. 4th 988 (2015). Among the significant holdings are the following:
    - Unless the insured agrees otherwise, in a case where, because of the insurer's reservation of rights based on possible noncoverage under a CGL policy, the interests of the insurer and the insured diverge, the insurer must pay reasonable costs for retaining independent counsel by the insured (citing to Cal. Civ. Code § 2860). *Id.* at 998.
    - The statute requiring an insurer to provide independent counsel for an insured in the event of a conflict of interest is not triggered simply because an insurer defends under a reservation of rights, the underlying litigation alleges facts under which the insurer would deny coverage, or the litigation includes claims for punitive damages or damages in excess of policy limits; rather, the statute comes into play only when there exists a real and significant disjuncture between the interests of an insurer and its insured (citing to Cal. Civ. Code § 2860). *Id.* at 1003.
    - Independent *Cumis* counsel representing an insured, due to a conflict of interest on the part of the insurer, must be free to represent the insured as they see fit, subject only to generally applicable legal provisions and professional standards (citing to Cal. Civ. Code § 2860). *Id.* at 1006.
    - The proper test for any hindsight claim of excessive billing by independent *Cumis* counsel representing an insured due to a conflict of interest with the insurer is the same as for a contemporaneous challenge—i.e., whether the charges were objectively reasonable at the time they were incurred, under the circumstances then known to counsel (citing to Cal. Civ. Code § 2860). *Id.*

See also John DiMugno, Hartford Casualty Insurance Company v. J.R. Marketing: *New Questions about California's Independent Counsel Statute*, CAL. INS. L. & REG. RPTR 1, Vol. 28 Issue 4 (May 2016).

- *Dorroh v. Deerbrook Ins. Co.*, No. 1:11-cv-02120-DAD-EPJ, 2016 WL 7209808, __ F. Supp. 3d __ (E.D. Cal. Dec. 12, 2016) (because an attorney retained by an insurer to defend its insured is an independent contractor, a liability insurer cannot be held liable for the attorney's tortious conduct under California law).
- *Hollyway Cleaners & Landry Co. v. Central Nat'l Ins.*, No. 2:13-cv-07497-ODW(E), 2016 WL 6602544 (C.D. Cal. Nov. 7, 2016) (citing to Cal. Cv. Code § 2860, under California law, in some types of conflict-of-interest situations, an insurer must provide not only a defense for its insured, but an independent attorney selected by the insured; the scope of the conflict of interest requiring the provision of independent counsel to insured under California law is narrow, and where a reservation of rights is based on coverage disputes that have nothing to do with the issues being litigated in the underlying action, there is no conflict of interest requiring independent counsel). In this case, the court held that a conflict of interest arising from a CGL's reservation of rights concerning the policy's chemical-discharge exclusion did not require appointment of independent counsel to defend the insurer dry-cleaning establishment, and its owners, in an underlying environmental-contamination lawsuit, where the insurer's efforts to demonstrate that the subject contamination was intentional and, therefore, excluded from coverage did not undermine the insureds' defense in the underlying lawsuit, since the causes of action in said lawsuit were not restricted to deliberate or intentional acts. And the insurer's assertion of a fraud defense did not create a conflict of interest requiring appointment of independent counsel where insurer did not reserve its rights as to its fraud defense.

- *St. Paul Mercury Ins. Co. v. McMillin Homes Construction, Inc.*, No. 15-cv-1548 JM(BLM), 2016 WL 5464553 (S.D. Cal. Sept. 29, 2016) (not every conflict gives rise to the right of an insured to independent counsel).

- *Travelers Cas. Ins. Co. v. Hirsh*, 831 F.3d 1179 (9th Cir. 2016) (insurer's claims of unjust enrichment, violation of state governing independent counsel, and concealment against independent counsel for an insured arose from counsel's post-settlement conduct, and not counsel's communications with insured in settling a lawsuit, and thus, insurance company's claims were not barred by California's litigation privilege, where insurer alleged that independent counsel unjustly retained received funds received from settlement of insured's claims without providing insurer a setoff in fees insurer owed counsel, and that counsel failed to disclose material, nonprivileged information regarding amendment of settlement of insured's lawsuit).

- *Centex Homes v. St. Paul Fire & Marine Ins. Co.*, 237 Cal. App. 4th 23 (4th Dist. 2015) (contractor, subcontractor, and subcontractor's insurer did not currently have a conflict of interest in connection with underlying construction-defend litigation, which required appointment of independent counsel for general contractor, which was a named insured under subcontractor's insurance policy; while insurer's and general contactor's interests were slightly different because insurer's liability was limited to subcontractor's work and insurer claimed a right to reimbursement against general contractor for all defense fees unrelated to property damage caused by subcontractor, general contractor's liability was merely derivative of all of its subcontractors' liability such that the parties had the same interest in defending against the underlying claim). *See also Differing Interests of Developer and Subcontractor's Insurer, Which Covered Developer as an Additional Insured, Did Not Entitle Developer to Independent Counsel at Insurer's Expense*, 36 CAL. TORT REP. 8, No. 7 (July-Aug. 2015).

C. Statute:

§ 2860. Conflict of interest; duty to provide independent counsel; waiver; qualifications of independent counsel; fees; disclosure of information

(a) If the provisions of a policy of insurance impose a duty to defend upon an insurer and a conflict of interest arises which creates a duty on the part of the insurer to provide independent counsel to the insured, the insurer shall provide independent counsel to represent the insured unless, at the time the insured is informed that a possible conflict may arise or does exist, the insured expressly waives, in writing, the right to independent counsel. An insurance contract may contain a provision which sets forth the method of selecting that counsel consistent with this section.

(b) For purposes of this section, a conflict of interest does not exist as to allegations or facts in the litigation for which the insurer denies coverage; however, when an insurer reserves its rights on a given issue and the outcome of that coverage issue can be controlled by counsel first retained by the insurer for the defense of the claim, a conflict of interest may exist. No conflict of interest shall be deemed to exist as to allegations of punitive damages or be deemed to exist solely because an insured is sued for an amount in excess of the insurance policy limits.

(c) When the insured has selected independent counsel to represent him or her, the insurer may exercise its right to require that the counsel selected by the insured possess certain minimum qualifications which may include that the selected counsel have (1) at least five years of civil litigation practice which includes substantial defense experience in the subject at issue in the litigation, and (2) errors and omissions coverage. The insurer's obligation to pay fees to the independent counsel selected by the insured is limited 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 arose or is being defended. This subdivision does not invalidate other different or additional policy provisions pertaining to attorney's fees or providing

for methods of settlement of disputes concerning those fees. Any dispute concerning attorney's fees not resolved by these methods shall be resolved by final and binding arbitration by a single neutral arbitrator selected by the parties to the dispute.

(d) When independent counsel has been selected by the insured, it shall be the duty of that counsel and the insured to disclose to the insurer all information concerning the action except privileged materials relevant to coverage disputes, and timely to inform and consult with the insurer on all matters relating to the action. Any claim of privilege asserted is subject to in camera review in the appropriate law and motion department of the superior court. Any information disclosed by the insured or by independent counsel is not a waiver of the privilege as to any other party.

(e) The insured may waive its right to select independent counsel by signing the following statement: "I have been advised and informed of my right to select independent counsel to represent me in this lawsuit. I have considered this matter fully and freely waive my right to select independent counsel at this time. I authorize my insurer to select a defense attorney to represent me in this lawsuit."

(f) Where the insured selects independent counsel pursuant to the provisions of this section, both the counsel provided by the insurer and independent counsel selected by the insured shall be allowed to participate in all aspects of the litigation. Counsel shall cooperate fully in the exchange of information that is consistent with each counsel's ethical and legal obligation to the insured. Nothing in this section shall relieve the insured of his or her duty to cooperate with the insurer under the terms of the insurance contract.

COLORADO

No Colorado state court has yet addressed this issue.

But a recent federal court analyzed the applicable Colorado Rules of Professional Conduct and Colorado Ethics Opinions in determining that, in the case at bar, no conflict of interest existed to require the insurer to relinquish control of the defense to independent counsel. *Weitz Co., LLC v. Ohio Cas. Ins. Co.*, No. 11-cv-00694-REB-BNB, 2011 WL 2535040 (D. Colo. June 27, 2011).

CONNECTICUT

There is no Connecticut statute or reported opinion addressing the insured's right to select independent counsel. However, in *Aetna Life & Casualty v. Gentile,* 15 Conn. L. Rptr. 451, 1995 WL 779102 (Conn. Super. Dec. 12, 1995), an unpublished opinion addressing a declaratory judgment action filed by the insurer seeking a declaration that it had no duty to defend or indemnify its insured, the Court noted:

> Where an insurer perceives a conflict of interest between itself and its insured prior to or during the course of trial, it is customary, legally appropriate, and often legally necessary for the insurer to provide independent counsel to the insured, so as to not jeopardize the insured's rights under the terms of the contract.

Id. In *Gentile,* the Court found in favor of the insured and ordered the insurer to defend. In addition the Court ordered that the insurer reimburse the insured for the reasonable costs and fees it had incurred to date in defending the action, but did not elaborate on any standard for determining such reasonable costs and fees.

Gentile was abrogated by *ACMAT Corp. v. Greater N.Y. Mut. Ins.*, 282 Conn. 576 (2007), holding that the insured was not entitled to attorney fees as the prevailing party in an action against its liability insurer for declaratory judgment regarding the existence of a policy issued in the 1960s; no finding of bad faith conduct by the insurer was made, and no statutory or contractual provision authorized such an award.

Similarly, in *Hartford Fire Ins. Co. v. Rivers*, 19 Conn. L. Rptr. 183, 1997 WL 162750 (Conn. Super. Mar. 27, 1997), a case involving a declaratory judgment action initiated by the underlying plaintiff (as opposed

to either the insurer or insured), the Court, noted, *inter alia,* that the insurer had provided the insured with independent counsel and, in doing so, had satisfied its contractual obligations to the insured.

See also Nationwide Mut. Ins. Co. v. Pasiak, No. X08FSTCV084015401, 2011 WL 6413817 (Conn. Super. Nov. 30, 2011).

Finally, in *King v. Guiliani*, 9 Conn. L. Rptr. 527, 1993 WL 284462 (Conn. Super. July 27, 1993), the Superior Court was called upon to consider the propriety of an insurance company's practice of engaging a "captive" law firm to defend its insureds. The case arose from a dispute involving a former insurance company staff counsel who sought to continue to represent his insured clients after his employment was terminated by the insurer. In considering the issue, the Court concluded that, absent a conflict, such a practice was appropriate. However, the Court pointed out:

> I can only observe that anyone who believes that in conflict of interest situations, a salaried employee of [the insurer] would not place the welfare of the corporation above that of the policyholder, who theoretically he represents, probably also believes in the tooth fairy and the Easter bunny.

Id. (citations omitted).

Although it appears that Connecticut would conclude that an insured is entitled to separate counsel when a conflict of interest exists, there is no reported opinion on this issue and the few unreported opinion that touch on this issue do not elaborate upon an insurer's obligations under these circumstances.

DELAWARE

The Delaware courts have not addressed the issue of an insured's right to select independent counsel. However, in *Baio v. Comm'l Union Ins. Co.,* 410 A.2d 502 (Del. 1979), the Supreme Court recognized that an insurance company had a duty to act "equitably" towards its insured. There, an insurer sought to recover for its subrogated interest against a third party for funds it had paid out on a worker's compensation claim. The insurer subsequently discovered that it also insured the defendant tortfeasor, whom the insurer was obligated to defend. The Court suggested that the insurer's equitable conduct might include maintenance of separate files or "the employment of separate counsel . . . and so on," but did not address the issue any further. *Id.* at 508 n.6. Likewise, in *Corrado Bros., Inc. v. Twin City Fire Ins. Co.*, 562 A.2d 1188 (Del. 1989), the court commented that an insured might need independent counsel when a claim exceeds policy limits.

DISTRICT OF COLUMBIA

No District of Columbia court has yet addressed this issue. A Federal court, however, has found an insurance policy ambiguous on the question of when an insured is entitled to select independent counsel where the insurer defends under a reservation of rights. *See O'Connell v. Home Ins. Co.*, CIV. A. No. 88-3523, 1990 WL 137386 (D.D.C. Sept. 10, 1990).

A federal district court sitting in New York, applying D.C. law, relied on *O'Connell* in support of insured's right to select independent counsel. *Wallace v. Nat'l Railroad Passenger Corp.*, 5 f. Supp. 3d 452 (Mar. 18, 2014) (D.C. law).

FLORIDA

By statute,[9] Florida law requires that the *insurer* retain "independent counsel which is mutually agreeable to the parties." FLA. STAT. § 627.426. To be mutually agreeable, the insured must actually approve the

[9] See Appendix.

selected counsel. *See Cont'l Ins. Co. v. City of Miami Beach*, 521 So. 2d 232, 233 (Fla. App. 3d Dist. 1988); *Am. Empire Surplus Lines Ins. Co. v. Gold Coast Elevator, Inc.,* 701 So. 2d 904, 906 (Fla. App. 4th Dist. 1997).

When an insurer defends under a reservation of rights, the insured may reject the carrier's defense and retain its own attorneys without jeopardizing its right to seek indemnification from the insurer for liability. *See Travelers Indem. Co. of Ill. v. Royal Oak Enterprises, Inc.,* 344 F. Supp. 2d 1358, 1370 (M.D. Fla. 2004). Under Florida law, however, the policyholder is required to take several steps before he or she can actually retain his or her own attorney. First, the insured must actually *reject* the defense that the carrier offers before the insured is allowed to select his or her own counsel. *See Aguero v. First American Ins. Co.*, 927 So. 2d 894, 898 (Fla. App. 3d Dist. 2005). An unreported federal court decision indicates that, to reject the insurer's counsel, the policyholder may have to show "harm or prejudice" as to why counsel provided by the insurer is not "mutually agreeable." *See Prime Ins. Syndicate, Inc. v. Soil Tech Distributors, Inc.,* 2006 WL 1823562, *6 (M.D. Fla. 2006) (rebutting arguments that counsel was not "mutually agreeable" on an estoppel theory with the argument that counsel did not harm or prejudice the insured).

See also:

Mid-Continent Cas. Co. v. Am. Pride Building Co., 601 F.3d 1143 (11th Cir. 2010) (while an insurer must defend its insured, and may tender its defense subject to a reservation of rights, Florida law does not require an insured to accept such a defense; when an insurer agrees to defend under a reservation of rights or refuses to defend, the insurer transfers to the insured the power to conduct its own defense and, under Florida law, if the insurer offers to defend under a reservation of rights, the insured has the right to reject the defense and hire its own attorneys and control the defense).

U.S. Specialty Ins. Co. v. Burd, 833 F. Supp. 2d 1348 (M.D. Fla. 2011) (under Florida law, an economic conflict occurs, precluding an attorney from representing both the insurer and the insured, when the financial interests of the insurer and insured diverge; this typically happens when the insured, facing an excess claim, wants the policy limits offered in order to head off an excess judgment, but the insurer is reluctant to do so in the belief that the claim is not worth the policy limit; and when the insurer that has hired an attorney to represent its insured raises coverage defenses to the insured's claim, the interests of the insured and the insurer are in conflict, and the insurer normally issues a reservation of rights letter informing the insured that he might want to obtain independent counsel).

U. of Miami v. Great Am. Assur. Co., 112 So. 3d 504 (3d Dist. Ct. App. 2013) (conflict in legal defenses raised by university and operator of summer swim camp held on university campus required insurer to appoint separate independent counsel for university in a third-party negligence action falling under camp operator's general liability policy, which covered university as an additional insured; complaint alleged that each of the co-defendants was directly liable, camp operator alleged that plaintiff's injury was caused by the fault of university for which it was entitled to indemnification and contribution, university alleged that plaintiff's injury was caused by the fault of camp operator, and single defense counsel was put in the position of arguing that each of its clients was not at fault, and the other was).

Embroidme.com v. Travelers Cas. & Sur. Co. of Am., 992 F. Supp. 2d 1259 (S.D. Fla. 2014) (insurer was not foreclosed under Fla. Stat. § 627.426 from raising defense that insured had incurred disputed defense costs without insurer's knowledge and not at insurer's request in violation of plain language of policy, on insured's claim that insurer had breached CGL insurance policy by not reimbursing it for full cost of defending underlying legal action; although law firm was "mutually agreeable" independent counsel and insurer did not retain that firm until 133 days after notice of claim, the statute did not apply if there was no coverage).

Petro v. Travelers Cas. & Sur. Co. of Am., 54 F. Supp. 3d 1295 (N.D. Fla. 2014) (insured had timely actual knowledge of reservation of rights and policy exclusions potentially applicable to the facts, and timely

accepted the retained counsel, and thus insurer fulfilled its duty under Fla. Stat. § 627.426 to select mutually agreeable counsel; insurer thus fulfilled its duty under the statute to select mutually agreeable counsel; although insurer unilaterally retained independent counsel and reservation-of-rights letter did not explicitly mention that counsel had to be "mutually agreeable," insured had been consulted and agreed to counsel within requisite 60 days, and retained counsel then proceeded to represent insured for almost five years without objection).

Maronda Homes, Inc. of Fla. v. Progressive Express Ins. Co., 118 F. Supp. 3d 1332 (M.D. Fla. 2015) (although Florida law requires an insurer to provide an adequate defense of a claim against its insured that is covered by a policy and that if such defense is not adequate and it is reasonable for an insured to retain its own counsel, then an insured may recoup attorney fees from the insurer because it has, in effect, forced the insured to retain its own counsel, and although under Florida law the right to manage claims and defenses by an insurer can be overridden only when the insurer's interest interferes with the independent representation by counsel provided by the insurer, insured was not entitled to recoup because insured precluded insurer's efforts to provide a defense from the start of the underlying lawsuit by rejecting first defense counsel due to alleged conflict of interest and second defense counsel because insured disagreed with his litigation strategy; there was no showing that any aspect of insurer's defense was inadequate).

Traci K. Stevenson, as Ch. 7 Trustee for Ayyoub v. Corporation of Lloyd's, et al., No. 8:15-cv-2745-T-30, 2016 WL 524735 (M.D. Fla. Feb. 10, 2016) (bankruptcy trustee failed to establish that a conflict of interest existed; debtors not entitled to appointment of independent counsel).

EmbroidMe.com, Inc. v. Travelers Prop. Cas. Co. of Am., No. 14-10616, 2017 WL 74694, __ F.3d __ (11th Cir. Jan. 9, 2017) (under Florida law, if an insurer offers to defendant insured under a reservation of rights, the insured has the right to reject the defense and hire its own attorneys and control the defense, without jeopardizing its right to later seek indemnification from the insurer for liability; and, further, an insured must actually reject the insurer's defense, which it offered under a reservation of rights, before the insured may hire its own attorneys and control the defense without jeopardizing its right to seek indemnification from the insurer for liability).

Houston Specialty Ins. Co. v. Vaughn, No. 8:15-cv-2165-T-17AAS, 2017 WL 990581 (M.D. Fla. Mar. 14, 2017) (insurer failed to comply with § 627.426(2)(a), rendering its reservation-of-rights letter untimely).

Statute:

627.426. Claims administration

(1) Without limitation of any right or defense of an insurer otherwise, none of the following acts by or on behalf of an insurer shall be deemed to constitute a waiver of any provision of a policy or of any defense of the insurer thereunder:

(a) Acknowledgment of the receipt of notice of loss or claim under the policy.

(b) Furnishing forms for reporting a loss or claim, for giving information relative thereto, or for making proof of loss, or receiving or acknowledging receipt of any such forms or proofs completed or uncompleted.

(c) Investigating any loss or claim under any policy or engaging in negotiations looking toward a possible settlement of any such loss or claim.

(2) A liability insurer shall not be permitted to deny coverage based on a particular coverage defense unless:

(a) Within 30 days after the liability insurer knew or should have known of the coverage defense, written notice of reservation of rights to assert a coverage defense is given to the named insured by registered or certified mail sent to the last known address of the insured or by hand delivery; and

(b) Within 60 days of compliance with paragraph (a) or receipt of a summons and complaint naming the insured as a defendant, whichever is later, but in no case later than 30 days before trial, the insurer:

1. Gives written notice to the named insured by registered or certified mail of its refusal to defend the insured;

2. Obtains from the insured a nonwaiver agreement following full disclosure of the specific facts and policy provisions upon which the coverage defense is asserted and the duties, obligations, and liabilities of the insurer during and following the pendency of the subject litigation; or

3. Retains independent counsel which is mutually agreeable to the parties. Reasonable fees for the counsel may be agreed upon between the parties or, if no agreement is reached, shall be set by the court.

GEORGIA

In reservation-of-rights cases, the insurance company seeking to defend must obtain the consent of the insured. *Richmond v. Georgia Farm Bureau Mut. Ins. Co.*, 140 Ga. App. 215, 219, 231 S.E.2d 245, 248 (1976). "Where the insured refuses to consent to a defense offered subject to a reservation of rights, the insurer must thereupon (a) give the insured proper unilateral notice of its reservation of rights, (b) take necessary steps to prevent the main case from going into default or to prevent the insured from being otherwise prejudiced, and (c) seek immediate declaratory relief including a stay of the main case pending final resolution of the declaratory judgment action." *Id.* Consent can be express or implied. *Jacore Systems, Inc. v. Central Mut. Ins. Co.*, 194 Ga. App. 512, 390 S.E.2d 876 (1990).

Although Georgia law does not directly address the hiring of entirely independent counsel nor the payment thereof, it does discuss joint counsel. An Eleventh Circuit case applying Georgia law states the following:

> Where an insured hires co-counsel instead of rejecting the defense offered by the insurance company after an insurance company denies coverage but offers to provide a defense, it does not seem to us misplaced to put the burden on the insurance company to choose between denying a defense and providing a defense in cooperation with co-counsel retained by the insured.

Am. Family Life Assur. Co. of Columbus, Ga. v. U.S. Fire Co., 885 F.2d 826, 832 (11th Cir. 1989).

HAWAII

A. Insured's Right to Independent Counsel?

The Hawaii Supreme Court directly addressed the question of whether an insured is entitled to the appointment of independent counsel in *Finley v. Home Ins. Co.*, 975 P.2d 1145 (Haw. 1998). There, the court rejected the requirement that that the insurer must fund a separate "independent" counsel of an insured's choice when an insurer reserves rights. The court specifically explained:

> [W]e are convinced that the best result is to refrain from interfering with the insurer's contractual right to select counsel and leave the resolution of the conflict to the integrity of retained defense counsel. Adequate safeguards are in place already to protect the insured

> in the case of misconduct. If the retained attorney scrupulously follows the mandates of the Hawaii Rules of Professional Conduct (HRPC), the interests of the insured will be protected.

Id. at 1152. The *Finley* court explained that if the insured is concerned about the situation, it is free to reject the appointed counsel. However, if it does so, it waives the right to defense fees:

> If the insured chooses to conduct its own defense, the insured is responsible for all attorneys' fees related thereto. The insurer is still potentially liable for indemnification for a judgment within the scope of insurance coverage. However, having refused the contractual terms of the policy, the insured foregoes its right to compensation for defense fees.

The Supreme Court reaffirmed this approach in the case of *Delmonte v. State Farm Fire & Cas. Co*., 975 P.2d 1159 (Haw. 1999), elaborating that the insured may refuse the counsel offered but is responsible for the attorney's fees incurred if it does so.

B. Additional Requirements or Duties

Although independent counsel need not be provided merely because a potential conflict exists, as subsequent cases have explained, the *Finley* case nonetheless adopted an "enhanced" standard of good faith when an insurer defends subject to a reservation of rights.

> [T]he potential conflicts of interest between insurer and insured inherent in this type of defense mandate an even higher standard: an insurance company must fulfill an enhanced obligation to its insured as part of its duty of good faith.... This enhanced obligation is fulfilled by meeting specific criteria. First, the company must thoroughly investigate the cause of the insured's accident and the nature and severity of the plaintiff's injuries. Second, it must retain competent defense counsel for the insured [subject to rejection by the insured].... Third, the company has the responsibility for fully informing the insured not only of the reservation-of-rights defense itself, but of all developments relevant to his policy coverage and the progress of his lawsuit.... Finally, an insurance company must refrain from engaging in any action which would demonstrate a greater concern for the insurer's monetary interest than for the insured's financial risk.

See CIM Ins. Corp. v. Masamitsu, 74 F. Supp. 2d 975, 989 (D. Hawaii 1999).

Although under Hawaii law, an insurer need not provide separate counsel if a potential conflict exists with the insured, such as if the insurer has reserved rights, and the insurer is subject to an enhanced standard of good faith under this circumstance to ensure that its ethical obligations are met, case law does not address the question of what obligations an insurer has if an *actual conflict* develops.

IDAHO

A. Parameters of Insured's Right to Independent Counsel

Although the Idaho courts have not directly considered the question of whether an insured is entitled to independent counsel when a conflict of interest exists, in 1941 the Supreme Court indirectly considered this question in the case of *Boise Motor Car Co. v. St Paul Mercury Indem. Co.*, 112 P.2d 1011 (Idaho 1941). There, the court briefly discussed the consequences that flow from an insurer reserving rights in connection with a matter, explaining that if the insured did not consent to the reservation, and the insurer nevertheless

continued to assert a right to withdraw[10], the insurer was in breach of the insurance contract such that it was appropriate for the insured to protect itself by employing its own counsel. The court concluded that under this circumstance, "[a] fee paid the attorneys is … properly chargeable against respondent." In other words, if an insurer reserves right, the insured may retain separate counsel funded by the defense.

B. Additional Requirements and Duties?

It appears that the *Boise* case is still relied on today for the general notion that an insurer must pay for separate counsel for its insured when it reserves rights. Since that time, however, there has been no elaboration on this requirement, such as the rate that must be provided or if there are any limitations on this requirement.

ILLINOIS

If there is an actual conflict of interest between the insurer and insured, the Illinois Supreme Court has held that the insured has the right to obtain independent counsel at the insurer's expense. *Murphy v. Urso*, 430 N.E.2d 1079, 1084 (Ill. 1981) (holding that insurer could not appoint counsel to defend insureds with diametrically opposed interests); *Thornton v. Paul*, 384 N.E.2d 335, 343 (Ill. 1978), *overruled on other grounds*, *Am. Family Mut. Ins. Co. v. Savickas*, 739 N.E.2d 445 (Ill. 2000); *Maryland Cas. Co. v. Peppers*, 355 N.E.2d 24, 31 (Ill. 1976) (holding that conflict existed between insurer and insured where insured in underlying lawsuit could be held liable on either negligent or intentional act claims and only negligence claim was covered under policy). In order to determine whether an actual conflict exists, the court must determine whether the resolution of the factual issues in the underlying lawsuit would allow insurer-retained counsel to lay the groundwork for a later denial of coverage. *Am. Family Mut. Ins. Co. v. W.H. McNaughton Builders, Inc.*, 843 N.E.2d 492, 498 (Ill. Ct. App. 2d Dist. 2006) (holding that an actual conflict existed between the insurer and the insured because the date on which the property damage began in the underlying construction defect lawsuit was disputed and would affect coverage); *but see National Cas. Co. v. Forge Indus. Staffing, Inc.,* 567 F.3d 871 (7th Cir. 2009) (applying Illinois law) (holding that an actual conflict did not exist merely because of the hypothetical possibility that the plaintiffs could amend their complaint to add uncovered punitive damages claims). "The insurer must underwrite the reasonable costs incurred by the insured in defending the action with counsel of his own choosing." *Ill. Masonic Medical Center v. Turegum Ins. Co.*, 522 N.E.2d 611, 613 (Ill. App. Ct. 1st Dist. 1988).

See also:

Santa's Best Craft, LLC v. Zurich Am. Ins. Co., 941 N.E.2d 291 (Ill. App. Ct. 1st Dist. 2010) (when a conflict of interest exists between insured and insurer that prevents insurer from defending insured in an underlying suit, the insurer must permit the insured to be represented by counsel of its own choosing, and must reimburse the insured for the reasonable cost of defending the action).

Am. Fam. Mut. Ins. Co. v. Westfield Ins. Co., 962 N.E.2d 993 (Ill. App. Ct. 4th Dist. 2011) (same; and, additionally, a reservation of rights must adequately inform the insured of the rights the insurer intends to reserve, because it is only when the insured is adequately informed of the potential policy defense that the insured can intelligently determine whether to retain his or her own counsel or accept the tender of defense counsel from the insurer).

Econ. Premier Assur. Co. v. Faith in Action of McHenry County, Nos. 1-11-2329, 1-11-2457, 2013 IL App (1st) 112329-U, 2013 WL 1227118 (1st Dist. Mar. 26, 2013) (trial court did not err in granting insured's motion on the issue of the appointment of counsel; appellate court agreed that the conflict outlined by the insured at the beginning of the case, and repeated by appointed counsel during the case, is akin to *Peppers*,

[10] By right to withdraw, the court here means the insurer maintains the position that it does not have duty to defend, but nevertheless continues to defend under a reservation of rights.

supra, because it created an unresolved conflict between the interests of the insured and the insurer as it would be in the insurer's interest to keep the insured in the case).

Standard Mut. Ins. Co. v. Lay, No. 4-11-0527, 2013 IL App (4th) 110527-UB, 2013 WL 6199952 (4th Dist. Nov. 25, 2013) ("Where a conflict exists, an insurer's obligation to defend is satisfied by reimbursing the insured for the cost of defense provided by independent counsel selected by the insured. *Maryland Cas. Co. v. Peppers*, 64 Ill. 2d 187, 198-99, 355 N.E.2d 24, 31 (1976). Under these circumstances, the insured is entitled to assume control of the defense. *Id.* When an insurer surrenders control of the defense, it also surrenders its right to control the settlement of the action and to rely on a policy provision requiring consent to settle. *Myoda Computer Center, Inc. v. Am. Fam. Mut. Ins. Co.*, 389 Ill. App. 3d 419, 425, 909 N.E.2d 214, 220 (2009). Standard had no right to require Lay to obtain permission to settle the underlying suit or to object to it itself."). ***Order withdrawn*, 2 N.E.3d 1253, 2014 IL App (4th) 110527-B (Jan. 21, 2014)**.

First Mercury Ins. Co. v. Nationwide Security Services, Inc., 2016 IL App (1st) 143924 (2016) (where liability insurer surrenders defense to independent legal counsel because of a conflict of interest, it thereby relinquishes control over the litigation, and a reasonable settlement by the insured should not prevent an action for or in opposition to indemnification).

Rainey v. Indiana Ins. Co., 2016 IL App (1st) 150862-U (May 11, 2016) (unpublished) (absent a conflict of interest in the underlying litigation, insurer was not obligated to pay for independent counsel and did not breach its duty to defend by failing to do so; because insured cannot show that insurer breached its duty, insured cannot satisfy his contention that insurer was estopped from denying its obligation to provide independent counsel).

DHR Int'l v. Travelers Cas. & Sur. Co. of Am., No. 15 C 4880, 2016 WL 561914 (N.D. Ill. Feb. 12, 2016) (insurer was under no obligation to appoint independent counsel or to advise insured of its right to independent counsel because no conflict of interest existed).

Essex Ins. Co. v. RHO Chem. Co., *et al.*, 145 F. Supp. 3d 780 (N.D. Ill. 2015) (insureds not prejudiced by potential conflict of interest resulting from insurer's representation of insureds, under reservation of rights, in underlying lawsuit, and thus insurer was not estopped under Illinois law from asserting policy exclusion as defense to coverage; although insurer opined in its reservation-of-rights letter that a material conflict of interest did not exist, it specifically identified the potential conflict of interest, insureds did not raise any such conflicts until five months after the letter was sent, and when insurer was informed that its letter created conflict of interest, it permitted insureds to hire their own defense counsel at insurer's expense).

Central Mut. Ins. Co. v. Tracy's Treasures, Inc., 2014 IL App (1st) 123339, 19 N.E.3d 1100 (2014) (insurer may cede control of the defense thus allowing insured to enter into reasonable settlement agreement without insurer's consent under two scenarios: (1) when a conflict of interest exists such that insured becomes entitled to control the defense through counsel of its own choosing or (2) when the insurer breaches its duty to defend thereby requiring the insured to assume its own defense; when a conflict of interest arises between insurer and insured the insured has the right to reject the defense offered by insurer and select counsel of insured's choosing and control the defense of the case and recover its defense costs from the insurer; CGL insurer retained its ability to contest both the reasonableness of settlement insured entered into in underlying class action after obtaining independent counsel and whether the claims giving rise to the settlement were covered under its policies; insurer never breached its duty to defend nor controlled the defense of the underling case to insured's detriment since it allowed insured to obtain substitute counsel and continued to pay for insured's independent counsel; lack of notice to CGL insurer of settlement agreement of underlying class action against insured was not determinative of the reasonableness of the settlement; at the time of settlement, insured had independent counsel whose sole obligation was to represent insured's interests, and insurer made no attempt to assign counsel to monitor case on insurer's behalf).

Perma-Pipe, Inc. v. Liberty Surplus Inc. Corp., 38 F. Supp. 3d 890 (N.D. Ill. 2014) (pursuant to an insurer's duty to defend under Illinois law, if there is a conflict between the interests of the insurer and the insured, the insurer must pay for independent counsel selected by the insured; a conflict of interest does not arise between and insured and an insurer merely because the insurer has an interest in negating coverage nor is a conflict absent simply because both parties would benefit from the insured's exoneration in the underlying suit; under Illinois law, there was a nontrivial probability that there would be a judgment in excess of limits of the CGL policy in the underlying suit against the insured and, thus, a conflict of interest existed that obligated insurer to pay for independent counsel selected by insured in the underlying action—insured was being sued for more than $40 million and the policy limit was $1 million per occurrence).

Indiana Ins. Co. v. CE Design Ltd., 6 F. Supp. 3d 858 (N.D. Ill. 2013) (under Illinois law, an insurer that fails to disclose conflicts of interests in connection with appointment of independent counsel for insured is not estopped from raising coverage defenses unless the insured has been prejudiced by the conflict of interest or appointed counsel; insurer was not estopped from contesting coverage in action seeking declaration that it had no duty to defend or indemnify insured based on its failure to disclose alleged conflict of interest or offer independent counsel to insured in reservation-of-rights letter absent evidence that insured was prejudiced by its representation in the underlying action).

For one commentator's views, *see* Scott O. Reed, *Conflicts and the Use of Independent Counsel*, 25 DCBA BRIEF 26 (July 2013).

INDIANA

Generally, under Indiana law, where there is a coverage dispute, the insurer must either hire independent counsel for the insured and defend under a reservation of rights or file a declaratory judgment action. *Nat'l Union Fire Ins. Co. v. Standard Fusee Corp*., 917 N.E.2d 170, 187 (Ind. Ct. App. 2009), *vacated on other grounds*, 940 N.E.2d 810 (Ind. 2010). Where a conflict of interest arises, an insurer "must" either retain independent counsel or choose to reimburse the insured for its choice of independent counsel. *All-Star Ins. Corp. v. Steel Bar, Inc.*, 324 F. Supp. 160, 165 (N.D. Ind. 1971) (holding that conflict existed necessitating retention of independent counsel where liability for underlying case and coverage dispute turned on whether injury was the result of an accident or insured's intentional conduct). While this rule of law seems to imply an insured may select counsel only if the insurer does not retain counsel itself, subsequent cases provide otherwise. In *Snodgrass v. Baize*, 405 N.E.2d 48, 51 (Ind. Ct. App. 1980), the court stated that in instances where a conflict of interest arises, "the insurer should not defend, but, rather, [] should reimburse the insured's personal counsel." In *Armstrong Cleaners, Inc. v. Erie Ins. Exch.*, 364 F. Supp. 2d 797, 808 (S.D. Ind. 2005), a federal district court similarly stated that "the conflict may be sufficient to require the insurer to pay for counsel of the insured's choice." A conflict of interest exists where there is a "*significant risk* that an attorney selected by and under the control [of the insurer] would be materially limited in the representation" as a result of the relationship with the insurer and the reservation of rights. *Id.* at 817 (emphasis added). In *Armstrong Cleaners*, an environmental pollution coverage matter, the district court denied the insurer's motion for summary judgment and granted a cross motion in favor of the insureds, holding that the insureds had the right to select defense counsel where the insurer's reservation of rights included coverage defenses concerning whether the pollution was the result of an "occurrence" or whether the insureds expected or intended to cause the alleged property damage. *Id*. at 815–16.

See also:

Am. Fam. Mut. Ins. Co. v. C.M.A. Mortgage, Inc., 682 F. Supp. 2d 879 (S.D. Ind. 2010) (under Indiana law, where insurer, in response to insured's tender of defense, reserves it rights to deny coverage based on a policy exclusion, thus creating a conflict of interest, the insurer is required to reimburse the insured's independent counsel as part of its duty to defend).

Auto-Owners Ins. Co. v. Lake Erie Land Co., Cause No. 2:12-CV-184 JD, 2013 WL 4401834 at *7 (N.D. Ind. Aug. 13, 2013) (citing *Armstrong* extensively, court stated: "Indiana has intentionally adopted the wider 'significant risk' approach reflected in [Indiana] Rule [of Professional Conduct] 1.7(a)(2), see *Armstrong Cleaners*, 364 F. Supp. 2d at 808, but even under the narrower standard advocated by the Plaintiff Insurers, [Lake Erie Land] would carry the day. The simple fact is that, by deciding the claims raised in the Hite Lawsuit, a jury must also necessarily decide the question of intent. The question of intent, in turn, goes a long way towards deciding the question of coverage. That clearly satisfies the *National* [*Cas. Co. v. Forge Indus. Staffing, Inc.*, 567 F.3d 871 (7th Cir. 2009)] test, and that creates a conflict of interest.").

Valley Forge Ins. Co. v. Hartford Iron & Metal, Inc., et al., 148 F. Supp. 3d 743 (N.D. Ind. 2015) (under Indiana law, insurer created conflict of interest that prevented it from controlling the defense by filing breach of contract action against insured that sought recovery of same environmental remediation costs that insured said CGL insurance policies covered; attorney could not represent both insured's and insurer's interests consistent with his or her ethical obligations due to risk of misaligned incentives as result of insured complaining that insurer's selection of remediation company contributed to further discharge issues and insurer maintained that discharge issues were due to insured's bad faith failure to cooperate (citing Ind. Code Ann. § 13-30-9-5 and Ind. R. Prof. Conduct 1.7(a)); insurer created conflict of interest that prevented it from controlling environmental remediation by filing breach of contract action against insured that sought recovery of same remediation costs that insured said CGL insurance policies covered; although policies prohibited voluntary payments, insurer did not dispute coverage, defense and remediation activities were inextricably intertwined, and insurer and insured blamed each other for further discharge issues that prevented attorney from representing both insured's and insurer's interests).

IOWA

This state has not yet addressed this issue.

KANSAS

The Kansas Supreme Court stated that when a conflict of interest arises between an insured and insurer, the insurer must hire independent counsel to defend the insured in the action and notify the insured of the reservation of rights. *Patrons Mut. Ins. Ass'n v. Harmon*, 732 P.2d 741, 745 (Kan. 1987). No case law has addressed whether an insured has a right to select its own counsel absent a designation by the insurer. *See also*, *Hackman v. W. Agric. Ins. Co.*, 275 P.3d 73 (Ct. App. Kans. 2012).

Eye Style Optics, LLC v. State Farm Fire & Cas. Co., No. 14-2118-RDR, 2014 WL 2472096 (D. Kan. June 3, 2014) (where underlying lawsuit involved covered and uncovered claims of negligent and intentional misconduct, insured did not allege any other facts from which the court could find that the insurer's appointed counsel was not "independent" or able to defend all claims asserted against insured).

KENTUCKY

Kentucky case law states that "an insured is not required to accept a defense offered by the insurer under a reservation of rights." *Med. Protective Co. of Fort Wayne, Ind. v. Davis,* 581 S.W.2d 25, 26 (Ky. App. 1979); *see Cincinnati Ins. Co. v. Vance*, 730 S.W.2d 521, 524 (Ky. 1987). Kentucky courts, however, have not addressed whether the insured may hire its own defense counsel or whether an insurer would be obligated to pay for such expense.

See also Lee v. Med. Protective Co., 858 F. Supp. 2d 803 (E.D. Ky. 2012) (if a conflict of interest arises for the attorney retained by the insurer to defend the insured against an underlying claim, the insured typically retains her own attorney due to the conflict, such as receipt of an offer to settle within the policy limits in a case where an excess verdict is possible; the attorney must advise the insured of the conflict and advise her further about the possibility of an excess verdict and of her right to retain her own attorney).

LOUISIANA

A 1936 Louisiana appellate case was the first case in the state to recognize a policyholder's right to independent counsel and award payment to such counsel of *reasonable* attorney fees. *Shehee-Ford Wagon & Harness Co. v. Cont'l Cas. Co.*, 170 So. 249 (La. App. 2d Cir. 1936). The court did state that it would generally not order payment of insured's attorney fees but for the fact that the counsel provided by the insurer so "directly opposed" the policy. *Id* at 252 (insurer's counsel denied the validity of the policy as part of the "defense" of the insured)

See also, *Emery v. Progressive Cas. Ins. Co.*, 49 So. 3d 17 (Ct. App. La. 1st Cir. 2010) (if insurer chooses to defend the insured but deny coverage, it must employ separate counsel).

Since the 1936 case, a state appellate court has held that "if the insurer chooses to represent the insured but deny coverage it must employ separate counsel. If it fails to do so, the insurer is liable for the attorney fees and costs the insured may incur for defending the suit." *Dugas Pest Control of Baton Rouge, Inc. v. Mut. Fire, Marine and Inland Ins. Co.*, 504 So. 2d 1051, 1054 (La. App. 1st Cir. 1987); *but cf. Trinity Universal Ins. Co. v. Stevens Forestry Service, Inc.*, 335 F.3d 353, 356 (5th Cir 2003) (Louisiana law) (not requiring reimbursement for the insured's *additional* counsel as long as insurer provided *competent* defense counsel).

For one commentator's views, *see* Melissa Claire Scioneaux, *Louisiana Recognizes the Insurance Policyholder's Entitlement to Select Independent Counsel, Now What?" A Legislative Proposal*, 81 TUL. L. REV. 537 (Dec. 2006).

See also J. S. Holliday, Jr., H. B. Shreves & D. R. Baringer, *Insurance coverage and independent counsel*, LA. PRAC. CONSTRUCTION L. § 16:6 (2016).

See also:

Lynch-Ballard v. Lammico Ins. Agency, Inc., 176 So. 3d 651 (Ct. App. La. 5th Cir. 2015) (professional liability insurer had no conflict of interest with insured physician objecting to settlement of malpractice case and, therefore, was not required to appoint new, separate counsel for physician since insurer had the right to settle case within policy limits without insured's consent).

Belanger v. Gabriel Chemicals, Inc., 787 So. 2d 559 (Ct. App. La. 1st Cir. 2001) (insured was entitled to select independent counsel to defend itself against claims of employees, where insurer denied coverage under the CGL and excess policies; the two attorneys offered by insurer had a potential conflict of interest between insurer's duty to defend the insured and insurer's right to contest coverage, and the insured's act of hiring independent counsel evinced a lack of consent to representation by insurer-selected attorneys with a potential conflict of interest, citing La. R. Prof. Cond. 1.7 and LSA-R.S. foll. 37:221; if an insurer chooses to represent the insured but deny coverage, separate counsel must be employed, and failure to do so subjects the insurer to the attorney fees and costs the insured may incur for defending the suit; in cases where the insurer and insured have a conflict of interest, the insured, rather than the insurer, is entitled to assume control of the defense of the underlying action, and select its own attorney; however, the insurer must underwrite the reasonable costs incurred by insured in defending the action with counsel of insured's own choosing).

Smith v. Reliance Ins. Co. of Ill., 807 So. 2d 1010 (Ct. App. La. 5th Cir. 2002) (insured allowed to select own counsel and insurer ordered to pay for all present and future defense costs where insurer attempted to deny coverage in effort to avoid providing a defense to insured; claims against insured and insurer's claim that exclusions applied served to create a conflict of interest that entitled insured to assume control of defense and to select own counsel; insurer's coverage denial is an event that entitles insured to select independent counsel to represent insured at insurer's expense).

Vargas v. Daniell Battery Mfg. Co., Inc., 648 So. 2d 1103 (Ct. App. La. 1st Cir. 1995) (if insurer chooses to represent insured by deny coverage it must employ separate counsel).

MAINE

In *Travelers Indem. Co. v. Dingwell*, 414 A.2d 220 (Me. 1980), the Supreme Judicial Court of Maine recognized in *dicta* the insurer's obligation to provide independent counsel when a conflict arises between insurer and insured:

> Of course, the insurers' obligation to defend can lead to a serious dilemma for the insurer. In some cases, the parties may agree that the insurer hire independent counsel for the insured. . . . The difficulties which these cases may pose will have to be addressed as they arise. For the case at bar, it is sufficient for us to hold that the complaint here does generate a duty to defend, because it discloses a potential for liability within the coverage and contains no allegation of facts which would necessarily exclude coverage.

414 A.2d at 227 (citing *Magoun v. Liberty Mut. Ins. Co.*, 346 Mass. 677, 195 N.E.2d 514 (1964)).[11]

The Supreme Judicial Court next addressed the issue in *Patrons Oxford Ins. Co. v. Harris*, 905 A.2d 819 (Me. 2006). There, in the context of reviewing a settlement entered by appointed counsel on behalf of an insured which was being defended under a reservation of rights, the Court commented that when an insurer defends subject to a reservation of rights—irrespective of the basis for the reservation and whether it creates an actual conflict of interest—it gives up its right to control the defense. *Id*. at 826.

See also, *Kohl's Dep't Stores, Inc. v. Liberty Mut. Ins. Co.*, No. BCD-CV-12-13, 2012 WL 6650619 (Me. Super. Oct. 11, 2012) (Trial Order), at § I.A. "Identification of the Correct Client."

MARYLAND

The Maryland state courts have concluded that, in the case of an actual conflict of interest, the insured is entitled to retain independent counsel to defend the claim and that the insurer is required to pay the reasonable cost of that defense. *See Brohawn v. Transamerica Ins. Co.*, 276 Md. 396, 414-15, 347 A.2d 842 (1975); *So. Md. Agric. Assoc., Inc. v. Bituminous Cas. Corp*., 539 F. Supp. 1295 (D. Md. 1982); *Allstate Ins. Co. v. Campbell*, 334 Md. 381, 392, 639 A.2d 652, 657 (Md. App. 1994) ("We have recognized an obligation by the insurer to assume the reasonable costs of the defense provided by an independent attorney where independent counsel is necessary because there exists a conflict of interest between the insurer and the insured.").

In *Brohawn*, an insurer brought a declaratory judgment action against its insured, seeking a declaration that it had no obligation to defend or indemnify its insured in an action brought by third parties based on alternative allegations of negligence and assault. The policy expressly excluded from coverage liabilities arising from any intentional acts committed by the insured, and the insured had pleaded guilty to assault in a criminal action arising out of the same incident. The Court concluded that the insurer's obligation to defend is determined by the allegations in the complaint and if the complaint alleges a claim potentially covered by the policy, the insurer has a duty to defend. *Id.* at 407, 347 A.2d 842. In order to fulfill this duty, the *Brohawn* Court concluded that the insurer must permit the insured to select independent counsel to defend the entire case and pay that independent counsel a reasonable fee:

> We hold that an insured is not deprived of his contractual right to have a defense provided by the insurer when a conflict of interest between the two arises under circumstances like

[11] Of interest, in the *Magoun* case cited by the *Dingwell* Court, the Massachusetts Court concluded that absent a separate agreement on the issue, when an insurer issues a reservation of rights and thereafter "acquiesces" in the insured's selection of counsel, the insurer must pay the "reasonable charges" of that counsel.

> those in this case. When such a conflict of interest arises, the insured must be informed of the nature of the conflict and given the right either to accept an independent attorney selected by the insurer or to select an attorney himself to conduct his defense. If the insured elects to choose his own attorney, the insurer must assume the reasonable costs of the defense provided.

Id. at 414-15, 347 A.2d at 854.

At least one Maryland federal court, however, appears to differ. In *Cardin v. Pac. Employers Ins. Co.,* 745 F. Supp. 330 (D. Md 1990), the Court concluded the insured was not entitled to select independent counsel of his own choosing when the counsel retained by the carrier is instructed to defend all claims. In *Cardin,* the insurer hired a private attorney from a noncaptive law firm to represent its insured subject to a reservation of rights in which the insurer asserted that it would not pay any judgment against the insured based on any "non-covered or excluded grounds." The insured asserted that he was entitled to select his own counsel at the insurer's expense because there was a conflict between his interests and that of the insurer in light of the fact that claims were made for both negligent and intentional acts and because there were claims for punitive damages. The District Court held that because appointed counsel: (1) was instructed by the insurer to represent *only* the interests of the insured; (2) was at no time also representing the insurer in the case; and (3) had an ethical responsibility to work only on behalf of the insured, his client, that no actual conflict of interest was created. The Court held, therefore, that the insurer had no duty to pay for independent counsel selected by the insured.

> [The insured] asserts that he was entitled to independent counsel in the defense of the [claim] due to the conflict of interest that arose from [the insurer's] reservation of rights based on the presence of covered and uncovered claims in the underlying suits. In addition, [the insured] alleges that unusual circumstances in this case, including the claim for compensatory damages far in excess of policy limits (with a provision for allocation of counsel fees if there were a recovery in excess of coverage), the claim for punitive damages and the related criminal investigation and prosecution, justified [his] right to select his own counsel and have that counsel paid by the insurer. Finally, Cardin argues that because [the law firm selected by the insurance company] receives referrals frequently from [the insurer], the lawyer might appear to have an incentive to steer his defense of [the insured] in a direction favorable to [the insurer].
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> * * *
>
> [T]he potential existence of such different objectives cannot, *per se,* warrant requiring the insurer to pay the fees of the insured's criminal defense counsel even if there could be an allocation of fees between the civil and criminal defense functions.

Id. at 335-36.

MASSACHUSETTS

In *Magoun v. Liberty Mutual Insurance Co.*, 346 Mass. 677, 195 N.E.2d 514 (1964), the Massachusetts Supreme Judicial Court was called upon to discuss the "dilemma confronting an insurance company, when it discovers in the course of defence [*sic*] of an action that it has a probable basis for disclaiming liability." In *Magoun,* the insurer issued a reservation of rights to the insured, who rejected the insurer's offer and selected its own counsel to defend the litigation. The insurer did not insist that it maintain control of the defense and merely cooperated with its insured's chosen counsel. Ultimately, the insured prevailed in its defense of the underlying claim and thereafter filed suit against the insurer to recover the fees and expenses incurred in defending the litigation. The Court ruled that under such circumstances the insurer was required to pay the "reasonable charges" of the insured's counsel, but did not elaborate.

More recently, in *N. Sec. Ins. Co. v. Sandpiper Village Condominium Trust*, 24 Mass. L. Rptr. 500, 2008 WL 4514515 (July 3, 2008), the Superior Court was called upon to address the insurer's obligation to reimburse its insureds for costs and fees paid by the insured to independent counsel who successfully defended the insured after the carrier issued a reservation of rights. In *Sandpiper*, the insurer argued that it should not be required to pay more than $150.00 per hour for counsel since this was the rate it paid counsel it typically retained. The insured's selected counsel, however, billed at a higher hourly rate and the insured argued that it was entitled to be reimbursed for the full amount it had incurred. Although the Court concluded that the insured was entitled to be reimbursed for "reasonable fees" and outlined the parameters for making this determination, the Court declined to decide the issue in the context of the summary judgment motion before it because the Court concluded that the determination was a factual issue:

> Next, the Court considers the defendants' argument on summary judgment that the Court should require Northern Security to pay the $15,563.00 in attorney's fees incurred by Marcus Errico Emmer & Brooks in the underlying case. The question of reasonable attorneys fees is a question left up to the sound discretion of the judge. . . In making that determination the Court considers, "the nature of the case and issues presented, the time and labor required, the amount of damages involved, the result obtained, the experience, reputation and ability of the attorney, the usual price charged for similar services by other attorneys in the same area, and the amount of awards in similar cases." . . . The defendants point to Marcus Errico Emmer & Brooks' experience representing condominium associations and note that they successfully obtained a rare motion for reconsideration in the underlying case. In the instant case, however, the issue of "reasonableness," is a genuine issue of material fact inappropriate on summary judgment.

Id.[12]

While the *Sandpiper* Court did not elaborate on which party bore the burden of establishing the reasonableness of counsel fees, this issue was addressed by the United States Court of Appeals in *Liberty Mut. Ins. Co. v Cont'l Cas. Co*., 771 F.2d 579 (1st Cir. 1985), which held that the insured, as the party claiming attorney's fees, has the burden of proving that the fees are reasonable. *Id.* at 582.

See also:

N. Sec. Ins. Co., Inc. v. R.H. Realty Trust, 78 Mass. App. Ct. 691, 941 N.E.2d 688 (2011) (when an insurer seeks to defend its insured under a reservation of rights, and the insured is unwilling to allow the insurer do so, the insured may require the insurer either to relinquish its reservation of rights or relinquish its right to defend the insured and reimburse the insured for its defense costs; in such an instance, the insurer must pay the reasonable charges of the insured's retained counsel); *Vicor Corp. v. Vigilant Ins. Co.*, Civil Action No. 07-10517-RGS, 2012 WL 4469084 (D. Mass. Sept. 28, 2012) (same); *Citation Ins. Co. v. Newman,* 80 Mass. App. Ct. 143, 951 N.E.2d 974 (2011) (same); *Norfolk & Dedham Mut. Fire Ins. Co. v. Cleary Consultants, Inc.*, 81 Mass. App. Ct. 40, 958 N.E.2d 853 (2011) (same).

Riva v. Ashland, Inc., Civil Action Nos. 09-cv-12074-DJC, 11-cv-12269-DJC, 11-cv-12277-DJC, 2013 WL 1222393 (D. Mass. Mar. 26, 2013) (following *Magoun* in an indemnitor-indemnitee situation).

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[12] The Court added the following footnote to its discussion:

> The Court declines to reach the argument regarding whether the Court should only consider the usual price charged for similar services by other attorneys in the same area in place of the usual price paid by insurance companies to other attorneys for similar services in the same area.

Id. at n.6.

MICHIGAN

The Michigan Supreme Court has not specifically addressed the issue of whether an insured, upon receipt of a reservation-of-rights letter, may insist upon independent counsel at the insurer's expense. The federal district courts in Michigan, however, repeatedly have addressed that question. Those courts have held that where a conflict of interest between the insured and insurer arises—*i.e.* when the insurer "reserves its rights"—the insurer's duty to defend is discharged when it selects independent counsel to represent the insured, as long as the insurer exercises good faith in its selection and the attorney selected is truly independent. *Central Mich. Bd. of Trustees v. Employers Reinsur. Corp.*, 117 F. Supp. 2d 627, 633-35 (E.D. Mich. 2000) (insured could not recover costs of retaining counsel it selected in the absence of evidence that counsel selected by insurer could not be independent); *Aetna Cas. & Sur. Co. v. Dow Chem. Co.*, 44 F. Supp. 2d 847, 860-61 (E.D. Mich. 1997) (insured has the right to select counsel where there is a conflict of interest between the insurer and the insured, but denying insured's motion for partial summary judgment on recovery of pretender defense costs because there was a genuine issue of material fact as to whether a conflict-of-interest situation existed); *Fed. Ins. Co. v. X-Rite*, *Inc.*, 748 F. Supp. 1223, 1226 (W.D. Mich. 1990) (policyholder was not entitled to recovery of defense costs incurred by law firm it selected in the absence of evidence that the law firm selected by the insurer could not act independently). Should the insurer fail to provide independent counsel, the insured is at liberty to hire its own defense counsel, and the insurer is then liable for all reasonable attorney fees. *See Fireman's Fund Ins. Cos. v. Ex-Cell-O Corp.*, 790 F. Supp. 1339, 1346 (E.D. Mich. 1992). "Reasonable" is measured by what a typical defense lawyer would have done under same or similar circumstances. *Id.*

But see, *Lapham v. Jacobs Technology, Inc.*, Nos. 295482, 295489, 2011 WL 2848802 (Ct. App. Mich. July 19, 2011) (in case where issue was whether counsel selected by insurer on account of a conflict of interest necessitating the need for independent counsel truly was "independent," court held that "communications between the [law] firm and [the insurer] is not enough to show that the [law] firm acted against [the insured's] interests.").

See Brooks Kushman P.C. v. Cont'l Cas. Co., No. 15-12351, 2016 WL 5661577 (E.D. Mich. Sept. 30, 2016) (under Michigan (as well as California) law, there is no attorney-client relationship between an insurer and a law firm that has been retained by the insured party as independent counsel).

MINNESOTA

The insurer retains the right to appoint counsel even after the issuance of a reservation of rights absent the showing of "actual conflict." *Mut. Serv. Cas. Ins. Co. v. Luetmer*, 474 N.W.2d 365, 368 (Minn. Ct. App. 1991); *see also Hawkins, Inc. v. Am. Int'l. Specialty Lines Ins. Co.*, 2008 WL 4552683 at *7 (Minn. Ct. App. Oct. 14, 2008). Where such conflict is shown to exist, an insurer must pay for independent defense counsel selected by the insured. *Prahm v. Rupp Constr. Co.*, 277 N.W.2d 389, 391 (Minn. 1979); *see also Chicago Title Ins. Co. v. F.D.I.C.*, 172 F.3d 601, 605 (8th Cir. 1999).

See also:

Cont'l Cas. Co. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa., 940 F. Supp. 2d 898, 928 (D. Minn. Mar. 29, 2013, as amended and op. denying reconsideration, Aug. 9, 2013) ("Generally, in the absence of an actual conflict of interest between the insured and the insurer, the insured has no right to choose independent defense counsel to provide the insured with a defense. *Mut. Serv. Cas. Ins. Co. v. Luetmer*, 474 N.W.2d 365, 368 (Minn. Ct. App. 1991). When a conflict of interest exists—such as when an insurer accepts the tender of defense but also disputes coverage—the insurer's duty to defend is transformed into a 'duty to reimburse [the insured] for reasonable attorneys' fees.' *Prahm v. Rupp Constr. Co.*, 277 N.W.2d 389, 391 (Minn. 1979).").

Select Comfort Corp. v. Arrowood Indem. Co., No. 13-2975 (JN3/FLN), 2014 WL 4232334 (D. Minn. Aug. 26, 2014) (insurer's reservation of rights created a conflict of interest that converted insurer's duty to defend into a duty to reimburse insured for the reasonable costs of defending itself using separate, independent counsel).

MISSISSIPPI

Where only a part of the claim against the insured, or only one (or less than all) of the underlying plaintiff's multiple theories of recovery from the insured, is subject to potential coverage, the insurer is obligated only to provide a defense with respect to the potentially-covered claim and the insured must retain its own counsel, at its own expense, to defend the remaining noncovered claims. If, however, the insurer, at its election, agrees to provide a defense as to the entire action, encompassing both covered and noncovered claims, subject to a reservation of rights, the resulting potential conflict of interest entitles the insured to retain additional counsel with respect to the noncovered claims at the insurer's expense. *Moeller v. Am. Guar. & Liab. Ins. Co.*, 707 So. 2d 1062, 1070-71 (Miss. 1996); *see also Twin City Fire Ins. Co. v. City of Madison, Miss.*, 309 F.3d 901 (5th Cir. 2002); *Scottsdale Ins. Co. v. Bungee Racers, Inc.*, 2006 WL 2375367 (N.D. Miss. Aug. 14, 2006); *Hartford Acc. & Indem. Co. v. Foster* 528 So. 2d 255 (Miss., 1988) (discussing in detail the ethical dilemmas of an attorney selected by the insurer and noting that coverage, not policy limits, creates a conflict).

See also:

PIC Group, Inc. v. LandCoast Insul., Inc., 795 F. Supp. 2d 459 (S.D. Miss. 2011) (under Mississippi law, attorney fees incurred by the insured in retaining its own counsel to defend it against claims falling outside coverage of policy, after insurer chose to defend insured under a reservation of rights, were reasonable and, thus, were encompassed within the indemnity provision of a subcontractor's agreement requiring the subcontractor to indemnify the insured for any "costs" or "expenses" in any matter "arising out of, resulting from, caused by or in connection with" the agreement. Further, under Mississippi law, when an insurer undertakes the defense of its insured while reserving its right to deny coverage, the insurer must permit the insured to select its own counsel for those claims outside the coverage of the policy, and is responsible for the reasonable legal expenses incurred in defense of such claims). *Compare with U.S. Liab. Ins. Co. v. Goldin Metals, Inc.*, 2012 WL 130254 (S.D. Miss. June 17, 2012), holding that the insurer is not entitled to depose insured's counsel on issue of reasonableness of fees.

Fed. Ins. Co. v. Singing River Health System, No. 15-60774 consolidated with No. 15-60876, 2017 WL 816235, __ F.3d __ (5th Cir. March 1, 2017) (under Mississippi law, insurer must pay for the insured's separate counsel where a conflict of interest exists).

Deviney Constr. Co., Inc. v. Ace Utility Boring & Trenching, LLC, et al., Nos. 3:11cv468-DPJ-FKB, 3:13cv60-DPJ-FKB, 2014 WL 2932169 (S.D. Miss. June 30, 2014) (Deviney, an additional insured under a policy issued by Penn National, was entitled to independent counsel because of potential conflicts between Deviney and Penn National).

James L. Warren III, Maggie Nasif & Erin D. Guyton, *Defending Under a Reservation of Rights: Mississippi Insurance Defense in the Wake of* Moeller *and its Progeny*, 83 MISS. L.J. 1219 (2014).

MISSOURI

The Missouri Supreme Court recently explained that where an insurer offers its insured a defense subject to a reservation of rights, the insured, in turn, may elect to allow the insurer to defend or refuse the insurer's offer. If the insured rejects the defense offered the insurer subject to reservation, the insurer has one of three options: (1) represent the insured without reservation; (2) withdraw from representing the insured altogether; or (3) file a declaratory judgment action to determine the insurer's obligations under the policy. *Kinnaman-Carson v. Westport Ins. Corp*., 283 S.W.3d 761, 765 (Mo. 2009) (citing *Truck Ins. Exch. v.*

Prairie Framing, LLC, 162 S.W.3d 64, 88 (Mo. Ct. App. 2005)). If the insurer selects the first option, it may maintain control of the defense; if, however, it selects the second or third options, it necessarily relinquishes control of the defense to the insured. Federal courts applying Missouri law have further held that where a conflict of interest arises, the carrier must provide independent counsel or pay the costs incurred by the insured in securing counsel of its choosing. *Howard v. Russell Stover Candies, Inc.*, 649 F.2d 620, 625 (8th Cir. 1981) (applying Missouri law) (quoting *U.S. Fid. & Guar. Co. v. Louis A. Roser Co.*, 585 F.2d 932, 939 n.6 (8th Cir. 1978)).

See also Heubel Materials Handling Co., Inc. v. Universal Underwriters Ins. Co., 704 F.3d 558 (8th Cir. 2013) ("Under Missouri law, a 'reservation of rights' refers to an insurer's offer 'to defend its insured but reserve the right to later disclaim coverage.' " citing *Truck Ins. Exch. v. Prairie Framing, LLC*, 162 S.W.3d 64, 88 (Mo. Ct. App. 2005)) (per curiam). The insured may reject an insurer's offer to defend with a reservation of rights, and if the insurer refuses to withdraw the reservation of rights, the insured is then free to hire independent counsel to defend the underlying suit and obtain compensation from the insurer if the underlying suit later is held to be covered by the policy. *Id.*.

MONTANA

A. Parameters of Insured's Right to Independent Counsel

Montana has not directly addressed the question of whether an insured is entitled to independent counsel if a reservation of rights is asserted and/or when a conflict of interest exists. Montana appears to have concluded indirectly, however, that an insurer is obligated to pay for separate counsel for its insured when an actual conflict has developed. *See St. Paul Fire & Marine Ins. Co. v. Thompson,* 433 P.2d 795 (Mont. 1967). In *Thompson*, an employee of a company was in an auto accident during the course and within the scope of his employment, but while driving his own vehicle. After resolution of the underlying action, the employer's insurer, St. Paul, sued the employee as a subrogee because the company's liability was based on respondeat superior. The employee's own insurer, State Farm, defended the first action, however it refused to defend the indemnity action by St. Paul (it initially accepted, but then withdrew). In analyzing whether State Farm had a duty to defend this second action, the Court stated:

> State Farm argues that it should be allowed to defend rather than paying counsel to defend the action. There can be no question of the good faith and sincere defense by counsel for State Farm in the Welch suit nor here. However, the inconsistent and yes, antagonistic positions that have developed make it clear that Thompson was required to hire his own counsel.

Id. at 799. In other words, the insured was entitled to retain separate counsel, apparently of his own choosing, because a conflict exited, and the insurer was obligated to fund it.

It should also be noted that in *In the Matter of the Rules of Professional Conduct and Insurer Imposed Billing Rules and Procedures,* 2 P.3d 806 (Mont. 2000)—a declaratory relief action challenging insurer-imposed billing guidelines—the Supreme Court ruled that an insured is the sole client of defense counsel appointed by the insurer, and thus, the insurer is not a co-client of defense counsel. Nevertheless, the court explained that a potential conflict of interest may exist where an insurer provides a defense under a reservation of rights. Given the *Thompson* case, it appears an insured may retain separate counsel whenever an insurer reserves rights under Montana law, although, as indicated, no Montana court has directly considered this issue.

See also, *Mid-Century Ins. Co. v. Windfall, Inc., et al.*, No. CV 15-146-M-DLC, 2016 WL 2992114 (D. Mont. May 23, 2016) ("Under Montana law, an insurer has a duty to provide independent counsel due to 'inconsistent and yes, antagonistic positions that have developed[.]' *St. Paul Fire & Marine Ins. Co. v. Thompson*, 433 P.2d 795, 799 (Mont. 1967). The Montana Supreme Court has not specifically addressed when a potential conflict is sufficiently antagonistic to trigger an insurer's duty to provide independent

counsel." In this case, insured failed to show any inconsistent or antagonistic positions between the insured and her co-defendants.)

B. Additional Requirements and Duties?

It appears that no case since *Thompson* has addressed this issue, and thus there has been no elaboration on the scope of this requirement or accompanying duties.

NEBRASKA

The Nebraska Supreme Court explained in *Hawkeye Cas. Co. v. Stoker*, 48 N.W.2d 623 (Neb. 1951) that while an insurer may defend its insured under a reservation of rights with its insured's consent, the insurer may not continue to defend the insured if it initiates a declaratory judgment action or other denies coverage under the policy. The existence of a conflict of interest between the insurer and the insured is not a basis upon which the insurer can refuse to defend the insured. *Babcock & Wilcox Co. v. Parsons Corp*., 430 F.2d 531, 537-38 (8th Cir. 1970) (applying Nebraska law).

NEVADA

A. Right to Independent Counsel?

The state courts of Nevada have not yet considered the issue of whether an insured is entitled to independent counsel when a conflict of interest arises between the insurer and insured. A federal district court in Nevada has touched upon this issue, but did not reach a determination on the subject. In particular, in the case of *Crystal Bay Gen'l Improvement Dist. v. Aetna Cas. & Sur. Co.,* 713 F. Supp. 1371 (D. Nev. 1989) , an insurer reserved rights on a claim tendered by its insured because of the possible application of the sudden and accidental pollution exclusion. The insurer, acknowledging the presence of a conflict, suggested the insured retain independent counsel, at its own expense. The court analyzed this conduct in the context of bad faith and in particular, in terms of the whether the insurer had given consideration to its insured's interests equivalent to its own. The court explained:

> The result is that … the insurer must conduct itself with that degree of care which would be used by an ordinarily prudent person in the management of his own business, with no policy limits applicable to the claim.

Id. at 1379. The court stated that some courts have found this standard to require the insurer to provide its insured with independent counsel, but expressly declined to address this issue since it had not been briefed.

In a more recent Federal district court case, however, the Court held that "Nevada law requires that independent *Cumis* counsel must be appointed when a conflict of interest arises between the insured and insurer." *Hansen v. State Farm Mut. Auto. Ins. Co.*, No. 2:10-cv-01434-MMD-RJJ, 2012 WL 6205722 at *7 (D. Nev. Dec. 12, 2012).

See also:

USF Ins. Co. v. Smith's Food & Drug Center, Inc., 921 F. Supp. 2d 1082, 1092 n.3 (D. Nev. 2013) ("Notwithstanding the admission of its claims officer, USF erroneously argues that Smith's' demand for separate counsel destroyed the conditions for USF's representation of Smith's. First, the Policy designated Smith's as an insured regardless of the supplementary payments section. Second, USF may have been under an obligation to provide its insured with independent counsel when a conflict with Smith's arose. *See Hansen v. State Farm Mut. Auto Ins. Co.*, No. 2:10-cv-1434-MMD-RJJ, 2012 WL 6205722, at *8-9 (D. Nev. Dec. 12, 2012) (interpreting Nevada law to adopt requirement that insurers must provide independent counsel to insureds when conflict arises, per *San Diego Navy Fed. Credit Union v. Cumis Ins. Soc'y, Inc.*, 162 Cal. App. 3d 358, 364, 208 Cal. Rptr. 494 (1984)).").

State Farm Mut. Auto. Ins. Co. v. Hansen, 357 P.3d 338 (Nev. 2015) (as matters of first impression and in answer to certified questions from the federal district court for the District of Nevada, the Nevada Supreme Court held that when an actual conflict of interest exists between an insurer defending its insured under a reservation of rights to determine coverage and the insured, the insurer is required to satisfy its contractual duty to provide representation by permitting the insured to select independent counsel and by paying the reasonable costs of such counsel; and an insurer defending under a reservation of rights is obligated to provide independent counsel of the insured's choosing only when an actual conflict of interest exists, and courts must inquire, on a case-by-case basis, whether there is an actual conflict of interest; a reservation of rights does not create a *per se* conflict of interest).

Accord, Dogra v. Liberty Mut. Ins. Co., No. 2:14-cv-01841-GMN-GWF, 2016 WL 5419418 (D. Nev. Sept. 27, 2016); *Andrew v. Century Sur. Co.*, 134 F. Supp. 3d 1249 (D. Nev. 2015) (citing *Hansen* but finding no conflict)

See also, Sarah J. Odia, *Venada Supreme Court: Insurers Must Provide Independent Counsel for their Insureds*, 23 NEV. L. 8 (Dec. 2015).

B. Further Requirements and Duties?

As the above discussion notes, the insurer must give the same degree of consideration to the interests of the insured as it does to its own, and this may include provision of independent counsel to defend the insured if a conflict develops. Except for the federal court's decision in the *Hansen* case, however, there has been no further elaboration on this principle in connection with whether an insured has a right to independent counsel if a conflict of interest exists under Nevada law.

C. Statute

§ 41A.085. Recommendation of settlement for amount of limits of policy of insurance: When authorized; insurer to pay for opinion of independent counsel upon request

1. In an action for damages for professional negligence in which the defendant is insured pursuant to a policy of insurance covering the liability of the defendant for a breach of the defendant's professional duty toward a patient:

(a) At any settlement conference, the judge may recommend that the action be settled for the limits of the policy of insurance.

(b) If the judge makes the recommendation described in paragraph (a), the defendant is entitled to obtain from independent counsel an opinion letter explaining the rights of, obligations of and potential consequences to the defendant with regard to the recommendation. The Insurer shall pay the independent counsel to provide the opinion letter described in this paragraph, except that the insurer is not required to pay more than $1,500 to the independent counsel to provide the opinion letter.

2. The section does not:

(a) Prohibit the plaintiff from making any offer of settlement.

(b) Require an insurer to provide or pay for independent counsel for a defendant except as expressly provided in this section.

Eff. June 9, 2015.

NEW HAMPSHIRE

In *White Mountain Cable Constr. Co., Inc. v. Transamerica Ins. Co.*, 137 N.H. 478, 631 A.2d 907 (1993), the New Hampshire Supreme Court held that where there is a conflict between the insurer and the insured,

the insurer is not relieved of its duty to defend and, although the insurer must defend, it is precluded from controlling the defense. The Court appears to hold that independent counsel must be provided:

> Having a duty to defend, and faced with a conflict of interest, the [insurer] could have hired independent counsel to defend the [insured] while intervening on its own behalf. In the alternative, the [insurer] could have provided the defense but reserved its right to later deny coverage.

Id. at 913.

NEW JERSEY

Under New Jersey law, if an actual conflict exists between the insured and the insurer as a result of the issuance of a reservation of rights with respect to mutually exclusive covered and noncovered claims, the insured is permitted to select independent counsel at the expense of the insurer. Under such circumstances, the insurer is required to pay independent counsel for the reasonable costs incurred in defending the entire action.

Burd v. Sussex Mut. Ins. Co., 56 N.J. 383, 267 A.2d 7 (1970), is the earliest reported New Jersey case addressing this issue. In *Burd*, the Court recognized that in circumstances where there is a conflict of interest between the carrier and the insured over coverage and where "the case may be so defended by a carrier as to prejudice the insured thereafter upon the issue of coverage," the carrier is not permitted to control the defense.

The issue was next addressed in *Yeomans v. Allstate Ins. Co.*, 130 N. J. Super. 48, 324 A.2d 906 (1974). In *Yeomans* the carrier insured two codefendants who had antagonistic defenses, and selected separate counsel to defend each insured. In holding that the carrier had fulfilled its duty to both insureds by retaining separate counsel for each, the Court distinguished this situation, (*i.e.* a conflict between two insureds), from that presented in *Burd*, *supra*, where an actual conflict existed between insurer and insured. The Court pointed out that only in the later situation is the insured entitled to select independent counsel to defend the action.

> We must, however, disassociate ourselves from that portion of the trial court's opinion holding that under the circumstances [the insurer] should not have selected defense counsel, but should have permitted the [insured] to do so, subject to [the insurer's] approval and at its expense. Two of the cases cited in support of this theory . . . are not pertinent. They involved the issue of the company's right to control the defense of pending tort litigation where the company disputed its obligation to pay any adverse judgment that might be rendered.

Id. at 53-54.

The issue of what billing rate an insurer is required to pay independent counsel retained to defend an insured when an actual conflict exists was addressed in *Aquino v. State Farm Ins. Co.*, 349 N.J. Super. 402, 793 A.2d 824 (2002). There, the Court concluded that independent counsel was not able to dictate the rate the carrier was required to pay, and concluded that the insurer was only required to pay a "reasonable fee" for work performed after counsel entered his appearance in the case. While the Court declined to decide what a "reasonable fee" would be, the Court did outline factors which should be considered in making this determination.

> It does not follow, however, that [independent counsel] is entitled to be compensated by the carriers for that defense work on the same basis that he is entitled to be compensated for work performed in connection with the declaratory judgment action. While *Aquino* may have been entitled to an attorney of his selection to handle the claim of intentional conduct, he does not have the right to dictate to the insurers the hourly rate they must pay. The trial

> court here should have determined a reasonable hourly rate for defense work of this nature and set a fee accordingly. Published material indicates, for example, that lawyers who perform insurance defense work may bill at a significantly lower hourly rate than do lawyers rendering other legal services. [Citation omitted.]
>
> Nor does it follow that counsel is entitled to an award of fees for all the work he has performed. We have conducted our own cursory review of the affidavit of service in *Faison v. Aquino*. It commences with his initial meeting with Aquino in December 1997 and his background investigation. He did not formally enter the case until he was granted that limited relief in March 1999. Clearly, much of the earlier work was entirely unrelated to the conflict of interest confronting Travelers and we are unable to perceive any basis why the carriers should be required to assume responsibility for those fees.
>
> Moreover, it has not escaped our notice that [the insured's independent] counsel was unhappy with the nature of the defense efforts put forth by the firm selected by [the insurer], and spent at least a portion of his time monitoring that work. Again, we see no basis to charge such work to the carriers at all, at least to the extent it was not specifically designed to protect [the insured] against the conflict of interest.
>
> * * *
>
> We are satisfied that with the limitations we have set forth, the result which we have reached is fair and appropriate in the context of this case. [The insurer], in essence, undertook, according to its letter of December 17, 1997, to defend [its insured] against allegations of intentional conduct, as well as negligence, and assured him his "rights and interests [would be] protected." Having undertaken that responsibility, we cannot consider it unfair to charge it with the reasonable cost of defending against allegations of intentional conduct when the attorneys it selected had an inherent conflict of interest which precluded them from handling both aspects of the defense. It will, in substance and effect, be responsible for that which it originally agreed to provide, no more and no less.

Id. at 349 N.J. Super. at 415-16; 793 A.2d at 832-33.

In a more recent unpublished opinion, *Township of Readington v Gen'l Star Ins. Co.*, 2006 WL 551404 (N.J. Super. March 3, 2006), the Superior Court held that in a matter involving nonmutually exclusive claims against an insured, an insurer was permitted to defend the entire action under a reservation of rights and to select and retain counsel. The Court further held that under such circumstances, if the insured rejects the proffered defense and retains its own counsel, it is precluded from recovering the fees it incurs.

Most recently, a federal district court summarized the current state of New Jersey law as follows:

> An insurer who owes its insured a duty to defend is not permitted to control the defense if there is a conflict of interest between the two parties. *See*, *e.g.*, *Schmidt v. Smith*, 294 N.J. Super. 569, 590, 684 A.2d 66 (App. Div. 1996) (citing *Burd v. Sussex Mau. Ins. Co.*, 56 N.J. 383, 389, 267 A.2d 7 (1970)). In such a situation, some method must be devised for the insurer to fulfill its duty other than by retaining its own counsel to represent the insured. *Morrone v. Harleysville Mut. Ins. Co.*, 283 N.J. Super. 411, 421, 662 A.2d 562 (App. Div. 1995) (citing cases). *Burd* and subsequent cases indicate that the usual course of action is for the insured to select its own attorney and for the insurer to reimburse the insured. *See*, *e.g.*, *Morton Int'l, Inc. v. Gen'l Accident Ins. Co. of Am.*, 266 N.J. Super. 300, 341-43, 629 A.2d 895 (App. Div. 1991). Of course, this does not mean that the insurer is required to pay whatever fee the insured's retained attorney happens to charge; rather, the insured is required to pay a reasonable fee for those services reasonably related to the defense of any

covered claims. *Aquino v. State Farm Ins. Co.*, 349 N.J. Super. 402, 415-16, 793 A.2d 824 (App. Div. 2002).

Szelc v. Stanger, Civ. No. 08-4782, 2010 WL 2925847 at *2 (D.N.J. July 21, 2010).

In *YA Global Investments, L.P. v. Mandelbaum, Salsburg, Gold, Lazris & Discenza, P.C.*, No. 2:12-cv-219 (WJM), 2014 WL 2737894 (D.N.J. June 17, 2014), the court faced plaintiff's motion to disqualify McCarter & English LLP from representing Wiss & Co., a defendant in this lawsuit. In the lawsuit, plaintiffs alleged that, but for the alleged acts, omissions and purported conflicts of interest of the named defendants, YA would never have consummated a $14 million loan transaction with Global Outreach. Wiss, a named defendant, notified and requested coverage from its professional liability insurer, Liberty Mutual. Liberty reserved its rights and appointed one of its panel firms to represent Wiss. Wiss objected to Liberty's offer to appoint panel counsel, and Wiss informed Liberty that it would retain McCarter & English as independent counsel. Later, Liberty sued Wiss and certain employees for declaratory judgment. In the declaratory, McCarter & English represented Wiss, and Ropes & Gray represented Liberty. In Plaintiff's motion to disqualify, they argued that as a consequence of Liberty paying McCarter to provide a defense to its insured, Wiss, in this lawsuit, "McCarter represents two clients—Liberty Mutual and Wiss." Plaintiffs then argue that McCarter should be disqualified from representing Wiss in this action because a conflict of interest arose when Liberty brought its declaratory action against Wiss. The court denied the motion, saying:

> The arrangement at issue here is distinctly different from situations "wherein an attorney selected by the insurer was assigned to represent the insured in the defense of a covered claim. More is required to establish a lawyer-client relationship than, as appears here, merely that the insurer ultimately absorbs the cost of the insured's legal representation." *Historic Smithville Dev. Co. v. Chelsea Title & Guar. Co.*, 190 N.J. Super. 567, 572, 464 A.2d 1177 (App. Div. 1983). In the instant matter, Wiss refused Liberty Mutual's appointment of counsel, and Wiss specifically hired McCarter as independent counsel. Liberty Mutual did not even pay McCarter directly for their services, but rather McCarter submitted invoices directly to Wiss. [Citation to record omitted.] Where, as here, the policyholder retains its own independent counsel, no conflict of interest exists because the independent counsel does not represent the carrier. *See Cay Divers Inc. v. Raven*, 812 F.2d 866, 870 (3d Cir. 1987) ("We … hold that when … an action against an insured is arguably within the scope of the insurance coverage, an insurer's discharge of its duty to defend by providing independent counsel, even though reserving the right to contest coverage, relies it of control over the litigation."); *Cf. Illinois Masonic Medical Ctr. v. Turegum Ins. Co.*, 168 Ill. App. 3d 158, 163, 118 Ill. Dec. 941, 522 N.E.2d 611 (1st Dist. 1988) ("[W]here a conflict of interests exists the insured, rather than the insurer, is entitled to assume control of the defense of the underlying action; but by reason of its contractual obligation to furnish a defense, the insurer must underwrite the reasonable costs incurred by the insured in defending the action with counsel of his own choosing.").
>
> Plaintiffs have not met the high burden of proving that a conflict of interest exists in McCarter representing Wiss. Liberty Mutual's mere agreement to pay some of McCarter's fees for representing Wiss did not create an attorney-client relationship between McCarter and Liberty Mutual.

YA Global, 2014 WL 2737894 at *3-4.

NEW MEXICO

The New Mexico Supreme Court has held that when an insurer perceives a conflict of interest, it may demand that the policyholder obtain independent counsel, or the insurer may satisfy its duty to defend by employing two sets of attorneys, one to represent the insured and one to represent the insurer. *Am.*

Employers Ins. Co. v. Crawford, 533 P.2d 1203, 1209 (N.M. 1975) (citing *Employers' Fire Ins. Co. v. Beals*, 240 A.2d 397 (R.I. 1968), abrogated on other grounds by *Peerless Ins. Co. v. Viegas*, 667 A.2d 785 (R.I. 1995)).

NEW YORK

While there is no New York statute pertaining to an insured's right to select independent counsel, under New York case law, an insured is permitted to select independent counsel when there is an actual conflict of interest between the interests of the insured and the insurer concerning the defense of a liability claim. Under such circumstances, the insurer is required to pay independent counsel a "reasonable fee". *Prashker v. U.S. Guar. Co.*, 1 N.Y.2d 584, 136 N.E.2d 871 (1956); *Public Service Mut. Ins. Co. v. Goldfarb*, 53 N.Y.2d 392, 425 N.E.2d 810 (1981).

Accord, Pac. Employers Ins. Co. v. Troy Belting & Supply Co., No. 1:11-CV-912, 2014 WL 2805312 (N.D.N.Y. June 20, 2014) n.5.

The *Prashker* case involved a claim brought by the personal representative of a deceased passenger who was killed in a private airplane crash against the estate of the pilot. It was alleged that the pilot operated the aircraft in violation of his license, which allegation could serve as a basis for the pilot's insurer to deny coverage. The Court held that the insurer had a duty to defend the claim and, when it was presented with the suggestion that counsel appointed by the carrier to defend might have divided loyalties, responded as follows:

> The objection taken by the insurance company is without substance that it 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. If any such conflict of interest arises, as it probably will, the selection of the attorneys to represent the assureds should be made by them rather than by the insurance company, which should remain liable for the payment of the reasonable value of the services of whatever attorneys the assureds select.

In *Goldfarb*, *supra*, New York's highest court addressed the conflict situation and the right to select independent counsel in the context of a case where the plaintiff asserted mutually exclusive alternative claims for negligence and intentional tort in a case alleging that a dentist had sexually abused a patient during the course of treatment. Relying on the *Prashker* decision, the Court concluded that because "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—[the defendant] is entitled to defense by an attorney of his own choosing, whose reasonable fee is to be paid by the insurer." 53 N.Y.2d at 427, 425 N.E.2d 815. The Court clarified, however, that not every conflict requires the appointment of 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.

53 N.Y.2d at 427 n.1, 425 N.E.2d 815 n.1; *see also 69th Street and 2nd Avenue Garage Assocs., L.P. v. Ticor Title Guar. Co.,* 207 A.D.2d 225, 622 N.Y.S.2d 13 (1995) (crucial conflict of interest gave policyholder the right to select independent counsel).

See also:

Sea Tow Services Int'l, Inc. v. St. Paul Fire & Marine Ins. Co., No. 09-CV-5016 (PKC)(GRB), 2016 WL 6092486, __ F. Supp. 3d __ (E.D.N.Y. Sept. 29, 2016) (Under N.Y. law, insured franchisor was not entitled to independent counsel in underlying action against insured and its franchisee brought by one of franchisee's employees who had sustained injuries in work-related accident at franchisee's site; franchisor's insurer had accepted coverage of vicarious liability and direct liability claims asserted against insured at all times, and even though its position was that franchisee's insurance carrier's coverage was primary, insurer continued to have a vested interest in defending insured because insurer, and not insured, would be stuck with the defense costs in the event franchisee's insurance carrier later prevailed with respect to its coverage position. Under N.Y. law, independent counsel is only necessary in cases where 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).

Landon v. Austin, 129 A.D.3d 1282, 11 N.Y.S.3d 721, 2015 N.Y. Slip Op. 04911 (3d Dep't 2015) (Although law firm was retained by insured's CGL insurer to provide a defense for insured, the paramount interest that counsel represented was that of insured, and insurer was precluded from interference with counsel's independent professional judgments in the conduct of the litigation on behalf of its client. Where law firm has been retained by liability insurer to provide a defense for insured, a conflicting interest exists, for example, when defense attorney's duty to the insured would require that he or she defeat liability on any ground and his or her duty to the insurer would require that he or she defeat liability only upon grounds which would render the insurer liable.)

NORTH CAROLINA

In a case where the insurance company as reserved its rights, a North Carolina appellate court has held that a policyholder may refuse the insurance company's defense, select its own counsel, and seek indemnification of its legal expenses. *Nat'l Mortg. Corp. v. Am. Title Ins. Co.* 41 N.C. App. 613, 622-23, 255 S.E.2d 622, 629 (1979) reversed on other grounds, 299 N.C. 369, 261 S.E.2d 844 (1980). The Supreme Court reversed this case on other grounds, stating that the policy did not cover the insured. The Court, however, made no mention of independent-counsel or attorney's-fees issues.

NORTH DAKOTA

A trial court may require an insurer, in instances where a conflict of interest is present, to "furnish independent counsel to represent the insured on the insurer's claims and defenses, or by requiring reimbursement of the insured's reasonable attorney fees for those services." *Fetch v. Quam*, 530 N.W.2d 337, 341 (N.D. 1995).

OHIO

The Ohio Supreme Court has stated that an insurer's issuance of a reservation of rights letter, by itself, does not automatically obligate the insurer to pay for an insured's independent counsel. *Socony-Vacuum Oil Co. v. Cont'l Cas. Co.*, 59 N.E.2d 199 (Ohio 1945). Only when the interests of the insurer and insured are "mutually exclusive" does an obligation on the part of the insurer to pay the cost of the insured's private counsel arise. *Id.* Therefore, the test in determining whether an insured can secure its own counsel at the expense of the insurer "is whether the insurer's reservation of rights renders it impossible for the company to defend both its own interests and those of its insured." In *Socony-Vacuum*, the Supreme Court held that

interests of the insurer and the insured were mutually exclusive, as both the liability in the underlying case and the coverage questions turned on whether the alleged tortfeasor was a Socony-Vacuum employee acting within the course and scope of his employment at the time of the incident. Intermediate appellate courts, however, have held that conflicts of interest of lesser magnitude do not require the insurer to pay for the insured's independent or private counsel. *See*, *e.g.*, *Lusk v. Imperial Cas. & Indem.*, 603 N.E.2d 420, 423 (Ohio Ct. App. 1992) (holding that insured was not entitled to reimbursement for private counsel where two insurers had offered to defend insured under reservations of rights and the insurers' reservations concerned only which insurer's policy had a duty to indemnify the insured in event of adverse judgment); *see also Red Head Brass, Inc. v. Buckeye Union Ins. Co.*, 735 N.E.2d 48, 55 (Ohio Ct. App. 1999) (holding that the insured was not entitled to reimbursement for cost of private counsel hired to prosecute compulsory counterclaims or for defense costs incurred after covered claims had been dismissed by court on summary judgment). Where the insurer's interest and the insured's interest are mutually exclusive, an insurer that offers the insured the option to hire private counsel must bear the expense for reasonable attorney fees. *Socony-Vacuum*, 59 N.E.2d at 205.

OKLAHOMA

The only Oklahoma case that has addressed this issue stated the following:

> From our review of these decisions and others, we discern a common theme: not every perceived or potential conflict of interest automatically gives rise to a duty on the part of the insurer to pay for the insured's choice of independent counsel. 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 that would render the insurer liable. Conversely, absent a threat of divided loyalty between the insured and insurer, no need for retention of independent counsel arises because the issue of coverage is then separate from the issue of liability. However, an insurer may demand their insured obtain independent counsel when the *insurer* perceives a conflict of interest.

Nisson v. Am. Home Assur. Co., 917 P.2d 488, 490 & n.1 (Okla. App. 1996) (emphasis added; citations omitted).

OREGON

A. Parameters of Insured's Right to Independent Counsel

Oregon law does not require the insurer to provide the insured with separate counsel, even when a clear conflict of interest arises.[13] The Oregon courts first considered this issue in the case of *Ferguson v. Birmingham Fire Ins. Co.*, 460 P.2d 342 (Or. 1969), in which an insurer reserved rights after its insured tendered a complaint alleging willful trespass. The insured refused the defense offered by the insurer under reservation, and retained separate counsel. In analyzing whether the insurer had acted inappropriately, the *Ferguson* court concluded that the danger that an insurer would not provide the insured with an adequate defense because it could later assert a defense of noncoverage was minimal. In particular, the court explained that "[t]he insurer knows that when it is the defendant in a lawsuit brought by one of its policy holders the jury's sympathy for the insured frequently produces a plaintiff verdict even when the insurer's case is strong. Knowing this, the insurer is not likely to relax its efforts in defending the action against the insured. If the insurer feels certain that it can successfully defend an action brought against it by the insured,

[13] It should be noted that despite the case law cited herein, certain treatises and authorities have concluded that Oregon does not have case law directly considering this question.

it is not likely to accept the insured's tender of the defense in the first place." This analysis was reiterated in the subsequent case of *Home Indem. Co. v. Stimson Lumber Co.*, 229 F. Supp. 2d 1075 (D. Or. 2001).

The *Ferguson* court did find that if the insured prevailed in the coverage dispute on remand, the insurer would have to pay for the defense costs incurred in the underlying lawsuit. Thus, in effect, an insurer risks having to pay for separate counsel if it concludes no defense is owed and its coverage evaluation is incorrect. *Ferguson, supra*, 460 P.2d at 349-50.

See also:

Siltronic Corp. v. Employers Ins. Co. of Wausau, 176 F. Supp. 3d 1033 (D. Or. 2016) (under Oregon law, as predicted by the federal district court, insurer was obligated to pay some or all of the attorney fees incurred by insured corporation's independent counsel to protect its interest adverse to insurer on coverage issues involving the Portland Harbor Superfund Site, citing to O.R.S. § 465.483). This case is interesting for its compare-and-contrast analysis comparing the Oregon statute to Cal. Civ. Code § 2860.

Accord, Century Indem. Co. v. The Marine Group, LLC, No. 3:08-CV-1375-AC, 2016 WL 2730675 (D. Or. May 10, 2016), *but see* n.4 ("Third-Party Plaintiffs also argue [O.R.S. §] 465.483 requires independent counsel for the insured in part so the insured can control what type of defense material is disclosed to the insurer. While the statute requires the insurer to provide independent counsel under certain circumstances, nothing in the statute compels the conclusion the independent counsel requirement is intended to allow the insured to control the information to which the insurer has access. To the contrary, the statute envisions cooperation between insured and insurer, as it specifically states the insured has a duty to cooperate with the insurer under the terms of the parties' insurance contract. [O.R.S. §] 465.483(4). The court therefore finds this argument unpersuasive.")

And see, Century Indem. Co. v. The Marine Group, LLC, No. 3:08-CV-1375-AC, 2015 WL 810987 (D. Or. Feb. 25, 2015) ("With regard to independent counsel financed by Argonaut [intervenor insurer] for Marine, Argonaut is entitled to rely on the statutory presumption found in [O.R.S. §] 465.483(3)(a) that amounts paid to independent counsel and environmental consultants as defense costs at the regular and customary rates charged for environmental claims similar to the one at hand are reasonable. Marine is not entitled to recover pre-tender defense costs.

B. Additional Requirements and Duties?

It does not appear that any Oregon statute or case law has established any additional requirements on insurers or insureds in connection with this issue.

C. Statute

O.R.S. § 465.483. Defense of environmental claim; provision of independent counsel by insurer

(1) If the provisions of a general liability insurance policy impose a duty to defend upon an insurer, and the insurer has undertaken the defense of an environmental claim on behalf of an insured under a reservation of rights, or if the insured has potential liability for the environmental claim in excess of the limits of the general liability insurance policy, the insurer shall provide independent counsel to defend the insured who shall represent only the insured and not the insurer.

(2) (a) (A) Independent counsel retained by the insurer to defend the insured under the provisions of this section must be experienced in handling the type and complexity of the environmental claim at issue.

(B) If independent counsel who meet the requirements specified in this paragraph are not available within the insured's community, then independent counsel from outside the insured's community who meet the requirements of this paragraph must be considered.

(b) (A) An insurer may retain environmental consultants to assist an independent counsel described in subsection (1) of this section. Any environmental consultants retained by the insurer must be experienced in responding to the type and complexity of the environmental claim at issue.

(B) If environmental consultants who meet the requirements specified in this paragraph are not available within the insured's community, then environmental consultants from outside the insured's community who meet the requirements of this paragraph must be considered.

(c) As used in this subsection, "experienced" means an established environmental practice that includes substantial defense experience in the type and complexity of environmental claim at issue.

(3) (a) The obligation of the insurer to pay fees to independent counsel and environmental consultants is based on the regular and customary rates for the type and complexity of environmental claim at issue in the community where the underlying claim arose or is being defended.

(b) In the event of a dispute concerning the selection of independent counsel or environmental consultants, or the fees of the independent counsel or an environmental consultant, either party may request that the other party participate in nonbinding environmental mediation described in ORS 465.484(2).

(4) The provisions of this section do not relieve the insured of its duty to cooperate with the insurer under the terms of the insurance contract.

Added by Laws 2013, c. 350, § 7, eff. June 10, 2013.

PENNSYLVANIA

Before 2013, no state appellate court had addressed the issue of an insured's right to select independent counsel, although at least one trial court has concluded that the issuance of a reservation of rights letter does not automatically create a conflict and the insurer's appointed counsel has only one client: the insured. *Bedwell Co. v. D. Allen Bros. Inc.,* 2006 WL 3692592, at *2 (Pa. Com. Pl. Dec. 6, 2006).

On July 10, 2013, the Superior Court affirmed a lower-court decision, holding that, as a matter of first impression, when an insurer tenders a defense subject to a reservation of rights to contest coverage, the insured may choose to accept the defense or decline the insurer's tender of a qualified defense and furnish its own defense. *Babcock & Wilcox Co. v. Am. Nuclear Insurers*, 2013 PA Super 174, 76 A.3d 1 (Pa. Super. Ct. 2013), *reversed* 131 A.3d 445 (Pa. 2015) (in which the Pa. S. Ct. held that, as a matter of first impression, the insured did not forfeit the right to coverage when it reasonably settled a lawsuit without the insurer's consent, where the insurer had defended the suit subject to a reservation of rights and, further concluding, that the Superior Court erred by requiring an insured to demonstrate bad faith when the insured accepts a settlement offer in a reservation of rights case).

Alternatively, Pennsylvania's federal courts have held that if there is an actual conflict of interest between the insurer and the insured, that the insured is permitted to select counsel of its choosing whose reasonable fee is to be paid by the insurer.

In *Krueger Assocs. Inc., v. ADT Sec. Systems*, No. CIV.A. 93-1040, 1994 WL 709380 (E.D. Pa. Dec. 20, 1994), the Court concluded that "[i]t is settled law that 'where conflicts of interest between an insurer and its insured arise, such that a question as to the loyalty of the insurer's counsel to that insured is raised, the insured is entitled to select its counsel, whose reasonable fee is to be paid by the insurer.' " *Id.*, at *5 (quoting *Emons Industries, Inc. v. Liberty Mut. Ins. Co.,* 749 F. Supp. 1289, 1297 (S.D.N.Y. 1990)). The *Krueger* Court did not elaborate on what a reasonable fee is or the factors which should be considered in making this determination.

More recently, in *Rector, Wardens and Vestryman of St. Peters Church v. Am. Nat'l Fire Ins.*, No. CIV.A. 00-2806, 2002 WL 59333 (E.D. Pa. Jan. 14, 2002), the Court elaborated on this principal:

> "It is clear that in Pennsylvania, as in most other jurisdictions, if an insurance company breaches its duty to defend, it is liable to reimburse the [insured] the costs the latter incurred in conducting its own defense." *St. Paul Fire & Marine Ins. Co. v. Roach Bros. Co.*, 639 F. Supp. 134, 138-39 (E.D. Pa. 1986). An insurance company breaches its duty to defend when a conflict of interest arises between the insurer and its insured "such that the company's pursuit of its own best interests in the litigation is incompatible with the best interests of the [insured]." *Id.* at 139. A conflict of interest between an insurer and its insured will not relieve insurer of its duty to provide a defense. *See Consolidated Rail Corp. v. Hartford Acc. & Indem. Co.*, 676 F. Supp. 82, 86 (E.D. Pa. 1987). Rather, courts have concluded that one appropriate resolution in this circumstance "is for the insurer to obtain separate, independent counsel for each of its insureds, or to pay the costs incurred by an insured in hiring counsel." *Id.*
>
> In support of its contention that it is entitled to remuneration for the procurement of conflict-free counsel, [insured] cites to *Cay Divers, Inc. v. Raven*, 812 F.2d 866 (3d Cir. 1987) (applying law of the Virgin Islands). In *Raven*, the Third Circuit found that the
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> > Provision of independent counsel or reimbursement for the insured's choice of counsel and expenses ordinarily fulfills the duty to defend, and is particularly appropriate where, as here, there is a conflict of interest between the insurer and the insured.... Indeed, where there is a conflict of interest, ethical considerations may even require that the insurer provide independent counsel rather than participate in the defense.
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> *Id.* at 870 n.3.

Rector, Wardens and Vestryman, 2002 WL 59333 at *9.

The insured's right to select independent counsel at the expense of the insurer only applies, however, if there is an actual conflict, and at least one Pennsylvania federal court has concluded that the fact that an insured is sued for both covered and noncovered claims does not, in itself, create an actual conflict. In *St. Paul Fire & Marine Ins. Co. v. Roach Bros. Co.*, 639 F. Supp. 134 (E.D. Pa. 1986), the Court explained:

> In the present case, there were at least two potential sources of conflict between [insurer] and its insureds, the defendants: [insurer's] policy did not cover intentional acts of wrongdoing or claims for punitive damages, and the [plaintiffs'] claims greatly exceeded the policy limits. But, since the [plaintiffs] would be entitled to prevail even if they did not prove intentional wrongdoing on the part of the defendants, but merely negligence (for example, a genuine but erroneous belief that the [plaintiffs] had abandoned the project, or a genuine but unfound belief that the [plaintiffs] had consented to defendant's activities, or lack of communication within defendant's organization concerning their representation of the [plaintiffs], it was the obligation of the [insurer] to provide a defense. Moreover, that obligation extended to *all* claims asserted by the [plaintiffs], regardless of the limited nature of [insurer's] obligation to indemnify. *Gedeon v. State Farm Mut. Auto. Ins. Co.*, 410 Pa. 55, 188 A.2d 320 (1963); *Wilson v. Md. Cas. Co.*, 377 Pa. 588, 105 A.2d 304 (1954); *Cadwallader v. New Amsterdam Cas. Co.*, 396 Pa. 582, 152 A.2d 484 (1959).
>
> With respect to the policy limits, no actual conflict of interest arises except in connection with possible settlement negotiations (for example, an opportunity to settle within the policy limits, favored by the insured but not by the company); although a very great disparity between exposure and policy limits may suggest that the uninsured portion of the claim is what is really at stake in the litigation. But where a claim is settled for the full

> policy limits, with the consent of the insured, there is obviously neither conflict nor the potential for conflict.
>
> With respect to the existence of both covered and uncovered claims or theories of liability, the potential for conflict is much greater, but actual conflict is not inevitable. In some circumstances, the company might be tempted to save money by urging that the insured was guilty of intentional wrongdoing or wanton recklessness, rather than mere negligence. At the least hint of such a development, an obligation to provide independent counsel would be triggered, and the company's unwillingness to protect the full interests of its assured would probably also trigger a reimbursement obligation.
>
> But I am aware of no case, from any jurisdiction, which has held that the mere theoretical possibility of such a conflict requires the company to pay for the assured's separate representation. The [insureds] place principal reliance upon the California case of *San Diego Navy Fed. Credit Union v. Cumis Ins. Co.*, 162 Cal. App. 3d 358, 208 Cal. Rptr. 494 (1984). That case, however, held merely that where punitive damages (not covered) and compensatory damages (covered) are sought against the assured, and the exposure is in excess of the policy limits, and there is an opportunity to settle the entire case within the policy limits, the company is obligated either to settle within the policy limits, or to pay the reasonable expenses of independent counsel to represent the interests of the assured. It is unnecessary for me to essay a prediction as to whether the Pennsylvania Supreme Court would agree with the *Cumis* decision; for even under the holding of that case, [insureds] would not prevail here.

Id. at 139.

See also:

Eckman v. Erie Ins. Exch., 2011 PA Super 87, 21 A.3d 1203, 1208-09 (2011) (fact that any attorney appointed by insurer to represent insureds in underlying defamation action would be compensated by insurer did not require per se disqualification of the attorney on the grounds of conflict of interest, relying on Pa. R. Prof. Conduct 1.7(a)(2)).

Am. & Foreign Ins. Co. v. Jerry's Sport Center, Inc., 606 Pa. 584, 616, 2 A.3d 526, 545 (2010) (an insurer faced with uncertainty about its duty to indemnify offers a defense under a reservation of rights to avoid the risks to which it might be exposed if an inept or lackadaisical defense of the underlying action results in the imposition of liability for which it ultimately turns out there was a duty to indemnify).

Yaron v. Darwin Nat'l Ins. Co., No. 502, 2011 WL 3027835 (Pa. Com. Pl. July 5, 2011) (Trial order) (liability insurer's issuance of a reservation of rights letter, warning insureds that the claims asserted against them could trigger an exclusion of coverage, did not automatically create a conflict of interest between insurer and insureds, so as to entitle insureds to select their own defense counsel to be paid for by insurer subject to its reservation of rights; reservation of rights presented only the possibility of a conflict, and some evidence of an actual conflict would be required before requiring insurer to pay for insured's chosen counsel).

Erie Ins. Exch. v. Lobenthal, 2015 PA Super 78, 114 A.3d 832 (2015) (homeowner's insurer's reservation-of-rights letter was untimely sent more than seven months after filing of complaint alleging that insured permitted and encouraged use of controlled substances at a party from which impaired driver caused automobile accident and, thus, insurer was estopped from relying on controlled-substances exclusion, even though case was not yet listed for trial and insurer had duty to defend until dismissal of allegations regarding furnishing of alcohol to driver; over three months had passed from disposition of preliminary objections limiting claim to alleged furnishing of controlled substances, and insured could have declined insurer's defense, engaged separate counsel, managed her own defense, and was prejudiced; and further holding that

where liability insurer fails to clearly communicate a reservation of rights to an insured, prejudice may be fairly presumed).

Mine Safety Appliances Co. v. N. Riv. Ins. Co., 73 F. Supp. 3d 544 (W.D. Pa. 2014) (under Penn. law, co-client exception to attorney-client privilege did not apply as would allow selective waiver of attorney-client privilege for insured's documents submitted in support of summary judgment motion and discussing how insured defended, valued, or settled underlying lawsuits advancing asbestos, silica, and coal-workers' pneumoconiosis personal-injury and wrongful-death claims against insured and reflecting attorney-client communications with insured's underlying defense counsel, where insured and insurer did not hire separate counsel and then direct their counsel to engage in joint defense against common adversary as would create co-client relationship, but instead insurer denied all insured's claims for coverage, under umbrella commercial general liability policy, for losses arising from underlying lawsuits).

RHODE ISLAND

The Rhode Island courts have concluded that in the case of a conflict of interest between insurer and insured, the insured is permitted to reject the insurer's selected counsel and retain independent counsel of its own choosing at the reasonable expense of the insurer. But Rhode Island's court have yet to provide guidance as to how this "reasonable fee" is to be determined.

In *Employers' Fire Ins. Co. v. Beals*, 103 R.I. 623, 240 A.2d 397 (1968), *abrogated on other grounds by Peerless Ins. Co. v. Viegas*, 667 A.2d 785 (R.I. 1995), the Court concluded:

> If, however, an insured, after having been apprised of the conflicting interests existing between him and his insurer, declines to be represented by the insurer's attorney, we have a different situation. Concerned as we are that the public's trust in the judicial processes be maintained, this court cannot stand idly by in such circumstances. We are as conscious of an insurer's concern that it control the defense of any action brought against one of its insureds as we are of an insured's expectations that his rights will be properly protected. In our opinion, however, an insured, when faced with the quandary posited by the facts of the instant case, has a legitimate right to refuse to accept the offer of a defense counsel appointed by the insurance company; and when an insured elects to exercise this prerogative, the insurer's desire to control the defense must yield to its obligation to defend its policyholder.
>
> There is, therefore, a discernible need to discover a solution to this dilemma which will, at the same time, be mutually protective and satisfactory to the parties.

Beals, 103 R.I. 633-34; 240 A.2d at 403.

More recently, the Supreme Court, in *Labonte v. National Grange Mut. Ins. Co.,* 810 A.2d 250 (R.I. 2002) re-affirmed the *Beals* holding, but declined to extend the insurer's obligation to provide independent counsel to a presuit coverage investigation:

> In *Beals,* the insurer found itself in a situation in which it was simultaneously suing the insured in a declaratory judgment action and defending the insured in a tort suit. In the declaratory judgment action, the insurer attempted to demonstrate that the insured's actions were intentional, a position it certainly did not want to advance in the tort action. In face of the clear conflict, this Court required the insurer to provide the insured with an independent attorney in the tort action and held that "the insurer's desire to control the defense must yield to its obligation to defend its policyholder." . . . Here, in contrast, plaintiff had not yet been sued when he requested independent counsel. Moreover, defendant had not yet brought a declaratory action against plaintiff at the time it sought to examine him.

> Therefore, on the basis of the facts of this case, we decline to extend *Beals* to require an insurer to provide independent counsel to an insured on each occasion that the insurer initiates a coverage investigation.

Labonte, 810 A.2d at 254-55.

See also Quality Concrete Corp. v. Travelers Prop. Cas. Co. of Am., 43 A.3d 16, 20-22 (R.I. 2012) (insured not entitled to have insurer—which issued CGL policy—subsidize engagement of independent counsel to represent insured in addition to law firm that insurer had hired to represent insured in connection with death of trespasser, even though insurer reserved right to deny coverage for punitive damages; there was no actual conflict between prime interests of insurer and those of insured given that no complaint was ever filed by trespasser's estate and, as a general rule, the engagement of an independent counsel to represent the insured due to a conflict of interest between the insured and the liability insurer should be approved by the insurer).

And see, Andromeda Real Estate Partners, LLC v. Commonwealth Land Title Ins. Co., No. 15-224-M-LDA, 2016 WL 715777 (D.R.I. Feb. 19, 2016), *vacated* June 23, 2016, but included here for its holding in conformity with *Beals*.

SOUTH CAROLINA

In South Carolina, a case defended under a reservation of rights only gives rise to a "potential," not actual, conflict of interest. *Twin City Fire Ins. Co. v. Ben Arnold-Sunbelt Beverage Co. of S.C., LP,* 336 F. Supp. 2d 610, 621 (D.S.C., 2004). Thus, an insured does not have an automatic right to select and retain his or her own counsel. *Id.*

Ben Arnold was affirmed at 433 F.3d 365 (4th Cir. 2005) (under S.C. law as predicted by federal court, CGL insurer's reservation of rights letter disclaiming coverage as to some claims asserted against insured, but not as to others, did not create per se conflict of interest; thus, insurer was not required to cover legal fees of counsel that insured appointed to replace insurer's chosen counsel, after insured had rejected insurer's counsel on conflict grounds and excluded insurer from litigation. Further, under S.C. law, no actual conflict of interest arose when CGL insurer sent reservation of rights letter disclaiming coverage as to some sexual harassment claims asserted against insured, but not as to others, and thus insured was not entitled to reimbursement from insurer of legal fees and costs of settling cases using insured's own counsel; there was no inherent conflict since claims turned largely on credibility determination and thus fact that only some claims were covered would not divide insurer and insured, and further more insured ousted insurer from defense before any hypothetical conflict could materialize).

See also:

Cincinnati Ins. Co. v. Crossmann Communities of North Carolina, Inc., No. 4:09-CV-1379-RBH, 2013 WL 1282017 (D.S.C. Mar. 27, 2013) (" 'Under South Carolina law, an insurer's duty to defend is triggered if any cause of action in a complaint seeks damages covered by the policy.' *Liberty Mut. Fire Ins. Co. v. J.T. Walker Ind., Inc.*, C.A. No. 2:08-2043-MBS, 2012 WL 3292973 at *16 (D.S.C. Aug. 10, 2012). Similarly, in *Twin City Fire Ins. Co. v. Bear Arnold-Surebelt* [sic] *Beverages*, 433 F.3d 365, 366 (4th Cir. 2010), the Court held that when a policyholder notifies its insurer of a potentially covered suit, the 'insurance company, in turn, typically chooses, retains, and pays private counsel to represent the *insured as to all claims in that suit*.' *Id.* at 366." [emphasis added by *Crossmann* court]).

Episcopal Church in S.C. v. Church Ins. Co. of Vt., 53 F. Supp. 3d 816 (D.S.C. 2014) (court held: (a) CGL insurance policy gave right to insurer under S.C. law to select defense counsel and control defense in underlying action, where policy provided that insurer had "the right and the duty to defend a suit seeking damages which may be covered under the Commercial Liability Coverage"; (b) insurer that wrongfully refused to defend insured in underlying action forfeited its right to defend insured under CGL insurance policy after it reversed its position and acknowledged its obligation, and thus insured was entitled to

continue to be represented by its chosen attorney, as predicted by federal court; insured's attorney had been working on case for over one year, and insured would have suffered material harm if forced to relinquish control of its defense).

SOUTH DAKOTA

A. Parameters of Insured's Right to Independent Counsel

South Dakota considered the issue of what duties an insurer has when a conflict of interest arises between itself and its insured in the case of *Connolly v. Standard Cas. Co.,* 73 N.W.2d 119 (S.D. 1955). The insurer defended under a reservation of rights.

The insured argued that, by assuming defense of the underlying case, the insurer was estopped from denying liability. However, the court explained that it was a well-settled rule that an insurer is not so estopped as long as timely notice is given to the insured that it has not waived the benefit of its coverage defenses under the policy, *i.e*., reserved rights. The court found the insured here had impliedly consented to defense under these circumstances. If it had not, however, the court suggested that the insurer could not retain control of the defense and at the same time reserve the right to disclaim liability. Thus, while the court does not explicitly set forth a requirement, it suggests that under these circumstances, separate counsel for the insured is warranted. *Id.* at 122. The Supreme Court reaffirmed this approach in *St. Paul Fire and Marine Ins. Co. v. Engelmann,* 639 N.W.2d 192, 201 (S.D. 2002).

The South Dakota federal district court and the Eight Circuit have reached the same conclusion, specifically finding that a reservation of rights can create a conflict of interest. *See State Farm Mut. Auto. Ins. Co. v. Armstrong Extinguisher Service, Inc.,* 791 F. Supp. 799 (D.S.D. 1992); *Kansas Bankers Sur. Co. v. Lynass,* 920 F.2d 546 (8th Cir. 1990). The *Lynass* Court explained: "It is clear how a conflict of interest can develop in a situation like this. Kansas Bankers could conceivably offer only a token defense if it knows that it can later assert non-coverage. If an insurer does not think that the loss on which it is defending will be covered under the policy, the insurer may not be motivated to achieve the best possible settlement or result." *Id.* at 549.

B. Additional Requirements and Duties?

Although South Dakota appears to have concluded that an insured may retain separate counsel when a conflict of interest exists, and that a reservation of rights alone can create a conflict, South Dakota has not elaborated upon an insurer's obligations under these circumstances.

TENNESSEE

The Tennessee Supreme Court has recognized the existence of a conflict of interest in an insurer's provision of a defense under a reservation of rights. *Petition of Youngblood*, 895 S.W.2d 322, 328 (Tenn. 1995). Courts in Tennessee have also held that "an *insurer* in Tennessee clearly possesses *no* right to control the methods or means chosen by an attorney to defend the insured." *Givens v. Mullikin ex rel. Estate of McElwaney*, 75 S.W.3d 383, 394 (Tenn. 2002) (emphasis added). However, the courts have not yet addressed the right to independent counsel.

TEXAS

A. When The Right Arises

Prior to guidance from the Texas Supreme Court, Texas courts routinely allowed the insured to choose independent counsel—at the insurer expense—when an insurer offered a defense under a reservation of rights. *See Rhodes v. Chicago Ins. Co.,* 719 F.2d 116, 120 (5th Cir. 1983) (applying Texas law); *Britt v. Cambridge Mut. Fire Ins. Co*., 717 S.W.2d 476, 481 (Tex. App.—San Antonio 1986, writ ref'd n.r.e. May

6, 1987); *Steel Erection Co. v. Travelers Indem. Co.*, 392 S.W.2d 713, 716 (Tex. Civ. App.—San Antonio 1965, writ ref'd n.r.e. Nov. 3, 1965).

The Texas Supreme Court refined this rule in *N. County Mut. Ins. Co. v. Davalos*, 140 S.W.3d 685 (Tex. 2004). This case arose from a car accident in Dallas County. Davalos, the insured, was injured in the accident and sued the driver of the other car in Matagorda County. *Id.* at 687. The other driver then sued Davalos in Dallas County, which suit Davalos tendered to his insurer for a defense. Before insurer-appointed counsel appeared in the case, Davalos, through his Matagorda County counsel, moved to transfer venue of the Dallas case to Matagorda County. *Id.* The insurer informed Davalos that it opposed the transfer of venue. Davalos advised the insurer that its opposition to the transfer of venue created a conflict, which Davalos believed gave him the right to choose his own independent counsel. *Id.* Davalos refused to accept the insurer-appointed defense counsel and demanded that the insurer pay for his independently retained lawyer. The case centered around whether the insurer's disagreement with Davalos, its insured, over the proper venue of the case created the type of conflict that triggered the insured's right to independent counsel (and the insurer's obligation to pay that lawyer's fees).

The Texas Supreme Court initially accepted the proposition that the carrier may be precluded from insisting on its contractual right to control the defense where there is a "conflict of interest" between the carrier and the insured. The most common situation giving rise to such a conflict, the Court acknowledged, is where there is a dispute between the carrier and the insured as to the existence or scope of coverage. "When the facts to be adjudicated in the liability lawsuit are the same facts upon which coverage depends, the conflict of interest will prevent the insurer from conducting the defense." *Id.* at 689. Under those circumstances, the insured has the right to select defense counsel and send the bill to its carrier.

The *Davalos* Court listed other types of conflicts that may justify an insured's refusal of a defense offered by the carrier:

- When the defense tendered "is not a complete defense under circumstances in which it should have been."
- When "the attorney hired by the carrier acts unethically and, at the insurer's direction, advances the insurer's interest at the expense of the insured's."
- When "the defense would not, under the governing law, satisfy the insurer's duty to defend."
- When, although the defense is otherwise proper, "the insurer attempts to obtain some type of concession from the insured before it will defend."

The conflict alleged by Davalos, however, concerned a disagreement over the appropriate venue for the defense of a third-party claim, not Davalos's independent right to pursue his own remedy. According to the Court, the insurer's actions did not actually deprive Davalos of the defense attorney's independent counsel on any issue and, thus, did not amount to a disqualifying conflict of interest. Because Davalos rejected the insurer's defense in the absence of a qualifying conflict, he lost his right to recover the costs of that defense.

See also:

Mid-Continent Cas. Co. v. Petroleum Solutions, Inc., No. 4:09-0422, 2016 WL 5539895 (S.D. Tex. Sept. 29, 2016) ("an insured is entitled to independent counsel at the insurer's expense if a conflict of interest precludes the insurer from controlling the insured's defense" and n.233 ("*See, e.g., Hous. Auth. Of City of Dallas v. Northland Ins. Co.*, 333 F. Supp. [2d] 595, 600-02 (N.D. Tex. 2004) (Lindsay, J.). Under Texas law, '[a] conflict of interest exists that prevents the insurer from insisting on its contractual right to control the defense when the insurer has reserved its rights and the facts to be adjudicated in the liability lawsuit are the same facts upon which coverage defends.' *Allstate Cnty. Mut. Ins. Co. v. Wootton*, No. 14-14-00657-

CV, 2016 WL 1237872, at *9 (Tex. App.Houston [14th Dist.] Mar. 29, 2016) ((citing *N. Cnty. Mut. Ins. Co. v. Davalos*, 140 S.W.3d 685, 688 (Tex. 2004)))").

Graper v. Mid-Continent Cas. Co., 756 F.3d 388 (5th Cir. 2014) ((a)under Texas law, if a conflict of interest actually exists it may be disqualifiable, giving the insured the privilege of rejecting limited representation under an insurer's reservation of rights and hiring a lawyer of its own choosing and looking to the insurer for the payment of the attorney's fees; (b) with regard to the duty to defend, a reservation of rights does not, by itself, create a conflict between the insured and insurer, but only recognizes the possibility that such a conflict may arise in the future; the test to apply is whether the facts to be adjudicated in the underlying lawsuit are the same facts upon which coverage depends; (c) adjudication of accrual date in underlying lawsuit that claimed copyright infringement did not create disqualifying conflict of interest between insurer and insureds, thus weighing in favor of insurer's right under Texas law to appoint counsel to defend insureds, since adjudication of accrual date in support of insureds' state of limitations defense did not require judicial ruling on whether insureds' infringement occurred outside of CGL policy period which would relieve insurer of duty to defend in that infringement could have occurred long before it was discovered and thus occurred within limitations period but outside of policy period; (d) insured is not entitled to select its own counsel merely because the potential for a conflict of interest exists; (e) adjudication of willfulness in underlying lawsuit that claimed copyright infringement did not create disqualifying conflict of interest between insurer and insureds, thus weighing in favor of insurer's right under Texas law to appoint counsel to defend insureds under CGL policy, since adjudication of willfulness in support of underlying plaintiff's claim for upward adjustment of statutory damages would not require proof of knowing conduct that violated the rights of another person, as required for policy exclusion to apply, in that violation could amount to reckless conduct and still be willful under the statue).

And see 46 TEX. JUR. 3D INSURANCE CONTRACTS AND COVERAGE § 944. Care required in exercising duty to defend—Where conflict of interest arises (Jan. 2017 update).

B. When A Reservation Of Rights Might Not Be Sufficient To Create A Conflict

Texas case law provides very few examples of reservation-of-rights letters that are insufficient to create an independent-counsel-triggering conflict of interest. Clearly, a disagreement over the venue of the lawsuit will not create such a conflict. *See Davalos, supra.* If in doubt about whether an insurer's reservation of rights is of such nature as to create a conflict of interest, one might look to the general rule provided by United States District Judge Lee Rosenthal in *Rx.com, Inc. v. Hartford Fire Ins. Co.,* 426 F. Supp. 2d 546, 559 (S.D. Tex. 2006): "[a] conflict of interest does not arise unless the outcome of the coverage issue can be controlled by counsel retained by the insurer for the defense of the underlying claim."

C. How Much Does The Insurer Have To Pay The Independent Counsel?

It is not unusual for an insurance carrier to concede the insured's right to select its own counsel, but then refuse to pay the insured's selected lawyer a rate higher than those charged by the carrier's local "panel counsel." These "panel counsel" rates are typically the lowest rate that an insurer can contractually impose on particular firms in particular regions. Most of the "panel counsel" firms are willing to charge lower rates because of the high volume of business provided by the insurer. According to one insurance commentator, defense attorneys who serve as "panel counsel" or "captive counsel" are paid 15% to 50% less per hour than the hourly rate of outside counsel selected by the insured. *See* Charles Silver, *Does Insurance Defense Counsel Represent the Company or the Insured?*, 72 TEX. L. REV. 1583, 1597-98 n.72 (1994).

Absent an express provision in the insurance policy, an insurer does not have the right under Texas law to impose its "panel counsel" rates on its insured and the insured's independent counsel. Once the insured exercises its right to select its own defense counsel to defend the claim, the insurer must then pay the legal fees ***reasonably incurred*** in the defense. *See, e.g.,* "Chapter V Insurance Defense," 50 BAYLOR L. REV. 671, 679 (1998) ("The insurer has to pay only the reasonable expenses of independent counsel"). A

determination of the reasonableness of attorneys' fees should be guided by the following factors (not the insurer's "panel counsel rates"):

(1) The time and labor required, the novelty and difficulty of the questions involved, and the skill required to perform the legal service properly;

(2) The likelihood that the acceptance of the particular employment will preclude other employment by the lawyer;

(3) The fee customarily charged in the relevant locality for similar legal services;

(4) The amount involved and the results obtained;

(5) The time limitations imposed by the client or by the circumstances;

(6) The nature and length of the professional relationship with the client;

(7) The experience, reputation, and ability of the lawyer or lawyers performing the service; and

(8) Whether the fee is fixed or contingent on results obtained or uncertainty of collection before the legal services have been rendered.

See, TEX. DISCIPLINARY R. PROF. CONDUCT 1.04(b). *See also Arthur Andersen & Co. v. Perry Equip. Corp.,* 945 S.W.2d 812, 818 (Tex. 1997).[14]

There are no Texas statutes addressing this issue (unlike the *Cumis* statute in California), but two Texas courts—both federal courts in the Northern District of Texas—have rejected an insurer's attempt to limit fees to panel counsel rates. In *Housing Auth. of the City of Dallas, Texas v. Northland Ins. Co.,* 333 F. Supp. 2d 595 (N.D. Tex. 2004) (Lindsay, J.), the insured retained its own counsel to defend against a lawsuit involving covered claims because the insured was dissatisfied with the insurer-appointed defense counsel. The insurer disagreed that there was an independent-counsel-triggering conflict, and also argued that it should only have to pay the insured's defense counsel the same rates that it paid its panel counsel. At the most senior lawyer level, the panel counsel rates were less than half of the rates charged by the insured's chosen counsel. Finding that the insurer created a conflict that allowed the insured to choose its own defense counsel, Judge Lindsay ordered that the insurer pay the "reasonable attorney's fees" incurred by the insured in the defense of the lawsuit.

Shortly thereafter, the parties submitted the attorney's fees issue to Judge Lindsay by way of written submissions. The Judge made his determination in an eleven-page order issued on January 27, 2005. *Housing Auth. of the City of Dallas, Texas v. Northland Ins. Co.,* Case No. 3:03-cv-00385 (N.D. Tex. January 27, 2005) (unpublished). In his ruling, Judge Lindsay applied the two-step process for determining a reasonable fee award in the Fifth Circuit ("lodestar" plus the *Johnson* factors) and found that the rates charged by the insured's counsel were reasonable. In one instance the court noted that the insured's lawyer's rate "is on the low end of reasonableness for an attorney of [the lawyer's] experience." Significantly, the court expressly rejected the insurer's proffer of its panel counsel's rates as ***any evidence*** of reasonableness of the hourly rates charged by the insured's counsel.

[14] These factors are closely associated with the federal appellate decision in *Johnson v. Georgia Highway Express, Inc.*, 488 F.2d 714 (5th Cir. 1974), and have come to be referred to as "the *Johnson* factors." They are commonly considered in the resolution of disputes regarding attorneys' fee awards arising in federal court actions decided under fee-shifting statutes.

Additionally, in *Kirby v. Hartford Cas. Ins. Co.,* 2003 WL 23676809, at *2 (N.D. Tex. June 9, 2003) (Stickney, M.J.), the court stated as follows:

> In addition to its failure to offer any evidence to support its assertion that $135.00 per hour represents the only "reasonable and customary" rate for defense counsel in a matter like the Underlying Lawsuit (MPSJ ¶ 9), Hartford cites no authority for its conclusion that Kirby is obligated to accept defense counsel "appointed" by Hartford or be limited to any rate the insurer is able to negotiate with such counsel. Hartford cites one case confirming that the insurer is obligated to pay "reasonable and necessary" defense costs. (MPSJ ¶ 19, citing *Travelers Ins. Co. v. Chicago Bridge & Iron Co.,* 442 S.W.2d 888, 900 (Tex. Civ. App.—Houston [1st Dist.] 1969, writ ref'd n.r.e.)). Neither that case nor any other authority establishes, as Hartford contends, that "any rate above [$135 per hour] simply cannot be deemed as necessary." *See Ripepi v. Am. Ins. Cos.,* 234 F. Supp. 156, 158 (W.D. Pa. 1964) (insured "was not required to employ the cheapest lawyer he could get, or solicit competitive bids" after insurer failed to defend), aff'd, 349 F.2d 300 (3rd Cir. 1965).

D. Recent Cases

Partain v. Mid-Continent Specialty Ins. Services, Inc., 838 F. Supp. 2d 547, 566-67 (S.D. Tex. 2012):

- Insurer's right of control, pursuant to its defense of the insured under a liability policy, generally includes the authority to make defense decisions as if it were the client.
- Insurer's right to appoint counsel to defend insured in an underlying suit gives way when a disqualifying conflict of interest exists; in such a situation, the insured may select its own, independent counsel, thus protecting the insured from an insurer-hired attorney who may be tempted to develop facts or legal strategy that could ultimately support the insurer's position that the underlying lawsuit fits within a policy exclusion.
- Reservation of rights letters do not necessarily create a conflict between the insured and the liability insurer; rather, a reservation of rights letter only recognizes the possibility that such a conflict may arise in the future.
- Disqualifying conflict of interest exists under Texas law, such that a liability insurer's right to appoint counsel to defend insured in an underlying suit gives way to the insured's selection of its own, independent counsel, where the facts to be adjudicated in the underlying suit are the same facts upon which coverage depends.

Partain v. Mid-Continent Specialty Ins. Services, Inc., Civil Action No. H-10-2580, 2012 WL 524130 (S.D. Tex. Feb. 15, 2012) (insurer's remaining argument—that insureds are no longer entitled to defense and indemnity on grounds that: (i) by refusing to accept insurer's counsel and allowing insured's counsel to assume the defense, insured's repudiated the insurance contract and prevented insurer from performing under it; (ii) by failing to cooperate with insurer, insureds breached a condition precedent to coverage; and (iii) because insurer was prejudiced by insured's acts, insureds have forfeited their rights under the insurance policies—are rejected and remaining portion of insurer's Motion for Summary Judgment is denied).

Downhole Navigator, LLC v. Nautilus Ins. Co., 686 F.3d 325, 328-31 (5th Cir. 2012) (under Texas law, potential conflict of interest created by insurer's reservation of rights letter did not disqualify counsel offered by insurer to represent insured or entitle insured to reimbursement for cost of hiring independent counsel absent any demonstrated overlap between the facts implicated in the underlying negligence action and the facts determinative of the coverage defenses upon which the insurer's reservations were based).

Coats, Rose, Yale, Ryman & Lee, P.C., v. Navigators Specialty Ins. Co., 830 F. Supp. 2d 216, 219 (N.D. Tex. 2011) (under Texas law, if attorney appointed by insurance company would have incentive to act for insurance company's interest rather than insured's interest and, therefore, deprive insured of its right to independent counsel, conflict of interest exists triggering insured's right to select counsel; but only *actual* conflict of interest will trigger insured's right to select independent counsel).

UTAH

A. Parameters of Insured's Right to Independent Counsel

Although Utah has not directly addressed the question of whether an insurer must provide independent counsel to its insured when a conflict of interest exists, the courts have commented on this issue in *dicta*. In particular, in two cases, the Supreme Court indicated that an insured should be allowed to choose independent counsel to be funded by the insurer when there is a conflict. *Lima v. Chambers*, 657 P.2d 279, 285 (Utah 1982), *superseded by rule on other grounds by State v. Bosh,* 266 P.3d 788 (Utah 2011); and *Foster v. Salt Lake County,* 712 P.2d 224, 228 (Utah 1985).

Although it is not binding, the Eighth Circuit evaluated this issue at length under Utah law. *See U.S. Fid. & Guar. Co. v Louis A. Roser Co*., 585 F.2d 932 (8th Cir. 1978). Because, as indicated, no Utah court had directly considered this question, the Eighth Circuit predicted how Utah would rule based on its law on conflict of interest more generally and concluded that when a conflict of interest between insurer and insured exists, an insurer must provide independent counsel to its insured. Because the Utah cases cited above echo this conclusion, it is reasonable to conclude that, in Utah, an insured is entitled to independent counsel, funded by its insurer, when a conflict of interest exists.

B. Additional Requirements and Duties?

Although Utah appears to have concluded that an insured is entitled to separate counsel when a conflict of interest exist, Utah has not elaborated upon an insurer's obligations under these circumstances.

VERMONT

The Vermont courts have not directly addressed the issue of an insured's right to independent counsel. In *Am. Fid. Co. v. Kerr*, 138 Vt. 359, 416 A.2d 163 (1980), the court noted generally that an insurer needs consent from the insured in order to control the defense when a reservation of rights is issued. While one could conceivably argue that implicitly, in the absence of such consent an insurer must cede control by hiring independent counsel, this issue was not addressed. Additionally, in a concurring opinion filed in the case of *Orleans Village v. Union Mut. Fire Ins. Co*., 133 Vt. 217, 335 A.2d 315 (1975), it was noted that notwithstanding the existence of a conflict of interest triggering the right of the insured to select its own defense counsel, there may be a duty for the company to reimburse an insured's legal costs.

More recently, the Supreme Court held that a homeowner's liability insurer had a duty to pay attorney fees and costs incurred in an appeal from a judgment in an underlying defamation lawsuit against its insured, where the underlying judgment exposed the insured to both covered and uncovered damages such that a reversal would have served the insured's interests, and the appeal raised at least reasonable, if ultimately unsuccessful, grounds for challenging the judgment. *Pharmacists Mut. Ins. Co. v. Myer*, 2010 VT 10, 187 Vt. 323, 993 A.2d 413 (2010).

See also:

Jonathan M. Dunitz, *Insurer's Duty to Defend: A Compendium of State Law—Vermont*, 2016 DRI-INSDD 233 (2016):

> **When is there a right to independent counsel?**

There is no Vermont Supreme Court case on point. However, in *Northern Security Insurance Co. v. Pratt*, No. 838-11-10 Wncv, 2011 WL 8472930 (Vt. Super. May 19, 201), the superior court determined that "under Vermont law, the lack of an insured's assent to a reservation of rights alone appears to be sufficient to require the insurer to relinquish control over the defense and appoint independent counsel." In the decision, the court quoted the following " 'classic' rule for determining whether a conflict exists such that independent counsel is necessary:

> The most widely employed criterion appears to be whether the nature of the divergent interests is such that, under the facts of the dispute between insurer and insured, contrasted with the dispute between the insured and the third-party claimant, the insured's attorney would have an incentive to steer the facts of the latter litigation to a conclusion which would benefit the insurer by avoiding or minimizing coverage, while prejudicing the insured in some manner, usually by rendering it necessary for the insured to pay a judgment which the insurer might otherwise have been required to pay.

Id. (quoting 14 Couch on Ins. § 202:23). The court further determined that the insurer has the right to select independent defense counsel *Id.*

Sharon Academy, Inc. v. Wieczorek Ins., Inc., No. 442-7-13 Wncv., 2015 WL 5176793 (Vt. Super. Feb. 25, 2015) (following *Pratt*, *supra*).

VIRGINIA

In Virginia, the insurer has the right to select counsel to defend its insured. In reaching this conclusion, the Supreme Court, in *Norman v. Ins. Co. of N. Am.*, 218 Va. 718, 239 S.E.2d 902 (1978), reasoned that the ethical obligations of an attorney to act in the interest of his or her client were sufficient to protect the insured:

> No one questions the fact that the standards of the legal profession require undeviating fidelity of a lawyer to his client, and no exceptions can be tolerated. A client may presume that his attorney has no interest which will interfere with his devotion to the cause confided in him. And an insurer's attorney, employed to represent an insured, is bound by the same high standards which govern all attorneys, and owes the insured the same duty as if he were privately retained by the insured.
>
> There is no allegation by Norman, and no intimation in the record, that in defending Norman in the [subject] case, his attorneys safeguarded the interest of INA and neglected that of Norman. This is not an action by Norman against his attorneys and INA for negligent representation, or one against INA for negligent employment of incompetent attorneys.

Id. at 727-28, 239 S.E.2d at 907. *See also State Farm Fire & Cas. Co. v. Mabry*, 255 Va. 286, 497 S.E.2d 844 (1998).

WASHINGTON

A. Right to Independent Counsel

Under Washington law, the insurer may retain the right to select defense counsel even where it reserves rights. However, Washington law essentially strips control of the defense from the insurer and places other heightened obligations on the insurer when it reserves rights.

The seminal case is *Tank v. State Farm Fire & Cas. Co.*, 105 Wash. 2d 381, 715 P.2d 1133 (Wash. 1986), in which the Supreme Court declared that an insurer has an "enhanced obligation" to its insured when defending under a reservation of rights. The insurer can fulfill its enhanced obligation by meeting four criteria: (1) the company must thoroughly investigate the claim; (2) it must retain competent defense counsel for the insured, and both retained defense counsel and the insurer must understand that only the insured is the client; (3) the company must inform the insured of the reservation of rights defense and all developments relevant to policy coverage and progress of the lawsuit; and (4) the company must refrain from any activity that would show a greater concern for its monetary interest than for insured's financial risk. *Tank*, 105 Wash. 2d at 388. *But see, Phila. Indem. Ins. Co. v. Olympia Early Learning Center*, No. C12-5759 RLB, 2013 WL 6174480 (W.D. Wash. Nov. 21, 2013) (following *Tank* but nevertheless finding that insured did not establish that, as a matter of law, the insurer's assertion of its policy limits or its defense of the underlying claims amounted to bad faith or unclean hands).

Additionally, defense counsel retained by insurers to defend an insured under a reservation of rights must also recognize that his or her ethical duties of loyalty and disclosure run solely to the insured. This means that counsel must understand that she or he represents the insured, not the insurer, and must not allow the fact that she or he is being paid by the insurer to influence her or his professional judgment. It also means that potential conflicts of interest between insurer and insured must be fully disclosed and resolved in favor of the insured; that all information relevant to the insured's defense must be communicated to the insured; and that the insured, not the insurer, has the ultimate choice regarding settlement. *Id*. In other words, the insured is the client, so counsel's obligations run to the insured and the insured can control the defense.

In *Johnson v. Cont'l Cas. Co.*, 57 Wash. App. 359, 788 P.2d 598 (1990), the Court of Appeals rejected an insured's contention that a conflict of interest automatically arises requiring that the insurer pay for independent counsel chosen by the insured anytime an insurer defends under a reservation of rights; the Court noted, however, that an insurer, defending under a reservation of rights, has an "enhanced obligation of fairness towards its insured. . . .." The obligation comes about because of "[p]otential conflicts between the interests of insurer and insured, inherent in a reservation of rights defense. . . ."

B. Additional Matters

While insurers may agree to counsel selected by the insured, there are strong arguments that they are not required to pay such counsel more than they would pay counsel they selected. There is no case directly addressing this, but *Griffin v. Allstate Ins. Co.*, 108 Wash. App. 133, 29 P.3d 777 (2001) supports the argument by implication.

C. Recent Cases

Weinstein & Riley, P.S. v. Westport Ins. Corp., No. C08-1694JLR, 2011 WL 887552 (W.D. Wash. Mar. 14, 2011). Insureds were not entitled to "independent counsel" under Washington law because they did not establish that insurer's reservation of rights created an actual, rather than merely a potential, conflict of interest, with the result that the insurer retained the right to select defense counsel. *Id.* at *21. Elaborating, the court said:

> In several states, including California, the law provides that where there are divergent interests between the insured and the insurer brought about by the insurer's reservation of rights, and where the insured does not consent to joint representation, the insured is entitled to select its own independent counsel at the expense of the insurer. *See San Diego Navy Fed. Credit Union v. Cumis Ins. Co.*, 162 Cal. App. 3d 358, 208 Cal. Rptr. 494 (1984) (superseded by statute as stated in *Dynamic Concepts, Inc. v. Truck Ins. Exch.*, 61 Cal. App. 4th 999, 101, 71 Cal. Rptr. 2d 882 n.1 (Cal. Ct. App. 1998)); Cal. Civ. Code § 2860.
>
> Washington does not recognize an entitlement to "independent counsel" as it is understood under the *Cumis* model. In Washington, an insured is not entitled by law to choose

> independent counsel to represent it where there is a potential conflict with the insurer in a reservation of rights situation. *Johnson v. Cont'l Cas. Co.*, 57 Wash. App. 359, 788 P.2d 598, 601 (Wash. Ct. App. 1990) ("In Washington, there is simply no presumption . . . that a reservation of rights situation creates an automatic conflict of interest. Therefore, the insurer has no obligation *before-the-fact* to pay for its insured's independently hired counsel." (emphasis in original)). Instead, the insured is entitled to a defense provided by a lawyer selected by the insurer, and the appointed lawyer owes an enhanced obligation of fairness to the insured. *Id.* At 600; *see Tank v. State Farm Fire & Cas. Co.*, 105 Wash. 2d 381, 715 P.2d 1133 (Wash. 1986). Thus, in contrast to *Cumis*, "any breach of the 'enhanced obligation of fairness' in a reservation of rights situation might lead to *after-the-fact* liability of the insurer, retained defense counsel, or both." *Johnson*, 788 P.2d at 601 (italics added).

Weinstein & Riley, 2011 WL 887552, at *19.

JACO Environmental, Inc. v. Am. Int'l Specialty Lines Ins. Co., No. C09-0145JLR, 2010 WL 415067 (W.D. Wash. Jan. 26, 2010) ("By contrast, under Washington law, 'the insurer selects a lawyer for the insured who then has an obligation to represent only the insured.' [*San Diego Navy Fed. Credit Union v. Cumis Ins. Soc'y*, 162 Cal. App. 3d 358, 208 Cal. Rptr. 494 (1984) (citing *Johnson v. Cont'l Cas. Co.*, 57 Wash. App. 359, 788 P.2d 598, 600 (Wash. Ct. App. 1990)).] Thus, 'the prerequisite for the clause to apply, that "the insured is entitled by law to select independent counsel," is absent here.' (*Id.*) The court also noted that 'the advent for JACO's hiring of its own defense counsel was not the creation of a potential conflict created by AISLIC's agreement to defend JACO under a reservation of rights, but rather AISLIC's outright rejection of its duty to defend at the time it was initially notified of the suit by JACO.'").

In a subsequent ruling in the same case, however, it was held that the insured was entitled to reimbursement for the costs of hiring independent counsel because the insurer refused to defend. *JACO Environmental, Inc. v. Am. Int'l Specialty Lines Ins. Co.*, No. C09-0145JLR, 2010 WL 807441 (W.D. Wash. Mar. 9, 2010) ("In sum, because AISLIC breached its duty to defend as established in the insurance contract, JACO is entitled to recover the reasonable attorneys' fees it incurred in defending itself in the *ARCA* suit. Whether JACO was entitled to independent counsel under the Truck policy is not relevant to JACO's rights under the AISLIC policy.")

Nat'l Surety Corp. v. Immunex Corp., 176 Wash. 2d 872, 297 P.3d 688 (Wash. 2013) (holding that: (1) an insurer may not seek to recoup defense costs incurred under a reservation of rights defense while the insurer's duty to defend is uncertain; abrogating *Holly Mountain Resources, Ltd. v. Westport Ins. Corp.*, 130 Wash. App. 635, 104 P.3d 725 (Wash. Ct. App. 2005); (2) for late notice of claim by insured to relieve insurer of duty to defend, insurer must show that the late notice actually and substantially prejudiced its interests; and (3) genuine issue of material fact as to whether insurer was prejudiced by insured's late notice of claim, as could relieve insurer of duty to defend, precluded summary judgment).

Weinstein & Riley PS v. Westport Ins. Corp., Nos. 11-35324, 11-35341, 484 Fed. App'x 121, 2012 WL 2024770 (9th Cir. June 6, 2012) (Ninth Circuit predicted that, under Washington law, professional liability insurer was required to reimburse insured law firm for 100% of its litigation costs in legal malpractice action that included covered and uncovered claims, where there was no reasonable basis for allocating costs between covered and uncovered claims).

Arden v. Forsberg & Umlauf, P.S., 193 Wash. App. 731, 373 P.3d 320 (Div. 2 2016) (holding: (a) at attorney who represents an insurer in coverage cases is not automatically prohibited on conflict-of-interest grounds from representing that insurer's insured when the insurer reserves its right to deny coverage; (b) law firm hired by homeowners' insurer to defend its insureds under a reservation of rights, in connection with a lawsuit alleging that they were liable for willful conversion of their neighbor's dog, did not have fiduciary duty to disclose to insureds the firm's longstanding relationship with the insurer; firm's

undertaking of a reservation-of-rights defense even when it represents the insurer in other cause did not automatically create a conflict of interest; (c) one requirement for attorneys handling a reservation-of-rights defense of an insured is that potential conflicts of interest between insurer and insured must be fully disclosed and resolved in favor of the insured; (d) an attorney handling a reservation-of-rights defense of an insured generally must explain the "reservation of rights" process; i.e., that the insurer could refuse to indemnify the insured even though it was providing a defense and that the attorney represents only the insured and not the insurer; (d) law firm hired by insurer to defend insureds did not breach its fiduciary duty to disclose potential conflicts of interest between insureds and insurer, where firm's attorney met with insureds and discussed the relationship between insurer, firm, and insureds, including that attorney's duties were "solely" to insureds, and insureds had personal counsel who was engaged in the reservation-of-rights process and who presumably provided insureds with information and legal advice about the process; (e) if insurer defends its insured under a reservation of rights, the insured under certain circumstances has the ability to settle the case at his or her own expense without defeating coverage, even when the insurer does not consent; (f) if an insurer defends its insured under a reservation of rights, under certain circumstances the insured can enter into an agreement with the plaintiff to execute a stipulated judgment; and (g) when the insurer ends its insured under a reservation of rights, the insured has the ability, under certain circumstances, to settle the case without the insurer's involvement or consent; this means that when the claimant makes a settlement demand, defense counsel must consult with the insured before that demand is rejected or allowed to expire).

Nat'l Union Fire Ins. Co. of Pittsburgh, Pa. v. Coinstar, Inc., 39 F. Supp. 3d 1149 (W.D. Wash. 2014) (under Washington law, insurer was responsible under CGL policy for reasonable defense costs incurred by its insured after relinquishing its right to choose attorney to defend underlying suits; insurer did not have power to unilaterally set rates it would pay for defense of lawsuit, without any restrictions, and regardless of unreasonableness of its rates, in absence of policy provision limiting rates or reservation of rights letters alerting insured to attorney fee rates; and under Washington law, insureds may not freely conduct their own litigation and then seek reimbursement where the policy obligates the insurer only to defend through counsel of its own choosing).

Nat'l Fire Ins. Co. of Hartford v. Commerce & Industry Ins. Co., No. 14-1398 RAJ, 2017 WL 468575 (W.D. Wash. Feb. 3, 2017):

> At issue, then, is whether CIIC is responsible for the cost of Mr. Jager, the attorney that Hartford hired while waiting for CIIC to accept the tendered defense. In the context of a reservation of rights agreement [footnote 1 says that "[t]he parties agree that there is no reservation of rights agreement in this matter"], insurers are not required to provide insureds with separate defense attorneys. *See, e.g., Tank v. State Farm Fire & Cas. Co.*, 105 Wash. 2d 381, 388 (1986). Instead, the insurer has an enhanced obligation to (1) thoroughly investigate the claim, (2) retain competent defense counsel for the insured with the understanding that the insured is the only client, (3) fully inform the insured about a reservation of rights agreement and any relevant issues that arise with respect to this coverage, and (4) refrain from acting in a way that "would demonstrate a greater concern for the insurer's monetary interest than for the insured's financial risk." *Id.* at 388. In addition, defense counsel retained by insurers in these instances must meet their own distinct criteria. *Id.* If an insurer meets the *Tank* standard, then it "has no obligation before-the-fact to pay for its insured's independently hired counsel," though the insurer may be liable after-the-fact for any breach of the enhanced obligation of fairness. *Johnson v. Cont'l Cas. Co.*, 57 Wash. App. 359, 363 (1990) (finding that the insurer did not face after-the-fact liability because it met its enhanced obligation in defending and settling the underlying claim).

2017 WL 468575, at *3.

Accord, *Berkshire Hathaway Homestate Ins. Co. v. SQI, Inc.*, 132 F. Supp. 3d 1275 (W.D. Wash. 2015) (citing *Tank*).

WEST VIRGINIA

The West Virginia courts have not addressed an insured's right to independent counsel. However, at least two published opinions indicate that counsel hired by an insurer to defend the insured owes a duty of loyalty solely to the insured client. In *Haba v. Big Arm Bar and Grill, Inc.*, 196 W. Va. 129, 468 S.E.2d 915 (1996), the Supreme Court of Appeals noted that:

> We sanction the view that "an insurer's attorney, employed to represent an insured, is bound by the same high standards which govern all attorneys, and owes the insured the same duty as if he were privately retained by the insured." *Norman v. Ins. Co. of N. Am.,* 218 Va. 718, 727, 239 S.E.2d 902, 907 (1978). In the absence of any claim to the contrary, it appears that the counsel employed by [the insurer] to represent [the insured] in the [underlying] action adequately discharged that duty.

196 W. Va. at 136, 468 S.E.2d at 922.

More recently, in *Barefield v. DPIC Cos., Inc.*, 215 W.Va. 544, 600 S.E.2d 256 (2004), the Supreme Court of Appeals reiterated this position:

> Arguably, the language of both Rules 1.7 and 1.8(f) might allow an attorney hired and paid by an insurance company to protect the insurance company's interests, and comply with the insurance company's directives and restrictions, in the representation of an insured if the insured "consents after consultation." However, the Rules also require that there must also be "no interference with the lawyer's independence of professional judgment," Rule 1.8(f)(2), and the attorney must reasonably believe that "the representation will not be adversely affected" by the joint representation. Rule 1.7(b)(1). More specifically, Rule 5.4(c) prohibits a third-party who pays for an attorney's services from "direct[ing] or regulat[ing] the lawyer's professional judgment in rendering such legal services."
>
> In sum, our *Rules of Professional Conduct* compel us to the conclusion that when an insurance company hires a defense attorney to represent an insured in a liability matter, the attorney's ethical obligations are owed to the insured and not to the insurance company that pays for the attorney's services. *In accord*, *In re Rules of Professional Conduct and Insurer Imposed Billing Rules and Procedures*, 299 Mont. 321, 333, 2 P.3d 806, 814 (2000); *Higgins v. Karp*, 239 Conn. 802, 810, 687 A.2d 539, 543 (1997); *Petition of Youngblood*, 895 S.W.2d 322, 328 (Tenn. 1995); *Atlanta Int'l Ins. Co. v. Bell*, 438 Mich. 512, 520, 475 N.W.2d 294, 297 (1991); *First Am. Carriers, Inc. v. Kroger Co.*, 302 Ark. 86, 89-91, 787 S.W.2d 669, 671 (1990).
>
> Because a defense attorney is ethically obligated to maintain an independence of professional judgment in the defense of a client/insured, an insurance company possesses no right to control the methods or means chosen by the attorney to defend the insured. As one court stated, an insurance company "cannot control the details of the attorney's performance, dictate the strategy or tactics employed, or limit the attorney's professional discretion with regard to the representation [of the insured]." *Petition of Youngblood*, 895 S.W.2d at 328. Accordingly, "an attorney hired by an insurer to defend an insured must be considered, at least initially, to enjoy the status of an independent contractor." *Givens v. Mullikin ex rel. Estate of McElwaney*, 75 S.W.3d 383, 392 (Tenn. 2002).

215 W.Va. at 558, 600 S.E.2d at 270.

WISCONSIN

The independent-counsel issue has not been addressed by the Wisconsin Supreme Court. There is a slight split of opinion between the federal district courts in Wisconsin that have addressed this issue. The U.S. District Court for the Eastern District of Wisconsin, citing various Wisconsin appellate court cases, has held that upon the insurer's issuance of a reservation-of-rights letter, the insured is allowed to control its own defense. *Nowacki v. Federated Realty Group, Inc.*, 36 F. Supp. 2d 1099, 1109 (E.D. Wis. 1999) (citing *Jacob v. W. Bend Mut. Ins. Co.*, 553 N.W.2d 800 (Wis. Ct. App. 1996)); and *Grube v. Daun*, 496 N.W.2d 106 (Wis. Ct. App. 1992) (*overruled on other grounds by Marks v. Houston Cas. Co.*, 2016 WI 53, 369 Wis. 2d 547, 881 N.W.2d 309 (Wis. 2016)). The rule of law reached in *Fireman's Fund Ins. Co. v. Waste Management, Inc.*, 777 F.2d 366 (7th Cir. 1985) (apparently applying Wisconsin law), which provides that an insurer is liable for the insured's attorney fees only if a mutual agreement with defense counsel is reached between the parties, is not to be interpreted to add an additional requirement. *Nowacki*, 36 F. Supp. 2d at 1109.

A subsequent unpublished opinion, however, reasoned that the insurer may still be entitled to a role in the selection of defense counsel even if, because of a conflict of interest, it may not control the defense. *HK Systems, Inc. v. Admiral Ins. Co.*, 2005 WL 1563340 (E.D. Wis. June 27, 2005). In that case, the district court stated (in *dicta*) that the insurer was still entitled to appoint defense counsel if the appointed counsel were truly independent of the insurer. *HK Systems*, 2005 WL 1563340, at *16. The district court also denied the insured's motion for summary judgment that it was entitled to reimbursement for the expense of its much higher-priced law firm, holding that the insured was only entitled to reimbursement for reasonable defense costs and that fact questions existed as to whether the rates charged by its selected firm were reasonable. *Id*. at *18-19.

The U.S. District Court for the Western District of Wisconsin, citing an Eighth Circuit opinion, stated that the insurer, when confronted with a conflict of interest, must either provide an independent attorney to represent the insured or pay the costs incurred by the insured in hiring counsel of the insured's own choice. *Am. Motorists Ins. Co. v. Trane Co.*, 544 F. Supp. 669, 686 (W.D. Wis. 1982) (citing *U.S. Fid. & Guar. Co. v. Louis A. Roser Co.*, 585 F.2d 932, 939 (8th Cir. 1978)).

In a relatively recent state appellate decision, the court addressed the issue of an insurer's obligation with respect to attorney's fees:

> Depending on the fact finder's determination on remand, the issue of attorney fees may be resolved. However, if the fact finder determines that the rate schedule was only temporary, the court will have to determine Liberty's obligation for attorney fees from the time of tender until the resolution of litigation. Whether the requested compensation for attorney fees is reasonable is a question of fact to be addressed by the trial court following consideration of the factors in SCR 20:1.5 (2010), which includes the fees customarily charged in the locality for similar service, SCR 20:1.5(a)(3). [Footnote omitted.] *See Wright v. Mercy Hosp. of Janesville, Wis., Inc.*, 206 Wis. 2d 449, 470, 557 N.W.2d 846 (Ct. App. 1996); *Fireman's Fund Ins. Co. v. Bradley Corp.*, 261 Wis. 2d 4, ¶ 67, 660 N.W.2d 666; *see also HK Sys., Inc. v. Admiral Ins. Co.*, 2005 WL 1563340 at *18, 19 (E.D. Wis. 2005) (applying Wisconsin law, holding that an insurer's responsibility for defense costs extends only to a reasonable charge and the market standard for attorney rates for a particular type of litigation in a particular geographic area is a question of fact preventing the grant of summary judgment); *see also* 14 LEE R. RUSS & THOMAS F. SEGALLA, COUCH ON INS. § 202:35, at 202-87 (3d ed. 1999) ("An insurer's obligation to reimburse independent counsel is limited to reasonable attorney's fees and disbursements.").

Lakeside Foods, Inc. v. Liberty Mut. Fire Ins. Co., 329 Wis. 2d 270, 789 N.W.2d 754 (Table) (2010).

A federal district court in Wisconsin cited to *Lakeside Foods* and other cases in grant an insurer's motion for summary judgment on an insured's claims for bad faith and breach of the duty to defend, stating:

> With respect to bad faith, defendant [insured] acknowledges that a claim for bad faith requires a showing that the insured [read "insurer"?] lacked any reasonable basis for its decision. [Citation to record omitted] (quoting *Lakeside Foods*, 2010 WI App 120 at ¶ 44). Although I sided with defendant regarding the right to choose counsel in the April 1, 2015 order, I also acknowledged that there is a split in authority regarding whether the insurer or the insured has the right to choose counsel when the insured [should read "insurer"] provides a defense under a reservation of rights. *Compare HK Systems*, 2005 WL 1563340 (insurers who defend under reservation of rights retain right to choose "independent" counsel) with *Nowacki v. Federated Realty Group, Inc.*, 36 F. Supp. 2d 1099 (E.D. Wis. 1999) (insured has right to choose counsel when insurer provides a defense under reservation of rights). The parties cited no cases in which any court had considered the circumstances under which an insurer could be estopped from choosing counsel. Thus, although defendant may have incurred additional costs by hiring separate counsel to litigate the dispute over the choice of counsel, I cannot say that the law on that issue was so clear as to justify a finding of bad faith by United States Fire. Accordingly, I am granting United States Fire's motion for summary judgment on defendant's claims for bad faith and breach of the duty to defend.

Haley v. Kolbe & Kolbe Millwork Co., Inc., No. 14-cv-99-bbc, 2015 WL 6669395 (W.D. Wis. Nov. 2, 2015), at *4.

Two months later, however, the same court ruled that the insurers were estopped from requiring insured to switch counsel:

> When an insurer agrees to defend and indemnify an insured in a lawsuit, the general rule is that the insurer gets to control the defense. *HK Systems, Inc. v. Admiral Insurance Co.,* No. 03 C 0795, 2005 WL 1563340, at *4 (E.D. Wis. June 27, 2005) (citing ERIC MILLS HOLMES, APPLEMAN ON INSURANCE 2D § 136.1, at 4 (2003)). This makes sense because, under those circumstances, it is the insurer rather than the insured that will have to pay a potential judgment. However, when, as in this case, an insurer agrees to defend an insured under a reservation of rights to contest its obligation to indemnify, a conflict of interest may arise because the insured has a greater interest in having the best possible defense while the insurer has a greater interest in keeping costs down. The parties assume in their briefs that a conflict of interest exists between defendant and its insurers in this case because the insurers agreed to defend defendant under a reservation of rights and that, as a result of the conflict, defendant rather than its insurers has the right to control its counsel. Accordingly, I need not consider those issues.
>
> The key question raised by the parties' motions is the extent to which defendant's right to *control* counsel includes the right to *choose* counsel in a case such as this one in which the policies at issue give the insurer the "right and duty" to defendant its insured. The parties assume that Wisconsin law governs this question, so I will do the same. *RLI Insurance Company v. Conseco, Inc.,* 543 F.3d 384, 390 (7th Cir.2008). However, neither side cites case law from the Wisconsin Supreme Court or the Wisconsin Court of Appeals that addresses the right to choose counsel when an insurer provides a defense under a reservation of rights. Defendant says that "there are a number of Wisconsin Court of Appeals decisions holding that the insured has a right to choose counsel" when the insurer defends under a reservation of rights, [citation to record omitted], but the cases defendant cites say only that the insured has the right to "control" counsel in that situation, *Jacob v. West Bend Mutual Insurance Co.,* 203 Wis. 2d 524, 536, 553 N.W.2d 800, 805 (Ct.

App.1996); *Grube v. Daun,* 173 Wis. 2d 30, 75, 496 N.W.2d 106, 123 (Ct. App.1992), a proposition that the insurers do not deny in their motion. Rather than citing controlling precedent, the parties cite opposing district court decisions from the Eastern District of Wisconsin. *Compare HK Systems,* 2005 WL 1563340 (insurers who defend under reservation of rights retain right to choose "independent" counsel) *with Nowacki v. Federated Realty Group, Inc.,* 36 F. Supp. 2d 1099 (E.D. Wis.1999) (insured has right to choose counsel when insurer provides defense under reservation of rights).

The insurers also cite *American Motorists Insurance Co. v. Trane Co.,* 544 F. Supp. 669 (W.D. Wis.1982), in which I stated that, "[w]here there is a conflict [of interest between the insurer and insured], the insurer must *either* provide an independent attorney to represent the insured *or* pay the costs incurred by the insured in hiring counsel of the insured's own choice." *Id.* at 686 (citing *U.S. Fidelity and Guaranty Co. v. Louis A. Roser Co.,* 585 F.2d 932, 939 (8th Cir.1978)) (emphasis added). However, the relevant issue in that case was whether the insurer had breached its contract with the insured by refusing to defend the insured because of a conflict of interest. I did not need to decide the extent to which the insurer or the insured has the right to choose counsel when there is a conflict. Outside Wisconsin, jurisdictions are split on the question whether the insurer or the insured has the right to select counsel when the insurer agrees to defend the insured under a reservation of rights. ARNOLD P. ANDERSON, WISCONSIN INSURANCE LAW vol. II, ch. 7, § 7.96 (6th ed.2010).

For the sole purpose of deciding the parties' cross motions for summary judgment, I will assume that insurers have a right to choose counsel even when they defend the insured under a reservation of rights. Even making that assumption, however, I conclude that defendant is entitled to summary judgment because the insurers lost whatever right they had through their own inaction.

It is undisputed that defendant tendered its defense to the insurers the day after plaintiffs filed their complaint. After that, the insurers did not object or otherwise place any restrictions on defendant with respect to counsel over the course of four months when defendant took the following actions:

- on February 19, 2014, when defendant informed its insurers that it was seeking counsel;
- on February 21, 2014, when defendant informed its insurers that it had chosen Foley & Lardner as counsel;
- on February 24, 2014, when counsel from Foley & Lardner held a conference call with the insurers and informed them of the firm's experience and rates;
- on March 4, 2014, when defendant informed the insurers that Foley & Lardner was preparing an answer (which was due by March 10, 2014); defendant stated that it was "await[ing] [the insurers] responses with regard to [their] coverage positions";
- on March 28, 2014, when defendant informed the insurers that it had received its first invoice from Foley & Lardner and again asked the insurers for their coverage positions.

It was not until June 18, 2014, four months after defendant tendered its defense, that the insurers informed defendant that they did not want defendant to use Foley & Lardner as counsel, but instead wanted defendant to choose one of two different law firms. Even then, the insurers provided no information to defendant about those firms except for their names.

Although the insurers referred to the firms as "independent," the insurers did not provide any foundation for that statement.

Defendant argues that insurers' conduct prohibits them from arguing now that they have a right to choose counsel. Defendant characterizes this argument in several ways: (1) the insurers "allowed" defendant to choose Foley & Larder or "consented" to defendant's choice; (2) the insurers should be estopped from requiring defendant to switch counsel because defendant relied on the insurers' failure to object; (3) the insurers did not act in good faith; and (4) the insurers did not choose "truly" independent counsel for defendant because Wilson Elser has an ongoing relationship with intervenor Fireman's Fund. Of these arguments, I believe that estoppel is the strongest.

As defendant points out, the Supreme Court of Wisconsin has applied the doctrine of equitable estoppel to disputes about insurance coverage. *Mercado v. Mitchell,* 83 Wis. 2d 17, 26-27, 264 N.W.2d 532, 537 (1978). Although the parties do not cite any cases in which a Wisconsin court has considered whether estoppel may apply to the selection of counsel, numerous courts in other states have applied estoppel to the analogous issue whether an insurer may reverse a decision to provide a defense after the insurer already started providing that defense. *E.g., Underwriters at Lloyds v. Denali Seafoods, Inc.,* 927 F.2d 459, 463-64 (9th Cir.1991); *Pacific Indemnity Co. v. Acel Delivery Service, Inc.,* 485 F.2d 1169, 1173 (5th Cir.1973); *Zurich Insurance Co. v. Continental Insurance Co.,* 101 Wash. App. 1023, 2000 WL 789861 (2000); *Providence Washington Insurance Co. v. A & A Coating, Inc.,* 30 S.W.3d 554, 556-57 (Tex. Ct. App.2000); *Safeco Insurance Co. v. Ellinghouse,* 223 Mont. 239, 725 P.2d 217, 220-21 (1986); *Maryland Casualty Co. v. Peppers,* 64 Ill. 2d 187, 355 N.E.2d 24, 29 (1976). In any event, the insurers do not deny that estoppel may apply in this context, so I need not resolve that issue. Instead, the insurers argue that defendant cannot meet the requirements of estoppel.

Estoppel applies when a party's action or inaction induces reliance by another party and prejudices the relying party as a result. *Mercado,* 83 Wis. 2d at 26–27, 264 N.W.2d at 537. The insurers argue that defendant could not have relied reasonably on anything the insurers did or did not do because "from the outset, [the insurers] informed [defendant] that [they were] exercising [their] right to select independent counsel pursuant to the policy and Wisconsin law." [Citation to record omitted].

The insurers' argument is not persuasive for two reasons. First, the insurers do not cite any evidence that they gave defendant any indication that they wanted to select different counsel until April 22, 2014, when Fireman's Fund wrote that it "is in contact with [the] other carriers to coordinate the defense and discuss the retention of independent counsel." However, that was two months after defendant tendered its defense and, even in the letter, the insurers simply say that they are "discuss[ing]" the retention of independent counsel; they did not suggest that they had reached any decisions and they did not tell defendant that Foley & Lardner would be expected to withdraw in the future.

Second, even if the April 22, 2014 letter qualifies as notice that Foley & Lardner may need to be replaced, that does not defeat an argument of reliance by defendant. Regardless when the insurers *told* defendant that they may be selecting their own counsel, there was little that defendant could do to ready itself until the insurers actually *provided* counsel. In other words, the prejudice to defendant was not simply a matter of not knowing that the insurers might choose another firm, but rather that the insurers failed to make a selection until defendant's counsel had already invested significant time and resources into the case. Under the insurers' view, if they had informed defendant that they were considering whether to choose different counsel the day defendant tendered its defense, the insurers

would be free to take as much time as they wished *1054 to make a decision regarding counsel, up until the day of trial, regardless of the disruption that it would cause to the defense.

By June 18, 2014, Foley & Lardner had already begun engaging in extensive discovery and formulating a litigation strategy, including conducting interviews, reviewing a large number of documents, retaining an expert and inspecting plaintiffs' homes. Thus, forcing defendant to switch counsel at that stage could have jeopardized the work that defendant's counsel had done up to that point or at least caused significant delays as new counsel attempted to get up to speed. Particularly because defendant would have no way of knowing whether the court would grant extensions of time while new counsel attempted to catch up, it is not surprising that defendant resisted the insurers' efforts to make the switch. Further, because the insurers did not provide defendant any information about the law firms it chose, defendant was not in a position to accept the insurers' offer as of June 18.

The insurers argue that they were not simply sitting on their hands doing nothing before June 18. Rather, they say that they were investigating coverage, which was complicated by the number of policies involved and the breadth of plaintiffs' claims. It is difficult to evaluate the merit of the insurers' allegation that they were investigating coverage diligently because they provide few details about what they were doing during the relevant time. Further, even if the insurers' conduct might have been reasonable under some circumstances, they should have known that time was of the essence under the circumstances of this case. When defendant notified the insurers of plaintiffs' claims, defendant already had been served with the complaint, so expedited consideration was required. Every day that passed without a decision from the insurers was a day in which the case progressed further and defendant's counsel invested more resources in the defense. Particularly because the insurers should have known that this court sets a tight schedule, they also should have known that a decision on counsel could not wait four months.

The insurers cite *American Design & Build, Inc. v. Houston Casualty Co.*, No. 11-C-293, 2012 WL 719061, at *11 (E.D. Wis. Mar. 5, 2012), and *Lakeside Foods, Inc. v. Liberty Mutual Fire Insurance Co.*, 2010 WI App 120, ¶ 13, 329 Wis. 2d 270, 789 N.W.2d 754 (nonprecedential opinion), for the proposition that there was no undue delay. However, the insurers' reliance on those cases is misplaced because the question in both cases was whether an insurer breached its duty to defend by waiting too long to accept the defense. The parties were *not* disputing the choice of counsel. This is important because the prejudice to the insured may be different in both situations. Although a four-month delay in deciding whether to defend an insured may not cause prejudice so long as the insurer agrees to make its decision retroactive and pay the costs of litigation from the time the insured tendered its defense, the same conclusion does not necessarily follow regarding the choice of counsel. Regardless whether the insurer promises to foot the bill for litigation expenses occurred before the insurer selected counsel, changing counsel after the lawsuit has progressed is more likely to be disruptive and prejudicial. Because the courts in *American Design* and *Lakeside Foods* emphasized that the insured in those cases had not made any showing that the insurer's delay had resulted in any prejudice, those cases actually support a view that an insurer should be estopped from requiring an insured to make a prejudicial change in the middle of a lawsuit.

In this case, not only did the insurers delay in choosing counsel, they delayed in seeking relief from the court when defendant rejected their offer. The insurers waited more than four more months after defendant rejected the insurers' offer to file a motion to intervene in this case so that the court could resolve the issue. The insurers' only explanation for that

delay is that they were trying to resolve the issue without court assistance. However, that argument is disingenuous in light of the fact that the insurers waited more than three weeks to even *respond* to defendant's rejection. Further, although making every effort to settle a dispute out of court is a laudable goal in most situations, it makes little sense simply to spend months exchanging letters at a leisurely pace in the context of an ongoing lawsuit when it is clear that a prompt resolution of a decision is needed to avoid further prejudice to the insured. Finally, defendant was clear in its June 24, 2014 letter to the insurers that it believed it had the right to keep Foley & Lardner as counsel. After that point, any further attempt to resolve the issue through mere persuasion was not an efficient use of time.

By the time that the insurers filed their motion for summary judgment on the selection of counsel issue, the case had been proceeding for more than ten months. (Although the insurers sought to stay the case while the coverage issue was pending, I denied this motion in accordance with this court's consistent practice in recent years. [Citation to record omitted] (citing *Neri v. Monroe,* No. 11-cv-429-bbc (W.D. Wis.2011); *Biewer–Wisconsin Sawmill, Inc. v. Fremont Industries, Inc.,* 2007 WL 5517466, *1 (W.D. Wis.2007); *Solofra v. Douglas County,* 2005 WL 3059488 (W.D. Wis.2005); *Wimmer v. Rental Service Corp.,* 2005 WL 949328 (W.D. Wis.2005)).) The motion for summary judgment was not fully briefed until two months later, in part because of extensions of time sought by the insurers. By that time, defendant had filed a 70-page motion for partial summary judgment. Thus, at this point, it would be impossible to grant the insurers' motion without causing substantial prejudice to defendant or completely resetting the schedule in this case, which is already on a slower track than the vast majority of cases in this court. Under these circumstances, it would not be fair to defendant (or plaintiffs) to allow the insurers to stall the proceedings by substituting new counsel. The insurers' insouciance regarding the developments in a pending lawsuit in a fast-paced court is simply not justified.

Fireman's Fund Insurance Co. v. Waste Management of Wisconsin, Inc., 777 F.2d 366 (7th Cir.1985), is instructive. In that case, after the insured was sued, it retained counsel and tendered its defense to its insurer. The insurer agreed to defend the insured under a reservation of rights and then made no objection to the insured's choice of counsel and did not suggest retaining other counsel until a few months later. *Id.* at 368. At that point, the insured refused to accept the new counsel. Both the district court and the Court of Appeals for the Seventh Circuit concluded that the insurer was not entitled to impose its own choice of counsel on the insured after not objecting for several months. *Id.* at 369.

The insurers in this case point out that in *Fireman's Fund,* the court directed the parties to choose new independent counsel. However, this was only because counsel for the insured chose had a conflict of interest with the insurer. *Id.* at 370. As a result of that conflict, the court "adopted the equitable suggestion of permitting [the insured] to select new independent counsel ... but subject to the approval and at the expense of" the insurer. *Id.* Because the insurers have not identified any conflicts they have with Foley & Lardner, I see no reason to require the selection of new counsel.

The insurers object to Foley & Lardner on the ground that the law firm has been "uncooperative," but the only example of this the insurers discuss in their briefs is that Foley & Lardner did not inform them of a settlement conference until after the conference occurred. The insurers cite no authority for the view that they are entitled to participate in every settlement discussion, but even if I assume that they are, the insurers have not shown that a single slight is a sufficient ground to remove Foley & Lardner from the case. The insurers do not dispute defendant's statement that since the one oversight, defendant has asked for the insurers' input on settlement offers. [Citation to record omitted].

> The insurers also object to Foley & Lardner on the ground that its rates are higher than the law firm the insurers chose. However, neither side develops an argument on the question whether there should be a "reasonable rate" cap on defendant's choice and, if so, whether Foley & Lardner's rates are reasonable. *HK Systems,* 2005 WL 1563340, at *18 (concluding that "the insurer's responsibility for defense costs extends only to a reasonable charge"). Accordingly, I conclude that it would be premature to resolve that issue in the context of this order.

Haley v. Kolbe & Kolbe Millwork Co., Inc., 97 F. Supp. 3d 1047, 1051-56 (W.D. Wis. 2015)

Wis. Pharmacal Co., LLC v. Neb. Cultures of Cal., Inc., 2016 WI 14, 367 Wis. 2d 221, 876 N.W.2d 72 (Wis. 2016) (liability insurer may avoid breaching the duty to defend by requesting a bifurcated trial on the issues of coverage and liability and moving to stay any proceedings on liability until the issue of coverage is resolved; however, insurer may need to provide a defense to its insured when the separate trial on coverage does not precede the trial on liability and damages).

WYOMING

Wyoming has not yet considered the issue of whether an insured is entitled to independent counsel if a conflict of interest develops between insurer and insured. Two Wyoming cases mention that an insurer provided independent counsel under such circumstances in their recitations of facts, but the courts did not comment on whether or not this was required. *See Gainsco Ins. Co. v. Amoco Prod. Co.,* 53 P.3d 1051, 1059 (Wyo. 2002), and *Crawford v. Infinity Ins. Co.,* 64 Fed. App'x 146 (10th Cir. 2003). Accordingly, it appears that whether an insurer must fund separate counsel in a conflict of interest situation remains an open question under Wyoming law. However, note that an insurer cannot defend under a reservation of rights and later seek reimbursement of defense costs in the event no coverage is owed. Rather, it must either deny the defense or seek declaratory judgment. *See Shoshone First Bank v. Pacific Employers Ins. Co*., 2 P.3d 510 (Wyo. 2000).

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Rights and Duties Where an Insured Is Defended by Independent Counsel

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Mr. Barker is a member of the American Law Institute and an Adviser to its project on the Restatement of the Law of Liability Insurance. He is a Special Advisor to the ABA Standing Committee on Ethics & Professional Responsibility. He is a past Director of the Association of Professional Responsibility Lawyers. He is Co-Chair of the Subcommittee on Ethics of the ABA Section of the Litigation Insurance Coverage Litigation Committee and a Vice Chair of the ABA Tort Trial & Insurance Practice Section ("TIPS") Committee on Insurance Coverage Litigation. He is TIPS Liason to the ABA Standing Committee on Lawyers' Professional Liability, a past Chair of the TIPS General Committee Board, the TIPS Ethics & Professionalism Committee, the TIPS Appellate Advocacy Committee, and the TIPS Robert B. McKay Law Professor Award Committee.

Chapter 14 Rights and Obligations When Policyholder Has Independent Counsel

SYNOPSIS

* * * *

§ 14.03 What Rights Do Insurers Have When Dealing with Independent Counsel?

[1] Insurers Are Entitled to Advance Consultation About Defense Expenditures and Activities

Once counsel has been selected, "[t]he *Cumis* rule requires complete independence of counsel."[1] (The *Cumis* rule is discussed in §§ 6.03 & 6.05, above.) "Cumis counsel represents solely the insured."[2] Counsel may select defense strategies disadvantageous to the carrier.[3] The insurance contract does not govern the relationship between the insurer and defense counsel. But counsel (especially counsel representing and answerable solely to the policyholder) could injure the policyholder's coverage by failing to act in accordance with the policyholder's duties under the policy (*e.g.*, by failing to communicate information the insurer is entitled to receive). At least as long as consulting with the insurer does not entail any substantial risk of harm to the policyholder, counsel's duties to the policyholder require counsel to engage in such consultation (if requested by the insurer) to avoid any risk of injuring the policyholder's coverage interests. Moreover, disclosure to the insurer of information relating to the representation is impliedly authorized to the extent necessary to avoid the risk of breaching the insurance policy, as long as

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CA—
State Farm Fire & Cas. Co. v. Superior Ct., 216 Cal. App. 3d 1222, 1226 (1989).

See also Mosier v. Southern Cal. Physicians Ins. Exchange, 63 Cal. App. 4th 1022, 1042 (1998).

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US/CA—
Emp'rs Ins. Co. of Wausau v. Albert D. Seeno Constr. Co., 692 F. Supp. 1150, 1157 (N.D. Cal. 1988);

CA—
63 Cal. App. 4th at 1042; Assurance Co. of America v. Haven, 32 Cal. App. 4th 78, 87 (1995).

3

NY—
Nelson Elec. Contr. Corp. v. Transcontinental Ins. Co., 231 A.D.2d 207 (1997) (subcontractor policyholder did not breach duty of cooperation by having independent counsel forego claim against general contractor which would have reduced carrier's net liability, but required subcontractor to provide uninsured indemnity to general contractor, on the basis that the best defense strategy was to present a common defense against the injured workers).

disclosure does not endanger any policyholder interests and as long as the policyholder has not directed that such information be kept confidential. (See §§ 10.02 above, 14.04[3] below.)

Again, California Civil Code § 2860 codifies some of these obligations and imposes them directly on defense counsel:

> (d) When independent counsel has been selected by the insured, it shall be the duty of that counsel and the insured to disclose to the insurer all information concerning the action except privileged materials relevant to coverage disputes, and timely to inform and consult with the insurer on all matters relating to the action … .

In *Hartford Casualty Insurance Co. v. J.R. Marketing, L.L.C.,*[41] a concurring opinion noted that that existence of a conflict on some issues

> does not mean the insurer and insured are entirely at odds. Their interests remain aligned as to third party claims unaffected by the coverage dispute. And even as to the claims implicating that dispute, "[b]oth the insured and the insurer, of course, share a common interest in defeating the claims." The conflict exists only to the extent that "if liability is found, their interests diverge in establishing the basis for that liability."[1]

The independent counsel scheme created by § 2860,

> like its counterparts in other jurisdictions, contemplates that "an insurer can reasonably insist that independent counsel fully inform it of factual and legal developments related to the defense, consult with it on defense strategy and tactics, and consult with it before incurring major expenses in the course of the defense." Indeed, "[t]he insurer's advice, insight, or suggestions may prove valuable to the insured."[2]

These duties to disclose relevant information and to consult with the insurer seem especially well founded in the insurance contract. While a conflict of interest denies the insurer the right to direct counsel,[4] to receive information prejudicial to the policyholder on the subject of

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CA—
Hartford Cas. Ins. Co. v. J.R. Marketing, L.L.C., 61 Cal. 4th 988 (2015).
[1] 61 Cal. 4th at 1012 (Liu, J., concurring)
[2] 61 Cal. 4th at 1012 (Liu, J., concurring), *quoting* (Richmond, *Independent Counsel in Insurance,* 48 San Diego L.Rev. 857, 890 (2011) (footnotes. Omitted by Justice Liu.).
[4] *See*:

US/RI—
Hartford Cas. Ins. Co. v. A & M Assocs., Ltd., 200 F. Supp. 2d 84, 90 (D.R.I. 2002) (explaining that the insurer cannot control the litigation);

WI—

the conflict, and to impede actions beneficial to the policyholder on that issue, it does not eliminate the insurer's interest in the defense. The insurer still desires the most effective and efficient defense, as the insurer is still obliged to pay defense costs and may be required to pay any judgment or settlement. The policyholder is still bound by the contractual duty of cooperation except insofar as that duty is excused by the conflict. Moreover, the insurer retains the right to settle at its own expense and the right to deny payment of any settlement not approved by it. Exercise of these rights requires full and timely information, so the insurer can consider settlement opportunities and actions that may be necessary to fulfill any duty to the policyholder to accept reasonable settlement demands.

Moreover, the insurer should at least be entitled to make suggestions on defense options and decisions and to have the information necessary to do so. While the policyholder and defense counsel are not bound by any such suggestions, they cannot be harmed and may be helped by receiving them. As Dean Syverud observed with respect to common defense counsel guidelines, "[t]he advance consultation by defense counsel contemplated in the Guidelines is as minimal a form of cooperation as one can imagine."[5] "As long as the consultations do not reveal confidential information held by the insured that might be used to defeat coverage, allowing the insurer to consult on the defense cannot harm the insured."[6]

Consultation is valuable, in and of itself, in achieving an economical defense. Lawyers make money by delivering services. Their incentive is, therefore, to maximize service levels, which is antithetical to minimizing costs. "Even a lawyer who aims to provide only worthwhile defense efforts can subconsciously resolve doubts in favor of doing more, and so earning more."[7]

Consultation, even without an approval requirement, tends to restrain inefficient efforts:

> The lawyer's evaluation is sharpened by responding to the adjuster's comments and questions. Consultation also allows the claims staff to consider with counsel whether the effort proposed could safely be postponed, particularly when there is still a possibility of settlement.[8]

In short, consultation is valuable to the insurer and cannot be prejudicial to the policyholder (as long as any confidential information bearing on coverage is withheld from the insurer, as all agree it must be). Moreover, "[t]o the extent that such consultation avoids unnecessary discovery or motion practice, it also benefits the judicial system."[9]

The Restatement of the Law of Liability Insurance provide such a right to consultation by stating that, when the insured has an independent defense, "[t]he insurer has the right to associate

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Jacob v. W. Bend Mut. Ins. Co., 203 Wis. 2d 524, 536 (Ct. App. 1996) (explaining that unless the insurer is willing to accept coverage, it has no authority to affect independent counsel's defense of the insured).

[5] Kent D. Syverud, *The Ethics of Insurer Litigation Management Guidelines and Legal Audits*, 21 No. 7 INS. LITIG. REP. 180, 188 (1999).

[6] Douglas R. Richmond, *Independent Counsel in Insurance*, 48 SAN DIEGO L. REV. 857, 890–91 (2011).

[7] Opinion of Geoffrey C. Hazard, Jr., 15, *In re* Ugrin, Alexander, Zadick & Higgins, P.C., 299 Mont. 321 (2000) ("Hazard Op.").

[8] Hazard Op. 15; see Hazard Op. at 15–17 (expanding on the point)

[9] Hazard Op. at 4.

in the defense of the legal action,"[10] just as an excess insurer or other nondefending insurer would have.[11]

Even in a case which most severely restricted the insurer's use of prior approval requirements, it was conceded that requirements of advance consultation are permissible. At oral argument, Justice Gray had the following exchange with one of Petitioners' counsel, Robert James:

> *Mr. James:* Rule 1.8 is fairly straight forward. A lawyer shall not accept compensation for representing a client from one other than the client unless there is no interference with the lawyers independence of professional judgment. Rule 5.4 is very similar. It essentially says the same thing. 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. When the billing rules say that we need pre-approval to hire experts to conduct research to file a motion, to file pleadings, to engage in trial preparation or to decide how to staff a case we simply can't agree to do so. Why? Our position is that the plain and ordinary meaning of these ethical rules prohibit us from allowing an insurance company from directing and regulating our judgment to do so. It's just that simple.
>
> *Justice Gray:* Counsel, if the billing rules said "consult" instead of "approve," would they still violate the rules?
>
> *Mr. James:* No, I think that we consult with the insurance company all the time with insurance adjusters and tell them here's what we think should be done so I think that one of the things that the insurance companies can expect defense counsel to do is to consult with them and find out what our thinking is, why we are thinking [that] and in many cases an adjuster may say let me question you about that. Maybe this isn't a good thing at this particular time and maybe you will agree or maybe you will disagree.[12]

Advance consultation on substantial expenses may also lead the insurer to settle to avoid that cost or to withdraw its reservation of rights to regain control of the defense. Either of these results would be beneficial to the policyholder.

Were the insurer unaware that independent counsel was representing only the insured, the provision of legal advice to the insurer could result in creation of an attorney-client relationship not intended by the lawyer[13] (and creating the very conflicts that the counsel's independence was intended to avoid). But that could occur only if the insurer had a reasonable belief that the lawyer

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[10] RESTATEMENT OF THE LAW OF LIABILITY INSURANCE § 17(4) (Tent. Dr. No. 1 April 11, 2016).

[11] *See* RESTATEMENT § 23(1)(b) (right to associate includes "[a]reasonable opportunity to be consulted regarding major decisions in the defense of the action that is consistent with the insurer's level of engagement with the defense of the action").

[12] Transcribed from tape of argument.

[13] RESTATEMENT (THIRD) OF THE LAW GOVERNING LAWYERS § 14 (2000).

was acting on its behalf, and the process by which independent counsel was retained ordinarily should negate any such expectation.[14] Any communication or consultation between independent counsel and the insurer is purely informational.[15] If there is any doubt about the lawyer's relationship with the insurer, the lawyer should clarify that the insurer is not a client. And, in some jurisdictions, the fact that the lawyer is independent counsel will automatically preclude existence of any attorney-client relationship with the insurer, without regard to the insurer's belief.[16]

[2] Insurers Are Entitled To Challenge Defense Expenditures and Activities That They Regard as Inappropriate and To Withhold Payment for Costs and Services They Have Not Approved

Even where there is a conflict of interest, an insurance policy is not a blank check, requiring payment by the insurer for whatever work defense counsel chooses to do. An insurer is entitled not to pay for services that are overpriced or inappropriate to the case.[17] The provider of services is not the sole judge of their necessity.[18] Insurers must also be able to review all legal

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[14] *See*

CA—
Mosier v. S. Cal. Physicians Ins. Exch., 63 Cal. App. 4th 1022, 1043 (1998) (quoting First Pac. Networks, Inc. v. Atl. Mut. Ins. Co., 163 F.R.D. 574, 579 (N.D. Cal. 1995)).
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CA—
63 Cal. App. 4th at 1043 (quoting First Pac. Networks, Inc. v. Atl. Mut. Ins. Co., 163 F.R.D. 574, 579 (N.D. Cal. 1995)).

See

US/WA—
Bell Lavalin, Inc. v. Simcoe & Erie Gen. Ins. Co., 61 F.3d 742, 748 (9th Cir. 1995) (status reports and confidential information about defense provided by independent counsel do not create any duty of loyalty to insurer).
16

OH—
Swiss Reinsurance Am. Corp. v. Roetzel & Andress, 163 Ohio App. 3d 336, at 1525 (2005) (concluding that conflict of interest precluded existence of attorney-client relationship between insurer and lawyer that it hired to defend insured).
[17] *See, e.g.,*

CA—
Center Found. v. Chicago Ins. Co., 227 Cal. App. 3d 547 (1991) (challenge to fees of Cumis counsel upheld in case where conflict of interest divests insurer of right to control defense); *see also* Caiafa Prof'l Law Corp. v. State Farm Fire & Cas. Co., 15 Cal. App. 4th 800 (1993) (same).
18

bills, including those submitted by independent counsel, to protect against fraud. For example, they must be able to determine that all services billed were actually performed, that lawyers are not turning expense items into profit centers by tacking surcharges onto them, etc.

So, sooner or later, a representative of the insurer must decide whether particular services are appropriate and should be paid for. A preapproval requirement simply requires that question to be addressed before the services are rendered instead of afterwards.

In other words, the insurer is entitled to challenge defense activities and expenditures it regards as excessive or inappropriate, and do so before they are executed, to the point of warning that it will not voluntarily pay for them. Accordingly, even where the policyholder is represented by independent counsel, insurers are still "entitled to apply billing Guidelines for purposes of obtaining the most effective, professional and efficient defense possible for their insureds."[19] But, while an insurer is entitled to some time to review and evaluate independent counsel bills that it is asked to pay, unreasonable delay in doing so can constitute a breach of the duty to defend.[19.1]

Of course, the insurer's refusal to pay does not end the matter. The policyholder can direct counsel to execute the disputed recommendations for expenses or activities, and counsel will be obliged to do so. Either before or after that is done, the policyholder or counsel can seek to collect from the insurer for those expenses or services. If a court or arbitrator finds the expenses or services appropriate, the insurer will have to pay.[20] Otherwise, the policyholder will have to pay, unless the inappropriateness of the expenses or services prevents counsel from collecting from anyone.

In short, neither party may sit as judge in its own case. If disputes cannot be compromised, they must be submitted to an outside adjudicator. Both sides must take account of the likely rulings of such an adjudicator on the facts presented, and disputes are unlikely to be pressed unless the parties have very different predictions about such a ruling.

CA—
Sarchett v. Blue Shield, 43 Cal. 3d 1, 8–10 (1987) (medical insurance, requiring payment for all "necessary" services; collecting cases from other jurisdictions).

[19] Kent D. Syverud, *The Ethics of Insurer Litigation Management Guidelines and Legal Audits*, 21 No. 7 INS. LITIG. REP. 180, 187 (1999); *accord* Opinion of Geoffrey C. Hazard, Jr., 3–4, *In re* Ugrin, Alexander, Zadick & Higgins, P.C., 299 Mont. 321 (2000);

CA—
Pepsi-Cola Metro. Bottling Co. v. Ins Co. of N. Am., 2010 U.S. Dist. LEXIS 144401, at *32-34 (C.D. Cal. Dec. 28, 2010) (reduction of payments in accordance with billing guidelines was a premissible method of disputing reasonableness of fees).

[19.1] **CA—**2010 U.S. Dist. LEXIS 144401, at *21–22.

[20]

CA—
A California statute provides for mandatory arbitration of fee disputes with independent counsel. CAL. CIV. CODE § 2860(c). If the policyholder contends that the insurer has breached the policy or acted in bad faith by prolonged delay in responding to the tender of defense, that dispute should be resolved by the court before compelling arbitration of the dispute about the amount of the fees. Janopaul Block Cos. v. Super. Ct., 200 Cal. App. 4th 1239, 1249–51 (2011).

Outright refusal to pay has significant risks for the insurer. If held to be incorrect, it may be deemed a breach of the duty to defend, freeing the policyholder from policy restrictions on refusal to settle and, in some jurisdictions, even subjecting the insurer to an estoppel to assert coverage defenses.[21] However, a California court has treated payment of independent counsel fees as a form of first-party benefit, meaning that an insurer is not subject to any extracontractual liability for withholding payment of amounts subject to a bona fide dispute.[22] To avoid these risks, an insurer may wish to advance the disputed funds, while reserving the right to seek to recoup them.[23] But the ability to recoup may be problematic where the policyholder is impecunious, and counsel may have defenses to recoupment not available to the policyholder. If recoupment is to be sought, the insurer should either (1) obtain an agreement that the advances will be returned if the insurer prevails in later litigation or (2) seek prompt adjudication of the propriety of the expenses or services in question. Failure to do one or the other may prevent recoupment even if the expenses or services might be found beyond the insurer's obligations to pay.

The Restatement of the Law of Liability Insurance provides that:

> In the event of a dispute during the course of the defense about the reasonableness of fees, either party should have the option of paying counsel under protest the difference between what the parties contend to be a reasonable fee, and counsel should have the option of receiving under protest what it regards as only a partial payment, and thereby defer the resolution of the reasonableness of the fees until after the duty to defend has ended and any coverage defenses have been adjudicated or settled, so as not to invade the attorney-client privilege or work-product immunity. [24]

Nothing in this alternate procedure regarding payment is inconsistent with a right to advance review of proposed defensive actions and to give notice if the insurer intends to dispute fees incurred to take what it regards as unnecessary or inefficient defensive actions.

Apart from the possibility of freeing the policyholder to settle, an unreasonable refusal to pay could be the basis of a bad faith claim, as defense costs are a form of first-party benefit.[25]

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[21] *See* 3 Jeffrey E. Thomas & Francis J. Mootz, III, NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION §§ 16.03[3][g][iii], 17.02, 20.04[2][b].

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CA—
Behnke v. State Farm Gen. Ins. Co., 196 Cal. App. 4th 1443, 1470 (2011).

[23]

CA—
Buss v. Super. Ct., 16 Cal. 4th 35, 52 (1997).

See also William T. Barker & Ronald D. Kent, NEW APPLEMAN INSURANCE BAD FAITH LITIGATION, SECOND EDITION, § 2.11.

[24] RESTATEMENT OF THE LAW OF LIABILITY INSURANCE § 17, cmt. *b* (Tent. Dr. No. 1 April 11, 2016).

[25] *E.g.*:

[3] The Montana Supreme Court's Rejection of Prior Approval Requirements Is Unlikely to Be Applied in an Independent Counsel Context

The Montana Supreme Court has held that any requirement of prior approval impermissibly interferes with a lawyer's obligation to exercise independent judgment on behalf of the policyholder.[26] The decision was rendered with respect to ordinary defense counsel, and the concern that motivated it does not justify an extension of the holding to representations in which independent counsel represent policyholders. This is so because independent counsel recommend options to policyholders and follow policyholders' instructions. They do not follow insurers' instructions and, therefore, are not subject to insurers' prior approval. They may learn that an insurer will not willingly pay for a defense-related service they believe should be employed, but they are nonetheless entirely free to recommend the service to the policyholder, to perform it at the policyholder's request, to bill for it, and to help the policyholder sue for reimbursement. Independent counsel thus stands in the same position as any other lawyer whose client has arguable contractual rights against another party which the latter disputes.

The propriety of this conclusion is reinforced by the similarity of the procedure to that approved by the ABA Standing Committee on Ethics for cases in which counsel is not independent.[27] Its Opinion 01-421 assumes that the insurer has directed the lawyer to proceed in a particular way, rather than merely declining to pay for services the lawyer has recommended. Because actual direction of the lawyer creates no insurmountable problem, a mere threat to withhold payment can hardly do so.

Much of the ABA Opinion addresses what the policyholder must be told about a representation in which the insurer expects to exercise a power to direct counsel. No such

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US/CA—
Tibbs v. Great Am. Ins. Co., 755 F.2d 1370 (9th Cir. 1985);

CA—
Continental Casualty Co. v. Royal Ins. Co., 219 Cal. App. 3d 111 (1990);

ND—
Smith v. Am. Family Mut. Ins. Co., 294 N.W.2d 751 (N.D. 1980).

See also William T. Barker & Ronald D. Kent, NEW APPLEMAN INSURANCE BAD FAITH LITIGATION, SECOND EDITION, § 3.08[3].

26

MT—
In re Ugrin, Alexander, Zadick & Higgins, P.C., 299 Mont. 321 (2000).

See also discussion in § 14.03[1], above.

[27] The procedures approved in ABA Opinion 01-421 for handling particular conflicts in insurance defense representations appear to have been first recommended in Ellen S. Pryor & Charles Silver, *Defense Lawyers' Professional Responsibilities: Part I-Excess Exposure Cases*, 78 TEX. L. REV. 599, 644 (2000). But those procedures are logically implied by the conflicts rules applicable to all representations involving duties to multiple persons.

requirements apply to an independent counsel representation, so they need not be discussed here.

If counsel believes that some insurer decision poses a substantial risk to the policyholder, counsel should point that out to the insurer and request reconsideration. If the insurer will not reconsider, then counsel must inform the policyholder, fully describe the risks and benefits, and inquire whether the policyholder will consent to having counsel proceed on the basis the insurer requests. The Tennessee Bar describes such a consultation as follows:

> Counsel should describe the decision and its risks and benefits from the standpoint of the insured. Of course, these will include whatever risks to the insured that counsel believes might result from the compliance. But objection to the insurer's directive would also have risks and therefore, where appropriate, counsel should point out that the insurer might take the position that any unjustified refusal to permit counsel to follow its direction would breach the insurance contract. If the insurer were correct in so contending[,] an objection would endanger the insured's coverage. On the other hand, if the insured permits counsel to follow the insurer's directive, the insured could also reserve the right to hold the insurer responsible for any resulting damage to the insured. (The insurer would be liable if the directive were found to breach its duties under the insurance policy.) The insured should be advised of the utility of obtaining independent counsel, at the insured's own expense, in considering whether to acquiesce in the insurer's directive (perhaps under protest). If the insured acquiesces, after being properly advised, counsel may comply with the insurer's directive.[28]

If the policyholder gives informed consent (perhaps coupled with a declaration of intent to hold the insurer responsible for any resulting injury), then counsel may comply with the insurer's direction. If the policyholder refuses to consent, then counsel cannot proceed in the way the insurer requests. If the insurer will not rescind the disputed decision, counsel must then withdraw. (A request to withdraw will necessarily involve the court, which may resolve any dispute between insurer and policyholder.)

In an independent counsel situation, there will be no possible need for withdrawal and no need to get the insurer's consent for proposed activities or expenses. The lawyer and the policyholder need only discuss whether to assume the risk of nonpayment and the burden of litigating for payment. If the policyholder is willing to advance the necessary funds or if the lawyer is willing to extend credit (possibly on a nonrecourse basis), they may proceed and pursue the insurer later. In the meantime, the insurer remains obligated to continue funding agreed expenses and activities.

While the Montana Supreme Court presumably would reject the ABA analysis, its opinion

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TN—
TENN. BD. OF PROF'L RESP., Formal Ethics Op. 2000-F-145, at 3.

is both distinguishable when the problem is presented in an independent counsel context and should be rejected by other courts even where it is not distinguishable. (See § 11.04, above.)

[4] An Insurer Is Entitled to Pay No More Than Market Rates for the Type and Quality of Service Reasonably Necessary to the Defense of the Case

In a few states, statutes regulate the fees that insurers must pay independent counsel. Thus, in California,

> [t]he insurer's obligation to pay fees to the independent counsel selected by the insured is limited 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 arose or is being defended … .[29]

Absent such a statute, lawyers are still limited to charging fees permissible under the applicable Rules of Professional Conduct. Most such rules are based on ABA Model Rule 1.5:

> (a) A lawyer shall not make an agreement for, charge, or collect an unreasonable fee or an unreasonable amount for expenses. The factors to be considered in determining the reasonableness of a fee include the following:

(1) the time and labor required, the novelty and difficulty of the questions involved, and the skill requisite to perform the legal service properly;

(2) the likelihood, if apparent to the client, that the acceptance of the particular employment will preclude other employment by the lawyer;

(3) the fee customarily charged in the locality for similar legal services;

(4) the amount involved and the results obtained;

(5) the time limitations imposed by the client or by the circumstances;

(6) the nature and length of the professional relationship with the client;

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CA—
CAL. CIV. CODE § 2860(c).

See also

AK—
ALASKA STAT. § 21.96.100(d) (similar provision).

(7) the experience, reputation, and ability of the lawyer or lawyers performing the services; and

(8) whether the fee is fixed or contingent.[30]

In addition to the limits imposed by the Rules of Professional Conduct, the insurer has a right to have the insured make the selection in accordance with the contractual duty of good faith and fair dealing. As explained in *Center Foundation v. Chicago Insurance Co.*:[31]

> the duty of good faith imposed upon an insured includes the obligation to act reasonably in selecting as independent counsel an attorney qualified to present a meaningful defense and willing to engage in ethical billing practices at a standard stricter than that of the marketplace. Conduct arguably acceptable in the ordinary attorney-client relationship where the latter pays the former from his own pocket is not necessarily appropriate in the tripartite context created when independent counsel undertakes to represent the insured at the expense of the insurer.

Insurers are likely to argue that a reasonable fee for defense services is established by the rates charged by lawyers from whom the insurers regularly purchase similar services. In their view, the cost of defending the insured ought not to be increased by the fortuitous existence of circumstances entitling the insured to independent counsel.

But lawyers not regularly retained by the insurer obliged to pay for independent counsel may resist accepting payment at the rates that the insurer normally pays for similar services. Insurers are able to provide their regular counsel with a volume of work warranting a significant discount in the rates charged for that work. Independent counsel do not receive a similar volume of work. If they have adequate business at rates not affected by such a discount, they have no incentive to accept the discounted rates charged by firms the insurer regularly retains.

If the insurer were obliged to pay no more than its customary discounted rates, a policyholder seeking independent counsel might find it necessary to supplement the insurer's payments to obtain comparable counsel or accept the services of less able (and therefore less expensive) counsel than would normally be retained for the particular case. Accordingly, policyholders would argue that the insurer's customary discounted rates are not adequate or reasonable for independent counsel.

One argument sometimes made in support of limiting the insurer's obligation to payment of its customary rates is that providing a defense by independent counsel is a form of substitute performance where a conflict of interest has rendered the performance contemplated by the contract partially impracticable.[32] One commentator summarizes this argument as follows:

> because the conflict does not excuse the insurer's duty to defend, the doctrine of substitute performance should be understood to

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[30] MODEL RULES OF PROF'L COND., Rule 1.5(a) (2011).

[31] Center Foundation v. Chicago Insurance Co., 278 Cal. Rptr. 13, 21 (Cal. Ct. App. 1991).

[32] *See* RESTATEMENT (SECOND) OF CONTRACTS § 270 (1981).

> effectuate the terms of the contract, i.e., the insurance policy, without conferring an advantage on either party. "Substitute performance" should therefore be a minimal variation from the performance originally contemplated. This approach is said to track courts' general recognition that a party injured by a contract breach should receive the benefit of its bargain but never a windfall.
>
> Continuing, substitute performance advocates theorize that courts that allow an insured to select defense counsel and control the defense because of a conflict of interest rendering the insurer's duty to defend impractical are supplying a substitute for the carrier's performance so as to preserve the carrier's remaining contractual obligations. As a substitute for the carrier's duty to defend, it follows that the alternative performance must conform to the original. The insured's defense should not be funded at a level substantially lower than the defense the carrier otherwise would have provided so that the insured receives the benefit of its bargain, but nor should the insured's defense costs substantially exceed those which the carrier would have paid were it in control lest the insured be unjustly enriched. Therefore, the carrier cannot be obligated to pay independent counsel hourly rates greater than those it would pay panel counsel.[33]

This argument has a number of flaws. Most fundamentally, the doctrine of impracticability applies to excuse performance only where "a party's performance is made impracticable without his fault by the occurrence of an event the non-occurrence of which was a basic assumption on which the contract was made."[34] Nonoccurrence of a conflict of interest can hardly have been a basic assumption by the insurer: existence of conflicts in a significant number of cases and the need to provide a defense despite them is well known to insurers. Moreover, increased expense in performance generally is not considered to render performance even partially impracticable.[35] An insurer drafts the policy, and it could contractually specify limits on

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[33] Douglas R. Richmond, *A Professional Responsibility Perspective on Independent Counsel in Insurance,* 33 No. 1 INSURANCE LITIGATION REPORTER 5, 9 (2011).
[34] RESTATEMENT (SECOND) OF CONTRACTS § 261.
[35] Allan Farnsworth, CONTRACTS § 9.6, at 646 (3d ed. 1999).

See, e.g.:

US—
Carabetta Enters., Inc. v. United States, 482 F.3d 1360, 1366 (Fed. Cir. 2007) (finding that increased cost of performance did not make government agency's performance impracticable);

DC—
East Capitol View Cmty. Dev. Corp. v. Denean, 941 A.2d 1036 (D.C. 2008) (noting the rule).

But see

the rates payable to independent counsel. If the insurer has failed to include such language, it can hardly claim surprise when it is called upon to pay more than its customary rates to retain independent counsel appropriate to the case. And the insurer is still protected by the limitation of the fees payable to a reasonable amount.[36]

Putting the matter succinctly, "while the substitute performance approach is superficially appealing, it quickly unravels when closely scrutinized."[37]

The policy promises the policyholder an adequate and appropriate defense to any suit seeking any relief that, if established, would be covered.[38] This is promised at no cost to the policyholder. To fulfill this promise, the insurer must be obliged to pay independent counsel fees equal to "the prevailing market rates in the relevant community" for the type and quality of services reasonably necessary for the defense of the particular lawsuit.[39] The market rate will

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CA—
Habitat Trust for Wildlife, Inc. v. City of Rancho Cucamonga, 175 Cal. App. 4th 1306, 1341 (2009) (excessive and unreasonable expense may render performance impracticable).
[36] *See*

IL—
Mobil Oil Corp. v. Md. Cas. Co., 288 Ill. App. 3d 743, 759 (1997) (approving rate of $150/hour for independent counsel, even though insurer only paid its own, very experienced attorneys $94/hour).
[37] Douglas R. Richmond, *A Professional Responsibility Perspective on Independent Counsel in Insurance*, 33 No. 1 INS. LITIG. REP. 5, 10 (2011).
[38] 3 Jeffrey E. Thomas & Francis J. Mootz, III, NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION § 17.01; William T. Barker & Ronald D. Kent, NEW APPLEMAN INSURANCE BAD FAITH LITIGATION, SECOND EDITION, § 3.02[1]–[4].
[39]

US—
Blum v. Stenson, 465 U.S. 886, 900 (1984) (statutory fees under 42 U.S.C. § 1988).

See

NJ—
Aquino v. State Farm Ins. Co., 349 N.J. Super. 402, 415–16 (App. Div. 2002) (trial court must determine reasonable hourly rate and consider necessity of the work done);

NY—
Prashker v.U.S. Guar. Co., 1 N.Y.2d 584, 593 (1956) (independent counsel entitled to a reasonable fee).

See also RESTATEMENT OF THE LAW OF LIABILITY INSURANCE § 17, cmt. *b* (Tent. Dr. No. 1 April 11, 2016) ("The reasonableness of defense fees in relation to the complexity of the claim and the risks at stake is a fact question. What the insurer usually pays lawyers to defend similar claims is relevant but not dispositive. Law firms regularly retained by an insurer commonly accept reduced rates in return for a good supply of business. A lawyer providing an independent defense should not be required to accept the rates paid to the insurer's regular defense lawyers, unless the lawyer so regularly accepts other business at those rates that they represent the reasonable value of his or her services. On the other hand, the lawyer's regular rates or

typically reflect the factors enumerated in Model Rule 1.5.

The market rate may or may not be the customary rate charged by the lawyer(s) the insured has chosen to retain, depending on whether it is appropriate to the case:

> not all cases are alike. The "novelty and difficulty" of a matter may be either factual or legal. A catastrophic injury, wrongful death, or professional liability case, for instance, is much different from a slip-and-fall or automobile case involving minor injuries. Insurers obligated to engage independent counsel chosen by an insured must acknowledge that the defense of difficult matters generally requires experienced and skilled lawyers and that such lawyers can command greater rates than lawyers who handle relatively minor or simple cases. Fortunately for all concerned, liability insurers, as professional litigants, understand this quite well. Most insurers factor the nature of a case into their defense assignments and they typically have strata of law firms on their panels. Thus, and by way of example, although Firms A and B on an insurer's panel may receive simple cases to defend at very low hourly rates, Firms C and D are assigned complex matters or large losses, and are compensated at higher hourly rates.[40]

If a policyholder chooses to use more capable attorneys than the case requires, the policyholder may have to pay the extra cost beyond what would be required for less capable, but adequate attorneys. And disputes regarding the required level of capability (and the corresponding reasonable rate) may need to be adjudicated. Pending adjudication, insurer, policyholder, and lawyers need to have some agreement on payment of fees as the litigation proceeds.

[5] An Insurer's Cost-Minimization Rights May Be Affected if It Breaches the Duty To Defend

[a] *Hartford Casualty Insurance Co. v. J.R. Marketing, L.L.C.*

[i] The Court of Appeal Decision

In *Hartford Casualty Insurance Co. v. J.R. Marketing, L.L.C.*,[41] a California court held that an insurer that had breached the duty to defend and had been required to pay its insured's independent counsel could not seek to recover from defense counsel the amount by which those

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amount of time spend on a matter may be excessive in relation to the complexity of the claim or the amount at stake in the matter.").

[40] Douglas R. Richmond, *Independent Counsel in Insurance*, 48 SAN DIEGO L. REV. 857, 885 (2011) (footnotes omitted).

[41]

CA—

Hartford Cas. Ins. Co. v. J.R. Marketing, L.L.C., 216 Cal. App. 4th 1444 (2013), *rev'd in part,* 61 Cal. 4th 988 (2015).

fees were allegedly excessive. The California Supreme Court granted review and reversed,[41.1] depriving the court of appeal opinion of precedential weight. The description of that opinion is retained to identify and illuminate issues not addressed by the supreme court and as background for the supreme court's decision.

Hartford issued policies to J.R. Marketing, L.L.C. and Noble Locks Enterprises, Inc. Certain suits were tendered to Hartford for defense. Hartford initially refused a defense, but (after the policyholders filed suit) ultimately provided a defense under reservation; it refused to provide independent counsel. The trial court held that Hartford was obliged to provide independent counsel. It ordered Hartford to pay bills within 30 days of receipt, subject to a right to seek recovery of allegedly excessive or unnecessary amounts after resolution of the underlying action. However, it also held that, because of its prior breaches of the duty to defend, Hartford could not invoke the limits on hourly rates imposed by § 2860 of the California Civil Code.[42] Squire Sanders was retained as independent counsel.

After the underlying matter was resolved, the policyholders submitted legal bills totalling over $15 million, which Hartford paid and then filed a new action seeking recovery of allegedly excessive charges and charges for allegedly unnecessary services. Squire Sanders demurred to the complaint, challenging Hartford's claimed right to recover allegedly unjust enrichment resulting from payment of the disputed charges, and the superior court sustained the demurrer. (It denied demurrers filed by the policyholders.)[43] The court of appeal affirmed.

Reiterating conclusions it had reached in a prior, unpublished decision, it first stated that the billing rate limitations and arbitration right provided by § 2860

> come with an important caveat. " '[T]o take advantage of the provisions of [section] 2860, an insurer must meet its duty to defend and accept tender of the insured's defense, subject to a reservation of rights.' " When, to the contrary, the insurer fails to meet its duty to defend and accept tender, the insurer forfeits the protections of section 2860, including its statutory limitations on independent counsel's fee rates and resolution of fee disputes. More generally, "[w]hen an insurer wrongfully refuses to defend, the insured is relieved of his or her obligation to allow the insurer to manage the litigation and may proceed in whatever manner is deemed appropriate."[44]

41.1 **CA—**Hartford Cas. Ins. Co. v. J.R. Marketing, L.L.C., 61 Cal. 4th 988 (2015).

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CA—
216 Cal. App. 4th at 1448–51.

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CA—
216 Cal. App. 4th at 1452.

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CA—
216 Cal. App. 4th at 1454–55 (citations omitted).

Because Hartford had refused the tender of defense, the court held that it was not entitled to the protections of § 2860.[45]

The court also recognized that Hartford had a right, after the underlying case was concluded to seek reimbursement of any defense expenditures solely allocable to noncovered claims.[46] However, that right is based on the law of unjust enrichment—a right that runs only against a party who has been unjustly enriched. In the court's view, the right to independent counsel

> "envisions an attorney pursuing an insured's defense independently of the insurer rather than intertwined with it." Thus, under this scheme, where, as here, the insurer breaches its duty to defend the insured, the insurer loses all right to control the defense, including, necessarily, the right to control financial decisions such as the rate paid to independent counsel or the cost-effectiveness of any particular defense tactic or approach. Retroactively imposing the insurer's choice of fee arrangement for the defense of the insured by means of a post-resolution quasi-contractual suit for reimbursement against the insured's separate counsel, such as Hartford seeks to pursue here against Squire, runs counter to these *Cumis*-scheme principles … .[47]

In addition to undercutting the policyholder's right to control the defense, allowing an independent suit against defense counsel would expand the insurer's dispute resolution rights as a result of its breach of its duty to defend. Had the breach not rendered § 2860 inapplicable, the insurer would be limited to proceeding in arbitration, and ought not to obtain the right to litigate as one fruit of its breach.[48] Moreover, Squire Sanders had not conferred a benefit primarily on Hartford, but rather on its (insured) clients. If they agreed to the payment of excessive or noncovered amounts, it is to them (rather than the law firm) that Hartford should look for reimbursement.[49]

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CA—
216 Cal. App. 4th at 1455.
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CA—
216 Cal. App. 4th at 1455, *following* Buss v. Superior Court, 16 Cal. 4th 35, 50 (1997).
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CA—
216 Cal. App. 4th at 1457–58 (citations and foonote omitted).
48 On this point, the opinion is a little schizophrenic: it had just correctly held the right to arbitrate to be a benefit to the carrier, which benefit was forfeited by breach of the duty to defend. Now it treats the right to litigate as a benefit which ought not to be acquired by breaching the duty to defend. More realistically, litigation is the inferior option remaining if the right to arbitrate has been lost.
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CA—

[ii] The Supreme Court Decision

The California Supreme Court narrowly defined the issue it had agreed to review:

> from whom may a CGL insurer seek reimbursement when (1) the insurer initially refused to defend its insured against a third party lawsuit; (2) compelled by a court order, the insurer subsequently provided independent counsel under a reservation of rights—so-called *Cumis* counsel—to defend its insured in the third party suit; (3) the court order required the insurer to pay all "reasonable and necessary defense costs," but expressly preserved the insurer's right to later challenge and recover payments for "unreasonable and unnecessary" charges by counsel; and (4) the insurer now alleges that independent counsel "padded" their bills by charging fees that were, in part, excessive, unreasonable, and unnecessary?[49.1]

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216 Cal. App. 4th at 1458–60.

[49.1] **CA—**61 Cal. 4th at 992 (citations omitted). The court identified three questions that it did not decide:

> the trial court's 2006 enforcement order, requiring Hartford to promptly pay *Cumis* counsel's bills, specified that Hartford "is … not permitted to take advantage of Section 2860." Nevertheless, the order stated that counsel's bills "still must be necessary and reasonable" and that, "[t]o the extent Hartford seeks to challenge fees and costs as unreasonable or unnecessary, *it may do so* by way of reimbursement after resolution of the [Marin County action]." (Italics added.) In light of the 2006 enforcement order's express provision authorizing Hartford to seek reimbursement for excessive fees, we need not and do not decide here whether, absent such an order, an insurer that breaches its defense obligations has *any* right to recover excessive fees it paid *Cumis* counsel.
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> Next, section 2860 specifies that disputes concerning the fees charged by *Cumis* counsel are to be resolved by final and binding arbitration. In contrast, the 2006 enforcement order provided that any dispute over allegedly excessive fees would be addressed in a court action. Because the 2006 enforcement order is final and not subject to our review, and because Squire Sanders has raised no issue about the effect of section 2860's arbitration provision on the current litigation, we do not decide whether, in general, a dispute over allegedly excessive fees is more appropriately decided through a court action or an arbitration.
>
> Finally, because the 2006 enforcement order expressly stated that resolution of any fee dispute would take place *after* the underlying litigation concluded, we do not decide *when* such fee disputes generally ought to be decided relative to the underlying litigation. [61 Cal. 4th at 997 n.7]

It summarized its conclusion as follows:

> We conclude that under the circumstances of this case, the insurer may seek reimbursement directly from *Cumis* counsel. If *Cumis* counsel, operating under a court order that expressly provided that the insurer would be able to recover payments of excessive fees, sought and received from the insurer payment for time and costs that were fraudulent, or were otherwise manifestly and objectively useless and wasteful when incurred, *Cumis* counsel have been unjustly enriched at the insurer's expense. *Cumis* counsel provide no convincing reason why they should be absolutely immune from liability for enriching themselves in this fashion. Alternatively, *Cumis* counsel fail to persuade that any financial responsibility for their excessive billing should fall first on their own clients—insureds who paid to receive a defense of potentially covered claims, not to face additional rounds of litigation and possible monetary exposure for the acts of their lawyers.[49.2]

The court reasoned that if

> Squire Sanders's bills were objectively unreasonable and unnecessary to the insured's defense in the underlying litigation and that they were not incurred for the benefit of the insured, principles of restitution and unjust enrichment dictate that Squire Sanders should be directly responsible for reimbursing Hartford for counsel's excessive legal bills.[49.3]

Squire Sanders argued that it was only an incidental beneficiary of Hartford's performance of a preexisting contractual obligation. But Hartford did not simply perform its contractual obligation. That obligation was limited both by the 2006 enforcement order and by the rules of professional conduct to payment of reasonable costs. Nor did Hartford voluntarily pay the amounts billed, but did so under compulsion of court order. These facts negated any claim that any benefit to Squire Sanders was incidental.[49.4]

Squire Sanders also urged that allowing a claim for restitution against defense counsel would frustrate public policy by unduly interfering with the insured's attorney-client privilege and its absolute right to direct independent counsel's defense. The court again disagreed: "Although *Cumis* counsel must indeed retain the necessary independence to make reasonable choices when representing their clients, such independence is not inconsistent with an obligation of counsel to justify their fees."[49.5] Moreover, the governing statute specifically requires *Cumis* counsel to justify their fees, albeit in arbitration, rather than litigation.[49.6] Squire Sanders argued

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[49.2] **CA—**61 Cal. 4th at 992–93.
[49.3] **CA—**61 Cal. 4th at 999.
[49.4] **CA—**61 Cal. 4th at 1000–01.
[49.5] **CA—**61 Cal. 4th at 1002.
[49.6] **CA—**61 Cal. 4th at 1002–03.

that the arbitration process was "more collaborative," but the court noted there is an inherent degree of tension in any dispute resolution process and concluded that it "fail[ed] to see how the degree of tension in the relationship between Hartford and the insureds in this case—even if purportedly higher than in cases where section 2860 is triggered—meaningfully heightens any threat to *Cumis* counsel's independence."[49.7]

Squire Sanders also contended that section 2860 arbitration was less disruptive

> because it provides for contemporaneous resolution of fee disputes as they arise during the course of the underlying lawsuit against the insureds. Squire Sanders asserts that contemporaneous proceedings intrude less on counsel's independence than after-the-fact litigation, because a contemporaneous proceeding provides "real-time guidance to counsel about which activities [they] may undertake," without raising the concern that counsel will "hav[e] the rug pulled out from under [them] years after the fact by the insurer."[49.8]

The court found this point "speculative at best."[49.9] The statute does not dictate timing, and defense counsel might prefer to delay addressing billing issues, "insofar as this would allow counsel to devote their full attention to the insureds' defense while the third party suit is in progress, rather than becoming embroiled in side arguments with the insurer over fees."[49.10] But there was no need to resolve timing issues, because those were dictated here by the enforcement order, drafted by Squire Sanders and upheld on a prior appeal.[49.11]

Squire Sanders argued that the insured had exclusive authority to monitor and control counsel's expenditures and that it should bear the responsibility for any failure to do so, subject to a right of indemnity from counsel, The court rejected this argument because it

> all but ignores the realities of cases like the one before us. Squire Sanders acknowledges that the insureds in this case were not sophisticated, frequent litigators accustomed to monitoring their counsel's day-to-day litigation decisions. Having contracted with Hartford, and having paid premiums, to be spared the fees and expenses of their defense, there is no indication that the insureds had reasonable cause to expect that they would nonetheless face exposure if Squire Sanders submitted unreasonable and excessive bills to Hartford. Nor is there any indication the insureds expected that they would have to mount and finance a separate litigation against their own counsel in order to have any hope of recovering the funds they were ordered to pay to the insurer as a result of counsel's unreasonable billing. Such a circuitous, complex, and expensive procedure serves neither

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[49.7] **CA—**61 Cal. 4th at 1004.
[49.8] **CA—**61 Cal. 4th at 1004.
[49.9] **CA—**61 Cal. 4th at 1004.
[49.10] **CA—**61 Cal. 4th at 1004.
[49.11] **CA—**61 Cal. 4th at 1004.

> fairness nor any other policy interest. We see no persuasive ground to hold that any direct liability to Hartford for bill padding by Squire Sanders must fall solely on the insureds.[49.12]

Squire Sanders also expressed the fear that if its client refused to waive attorney-client privilege, it might be unable to defend against Hartford's claim for fees. But there was no concrete indication that this would be necessary and, in any event,

> an objective assessment of the litigation as a whole to determine whether counsel's bills appear fundamentally reasonable is unlikely to involve an examination of individual attorney-client communications or the minute details of every litigation decision. If privileged information on these subjects is included in counsel's billing records, it can be redacted for purposes of assessing whether counsel's bills are reasonable. Trial courts are accustomed to dealing with claims of attorney-client privilege in a manner that balances the competing interests of the parties, and can thus presumably address any privilege issues that arise on a case-by-case basis.[49.13]

Justice Liu, in a concurring opinion, pointed out that there remained a significant issue as to the division of any liability to Hartford between Squire Sanders and J.R. Marketing. While the court assumed (in accordance with Hartford's allegations) that any unreasonable fees or unnecessary services conferred no benefit on J.R. Marketing, Squire Sanders was free to contest this assumption on remand. To the extent that any such fees or services were incurred for the benefit of J.R. Marketing,

> such fees necessarily fall outside the scope of today's holding. For that holding is premised on the dual assumptions "that Squire Sanders's bills *were* objectively unreasonable and unnecessary to the insured's defense in the underlying litigation *and* that they were not incurred for the benefit of the insured." On remand, it will be Hartford's burden to show not only that the fees it seeks to recover from Squire Sanders were not "*objectively reasonable at the time they were incurred*, under the circumstances then known to counsel" but also that the fees were not incurred for J.R. Marketing's benefit. If Squire Sanders's fees were unreasonable but incurred primarily for J.R. Marketing's benefit, Hartford's reimbursement action should lie against J.R. Marketing, not Squire Sanders.[49.14]

[iii] Analysis

Looking at the case solely in terms of the issue defined by the supreme court, the decision seems correct. If the fees were really so unreasonable that charging them would have been a violation of the California Rules of Professional Conduct, then Squire Sanders was unjustly

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[49.12] **CA—**61 Cal. 4th at 1005.

[49.13] **CA—**61 Cal. 4th at 1005–06 (citations omitted).

[49.14] **CA—**61 Cal. 4th at 1010 (concurring op.).

enriched to the extent that the fees exceeded the largest permissible charge. That would be equally true if the charges were "fraudulent" or the bills "padded" with clearly unnecessary work.

But an insurer's right to pay only reasonable charges is not merely a right not to pay amounts that counsel could not lawfully charge. It is a right to pay no more than the market rate for services reasonably necessary to the proper defense of the case. (See § 14.03[4], above.)

Insofar as the fees at stake were potentially lawful charges for services requested by or beneficial to J.R. Marketing, the court of appeal's result seems largely correct, though some of the court's reasoning is questionable. The policyholders presumably agreed to pay the rates charged by the law firm. By doing so, they incurred a valid debt to the law firm when it rendered service to them, even if adequate service could have been obtained from a less expensive firm, unless the rates were so exorbitant that it was unethical to charge them. Thus, at least with respect to the rates charged, the law firm was not unjustly enriched by Hartford's payment.

The Restatement (Third) of Restitution and Unjust Enrichment provides that "[e]ven if the claimant has conferred a benefit that results in the unjust enrichment of the recipient when viewed in isolation, the recipient may defend by showing that some or all of the benefit conferred did not unjustly enrich the recipient when the challenged transaction is viewed in the context of the parties' further obligations to each other."[50] An illustration of that rule is that

> A owes B $ 5,000. Intending to pay C, another creditor, A sends $ 5,000 to B who accepts the payment despite notice of A's mistake. (B's notice of A's mistake means that B is not entitled to defend as a bona fide payee by the rule of § 67.) A has a prima facie claim to restitution of the mistaken payment (§ 6), but B is not unjustly enriched by A's unintended payment of a valid debt. B is not liable to A in restitution.[51]

While the payment to the law firm in this case was compelled (by the order to pay), the law firm was still not, as to the rates charged, unjustly enriched. Even as to possibly unnecessary work, if the policyholders approved it, it also might have created a valid debt of the policyholder, precluding unjust enrichment of the law firm. While a more refined analysis would have been desirable, the result seems at least approximately correct.

Insofar as the court of appeal's reasoning suggests that the policyholders had unfettered freedom to approve law firm rates or the cost-effectiveness of particular work, that is inconsistent with the policyholders' own duty of good faith, as discussed in § 14.03[4] above. The duty of good faith is not dependent on the other party's performance of its own contractual obligations.[52] Even if the carrier has breached the duty to defend, the policyholder is obliged to reasonably manage defense costs. The policyholder alone is liable for any excessive amounts it agreed to pay and it would be unjustly enriched if the carrier instead had been required to pay such amounts

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[50] RESTATEMENT (THIRD) OF RESTITUTION & UNJUST ENRICHMENT § 62 (2011).

[51] RESTATEMENT (THIRD) OF RESTITUTION & UNJUST ENRICHMENT § 62, Illus. 2.

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CA—
Gruenberg v. Aetna Ins. Co, 9 Cal. 3d 566, 578 (1973).

without reimbursement.

[b] *National Union Fire Insurance Co. v. Seagate Technology, Inc.*

National Union Fire Insurance Co. v. Seagate Technology, Inc.[53] was a high stakes dispute over application of the principle that an insurer that wrongfully denies coverage cannot rely on the limitation of independent counsel rates provided by Section 2860 of the California Civil Code. Seagate was sued in 2000 by Convolve, Inc. and the Massachusetts Institute of Technology for patent infringement. National Union and certain of its affiliates (collectively, AIG) insured Seagate. AIG initially refused the tender of defense, but began paying for independent counsel (at § 2860 rates) in 2003. In 2004, AIG sought a declaration that it had no duty to defend. In 2007, the district court ruled that a duty to defend had arisen on November 1, 2001, but terminated on July 18, 2007. Seagate appealed, but AIG withdrew the defense. In 2012, the Ninth Circuit held that the duty to defend had not terminated. As a result, the question arose whether AIG was required to pay the full rates charged by Seagate's counsel after it withdrew the defense, or only § 2860 rates. This was said to be a $20 million question.[54]

As the court saw it, everything turned on whether, after the ruling that the duty to defend had terminated, AIG had "wrongfully" withdrawn its defense.[55] The court relied on general principles regarding the finality of judgments:

> In the ordinary case, the duty to defend terminates upon a judicial determination that the insured does not have a potentially-covered claim. The decision granting summary judgment became such a judicial determination when judgment was entered under Rule 54(b). The entry of judgment created a final order with res judicata effect. It is a "basic proposition that all orders and judgments of courts must be complied with promptly. If a [defendant] believes that order is incorrect the remedy is to appeal, but, absent a stay, he must comply promptly with the order pending appeal."[56]

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US/CA—
Nat'l Union Fire Ins. Co. v. Seagate Tech., Inc., 2013 U.S. Dist. LEXIS 10502 (N.D. Cal. Jan. 25, 2013).
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US/CA—
2013 U.S. Dist. LEXIS 10502, at *2–4; Nat'l Union Fire Ins. Co. v. Seagate Tech., Inc., 2013 U.S. Dist. LEXIS 89242, at *3–5. Some of the issues in the case turned on the distinctions among the companies, but those can be disregarded for purposes of the point discussed here.
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US/CA—
2013 U.S. Dist. LEXIS 10502, at *13–14.
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US/CA—
2013 U.S. Dist. LEXIS 10502, at *5 (citations omitted).

Seagate had appealed but had not sought a stay. "As a result, NIU was entitled to the benefit of the (erroneous) ruling that there was no longer a duty to defend."[57] The court also found persuasive an unpublished Fourth Circuit opinion concluding that withdrawal of a defense in a similar situation was not unjustified under North Carolina law:

> "it would tip the balance too far in favor of the insured to hold that an insurer must wait for all appeals of a declaratory judgment (relieving it of a duty to defend) to be exhausted before removing its defense of the insured. The fact that the insurer provided a defense for the insured until the time the insurer received a declaratory judgment Order demonstrates to this Court that the insurer adhered to the spirit of the public policy requiring defense of insured persons."[58]

Following reversal, AIG's contractual responsibilities were "reinstated retroactively."[59] In the court's view, "During the pendency of the appeals, Seagate should have been aware that it was retaining expensive counsel at a risk to itself. If Seagate had wanted to change this calculus, it should have made a motion for stay pending appeal."[60]

Putting aside the issue of what effect should be given to the judgment, prior to its reversal, there is some equitable appeal to Seagate's position on the particular facts in that case. Had AIG continued to fund the defense, California law would have permitted it to reserve the right to recover amounts expended on a defense it was not obligated to provide.[61] Seagate was the rare insured who could be relied upon to reimburse a multimillion defense bill, should it be found that no defense was due. In that situation, the issue was only who should have to advance costs during the pendency of the appeal. But one cannot base a rule of law on the exceptional ability of one insured to provide reimbursement for benefits not due.

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US/CA—
2013 U.S. Dist. LEXIS 10502, at *5–6.
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US/CA—
2013 U.S. Dist. LEXIS 10502, at *7, *quoting* Auto-Owners Insurance Co. v. Potter, 242 F. App'x 94, 101 (4th Cir. 2007),
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US/CA—
2013 U.S. Dist. LEXIS 10502, at *7.
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US/CA—
2013 U.S. Dist. LEXIS 10502, at *14.
61

US/CA—
Buss v. Super. Ct., 16 Cal. 4th 35, 46–53 (1997).

This decision will surely be appealed, unless the parties settle. How it will fare on appeal is hard to predict.

§ 14.04 Ethical Obligations of Independent Counsel

[1] Overview

There is a vast amount of literature on the ethical obligations and problems of lawyers defending policyholders on behalf of insurers. There is a smaller, but still substantial amount of literature dealing with whether and when a policyholder is entitled to independent counsel. There is very little published writing addressing the ethical obligations and problems of lawyers serving as independent counsel for policyholders.[1] Of course, those duties include all of the usual duties of a lawyer retained by the policyholder to defend a suit. But independent counsel do have their own special ethical issues, which deserve our attention. Some of these issues, notably regarding fees and consultation with the insurer are addressed in § 14.03 above, with particular attention to the interaction of the lawyer's duties and the insurance law duties of the policyholder. Insurance law has a primary role in those issues, with lawyer duties a secondary consideration. This section addresses issues where lawyer duties come to the fore and insurance law plays a secondary role.

[2] Obtaining Informed Consent to the Representation

A key feature of independent counsel is that the lawyer is paid by the insurer, even though the policyholder is the lawyer's sole client. Such third-party payment implicates Model Rule 1.8(f):

> A lawyer shall not accept compensation for representing a client from one other than the client unless:
>
> (1) the client gives informed consent;
>
> (2) there is no interference with the lawyer's independence of professional judgment or with the client-lawyer relationship; and
>
> (3) information relating to representation of a client is protected as required by Rule 1.6.[2]

Looking first to the requirement of "informed consent," the Model Rules define that as "the agreement by a person to a proposed course of conduct after the lawyer has communicated adequate information and explanation about the material risks of and reasonably available alternatives to the proposed course of conduct."[3] (See also § 9.03, above.) It is not necessary to "inform a client … of facts or implications already known to the client … ; nevertheless, a lawyer who does not personally inform the client … assumes the risk that the client … is inadequately

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[1] The only substantial treatments known to us are James M. Fischer, *The Professional Obligations of* Cumis *Counsel Retained for the Policyholder but not Subject to Insurer Control*, 43 TORT TRIAL & INS. PRAC. L.J. 173 (2008), and Douglas R. Richmond, *A Professional Responsibility Perspective on Independent Counsel in Insurance*, 33 No. 1 INS. LITIG. REP. 5 (2011). Our own thinking on these issues has benefited from those articles.

[2] MODEL RULES OF PROF'L COND. Rule 1.8(f) (2011). *See also* Rule 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.").

[3] Model Rule 1.0(e).

informed and the consent is invalid."

Thus, while the process by which independent counsel was provided and selected will often have informed the policyholder about some aspects of independent counsel's representation, it is wise for independent counsel to discuss the terms of that representation and some of the problems it can present at the outset and to have that consent and the underlying advice confirmed in writing. Of particular importance are any facts which might raise questions as to counsel's independence of the insurer, such as representations of the insurer or its affiliates in other matters. (See § 6.05[15] above.) Such facts might cause the policyholder to look elsewhere for counsel, if the policyholder makes the selection, or to object to the insurer's selection, if the insurer makes the selection.

The policyholder should understand any significant limitations on the scope of the representation and some important aspects of the way in which the representation will be conducted. The policyholder should be informed of the extent to which the insurer will be consulted in defense planning and the general nature of the problems that can arise if the insurer disagrees with the defensive activities proposed by counsel. (See § 14.03[1]–[2] above.) This information could affect the ways in which the policyholder chooses to be involved in defense planning, even where no dispute has yet arisen. The policyholder should be informed of the arrangements with the insurer regarding payment of fees or the need to negotiate such arrangements, and of any possibility that the policyholder might have to pay or advance some portion of the fees. (See § 14.03[2]&[4] above.) The policyholder should be informed of the extent to which confidential information will be shared with or withheld from the insurer and of the problems that can arise from such sharing or withholding. (See §§ 14.03[1] above and 14.04[3] below.)

In an independent counsel situation, the insurer will have no right to control the defense, so counsel's independence of judgment would seem assured. But the fee arrangement (or any collateral relationship with the insurer) may provide incentives that could affect counsel's judgment. If so, these must be explained.

[3] Handling Confidential Information and Cooperation with Insurer

[a] Providing and Withholding Information

As in all representations, information relating to the representation must be kept confidential, as provided in Model Rule 1.6.[4] However, disclosure of such information may be impliedly authorized if useful to the representation, not injurious to the interests of the policyholder, and not forbidden by the policyholder. (See § 10.01, above (discussing confidentiality in representations by assigned counsel).)

Disclosure is useful to the representation if necessary to comply with the policyholder's duty of cooperation, thereby preserving the policyholder's coverage. (See § 14.03[1] above.) Even if disclosure may not be necessary to comply with the policyholder's duty of cooperation, it may be useful if it avoids a risk that the duty might be breached. Disclosure may also be useful if it will help persuade the insurer to take or authorize some action favored by the policyholder (such as settling the case).

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[4] MODEL RULES OF PROF'L COND. Rule 1.6 (ABA 2011).

Disclosure would be injurious to the policyholder's interests if it would assist the insurer in disputing coverage, so coverage sensitive information must be kept from the insurer unless the policyholder gives informed consent to disclosure.[5] (If defense counsel is not a coverage lawyer, it may be necessary to obtain coverage advice to determine what information is or is not coverage sensitive.) Disclosure may also be injurious to other interests of the policyholder, such as interests in reputation. And, of course, the policyholder may forbid disclosure of certain information even if not otherwise injurious to the policyholder.

If information to be withheld is not coverage sensitive, withholding it might breach the policyholder's duty of cooperation. The policyholder should be advised of this risk. If defense counsel is not able to evaluate that risk, the policyholder should be warned of it and advised to consult other counsel if evaluation is desired. (See § 9.02[5] & [7], above.)

[b] Avoiding Waiver and the Common Interest Rule

But counsel must also beware of the risk of waiving privilege for information communicated to the carrier. Voluntary disclosure of privileged information to a nonprivileged person can waive the privilege.[6] Because the carrier shares common interests with the policyholder in defeating or minimizing the claim, it might be thought that information could be shared without risk of waiver under a common interest arrangement.[7] But the exception to the waiver rule permitting sharing of information among persons of common interest has an additional requirement that is often overlooked: each party to the common-interest arrangement must be represented by a lawyer.

The rejected Federal Rule of Evidence 503 on attorney-client privilege formulated the common-interest rule as one permitting sharing between lawyers: the privilege extends to communications "by [the client] or his lawyer *to a lawyer representing another* in a matter of common interest."[8] While that rule never took effect, federal courts often look to it as a succinct statement of the common law that Rule 501 of the Federal Rules of Evidence makes authoritative in cases where federal law provides the rules of decision.[9] The Third Circuit has explained the basis and evolution of the rule:

> Recognizing that it is often preferable for co-defendants represented by different attorneys in criminal proceedings to coordinate their defense, courts developed the joint-defense

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Illinois law is exceptional on this issue, taking the view that the insurer and policyholder are persons of common interest on all aspects of a defense representation, even where there is a coverage dispute and the policyholder is represented by independent counsel. Waste Management, Inc. v. International Surplus Lines Ins. Co., 144 Ill. 2d 178, 194 (1991). Where this rule applies, the policyholder must be warned. As a practical matter, this results in an exception to what would otherwise be the applicable attorney-client privilege. Independent counsel subject to this rule should still not make disclosures of material damaging to the policyholder's interests without a court order to do so.

[6] RESTATEMENT (THIRD) OF THE LAW GOVERNING LAWYERS § 79 (2000).

[7] RESTATEMENT § 76.

[8] Rule 503(b)(3), reprinted in 3 Joseph M. Mclaughlin, WEINSTEIN'S FEDERAL EVIDENCE, SECOND EDITION § 503 (emphasis added).

[9] 3 Joseph M. McLaughlin, WEINSTEIN'S FEDERAL EVIDENCE, SECOND EDITION § 501.02[1][c].

> privilege. In its original form, it allowed the attorneys of criminal co-defendants to share confidential information about defense strategies without waiving the privilege as against third parties. Moreover, one co-defendant could not waive the privilege that attached to the shared information without the consent of all others. Later, courts replaced the joint-defense privilege, which only applied to criminal co-defendants, with a broader one that protects all communications shared within a proper "community of interest," whether the context be criminal or civil. Thus, the community-of-interest privilege allows attorneys representing different clients with similar legal interests to share information without having to disclose it to others. It applies in civil and criminal litigation, and even in purely transactional contexts.[10]

But, as implied by the statement in Rejected Rule 503, one noteworthy feature of the resulting rule is that "to be eligible for continued protection, the communication must be shared with the attorney of the member of the community of interest."[11] The Restatement's formulation of the common-interest rule also imposes this requirement: "If two or more clients with a common interest in a litigated or nonlitigated matter *are represented by separate lawyers* and they agree to exchange information concerning the matter, a communication of any such client that otherwise qualifies as privileged … that relates to the matter is privileged as against third persons."[12] As a result, "[a] person who is not represented by a lawyer and who is not himself or herself a lawyer cannot participate in a common-interest arrangement."[13]

In 2012, the Texas Supreme Court applied the requirement that each party have counsel to deny privilege in a case where counsel for a workers compensation carrier had shared reports to the carrier with the employer, who was interested because payments under the policy were subject to a deductible of $1 million per claim.[14] Under Texas law, the carrier alone was liable, and the employer was not a party to the proceeding.[15] There is no insurer-insured privilege, though communications between the two relating to liability insurance claims may sometimes be

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US—
Teleglobe Communs. Corp. v. BCE, Inc. (In re Teleglobe Communs. Corp.), 493 F.3d 345, 36364 (3rd Cir. 2007).

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US—
493 F.3d at 364.

12 RESTATEMENT (THIRD) OF THE LAW GOVERNING LAWYERS § 79 (2000) (emphasis added).

13 RESTATEMENT § 79, cmt. *d*.

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TX—
In re XL Specialty Ins. Co., 373 S.W.3d 46 (Tex. 2012).

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TX—
373 S.W.3d 46, 53–54.

covered by the attorney-client privilege.[16] Because the employer was not represented by counsel regarding the matter, the communications could not be protected from waiver by the common-interest exception (which the Texas court dubbed the "allied litigant doctrine)."[17] Nor was the employer a joint client.[18] Accordingly, disclosure to the employer had waived the privilege, making the disclosed communications available to the employee in a bad faith action against the carrier.

It would seem that the communications might still have been protected by the work product immunity. (See § 10.07[5], above.) But no argument based on that doctrine was made in the case. Unless that protection were available and adequate to prevent adverse effect on the policyholder, the resulting risk to privilege would have meant that independent counsel's duty of confidentiality would preclude sharing of privileged information unless the carrier were represented by counsel, through whom the information was shared.

The Restatement of the Law of Liability Insurance provides that, even in an independent counsel situation, "[t]he insured's provision of information to the liability insurer does not waive confidentiality of the information with respect to third parties."[19] It reasons that:

> The grounds for protecting confidentiality in the independent counsel context are identical to those in ordinary-duty-to-defend context. The conflict of interest that lies behind the independent counsel requirement does not eliminate the common interest of insurer and insured in defeating the third-party claim; it does not change the factthat the insurer serves as the insured's agent for purposes of settling; and it does not eliminate the need forthe insurer and insured to share confidential information in a manner that is protected from third parties.[20]

Notwithstanding the Restatement, the implication of the foregoing is that a carrier that wishes to receive privileged information from independent counsel may itself need to have counsel regarding the matter and conduct any sharing through counsel, lest a court take the view that sharing without such counsel waives the privilege.

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TX—
373 S.W.3d 46, 53–54.
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TX—
373 S.W.3d 46, 54.
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TX—
373 S.W.3d 46, 54–55.
[19] RESTATEMENT OF THE LAW OF LIABILITY INSURANCE § 17(5) (Tent. Dr. No. 1 April 11, 2016).
[20] RESTATEMENT § 17, cmt. *d* (citation omitted).

[c] Courts Ought Not To Confuse the Common Interest Rule with the Joint Client Rule

In *Maplewood Partners, L.P. v. Indian Harbor Insurance Co.*[21] the court treated a nondefending insurer as a co-client of the policyholder's defense counsel, thereby granting the insurer access to the policyholder's privileged and work product materials from the underlying litigation for use in the coverage litigation. The error of constructing an attorney-client relationship for that purpose is discussed in § 4.04[6], above. This section will contrast the court's handling of the waiver issue under the joint client rule with the treatment that should have been accorded under the common interest rule.

This was a coverage suit, in which Maplewood and related entities and individuals contended that Indian Harbor had paid less than was due for defense and indemnification of underlying suits. There were three of these, the "RRGC action," the "Slashy matter," and the "Green claim." Indian Harbor sought discovery of materials the Maplewood parties claimed were privileged. Indian Harbor argued that it had been a joint client, so that no privilege or immunity barred its access to the documents.[22] The court essentially agreed.[23]

The policy was a financial services liability policy, which did not impose a duty to defend, but did require the insurer to pay for defense expenses (along with damages, judgments, settlements, etc.) in excess of the $250,000 retention. Defense expenses could not be incurred without Indian Harbor's consent, and the policyholders agreed " 'to provide the Insurer with all information, assistance, and cooperation that the Insurer may reasonably request.' "[24]

Retention of defense counsel is not described, but it appears that they (two separate firms) were retained by the policyholders, as would be the norm under a duty to reimburse policy (in contrast to a duty to defend policy). In the RRGC action, defendants acted as a joint defense group. Defense counsel Miller communicated regularly with Indian Harbor, through the insurer's [monitoring] counsel. Miller provided assessments of liability, litigation updates, and settlement estimates, all pursuant to and consistent with the Policy's cooperation clause. Miller also prepared a litigation budget and a "Pre-trial Report" for Defendant, who paid for the preparation of the

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US/FL—
Maplewood Partners, L.P. v. Indian Harbor Ins. Co., 295 F.R.D. 550 (S.D. Fla. 2013).
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US/FL—
295 F.R.D. at 556–57.
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US/FL—
295 F.R.D. at 603–04. The opinion extensively analyzed confidentiality issues, and that discussion is addressed in § 14.04[3], below. The discussion here focuses solely on whether there was joint representation.
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US/FL—
295 F.R.D. at 557–58.

Report, which included an assessment of the financial and legal risks of the litigation.[25]

Miller told Indian Harbor's counsel that he was "'always happy to speak with [insurer's counsel] to answer any questions you may have [regarding potential liability and damages/value of the RRGC action].'"[26]

Throughout the RRGC action, the Maplewood parties treated their interests as aligned, never discussing any allocation of responsibility among themselves.[27] Indian Harbor was included in settlement discussions.[28] It consented to the settlement and contributed to it. But another insurer, Travelers, and some of the Maplewood parties paid all defense expenses. They and Travelers paid the bulk of the settlement.[29] The Maplewood parties now sought reimbursement for some of the defense expenses and settlement costs they paid.

In the Shashy matter, all of the Maplewood parties were represented by Miller. The claims were resolved in a mediation, at which Indian Harbor was present. The Maplewood parties now sought reimbursement of defense expenses.[30]

The Green claim originated as a counterclaim in the Shashy matter and was resolved by arbitration. The Maplewood parties now sought reimbursement of defense costs.[31]

The court concluded that all of the Maplewood parties were joint clients of Miller and his

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US/FL—
295 F.R.D. at 563–65 (footnotes omitted).
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US/FL—
295 F.R.D. at 565 n.54.
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US/FL—
295 F.R.D. at 565–66.
28

US/FL—
295 F.R.D. at 566.
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US/FL—
295 F.R.D. at 567–68.
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US/FL—
295 F.R.D. at 569.
31

US/FL—
295 F.R.D. at 569.

legal team, and then inquired whether Indian Harbor was also a client, observing that " '[a]s a general matter, no co-client is entitled to have a lawyer withhold material information from another. There is no reason to make insurance defense representations an exception to this rule.' "[32]

The court relied on the fact that defense counsel provided extensive confidential information to Indian Harbor's monitoring counsel, without ever seeking a waiver from the Maplewood parties permitting such disclosure.[33] It also relied on cases allowing policyholders to discover communications between the insurer and the defense counsel retained to defend the policyholders.[34]

The court recognized that there were two distinct doctrines that would permit disclosure of privileged material without waiving the privilege:

> The confidentiality element of the attorney-client privilege can be viewed as a limit on the scope of the privilege, i.e., the privilege does not extend past the boundary within which the attorney and client maintain confidentiality in common. Two doctrines protect from disclosure those items as to which a court might otherwise conclude that the privilege had been waived by a failure to maintain confidentiality: the "joint client" and the "common legal interest" doctrines. These two doctrines are distinct and do not overlap.[35]

The court accurately described the common interest doctrine as follows:

> The "common legal interest" rule is an exception to the general rule that disclosure of otherwise privileged communications eliminates, or waives, the privileged status of those communications. This rule "enables litigants who share unified interests to exchange this privileged information to adequately prepare their cases without losing the protection afforded by the

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US/FL—
295 F.R.D. at 595, *quoting Defense Lawyers' Professional Responsibilities: Part II—Contested Coverage Cases*, 15 GEO. J. LEGAL ETHICS 29, 86 (2001) (citations and notes omitted).
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US/FL—
295 F.R.D. at 597.
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US/FL—
295 F.R.D. at 599–600.
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US/FL—
295 F.R.D. at 594 (footnote omitted).

> privilege." … .
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> Pursuant to this doctrine, attorneys representing clients with similar legal interests can share information without risk of being compelled to disclose such information generally. Interests of the members of the joint defense group need not be entirely congruent. One member of a joint defense group cannot waive the privilege that attached to the information shared by another member of the group without the consent of that member, but any defendant could, of course, testify as to her own statements at any time. By agreeing to be a part of a joint defense, she only agrees not to disclose anything learned from her co-defendants through that joint arrangement, nor could any of those co-defendants disclose what she had told them or their attorneys in confidence. However, if the parties to that agreement are later in opposition with each other, statements which were made by one co-defendant to another defendant's attorney are not protected by privilege.[36]

The court expressed "a healthy skepticism as to the doctrine's worth" and an intent to "rein in what may be considered an overly broad interpretation of the 'common legal interest' (formerly 'joint defense group') exception to traditional concepts of waiver of the attorney-client privilege."[37] Nonetheless, the court concluded that the doctrine "provides an alternative basis to support my conclusion that [the Maplewood parties] must disclose the documents listed in the privilege log."[38]

The court agreed that that the parties had a common legal interest in the underlying litigation:

> [Indian Harbor] also was engaged in [the Maplewood parties'] settlement discussions, as required by the Policy's explicit terms which [the Maplewood parties] accepted when purchasing the Policy. It is evident that [Indian Harbor] shared a common legal interest in defending its insured in the underlying proceedings. This interest was legal, and not just financial, because of the multiple additional issues—including, e.g., the question of whether other entities might proceed against the insurer in the

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US/FL—
295 F.R.D. at 605–06.
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US/FL—
295 F.R.D. at 606–07 & n.232.
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US/FL—
295 F.R.D. at 607 n.232.

> event of an unsatisfactory result.[39]

But even while analyzing application of the common interest doctrine, the court relied on its conclusion that Indian Harbor was a co-client:

> The interests of [the Maplewood parties] (and their entire joint defense group) were aligned with Indian Harbor as all had an interest in minimizing liability in the Underlying Matters. [The Maplewood parties] have declared that: "No legal effort was made in connection with the prosecution of Maplewood's counterclaims in RRGC or Shashy that did not operate to minimize the potential liability of an insured on a claim made against the insured." In other words, all of Miller's efforts were geared toward minimizing liability, which would be the goal of Indian Harbor as well. The law provides that *all of these joint clients, including Indian Harbor*, could freely communicate (without waiving any privilege) in order to prepare a successful defense.[40]

The joint client conclusion cannot be right in connection with a common-interest arrangement. The common interest doctrine applies only when the cooperating parties do *not* share an attorney (typically because they have conflicting interests on matters related to the one in which they share a common interest). As the court itself recognized, the two rules do not overlap.[41]

The court continued by reasoning that

> if it is assumed that the insurer shares a "common legal interest" with [the Maplewood parties], then Miller's communications to Defendant on behalf of all of his clients and as to all details of the RRGC settlement are construed to be two client's "consulting in common" of an attorney. Miller communicated, presumably, at all times with the permission of Maplewood Partners, acting through Glaser. The other clients cannot now claim that certain aspects were privileged, as they apparently raised no objection at the time and, in any event, Glaser apparently granted permission for the disclosures on behalf of

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US/FL—
295 F.R.D. at 610.
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US/FL—
295 F.R.D. at 607 (emphasis added, footnote and citation omitted).
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US/FL—
295 F.R.D. at 594.

the corporate entity holding the privilege.

That is true enough *as to information that was voluntarily shared* pursuant to the common-interest arrangement. It is wrong, as it applies to information and documents not voluntarily shared. If two clients were indeed consulting the lawyer in common, the lawyer would have a fiduciary duty to each client to provide full information as to all matters within the scope of the relationship. Clients who permit their lawyers to share certain matters bearing on their common interests do not thereby assume any duty to share other information which, while related to their common interest, may also pertain to matters where there are conflicting interests. Thus, except in Illinois,[42] existence of a common legal interest does not provide a basis for one party to demand access to information about another party's privileged communications that were not voluntarily shared with it.[43]

The discovery request pursuant to which the court ordered production was not limited to information that had been voluntarily shared, but rather demanded:

> 3. All documents and communications between You and any of Your Agents, including but not limited to [defense counsel], pertaining to the Underlying Matters.
>
> 4. All documents and communications pertaining to estimates, evaluations and/or assessments of your potential legal liability and/or settlement values in the Underlying Matters made by You and/or Your Agents.[44]

Nonetheless, having concluded that the parties "consulted [defense counsel] in common, the court applied what it thought to be the applicable Florida rule: " 'There is no lawyer-client privilege … [as to] a matter of common interest between two or more clients … or their successors in interest, if the communication was made by any of them to a lawyer retained or

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[42] *See*

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Waste Mgmt., Inc. v. Int'l Surplus Lines Ins. Co., 144 Ill. 2d 178, 193–95 (1991), criticized in § 2.06[2], above. The court based the requirement of disclosure, alternatively, on the insured's duty to cooperate and on the common-interest doctrine. The discussion in § 2.06[2] specifically addresses the cooperation clause rationale. But, the criticism expressed there applies equally to the common-interest rationale. Additional reasons to reject the cooperation-clause rationale are set forth in this sub-subsection.

[43] *E.g.*,

US/CT—
Remington Arms Co. v. Liberty Mut. Ins. Co., 142 F.R.D. 408, 418 (D. Del. 1992) (" 'the rationale which supports the 'common interest' exception to the attorney-client privilege simply doesn't apply if the attorney never represented the party seeking the allegedly privileged materials.' "), *quoting* Bituminous Casualty Corp. v. Tonka Corp., 140 F.R.D. 381, 386 (D. Minn. 1992).

[44]

US/FL—
Maplewood, 295 F.R.D. at 580.

consulted in common when offered in a civil action between the clients.' "[45] But that statute, on its face, applies to joint client relationships, not common-interest arrangements, where the parties have separate attorneys and do not "consult in common" with either of those attorneys in the way joint clients would do.

The court supported its analysis by concluding that it would be difficult, burdensome, and potentially complicated for defense counsel to distinguish and separately treat coverage sensitive information, while freely sharing information relating only to the defense:

> As defense counsel, Miller is not charged with knowledge of coverage issues. To effectively defend his clients, Miller needed the trust and confidence of his clients, and his primary objective was loss minimization in the Underlying Matters, an objective shared by the clients who hired him and the "client" who was potentially responsible for any judgment, and for Miller's fees. Miller was not being compensated to establish coverage (or lack thereof), but rather was contracted to advance his clients' interests, as they defined them, in the Underlying Matters. Nor should Miller, or any defense counsel, need to spend much time deciding who they represent as a client. Miller could get a waiver from [the Maplewood parties] as to his ability to communicate with the insurer and, if his clients are not willing, then perhaps they need other counsel. If Miller is going to disclose information to Indian Harbor that might be adverse to the coverage question, then Miller needs to tell his clients in advance. If the clients object to the disclosure, then they face the risk that the cooperation clause of the insurance policy will have been breached and there will be no coverage. If the clients agree to the disclosure, then Miller might need to withdraw as defense counsel rather than straddle the line between two sets of interests. There is no rational basis to burden Miller or other defense attorneys with the dual role of protecting privileged items while also trying to obtain reimbursement for defense expenses as to underlying claims defended before the insured ends up in litigation against its own insurer. Thus, the conception of a joint client relationship as to all communications relating to the Underlying Matters provides clear guidance as to boundaries of privilege.[46]

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US/FL—
295 F.R.D. at 594 n.189, *quoting* FLA. STAT. § 90.502(4)(e).

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US/FL—
295 F.R.D. at 609–10 (footnote omitted). Of course, there would be no need for Miller to straddle any line if Miller never undertook any duties to Indian Harbor, beyond the general legal duty to refrain from misrepresentation.

The Maplewood parties and defense counsel certainly could have proceeded in that way, if they were willing to accept the duties of disclosure which would flow from making Indian Harbor a joint client. But if the Maplewood parties desired to retain discretion as to what information would be shared (perhaps at the cost of facing accusations of noncooperation), they were free to accept the difficulties, burdens, and complexities of a common-interest arrangement without the duties of disclosure which would flow from making Indian Harbor a joint client. The court improperly conflated the common-interest doctrine with the joint client rules, thereby depriving the Maplewood parties of the benefits of their choice not to be joint clients with Indian Harbor. Other courts should not make that mistake.

[4] Honesty and Avoidance of Fraud

[a] Deceptive Statements or Omissions

Representation of a policyholder by independent counsel typically takes place in a context where the policyholder and the insurer are adversaries with respect to coverage. As a result, both policyholder and counsel are entitled to withhold from the insurer information relating to the defense representation that is coverage sensitive. But even in the context of an adversarial relationship, the lawyer is not permitted to lie to the insurer. Model Rule 4.1 provides that "[i]n the course of representing a client, a lawyer shall not knowingly … make a false statement of material fact or law to a third person"[47] (*i.e.*, someone other than the client). Moreover, Model Rule 8.4 provides that "[i]t is professional misconduct for a lawyer to … (c) engage in conduct involving dishonesty, fraud, deceit, or misrepresentation."[48]

Professor Fischer has noted the following implications of these rules:

> An attorney may not make a misrepresentation and may not use the rule of confidentiality to justify the speaking of untruths. When the attorney speaks, the attorney must speak honestly. A statement that is a half-truth because it omits material facts needed to put the statement in its proper context may be deemed a misrepresentation subjecting the speaker to civil liability. As recently noted by the Montana Supreme Court, the privilege to withhold client confidential information does not provide a license or justification for misleading utterances. An attorney who discloses information to the insurer to enable the insurer to determine its duties and obligations under the insurance contract must take care to disclose accurately and truthfully or not disclose at all. Even a negligent statement may be actionable if it contains a material misrepresentation on which the recipient of the information (the insurer) reasonably relies to its detriment. The scope of a lawyer's liability for negligent misrepresentation has been hotly debated and disputed. The fact that the identity of the recipient of the information is known and the specific end and aim of the communication is to induce action by the insurer are factors enhancing the likelihood that the court would find *Cumis* counsel owed a duty of candor to the insurer. *Cumis*

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[47] MODEL RULES OF PROF'L COND. Rule 4.1 (ABA 2011).

[48] MODEL RULES OF PROF'L COND. Rule 8.4 (ABA 2011).

> counsel must be careful not to confuse the absence of a duty of care owed to the insurer with the existing duty to avoid making material misrepresentations to the insurer.[49]

The lawyer need not even be the source of the false statement. Douglas Richmond notes that "a lawyer may violate Rule 4.1(a) by knowingly affirming or ratifying another person's false statement, or by failing to correct it."[50]

These rules can be triggered by very limited culpability. The Rule 4.1 requirement that the misrepresentation be made "knowingly" requires only actual knowledge of the falsity, not any "evil intent or a bad purpose."[51] Many courts require knowing falsehood to establish violation of Rule 8.4(c).[52] But others hold that even statements made with reckless disregard for their truth or falsity can constitute violations.[53] Indeed, at least one jurisdiction will find a violation based on grossly negligent misstatements.[54]

Nor does a violation of these rules require that anyone be misled or harmed by the

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[49] James M. Fischer, *The Professional Obligations of Cumis Counsel Retained for the Policyholder but not Subject to Insurer Control*, 43 TORT TRIAL & INS. PRAC. L.J. 173, 187–88 (2008) (footnotes omitted).

[50] Douglas R. Richmond, *A Professional Responsibility Perspective on Independent Counsel in Insurance*, 33 No. 1 INS. LITIG. REP. 5, 18 (2011).

[51]

ND—
In re Edison, 724 N.W.2d 579, 584 (N.D. 2006).

[52] *See, e.g.*:

FL—
Fla. Bar v. Mogil, 763 So. 2d 303, 309–11 (Fla. 2000);

MA—
In re Firstenberger, 878 N.E.2d 912, 913–14 (Mass. 2007);

OR—
In re Conduct of Skagen, 149 P.3d 1171, 1184 (Or. 2006).

[53] *E.g.*:

DC—
In re Ukwu, 926 A.2d 1106, 1113–14 (D.C. 2007);

IA—
Iowa Supreme Court Atty. Disciplinary Bd. v. Gottschalk, 729 N.W.2d 812, 818 (Iowa 2007);

PA—
Office of Disciplinary Counsel v. Surrick, 749 A.2d 441, 445 (Pa. 2000).

[54]

AR—
Walker v. Supreme Court Comm. on Prof'l Conduct, 246 S.W.3d 418, 424 (Ark. 2007).

misrepresentation.[55] Rule 8.4(c) contains no express requirement of materiality, though some courts will imply one.[56]

Thus, independent counsel must take care to avoid false or misleading statements or omissions in communicating with the insurer. Moreover, independent counsel must be careful in advocating the policyholder's position to the insurer. Thus, in trying to induce the insurer to settle, it may be useful to argue that there is a great risk of excess liability if the case is tried. And it may be possible to argue that the likelihood or likely magnitude of the judgment is greater than counsel personally believes it to be. If so, counsel must avoid stating any opinion regarding the risk that does not reflect counsel's actual beliefs.

[b] Assisting Fraud

Model Rule 1.2(d) forbids a lawyer to "counsel a client to engage, or assist a client, in conduct that the lawyer knows is criminal or fraudulent."[57] If independent counsel learns that the policyholder is perpetrating a fraud, counsel may not assist in doing so. The first step will usually involve remonstration with the policyholder to correct any prior misrepresentations and refrain from any in the future. If the policyholder will not do so, it may sometimes be sufficient for independent counsel to withdraw from the representation. But, as Prof. Fischer points out, in some instances

> [o]ne may even argue that counsel has affirmative disclosure obligations here and may not simply remain silent if counsel is aware that the policyholder client is perpetrating a fraud on the insurer. Rule 4.1(b) provides that an attorney must disclose a material fact when necessary to prevent assisting a criminal or fraudulent act by the client, unless disclosure is prohibited by Rule 1.6. Traditionally, the Rule 1.6 confidentiality exception swallowed the rule. Recent amendments to Rule 1.6 have, however, added exceptions that "permit" the attorney to disclose client confidential information to prevent "the client from committing a crime or fraud reasonably certain to result in substantial injury to the financial interests or property of another and in furtherance of which the client has used or is using the lawyer's services." Disclosure is no longer "prohibited," as that term is used in Rule 4.1(b) because Rule 1.6(b)(2)–(3) permits disclosure; therefore, the exception no longer significantly constrains the duties set forth in Rule 4.1(b), i.e., disclose material facts "to avoid assisting a criminal or fraudulent act by a

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CT—
Ansell v. Statewide Grievance Comm., 865 A.2d 1215, 1223 (Conn. App. Ct. 2005).
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OR—
In re Conduct of Skagen, 149 P.3d 1171, 1184 (Or. 2006).
[57] MODEL RULES OF PROF'L COND. Rule 1.2(d) (ABA 2011). *Accord* RESTATEMENT (THIRD) OF THE LAW GOVERNING LAWYERS § 94(2) (2000).

client."[58]

Of course, even if that argument is accepted, it would still be necessary to determine when disclosure is necessary to prevent assisting a fraud.

[5] Involvement in Policyholder Disputes with the Insurer

[a] Disputes Regarding the Representation

If there are disagreements with the insurer on conduct of the defense, the policyholder will require advice on the risks and benefits of acceding to the insurer's wishes or proceeding contrary to those wishes. Defense counsel is better positioned than any other lawyer in evaluating the impact on the lawsuit being defended of proceeding one way or another. After all, defense counsel may have considered both alternatives before making a recommendation and certainly considered both alternatives before concluding that another course was preferable to the one recommended by the insurer. Defense counsel might not be competent to advise on the risks of breaching insurance policy duties by proceeding contrary to the insurer's wishes. But the insured will require advice on this subject, and if defense counsel is competent to provide that advice, defense counsel is the most logical person to do so.

Such advice might be considered coverage advice, for which the policyholder, rather than the insurer, should pay. But it might not be separable from advice regarding the defense or any separable component might be too small to be worth trying to break out.

[b] Disputes Regarding Coverage and Claim Handling

Because the insurer is not a client of independent counsel, there is no ethical obstacle to

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[58] James M. Fischer, *The Professional Obligations of* Cumis *Counsel Retained for the Policyholder but not Subject to Insurer Control*, 43 TORT TRIAL & INS. PRAC. L.J. 173, 189 (2008) (footnotes omitted). *See* RESTATEMENT (THIRD) OF THE LAW GOVERNING LAWYERS § 67(1)–(2) (2000) (authorizing disclosure on the same basis as Model Rule 1.6(b)(2)-(3). The Restatement explains that these exceptions to the duty of confidentiality

> reflect a balance between the competing considerations of protecting interests in client confidentiality and lawyer loyalty to clients, on the one hand, and protecting the interests of society and third persons in avoiding substantial financial consequences of crimes or frauds, on the other … . The exceptions are … justified on the ground that the client is not entitled to the protection of confidentiality when the client knowingly causes substantial financial harm through a crime or fraud and when … the client has in effect misused the client-lawyer relationship for that purpose. In most instances of unlawful client acts that threaten such consequences to others, it may be hoped that the client's own sober reflection and the lawyer's counseling will lead the client to refrain from the act or to prevent or mitigate its consequences. [RESTATEMENT, § 67, cmt. *b.*]

counsel also representing the policyholder on coverage and other disputes with the insurer.[59] But there is an argument that, as a matter of insurance law, "an insurer is within its rights to insist that lawyers serving as independent counsel not advise insureds on coverage."[60]

This argument is not very strong. It relies on two cases,[61] which both take the position that the insurer is entitled to approve the policyholder's selection of defense counsel, such approval not to be unreasonably withheld.[62] Those cases are therefore unlikely to be followed in jurisdictions holding that the policyholder is entitled to select independent counsel unilaterally. (See § 14.02 above.)

More importantly, both cases proceed on the basis that the insurer

> is under a duty to provide only an impartial defense—not to sacrifice its own interests. [The policyholder's] defense counsel must not be motivated to slant the defense in any manner relating to whether a claim is or is not in the scope of coverage. Allowing [the policyholder] to appoint as "independent counsel" a firm that bears its loyalty to [the policyholder] or any animus to [the insurer] would reintroduce, albeit in a converse manner, the very difficulties that necessitate in the first instance the appointment of independent counsel.[63]

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[59] *See, e.g.*:

US/PA—
Maddox v. St. Paul Fire & Mar. Ins. Co., 2002 U.S. Dist. LEXIS 26686, at *10 n.6 (W.D. Pa. May 29, 2002), *appeal dismissed*, 2003 U.S. App. LEXIS 14715 (3d Cir. Jul. 22, 2003);

US/NY—
Emons Indus, Inc. v. Liberty Mut. Ins. Co., 747 F. Supp. 1079. 1083–84 (S.D.N.Y. 1990).

See also Douglas R. Richmond, *Independent Counsel in Insurance*, 48 SAN DIEGO L. REV. 857, 894 (2011).

[60] 48 SAN DIEGO L. REV. at 895.

[61] *See*:

US/NY—
N.Y. State Urban Dev. Corp. v. VSL Corp., 563 F. Supp. 187 (S.D.N.Y. 1983), *aff'd in pertinent part*, 738 F.2d 61, 65–66 (2d Cir. 1984);

US/PA—
Maddox v. St. Paul Fire & Mar. Ins. Co., No. 01-1264, 2002 U.S. Dist. LEXIS 26686 (W.D. Pa. May 29, 2002), *appeal dismissed*, 2003 U.S. App. LEXIS 14715 (3d Cir. Jul. 22, 2003).

[62]

US/NY—
In *VSL Corp.*, that position was based, in part, on policy language found to reserve that right. 738 F.2d at 65. That makes the case even less likely to be followed in the absence of such policy language.

[63]

But this ignores the fact that defense counsel often must advocate a position on coverage sensitive issues. Thus, when the policyholder is alleged to have harmed the plaintiff either negligently or intentionally, the policyholder surely does not receive a complete defense unless defense counsel argues that the injury was no more than negligent. A policyholder defended other than in this way could be subjected to both an unjustified finding of intentional injury (with the resulting increased damages) and, in consequence, a loss of coverage. Such a policyholder could wind up worse off than had there been no insurance The insurer's protection is not some artificial "impartial" defense; it is the right not to be bound on coverage by the findings made in a case where control of the defense rested in the hands of a policyholder with coverage interests adverse to those of the insurer.[64]

More generally, the right to independent counsel exists only because of a conflict arising out of the manner in which the defense can be conducted. The point of giving the insured independent counsel is to ensure that judgment calls relating to the defense are made in the way that benefits the policyholder rather than the insurer. Independent counsel must therefore be able to advise the policyholder as to how different defense choices could impact coverage.

The insurer is entitled to have bills limited to services required to defend the policyholder, so it does not pay for the policyholder's representation in coverage disputes. But there is no reason to deny the policyholder the right to the economies of using one law firm for both defense and coverage, if the lawyers in that firm are competent to render both types of service and the policyholder wishes them to do so.[65]

A different view was taken in *General Insurance Co. of America v. Walter E. Campbell Co.*[3] Walter E. Campbell Co. ("WECCO") had, "for decades, engaged in the business of handling, installing, disturbing, removing, and selling asbestos-containing insulation materials."[4] This was a coverage action regarding defense and indemnification of many underlying asbestos-personal-injury cases.[5] The principal coverage issues were (1) when the claimant in each case was exposed to asbestos (which affected allocation of coverage) and (2) whether and when the claimant had been exposed to asbestos during WECCO's ongoing operations (to which only per-occurrence limits applied) as opposed to injury resulting from completed operations (to which aggregate limits applied.).[6]

WECCO settled with two of its insurers, agreeing to assume their obligations and to reduce any claims against non-settling insurers by any amounts allocable to settling insurers.[7] By

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US/NY—
563 F. Supp. at 190 n.1, *followed by* 2002 U.S. Dist. LEXIS 26686, at *8–9.
[64] RESTATEMENT (SECOND) OF JUDGMENTS § 58(2) (1982).
[65]

US/NY—
Emons Indus, Inc. v. Liberty Mut. Ins. Co., 747 F. Supp. 1079 (S.D.N.Y. 1990).
[3] Gen. Ins. Co. of Am. v. Walter E. Campbell Co., 2016 U.S. Dist. LEXIS 62842 (D. Md. May 12, 2016).
[4] 2016 U.S. Dist. LEXIS 62842, at *7.
[5] Gen. Ins. Co. of Am. v. Walter E. Campbell Co., 107 F. Supp. 3d 466 (d. Md. 2015).
[6] 107 F. Supp. 3d at 473.
[7] 107 F. Supp. 3d at 480.

stepping into the shoes of the settling insurers, WECCO had the largest share of the defense obligation, so the court agreed that it should take the lead in managing the defense.[8]

WECCO had substituted its coverage counsel, Morgan Lewis & Bockius ("MLB") as defense counsel in the underlying actions and the non-settling insurers objected, arguing that it had a conflict of interest, and the court agreed: "Given the long and protracted efforts of [MLB] to pull cases into coverage under the Non-Settled Insurers' policies, [MLB] cannot also be placed into the position where it can slant the defense in a manner that could render the claims covered claims.'[9] Accordingly, so long as MLB remained counsel, the non-settled Insurers would have "no defense or indemnity obligations with respect to those suits."[10]

But this would appear to be an ordinary situation in which a pivotal issue (when exposure occurred and in what circumstances) is involved in both defense of the underlying action and the coverage dispute. If so, WECCO would have a right to independent counsel, even had it not assumed the rights of the settling insurers to defend. For the reasons stated above, WECCO would have had the right to have its counsel defend in a manner that maximized its interests, including its coverage interests.

If WECCO did not have a right to independent counsel, then the claim of the non-settling insurers would have depended on some right to have the settling insurers defend impartially on behalf of all insurers. We are not aware of any authority on whether such a right would exist. But even if it did, MLB would not have been conflicted. It would defend in whatever manner its client, WECCO directed. If that defense were improperly conducted, the responsibility would have rested on WECCO, not MLB.

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[8] 2016 U.S. Dist. LEXIS 62842, at *14-15.
[9] 2016 U.S. Dist. LEXIS 62842, at *15.
[10] 2016 U.S. Dist. LEXIS 62842, at *15.

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Six Insurance Coverage Lessons from 2016

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EXPERT ANALYSIS

Six Insurance Coverage Lessons From 2016

By Robert D. Chesler, Esq., and Christina Yousef, Esq.
Anderson Kill PC

The year 2016 saw a number of decisions that are important to every risk manager and insurance professional, and should influence the way they conduct business.

This article discusses six decisions that address key issues in the policy application, policy drafting and notice that are essential reading for anyone in the insurance business.

Give notice immediately

Templo Fuente De Vida Corp. v. National Union Fire Ins. Co. of Pittsburgh concerned a claims-made insurance policy.[1]

Most specialty insurance policies are claims made. As a general rule, notice of a claim outside the claims-made policy period is fatal.

In *Templo Fuente*, though, the policy also contained a requirement that the policyholder provide notice "as soon as practicable."

Templo Fuente gave notice six months after it received notice of a complaint, within the policy period, but without an explanation for its six-month delay.

The New Jersey Supreme Court held that an unexplained delay of six months was not "as soon as practicable," and denied coverage.

When a company receives a complaint, it may not immediately think of notice; the company's first concern is defending against the claim.

Delay in giving notice to the insurance company is not unusual. Now, notice must be a priority.

While notice law differs dramatically among jurisdictions, late notice is always a danger.

Give notice of anything that even resembles a claim

In *S.M. Electric Company, Inc. v. Torcon, Inc.*, SME, a contractor, sent Torcon, the construction manager, a letter in August 2008 entitled "A Request for Equitable Adjustment," which sought $15,337,068 "as compensation for the additional cost of performing the work."[2]

Torcon did not provide notice of this letter to its insurance company. SME sued Torcon in 2010, and Torcon at that point gave notice.

Torcon's insurance company denied coverage. It argued that the August 2008 letter constituted a claim, and that the SME complaint was simply a continuation of that claim. As a result, the insurance company asserted that late notice barred the claim.

The court agreed, and upheld the insurance company's disclaimer.

Many companies hesitate to give notice of pre-litigation claims to their insurance companies, and indeed, many companies do not recognize that a pre-litigation notice can be a claim.

S.M. Electric underscores that a company must give notice to its insurance company of anything that even smells like a claim.

Read the policy application

An insurance company can rescind an insurance policy because of an error in the application — and a number of insurance companies did so in 2016.

No case was as notorious as *H.J. Heinz Co. v. Starr Surplus Lines Ins. Co.*[3]

In *Heinz*, the advisory jury found that Heinz's risk manager had deliberately failed to report on the application certain prior losses in order to obtain a lower premium or self-insured retention.

The court agreed and rescinded the policy.

S.M. Electric underscores that a company must give notice to its insurance company of anything that even smells like a claim.

The Third Circuit recently affirmed.[4]

Rarely will misrepresentations be as egregious as in *Heinz*.

However, an insurance company can usually rescind a policy for even negligent misrepresentations.

Many companies simply do not expend enough due diligence when filling out an application for insurance coverage.

Such a failure can result in rescission of the policy should a claim arise. Insurance companies will scrutinize the application to see if a mistake exists that could be the basis for rescission.

Customize your cyber policy

P.F. Chang's v. Federal Insurance Co. was the first substantive decision on a so-called cyber policy, and it should serve as a wake-up call on the necessity of carefully drafting these policies.[5]

P.F. Chang's, a restaurant chain, had a contract with a third-party servicer to manage its credit card transactions, and that company had a separate contract with a bank.

The bank incurred various charges as the result of a data breach at P.F. Chang's and passed those charges onto the servicer, which passed them back to P.F. Chang's.

P.F. Chang's sought reimbursement from its cyber insurance company, Federal Insurance Company.

Federal had advertised its cyber policy as a "flexible insurance solution designed by cyber risk experts to address the full breadth of risks associated with doing business in today's technology-dependent world."

Federal denied coverage on the basis of a contract exclusion in the policy — P.F. Chang's was contractually obligated to pay the servicer.

P.F. Chang's might have been able to avoid this result with careful policy drafting.

The cyber insurance world does not have a single standardized insurance policy; rather, insurance brokers can manuscript policies.

A careful review of P. F. Chang's operations may have captured this risk, and the insurance professional could have crafted a solution.

Do not buy a cyber policy off the shelf.

Know your operations and risks, and make sure that they are covered.

Are you a professional?

A number of cases in 2016 concerned the extent of the professional services exclusion.

In *Educ. Affiliates, Inc. v. Fed. Ins. Co.*, former students sued a for-profit educational institution company for misrepresentations in advertising the schools.[6]

The insurance company, which had issued a directors and officers policy, denied coverage on the basis of the professional services exclusions.

The exclusion applied to "the rendering of ... any professional services ... for others."

Apparently, "professional services" was not defined.

The court found that the exclusion did not apply — the policyholder was marketing professional services, not rendering them.

The court further found that to read the exclusion as broadly as the insurance company contended would "eviscerate" coverage.

The line between professional and ordinary services is a fine one, a gray area that can become a quagmire.

Case law from different jurisdictions is difficult to reconcile.

Companies must, therefore, carefully review their operations to determine if they have a professional services exposure.

Many companies simply do not expend enough due diligence when filling out an application for insurance coverage.

Counting the occurrences

Counting the number of occurrences may seem like counting the number of angels on the head of a pin, except that there are real-world consequences.

Selective Ins. Co. of Am. v County of Rensselaer, concerned a class action by people who had been jailed and strip-searched.[7]

The county paid $5,000 to the lead plaintiff and $1,000 to the other members of the class, and incurred attorneys' fees of $442,701.74. The implicated insurance policies had annual per occurrence deductibles of $10,000 or $15,000.

The county argued that each claim by each class member constituted one occurrence, and that a single deductible applied.

The New York Court of Appeals disagreed, and held that each individual class member constituted a separate occurrence to which a separate deductible applied.

As a result, when the damages were prorated across the number of class members, each member's allocated damages fell within the per-occurrence deductible, and the county obtained no recovery.

There are ways to avoid this result. For some companies, a "batch clause" may be effective.

In some instances, the policyholder may be able to obtain an "aggregation clause," which states that all claims arising from a single product line or process will be deemed one occurrence.

An aggregate limit on the deductible may be available. Insurance professionals must address this issue.

Conclusion

Insurance coverage law is constantly evolving, and each turn of the wheel can have direct ramifications on policyholders.

Companies must not only be aware of their rights vis-à-vis their insurance companies, but must also be attuned to the pitfalls on the road to coverage.

NOTES

1 129 A.3d 1069 (N.J. 2016).

2 No. A-00846-15T3, 2016 WL 6091256 (N.J. Super. Ct. App. Div. Oct. 19, 2016).

3 No. 15-cv-631, 2016 WL 374307 (W.D. Pa. Feb. 1, 2016).

4 *H.J. Heinz Co. v. Starr Surplus Lines Ins. Co.*, No. 16-1447, 2017 WL 108006 (3d Cir. Jan. 11, 2017).

5 No. 15-cv-1322, 2016 WL 3055111 (D. Ariz. May 26, 2016).

6 No. 15-cv-1624, 2016 WL 4059159 (D. Md. July 28, 2016).

7 47 N.E.3d 458(N.Y. 2016).

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Marion B Adler
Rachlis Duff Adler Peel & Kaplan, LLC
You Screwed Up: You Trusted Us!: Conflicts Among Insurers, Independent Counsel, and Insureds

Marion B. Adler has over 25 years of experience in representing commercial policyholders in litigation, negotiations, and counseling in connection with complex insurance recovery matters. Her experience includes litigation under CGL and excess policies of long-tail coverage disputes, for product liability and environmental claims, as well as a wide range of other claims arising under CGL policies, including construction, intellectual property, civil rights, privacy (including TCPA and FCRA), and defamation claims. She has successfully represented both companies and directors and officers in obtaining coverage under D&O policies. Her experience also extends to other forms of insurance policies, including Fidelity Bonds, ERISA coverage, and Commercial Credit policies.

Marion frequently writes and speaks on subjects relating to commercial litigation, including insurance coverage

From July 2000 to 2002, she served as the Co-Chair of the Practices and Procedures Subcommittee of the ABA's Insurance Coverage Committee of the Section on Litigation.

Robert D. Allen
Law Offices of Robert D. Allen, PLLC
Show Me the Money: Latest Developments in the Recovery of Attorneys Fees in Coverage and Bad Faith Litigation

Bob Allen is the Principal in the Law Offices of Robert D Allen, PLLC where he practices tort and commercial trial and appellate litigation with a significant emphasis in handling insurance and reinsurance disputes. Since the mid-1980s, Mr. Allen has regularly represented parties in complex insurance coverage, bad faith, fraud, reinsurance and regulatory litigation matters including excess versus primary carriers/self insureds, priority of coverage, reinsurance, regulatory and insolvency related disputes. Mr. Allen also serves as a mediator, arbitrator, umpire, and expert witness in insurance, reinsurance, commercial and tort disputes.

Bob has been involved in several landmark and important insurance and reinsurance cases in Texas and other parts of the United States. For example, Bob was lead counsel in the original Texas Supreme Court cases on reimbursement, the dual employer doctrine for workers compensation and the case resulting in the first published opinion under Texas law involving advertising injury coverage. He has held leadership positions in the Dallas Bar Association, the International Association of Defense Counsel and DRI. At his former firms, Bob was the Chair of the Insurance Coverage and Bad Faith Litigation Practice Group at Vial Hamilton. At Baker & McKenzie, he was the Chair of the Insurance and Reinsurance Disputes Section of its North American Litigation Practice Group and the head of the Dallas litigation practice.

Michael F. Aylward
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Reflections on a Paradigm Shift for Extra-Contractual Liability in the Restatement of the Law, Liability Insurance

Michael F. Aylward is a senior partner in the Boston office of Morrison Mahoney LLP where he chairs the firm's Complex Insurance Coverage Practice group. For the past four decades, he 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 has served as lead counsel in major coverage cases around the country and has successfully argued several landmark appeals on issues such as the pollution exclusion, "known loss" the meaning of "occurrence" and the scope of CGL coverage for cybernet and intellectual property claims. He has also advised various medical malpractice insurers concerning professional liability claims and consults frequently on bad faith and ethics disputes. He has also served as an arbitrator in numerous insurance coverage matters and has testified as an expert in matters involving coverage and reinsurance issues arising out of such claims.

In 2012, Mr. Aylward was among the twelve founding members of the American College of Extra-Contractual and Coverage Counsel and continues to serve on its Executive Committee and Board of Regents. He has also served in leadership roles for the American Bar Association (Insurance CLE); Federation of Defense and Corporate Counsel (chair, Reinsurance, Excess and Surplus Lines Section) and the International Association of Defense Counsel (Reinsurance and Excess Committee Chair). He is a frequent lecturer on insurance, ethics and bad faith issues and has published numerous articles on these topics, including a chapter on Understanding Bad Faith in the 2012 Appleman insurance treatise. In 2014, he was appointed by the American Law Institute to serve as one of the 43 Advisers on the pending Restatement of the Law of Liability Insurance.

Mr. Aylward is a graduate of Dartmouth College, where he received his B.A. with Honors (History) in 1976 and the Boston College Law School (J.D. Cum Laude, 1981).

William T. Barker
Dentons
You Screwed Up: You Trusted Us!: Conflicts Among Insurers, Independent Counsel, and Insureds

William Barker is a member of Dentons in the Chicago office with a nationwide practice in the area of complex commercial insurance litigation, including coverage, claim practices, sales practices, risk classification and selection, agent relationships and regulatory matters. In addition to handling complex litigation, he counsels clients on insurance issues. He also counsels and litigates on matters of lawyers' professional responsibility.

William was a member of the joint defense briefing team that won *In re Katrina Canal Breaches*, 495 F.3d 191 (5th Cir. 2007), and *Chauvin v. State Farm Fire and Cas. Co.*, 495 F.3d 232 (5th Cir. 2007), the major federal cases on insurance coverage for damage caused by the flooding of New Orleans. He also contributed to the joint defense effort in the parallel cases in the Louisiana Supreme Court, including *Sher v. Lafayette Ins. Co.*, 2008 WL 928486 2008 WL 928486 (La. April 8, 2008) (flood exclusion bars coverage for Hurricane Katrina flooding).

William represents various insurers in defending bad faith claims, especially on appeal. For example, he was brought into *Torres v. Travelers Ins. Co.*, Civ. 01-5056 (D.S.D.), after a verdict exceeding US$12 million. He prepared post-trial motions that obtained a reduction to US$2 million and briefed an appeal that ended in a confidential settlement. He is currently handling or has recently concluded appeals in other eight-figure bad faith cases. He is a noted speaker and commentator on bad faith and claim handling issues.

William is a noted advisor and litigator on the professional responsibilities of insurance defense counsel. He was one of the lawyers for Travelers Indemnity Co. in *Unauthorized Practice of Law Committee v. Amer. Home Assur. Co.*, 2008 WL 821034 (Tex. Mar. 28, 2008), upholding the use of staff counsel to defend insureds).

William has litigated a number of cases regarding the constitutional rights of insurers and others, for example:

- *Goldberg v. Sweet*, 488 U.S. 252 (1989), dealing with the taxation of interstate telephone calls, in which the court adopted one theory urged by the amicus brief and the concurrence adopted another
- *McDonald's Corp. v. Nelson*, 822 F. Supp. 597 (S.D. Iowa 1993)
- *Holiday Inns Franchising, Inc. v. Branstad*, 29 F.3d 383 (8th Cir. 1994)
- *Iowa v. Holiday Inns Franchising, Inc.*, 513 U.S. 1032 (1994), dealing with a franchising statute that unconstitutionally impaired the obligation of franchise contracts
- *Allstate Ins. Co. v. Auto Damage Appraiser Licensing Bd.*, 507 N.E.2d 250 (Mass. 1987), which avoided a First Amendment question by the narrow construction of the statute

William's practice includes a concentration in appellate litigation. He has handled scores of appeals and has prepared many amicus briefs in various state and federal appellate courts. He is a former chair of the Appellate Advocacy Committee of the ABA Tort, Trial and Insurance Practice Section. William has served as an expert witness in bad faith and legal malpractice cases.

Bernard P. Bell
Miller Friel, PLLC
Chances Are … A Fortuity Case Study

Bernie Bell represents insureds in disputes with their insurers and is a nationally recognized leader in his field. He serves as lead counsel pursuing insurance recovery across a full range of disputed claims, from property damage and business interruption losses to claims arising from directors and officers (D&O) liabilities, as well as employment, environmental, fiduciary (ERISA), intellectual property, management, product, professional, representations and warranties (R&W), tax position, and toxic tort liabilities.

His recent representations include engagements to recover property damage and business interruption losses caused by catastrophic events at refineries, petrochemical plants, oil and gas pipelines, golf courses and hospitality venues. He regularly pursues recovery under liability policies for the costs of defending and resolving government subpoenas and investigations, and various breach-of-duty claims. Other recent representations include claims under pollution legal liability coverage for environmental clean-up costs. Bernie regularly appears in courts, arbitration tribunals, and mediations throughout the United States and in London arbitration under the Bermuda Form.

Bernie is a Fellow of the American College of Contractual and Extracontractual Counsel, and is the co-chair (policyholder side) of the College's First-Party Insurance Committee. He wrote or co-wrote chapters in the Appleman insurance law treatise on Commercial Property Insurance and Time Element (Business Interruption) Insurance, and is a frequent writer and speaker on insurance coverage issues.

Timothy Burns
Perkins Coie
Building Product Class Actions - Coverage Under the Roof?

Timothy W. Burns is a partner at Perkins Coie LLP. He is the former co-chair of the Insurance Coverage Litigation Committee of the American Bar Association. Tim is favorably ranked in the 2006 (Illinois), 2007 (recommended in "Insurance" nationally), and 2008 to 2014 (Band 2 - nationally) editions of Chambers USA: America's Leading Lawyers for Business. According to the publication, Tim "shines brightly in the sensitive and complex area of D&O [directors' and officers'] insurance," and corporate interviewees for the publication agreed that he "is probably the best counselor in the business for the procurement of this insurance . . . and is a real client magnet in this specialized field." According to one client quoted, "He is smart, diligent, innovative, resourceful and practical." Tim also is listed in The International Who's Who of Insurance & Reinsurance Lawyers and as one of the nation's top thirty policyholder-side insurance lawyers in the Executive Counsel Shortlist.

Tim has developed a nationally prominent D&O and fiduciary liability insurance practice. He advises clients on all aspects of D&O and fiduciary insurance, including counseling them with respect to the insurance aspects of securities and derivative litigation, fiduciary claims, government investigations, initial public offerings, spin-offs, mergers and acquisitions, and bankruptcies. Tim's practice also includes representing corporate policyholders in their disputes and litigation with their insurance carriers. He has represented major policyholders in insurance coverage litigation since 1992.

Bruce D. Celebrezze
Sedgwick LLP
War and Peace (The Abridged Version): Application of the War and Terrorism Exclusions

Bruce D. Celebrezze is a partner in the San Francisco office of Sedgwick LLP. He has been practicing in the field of insurance law for virtually his entire legal career spanning 38 years (so far). As one of the country's leading insurance industry litigators, he has represented a wide variety of international, national and regional insurers. In addition, Mr. Celebrezze frequently lectures and is widely published as a legal expert in the field.

Mr. Celebrezze is exceptionally well regarded by his peers and the wider market, with a national and international practice that focuses on complex general liability, including personal and advertising injury, property, and specialty lines. He also spends a substantial portion of his practice handling commercial disputes for insurers.

Mr. Celebrezze is President-Elect and a member of the Board of Regents and the Executive Committee of the American College of Coverage and Extracontractual Counsel. He is also active in the Federation of Defense and Corporate Counsel, having served as a Senior Director, member of the Executive Committee, Vice President, Dean of the Litigation Management College Graduate Program, and chair of the Insurance Coverage Section.

Mr. Celebrezze was a member of the civil grand jury in the City and County of San Francisco for a one year term. He was a member of the Board of Trustees of the Mechanics' Institute, a 6,000 member, 165,000 volume non-profit library in San Francisco, for 16 years, including serving as President of the Board for four years. He is a member of the President's Visiting Committee of St. Ignatius High School in Cleveland, Ohio.

Mr. Celebrezze has received many honors and recognitions for his insurance work and excellence. He has been recognized annually for many years by the pre-eminent legal directory Chambers USA as a leader in insurance, with highest esteem by his peers. Mr. Celebrezze has also been praised and recognized by Benchmark Litigation as a leader in his field.

Suzan F. Charlton
Covington & Burling LLP
Keeping Your "Food Recall Insurance" Fresh

Suzan Charlton, special counsel with Covington & Burling LLP in Washington, DC, represents policyholders in insurance disputes. Her litigation and settlement experience encompasses a broad range of losses and liabilities, including food contamination, product recalls, product liabilities (including asbestos), catastrophic property damage, pollution, and more. She has also represented indigent clients and non-profit organizations in their insurance recovery efforts.

Ms. Charlton has been recognized as a “SuperLawyer” in Washington, DC, is a past co-chair of the ABA Litigation Section ICLC’s annual CLE conference, is a managing editor of the ICLC’s website and social media platforms, and has held numerous subcommittee leadership positions within the ICLC. She is a frequent author and speaker on myriad insurance topics. She is also the creator of the comic strip Lawtoons.

Robert Chesler
Anderson Kill & Olick, P.C.

Fifteen Cases in Forty-Five Minutes: The Most Important Coverage and Extracontractual Decisions of the Past Year

Robert D. Chesler is a shareholder in Anderson Kill's Newark office. Mr. Chesler represents policyholders in a broad variety of coverage claims against their insurers and advises companies with respect to their insurance programs. Mr. Chesler is also a member of Anderson Kill's Cyber Insurance Recovery group.
A leading participant in the birth of modern insurance law in the early 1980s, Mr. Chesler has earned the reputation as "The Insurance Guru" for exceptional insurance coverage knowledge, and has emerged as a leader in such new areas of insurance coverage as cyber-Insurance, D&O, IP, privacy and "green" insurance.

Mr. Chesler has served as the attorney of record in more than 30 reported insurance decisions, representing clients including General Electric, Ingersoll-Rand, Westinghouse, Schering, Chrysler, and Unilever, as well as many small businesses including gas stations and dry cleaners. He has received numerous professional accolades, including a top-tier ranking for Insurance Litigation: New Jersey in Chambers USA: American's Leading Lawyers for Business, which dubs him a "top-notch attorney" and "dominant force in coverage disputes." He is also listed in The Legal 500, The Best Lawyers in America, Super Lawyers and Who's Who Legal in the Insurance and Reinsurance section of the publication.

Mr. Chesler is a relentless advocate for his clients in their efforts to obtain coverage from their insurance companies. He has strength in creatively analyzing complex insurance coverage disputes and rapidly driving towards resolution. He has spent his entire career obtaining settlements from insurance companies. He can speak "insurancese" as well as the insurers, and knows how to approach insurance companies, when to talk to them and when to litigate. His depth of experience enables him to distinguish a bad insurance claim from a good one, and understand and implement best strategies for obtaining money for his clients quickly and cost-effectively.

Mr. Chesler taught history at the State University of New York at Purchase and Legal Methods at Harvard University. He currently teaches insurance law at Rutgers Law School. He holds a Ph.D. in history from Princeton University and maintains a scholarly interest in insurance. He is co-author of the seminal article Patterns of Judicial Interpretation of Insurance Coverage for Hazardous Waste Site Liability, 18 Rutgers L.J. 9 (1986), which has been cited by numerous courts, including seven state supreme courts and the Second Circuit, along with dozens of other articles on insurance issues. He is co-author of Insurance Coverage for Intellectual Property and Cyber Insurance Claims, published by Thomas West, and is former co-editor in chief of the Environmental Claims Journal. Mr. Chesler is also co-editor of Coverage, the ABA Insurance Journal. He has chaired seminars on the new cyber-policies and food insurance issues for the ABA and NJSBA, and is currently Chair of the Insurance Sub-Committee of the American Intellectual Property Law Association.

Janet Davis
Cozen O'Connor
Building Product Class Actions - Coverage Under the Roof?

Janet R. Davis is a Shareholder of Cozen O'Connor in Chicago, Illinois. She practices in the areas of insurance coverage, professional liability and construction litigation. Janet represents and counsels insurers on a wide range of issues and policies including errors and omissions, directors and officers, employment practices liability, life sciences, and general liability. She represents architects and engineers in litigated and arbitrated matters and also provides design professionals with general corporate counseling on issues including contract drafting, insurance, fee disputes and employment. Janet is a frequent lecturer on a variety of topics including insurance coverage, design professional liability, and the role of counsel retained by insurers. She is a former Chair of the Tort Trial & Insurance Practice Section's Insurance Coverage Litigation Committee and served on the Editorial Board of the CGL Reporter from 1996-2008. Janet also served on TIPS Council and was the TIPS Secretary/Chief Diversity Officer from 2008-2011. She was honored by TIPS in 2013 with the Kirsten Christophe Award for Excellence in Trial & Insurance Practice and is a Fellow of the American College of Coverage and Extracontractual Counsel. She has also been recognized repeatedly by Super Lawyers and Leading Lawyers.

Barry J. Fleishman
Shapiro Lifschitz and Schram, PC
Subrogation, Equitable Contribution, and Other Insurance: Untangling The Gordian Knot Without Prolonged Litigation

Barry Fleishman focuses his practice on complex policyholder insurance coverage issues. His insurance coverage experience includes representation before federal and state courts, arbitral tribunals, and judicial and private mediators, focusing on corporate policyholder claims for insurance coverage arising out of liability and loss from property damage, bodily injury, personal injury, and alleged wrongful acts of directors and officers. Mr. Fleishman has represented major corporations seeking insurance coverage with respect to liabilities and losses incurred as the result of catastrophic property damage, defective or misused products, environmental damage, alleged discrimination, and directors' and officers' activities in cases involving natural disasters, including major hurricane and cyclone-related losses, fires and explosions, mold and moisture, and alleged corporate wrongful acts.

Mr. Fleishman was recognized in The Best Lawyers in America® for Insurance Law in 2017 and the seven years immediately preceding. He was recognized in 2016 and the five years immediately preceding as a Washington, D.C. "Super Lawyer" in the area of Insurance Coverage and a "Top 100 Lawyer" in Washington, D.C. from 2011-2016, as selected by Super Lawyers magazine and published in the Washington Post. In 2011, Mr. Fleishman was recommended in the area of Insurance by Legal 500 US. He is also member of the Washington, D.C. team recognized as a Tier 1 practice in Insurance Recovery in 2011 by US News - Best Lawyers® "Best Law Firms." Mr. Fleishman was recognized by Legal Media in its 2013 and 2014 Guide to the World's Leading Insurance and Reinsurance Lawyers. He was listed in the International Who's Who of Business Lawyers in 2014 for Insurance. Mr. Fleishman was listed in the International Who's Who of Reinsurance and Insurance Lawyers for 2013, 2015 and 2016.

Laura A. Foggan
Crowell & Moring
Louisiana Hayride—Arceneaux and Pro-rata Defense Allocation—the New Trend

Laura Foggan is a partner in Crowell & Moring's Washington, DC office, where she is a member of the firm's Insurance/ Reinsurance Group. She is described by LawDragon 500 Magazine as "one of the most successful advocates for the insurance industry to ever practice" and recently was named Washington DC Insurance "Lawyer of the Year" by Best Lawyers (2017). Laura represents clients in a variety of litigation and counseling matters, including:

- Serving as lead counsel in a wide range of complex insurance matters, such as coverage disputes involving environmental and toxic tort claims, construction, products liability, and privacy and cyber claims, among others. Also represents insurers in bad faith and extra-contractual matters.
- Representing clients in both federal and state appellate courts. Has participated in more than 200 appellate cases including key national precedents on insurance issues.
- Represented the U.S. Chamber of Commerce as amicus curiae before the U.S. Court of Appeals for the Eighth Circuit in Perras v. H&R Block. The Eighth Circuit affirmed denial of class certification, citing the U.S. Chamber's amicus brief in its opinion. Argued before numerous federal circuits and state appellate courts.
- Representing insurance trade associations in litigation, appellate, and other matters, including providing technical analysis of insurance issues and analyzing and formulating regulatory and legislative proposals. Possesses significant experience representing insurer trade groups on a wide variety of issues affecting the business of insurance. Also advocates for individual insurers in legislative and regulatory matters.
- Counseling property and casualty insurers on emerging risks and litigation trends including unmanned aircraft systems (UAS, or more commonly, drones), cyber-liability, global warming (climate change), nanotechnology, and additive ("3D") printing.
- Contributing to pro bono and community service activities, including hosting annual Summer Law Day for incoming students at Thurgood Marshall Academy.

A former co-chair of the Insurance Coverage Litigation Committee of the American Bar Association (ABA) Litigation Section, Laura is praised by Chambers USA as "a highly experienced appellate lawyer" who frequently handles "novel and ground-breaking cases" and "knows coverage issues A-Z" (2016) and by LawDragon 500 Magazine as "the best in the business at protecting insurers facing all types of major claims with an unmatched track record in significant trials and appellate cases" (2014). In addition to her litigation and counseling work described above, Laura represents insurers in arbitrations, as well as Alternative Dispute Resolution (ADR) and mediation proceedings. She handles multi-party negotiations involving private claimants, multiple carriers, and insureds. Laura also assists in drafting insurance policy forms and endorsements, offering strategic suggestions and form language to meet product goals and regulatory requirements.

Laura is regularly rated by Chambers USA as one of Washington's "Leading Lawyers" for insurers in commercial insurance work, is included in the Best Lawyers in America directory for insurance law, and has been named one of Washington's "Top 100 Lawyers" (2012-2016), "Top 50 Women Lawyers" (2009, 2011-2016), "Top 10 Lawyers" (2015), and "Super Lawyers" for Insurance Coverage (2008-2016), among many other honors.

Arthur S. Garrett
Keller and Heckman LLP
Keeping Your "Food Recall Insurance" Fresh

Arthur Garrett is co-chair of Keller and Heckman's national litigation practice. He also serves as the Firm's General Counsel.

Mr. Garrett's litigation practice focuses on insurance recovery with an emphasis on the representation of food industry policyholders. His trial experience has taken him all over the United States to try cases in state and federal courts and mediate/arbitrate disputes on behalf of corporations and trade associations. Mr. Garrett was recently trial counsel that was selected as a Top 10 Defense verdict in the State of California.

He specializes in advising food companies on their liability insurance programs (including GL, D&O, E&O, Excess, Umbrella and specialized recall policies, such as Product Contamination Insurance) and first-party property policies, including open marine/cargo insurance. In such matters, Mr. Garrett provides advice on the appropriate insurance coverage and the rights of policyholders in the event of a loss and in disputes with their insurance carriers. He also provides advice on appropriate risk transfer mechanisms (insurance and indemnity) in commercial transactions. Food recall/insurance coverage situations that Mr. Garrett has handled within the last two (2) years include pomegranate, parsley, alfalfa, soft cheese, and cumin.

Mr. Garrett also serves as Vice Chair of the Insurance Coverage Litigation Committee of the ABA's Tort and Insurance Practice Section.

Tarron Gartner-Ilai
Cooper & Scully, P.C.
Subrogation, Equitable Contribution, and Other Insurance: Untangling The Gordian Knot Without Prolonged Litigation

Tarron Gartner-Ilai has more than 25 years of experience in first-and third-party insurance coverage litigation, including general liability, errors & omissions, directors & officers liability, oil & gas, cyber liability, commercial property, specialty risk, disability, bond and fidelity disputes. Earlier in her career, Tarron spent close to a decade as a Second Vice President of an A+-rated insurer, first as a Managing Claim Coverage Counsel, and later as a General Counselor. Tarron's business and management experience, coupled with her legal acumen, enables her to provide a broad range services to her clients, including coverage analysis and litigation skills, risk management, and insurance program reviews.

Notable Cases:

- Recovered $3.1 million from a general liability insurer for amounts a general contractor paid in settlement of a construction defect claim— Tippman Construction Company v. Selective Insurance Company of South Carolina, Civil Action No. 4:11-cv-00591, in the United States District Court for the Northern District of Texas.
- Prevailed on summary judgment over the termination of an ERISA-based Occupational Injury/Employer's Liability policy— Demand In Arbitration No. 70195 Y 00736 11, Homeland Insurance Company of New York v. Marty Hoffman, Inc.
- Recovered delay damage claim for general contractor against property owner for owner's failure to provide specifications for customized fixtures, resulting in substantial project delays— Demand In Arbitration No. 71110E0000211, SLSJ Associates, LLC. v. St. Paul Place Acquisition Partners, LP.
- Successfully represented subcontractor policyholder in insurance coverage dispute under General Liability policies issued by multiple carriers over multiple policy years, effecting a
- $1.1million settlement of both the coverage and underlying liability dispute.
- Successfully represented a policyholder in a dispute under a non-subscriber policy, resulting in $1.5million settlement on the policyholder's behalf.

Laura Hanson
Meagher & Geer
The Cobbler's Children Have No Shoes: Professional Liability Insurance

Laura focuses her practice on commercial insurance coverage -- especially environmental and construction defect claims and litigation, which she has handled throughout the United States in the state and federal trial and appeals courts. She has appeared in three state supreme courts and four different federal circuit courts of appeals. She is licensed to practice law in Minnesota, Montana, South Dakota and Wisconsin.

Laura repeatedly has been named to the Super Lawyers® list in the category of insurance coverage by Minnesota Super Lawyers magazine. She is also listed in The Best Lawyers in America for her insurance coverage practice.

Laura is co-chair of the Section of Litigation's Insurance Coverage Litigation Committee for the American Bar Association. She is a member of the Defense Research Institute and a speaker at insurance conferences sponsored by the American Bar Association and DRI.

Laura has also published articles in insurance publications, including Claims Magazine, and the publication of National Association of Mutual Insurance Companies (NAMIC).

Susan B. Harwood
Boehm Brown Harwood PA
Chances Are … A Fortuity Case Study

Susan B. Harwood is a partner with Boehm Brown Harwood, P.A. in Maitland, Florida. She concentrates her practice in the areas of first and third party insurance coverage disputes, bad faith and third party liability matters. She has been a member of the Federation of Defense and Corporate Counsel (FDCC) since 2001, where she served on the its Board of Directors from 2011 to 2013. Ms. Harwood was chair of the FDCC's Property Insurance Section in 2007-2009, Dean of the FDCC's Litigation Management College's Graduate Program from 2011-2013, and currently serves on the FDCC's Admissions and Membership committees. A past member of the Tort Trial and Insurance Practice Section of the American Bar Association ("TIPS"), Ms. Harwood has served on the Women and Minority Involvement Committee, as chair of the Property Insurance Law Committee and on the editorial board of The Brief, a TIPS publication. A frequent speaker on insurance coverage topics, Ms. Harwood gave the keynote speech at the Australian Insurance Law Association's 2009 Annual Conference in Melbourne, Australia on recent catastrophic losses in the U.S.

Ms. Harwood currently sits on the Board of Directors of the Windstorm Insurance Network (WIND), an organization dedicated to promoting awareness of windstorm insurance issues through the application of educational initiatives. She was convention chair for WIND's annual 2006 conference held in Orlando, Florida, and she was elected as Secretary for WIND in 2014. Ms. Harwood is also a certified circuit mediator in Florida. She attended Wake Forest University (B.A. 1979) and Wake Forest University's School of Law (J.D. 1983).

Michael W. Huddleston
Munsch Hardt Kopf & Harr, PC
Master Class: Bad Faith Trial Tactics From the Best, For the Best

Mike represents policyholders and assists claimants in insurance recovery involving commercial insurance coverage. He began his career handling complex appeals and insurance litigation. Mike has been involved in many landmark insurance law decisions in Texas, including State Farm Fire & Cas. v. Gandy, Federal Ins. v. Samsung, Zurich Insurance v. Nokia, State Farm Insurance v. Johnson, William M. Mercer v. Woods, and St. Paul Insurance v. Dal-Worth Tank, Pa. Nat'l Insurance v. Kittyhawk, and St. Paul Insurance v. Convalescent Services.

Mike's is considered to be one of Texas' leading experts regarding the duty of liability carriers to settle under the Stowers doctrine. He is often called upon to assist in the drafting and handling of settlement offers in complex personal injury and professional liability cases. He is also often asked to assist policyholders in successfully protecting themselves from adverse verdicts where coverage is disputed.

Mike's insurance practice involves a very wide-range of insurance products, including D & O, professional liability, employment practices, fiduciary liability, commercial general liability, cyber liability, technology errors and omissions, excess/umbrella, non-subscriber plans and employer's liability coverage, healthcare provider insurance, commercial property, builder's risk, business interruption, executive liability, FLSA coverage, Medicare fraud coverage, product recall, crime and fidelity, adjuster errors and omissions, and reinsurance.

Mike is often called upon to serve as a litigation manager or quarterback in complex cases. This is due in part to not only his insurance expertise, but also his work in handling a number of non-insurance appellate matters involving commercial litigation and personal injury. His other appellate decisions include Rose v. Doctor's Hospital (constitutionality of medical malpractice caps) and Christopherson v. Allied Signal (en banc)(expert witness standards pre-Daubert).

His work also includes the drafting of risk management (self-insurance, indemnity and exculpatory clauses, etc.) and insurance procurement provisions in construction, real estate and other commercial contracts. He has also participated in insurance audits and acquisition analysis.

Mike has served as a mediator/arbitrator in complex commercial and insurance matters. He has also served as an expert witness in complex insurance cases.Mike has served on the Planning Committees and served as a Presiding Officer at most of the major insurance law seminars in Texas. He is a prolific writer and commentator on insurance law continuing legal education.

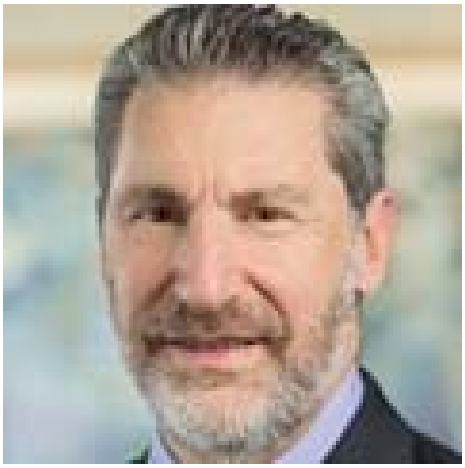
Ronald L. Kammer
Hinshaw & Culbertson LLP
The Cobbler's Children Have No Shoes: Professional Liability Insurance

Ronald Kammer focuses on the representation of insurers nationally. He has been involved in many significant third party coverage disputes including cases that interpreted an insurance company's duty to defend and indemnify, breach of policy conditions, claims involving bad faith and unfair and deceptive trade practices, as well as coverage obligations for construction defect, pollution, trademark and patent infringement claims.

Mr. Kammer also handles first party coverage disputes, including claims involving breach of policy warrants, business interruption, misrepresentation and fraud. He regularly provides advice to insurance carriers and policyholders on issues involving policy interpretation, claims handling practice and procedures, and the drafting of insurance policy provisions. Mr. Kammer also practices in general civil litigation including commercial litigation and legal malpractice.

He has tried cases and handled appeals involving bad faith as well as first and third party insurance coverage disputes including property, commercial general liability, excess and umbrella, professional lines, commercial and personal automobile, homeowners, fidelity bond and life insurance. In addition, Mr. Kammer has served as an expert in legal malpractice, insurance coverage, bad faith and attorney fee disputes.

Anthony B. Leuin
Shartsis Friese LLP
Fifteen Cases in Forty-Five Minutes: The Most Important Coverage and Extracontractual Decisions of the Past Year



Tony Leuin is a senior litigation partner at Shartsis Friese LLP in San Francisco. With over 35 years of experience, he has a broad background in civil disputes of all types, with particular concentration in insurance coverage. He represents policyholders in complex disputes involving commercial insurance policies, such as CGL, Directors and Officers, Errors and Omissions, Employment Practices, property, fidelity and crime policies, surety bonds, and newer products such as cyber coverages and "reps and warranties" insurance to facilitate mergers and acquisitions. Tony's clients include public and private companies who reflect the diversity of American business, from retailing to real estate, medicine to manufacturing, financial services to food and wine.

Tony is a Contributing Editor to California's leading treatise on insurance coverage, The Rutter Group's California Practice Guide: Insurance Litigation. He is a long-time member of the Insurance Coverage Litigation Committee of the ABA's Litigation Section, where he has been a frequent speaker at its annual conference, co-chaired the Construction Litigation sub-committee, and served as Website Managing Editor. He is also a member of the Insurance Coverage Section of the ABA's Forum on the Construction Industry.

Tony sits on the Board of Directors and Executive Committee, and Chairs the Claims Committee, of Pilot/Legis, a Risk Purchasing Group composed of approximately 40 law firms (comprising approximately 1800 lawyers) who purchase Professional Liability cover in the London Market. As a consequence of this work, he has a unique window into Professional Liability insurance, including not only coverage disputes, but also policy drafting and claims handling practices.

R. Hugh Lumpkin
Ver Ploeg & Lumpkin
The Cobbler's Children Have No Shoes: Professional Liability Insurance

Hugh Lumpkin was born in San Tomé, Venezuela, eventually making his home in Miami, Florida. He received his undergraduate degree from Duke University in 1977 and his law degree from the University of Miami in 1980. Since 1983, a substantial portion of his practice included representing both insurers and insureds in coverage and collateral litigation; a focus which became exclusive to policy holder representation beginning in 1999.

In 1999, Hugh made the decision to limit his practice to insurance consulting, litigation, trials and appeals and joined Brenton Ver Ploeg in forming the current firm. Ver Ploeg & Lumpkin, P.A. now employs over fifty people, including 27 attorneys in two Florida offices (Miami and Orlando), limiting its practice to policyholder insurance work, including extracontractual recoveries – a practice which is now national in both scope and reputation.

Mr. Lumpkin earned his AV rating from Martindale in 1994, has been honored as a SuperLawyer since 2006, a Best Lawyer since 2010, was recognized as the top insurance lawyer in Miami in 2013 and 2016, and has been repeatedly recognized by the South Florida Legal Guide and Florida Trend as one of the best lawyers in Florida for insurance coverage and bad faith litigation on the policyholder side of the versus. He was appointed to the American Academy of Contractual and Extra-contractual Counsel in 2014, where he now serves as co-chair of the first party insurance section. He has written and lectured extensively on a variety of topics; not limited to insurance, though the majority of his published and teaching work for the past twenty years has concerned insurance coverage and litigation

Randy J. Maniloff
White & Williams
Alexander Hamilton and James Donavan: Coverage Lawyers Who Mattered

Randy Maniloff is an attorney at White and Williams, LLP in Philadelphia. He concentrates his practice in the representation of insurers in coverage disputes over primary and excess obligations under a host of policies, including commercial general liability and various professional liability policies, such as public official's, law enforcement, educator's, media, computer technology, architects and engineers, lawyers, real estate agents, community associations, environmental contractors, Indian tribes and several others. Randy has significant experience in coverage for environmental damage and toxic torts, liquor liability and construction defect, including additional insured and contractual indemnity issues.

Randy is the co-author of General Liability Insurance Coverage – Key Issues In Every State (Second Edition; Oxford University Press 2012) (with Professor Jeffrey Stempel of the University of Nevada Las Vegas Boyd School of Law). "Key Issues" is a 664 page desk reference book that quickly and conveniently provides the law in every state for 21 important general liability coverage issues.

Randy has been quoted on insurance coverage topics by such media as The Wall Street Journal, The New York Times, USA Today, Dow Jones Newswires, Associated Press, A.M. Best, Business Insurance, National Underwriter, Insurance Journal, The Philadelphia Inquirer, The Times-Picayune and The National Law Journal.

For the past twelve years, Randy has published a year-end article that addresses the ten most significant insurance coverage decisions of that year. Randy has also written for such influential organizations as The Federalist Society, Manhattan Institute and Washington Legal Foundation.

Randy serves as one of three Deans of the White and Williams Coverage College - an annual event that brings together 500 insurance professionals from across the country, representing approximately 150 companies, for an intensive day-long curriculum of insurance coverage education.

Before entering private practice, Randy spent four years as counsel to Professional Travel Insurance Company, Ltd., a Gibraltar-based insurer conducting business primarily in the United Kingdom.

Randy is a frequent lecturer at industry seminars and has published approximately 60 articles in a variety of insurance publications addressing a multitude of coverage issues.

Christopher W. Martin
Martin Disiere Jefferson & Wisdom
Master Class: Bad Faith Trial Tactics From the Best, For the Best

Mr. Martin is one of the most recognized insurance attorneys in the country. He has a national reputation for trying insurance coverage and bad faith cases across the country with particular emphasis in Texas, Oklahoma, and the Gulf Coast. He is the founding partner of Martin, Disiere, Jefferson & Wisdom, LLP, a 70 lawyer insurance litigation boutique with offices in Houston, Dallas and Austin, Texas. Chris has authored three treatises on Texas Insurance Law and more than 100 articles on insurance claims, coverage issues and the trials of insurance lawsuits. For the last eight consecutive years, Chambers USA has named him the top insurance litigation attorney in Texas. Three times over the last decade, The Texas Lawyer named him one of the top five “Go To” Insurance Lawyers in Texas. He has received repeated accolades from Super Lawyers, Best Lawyers, and The International Guide to Insurance Lawyers. He is a graduate of Baylor University and the Baylor School of Law.

Lorelie S. Masters
Hunton & Williams
Reflections on a Paradigm Shift for Extra-Contractual Liability in the Restatement of the Law, Liability Insurance

A prominent insurance coverage litigator, Lorie handles all aspects of complex, commercial litigation and arbitration.
She has recovered millions of dollars of insurance coverage for products, environmental, employment, directors and officers, fiduciary, property damage, cyber and other liabilities. Lorie also handles various types of first-party property insurance claims, including claims under boiler and machinery, business-interruption, contingent business-interruption, extra expense and other related coverages.

Lorie is a partner in the insurance coverage practice, and clients say she “is very good at explaining complicated issues, and then distilling them for commercial use,” according to Chambers USA 2016, which ranks her in the upper echelons of her practice nationwide.

Lorie writes and speaks extensively on insurance coverage, technology and litigation. In addition to her legal practice, she is active in diversity and inclusion matters and has represented many individuals and groups pro bono, including policyholders denied health care coverage and victims of human trafficking.

Lorie is admitted to practice in the US Supreme Court, US Court of Appeals for the District of Columbia Circuit, US Court of Appeals for the Fourth Circuit, US District Court for the District of Columbia, US District Court for the District of Maryland, US District Court for the Eastern District of Michigan and the US District Court for the Northern District of Ohio.

Relevant Experience

- Represents large and small companies, trade associations and individuals seeking to enforce their insurance coverage.
- Lead counsel in a case awarding full policy limits, plus attorney fees and interest, to the policyholder under a contract requiring arbitration in London.
- Lead trial counsel for a major chemical company in a coverage case resulting in a jury verdict named by The National Law Journal as one of the most significant of the year.
- Served as lead counsel in numerous matters obtaining millions of dollars in recoveries in environmental coverage cases and has succeeded in helping clients find millions of dollars in “lost insurance” policy assets.

Doug McIntosh
McIntosh Sawran & Cartaya, P.A.
You Screwed Up: You Trusted Us!: Conflicts Among Insurers, Independent Counsel, and Insureds

Douglas M. McIntosh founded the firm in 1989. He has handled a broad range of personal injury, product liability, commercial and professional negligence litigation, including legal, dental and medical malpractice defense, product liability and insurance coverage litigation. He has had the opportunity to counsel insurance companies on bad faith, professional errors and omissions, general liability and all-risk policies of insurance and focuses his practice predominantly on catastrophic damages and insurance coverage matters. He developed the Healthcare Law Practice Division and the Insurance Coverage Division in the firm. He has served as a testifying expert in state and federal courts in bad faith, primary, excess and reinsurance law cases. He has served on the Board of Directors and is a past president of the Florida Defense Lawyers Association (FDLA), a one-thousand member organization of the civil defense bar of this state. He has been awarded this organization's highest achievement award for his efforts for the defense bar statewide and nationally. Doug is an elected member of the International Association of Defense Counsel (IADC) and serves on its professional liability, medical malpractice and admiralty law committees.

He is an elected member of the Association of Defense Trial Attorneys (ADTA). Doug is also an active member of DRI, and served for five years as the appointed Florida statewide representative to this national organization. He was elected as a National Director on its Board of Directors and served a three year term. Doug has served on numerous DRI committees, and chaired its insurance roundtable in 2009. He has served as chairperson of the Broward County Bar Association Professionalism Committee for many years and has chaired the Peer Review Council. He was awarded the BCBA Lynn Futch Professionalism in Practice Award in 2004, and the St. Thomas More Society Archbishop McCarthy Award in 2006. He has lectured to state leaders around the country on substantive and defense trial practice issues. Doug is a member of the Board of Governors of the Shepard Broad Law Center of Nova University. He is also an invited member of the Council on Litigation Management, a nonpartisan alliance of insurance companies, corporations, corporate counsel, litigation and risk managers, claims professionals and outside counsel.

He is admitted to practice in the state and federal courts in Florida and is admitted to practice before the United States Supreme Court. Doug helped found Hope Outreach Center, Inc., a community outreach program in Broward County (Florida) and served as its president for many years. He has also served as a member to Florida Supreme Court-appointed committees, and received an award from the Florida Supreme Court as a guardian ad litem for children in Broward County. Doug has been awarded a Peer Review Rating of “AV” by the LexisNexis Martindale-Hubbell Law Directory. He has also been voted by his peers for inclusion in Best Lawyers in America, the oldest and one of the most respected publications in the legal profession. He has been named a South Florida "Top Lawyer" and a "Super Lawyer" by peer publication reviews. Doug has authored numerous articles, published chapters on defense techniques for major publishers and has lectured frequently on a variety of topics, including trial techniques, bad faith and insurance coverage in Florida and law firm economics and business practices. Doug is a state qualified arbitrator and has served as selected mediator, panel and sole arbitrator, in a number of matters.

Suzanne C. Midlige
Coughlin Duffy LLP
Fifteen Cases in Forty-Five Minutes: The Most Important Coverage and Extracontractual Decisions of the Past Year

Suzanne Cocco Midlige is the Managing Partner and a founding member of Coughlin Duffy and a member of the Insurance and Reinsurance Services Group.

Prior to election to Managing Partner, Suzanne served as the Practice Group Leader for the Insurance and Reinsurance Services Group from 2004 to 2012. Suzanne's practice focuses on the representation of domestic and international insurers and reinsurers in litigated and non-litigated matters.

In 1992, Suzanne joined the law firm of McElroy Deutsch & Mulvaney LLP where she served as a Practice Group Administrator for the Insurance Services Group. She was made a partner in 1999 and remained at that firm until she resigned in March 2004 to start the firm of Coughlin Duffy LLP.

Julia A. Molander
Cozen O'Connor
Keeping Your "Food Recall Insurance" Fresh

Julia A. Molander represents the insurance industry in virtually all aspects of their business, including insurance coverage litigation, insurance counseling, extracontractual (bad faith) liability, insurance fraud, underwriting matters, policy drafting, regulatory compliance, brokerage and agency liability, insurance insolvency and legislative issues. She has served as first-chair in more than 20 bench trials, jury trials and arbitrations.

Julia has more than 30 years experience in strategically managing insurance risk, on an enterprise-wide basis (state, regional and national), in areas such as construction defects, class actions, cyber risks, trucking and cumulative trauma. Julia was elected a fellow of the American College of Coverage and Extracontractual Counsel in 2014 and the Insurance Litigation Institute of America, where she currently serves as chair. She is rated AV Pre-eminent by her peers and has been recognized as a “Super Lawyer” since 2005.

Julia has lectured at major professional conferences sponsored by the American Bar Association, Association of Defense Counsel, Defense Research Institute, Association of California Insurance Companies, the California Continuing Education of the Bar, the American Conference Institute, the Property Law Research Bureau, the Insurance Risk Management Institute and the Practising Law Institute. She is a contributing editor the CEB publication California Liability Insurance Practice: Claims and Litigation. She has published numerous articles and scholarly discussions on a variety of insurance topics.

Nicholas N. Nierengarten
Gray Plant Mooty
Show Me the Money: Latest Developments in the Recovery of Attorneys Fees in Coverage and Bad Faith Litigation

Nick Nierengarten is a principal at Gray Plant Mooty in its Minneapolis office, where his practice spans the full spectrum of insurance coverage issues. For over 30 years, Nick has represented policyholders on insurance coverage matters, including advising on and negotiating coverage, and litigating coverage disputes. He is an active member of the TIPS Insurance Coverage Litigation Committee, having recently been a contributing author to the Committee's treatise on the reasonable expectations doctrine. Nick is also a senior editor of the International Risk Management Institute (IRMI) Commercial General Liability Reporter. He is a frequent author and lecturer on insurance-related topics.

Barbara A. O'Donnell
Zelle McDonough & Cohen LLP
Master Class: Bad Faith Trial Tactics From the Best, For the Best

Barbara O'Donnell has more than 20 years of experience in matters of insurance coverage, extra contractual liability, insurance agent/broker liability, and professional liability law. Ms. O'Donnell's practice is regional, and she has substantial experience in handling coverage and bad faith claims in state and federal courts throughout the Northeast.

Ms. O'Donnell's insurance coverage practice encompasses a broad range of liability coverage issues under commercial, specialty lines, professional, directors and officers, and other standard form and manuscript policies. She regularly advises and represents insurers in complex coverage disputes involving allocation issues, primary/excess obligations, advertising injury coverage, additional and other insured questions, application misrepresentation defenses, and the application of exclusions under claims made and occurrence based policies. Ms. O'Donnell also counsels insurers concerning claims handling obligations and effective ways to minimize exposure to extra contractual liability claims. Drawing on the breadth of her industry experience, Ms. O'Donnell also drafts policy forms and endorsements for insurers.

Ms. O'Donnell holds leadership positions in national bar organizations and industry organizations. She is the immediate past Chair of the FDCC's Reinsurance, Excess and Surplus Lines Section and a past Chair of FDCC's Extra Contractual Liability Section. A past chair of the ABA/TIPS Insurance Coverage Litigation Committee, Ms. O'Donnell currently co-chairs the ABA/TIPS Book Publishing Board and serves on the ABA Standing Committee on Publishing Oversight. She is a past editor of TortSource, an ABA/TIPS publication, and also served for several years on the editorial board of the ABA/TIPS Tort Trial and Insurance Practice Law Journal. Ms. O'Donnell also served as the articles editor for The CGL Reporter, a biannual International Risk Management Institute publication, for a number of years. She also served as a Faculty Mentor at FDCC Graduate Litigation Management Programs offered to senior level insurance industry professionals.

Ms. O'Donnell frequently writes and speaks on insurance coverage topics. Ms. O'Donnell's article entitled "Preparing for and Defending Against Bad Faith Claims" appeared in the Summer 2016 issue of The Brief, an ABA Tort and Insurance Practice Section (TIPS) Publication. In February 2017, she participated in a panel discussion regarding significant trends in insurance coverage and bad faith litigation at the ABA/TIPS Insurance Coverage Litigation Committee Midyear meeting. In 2012, she spoke at DRI's Insurance Coverage Claims Institute on the topic "Defenses To Bad Faith Actions: Do They Exist And Do They Work" and moderated a panel discussion on "Multiple Claimants and Insufficient Limits - Can Insurers Lessen their Exposure to Bad Faith Claims" at the FDCC's Winter Meeting. She authored the opening chapter on "Insurance Policy Interpretation and Construction" in the West Group/American Bar Association (ABA) treatise entitled The Law and Practice of Insurance Coverage Litigation. Ms. O'Donnell's article entitled "The First Wave of Decisions Interpreting Employment Practices Liability Policies" appeared in the Fall 2005 issue of The Brief.

Lee H. Ogburn
Kramon and Graham PA
Building Product Class Actions - Coverage Under the Roof?

As chair of Kramon & Graham's Insurance Coverage practice, Lee Ogburn has established a national reputation for excellence as counsel to property and casualty insurers. Clients rely upon Lee's knowledge of the insurance industry, effective negotiation skills, and persuasive advocacy. He has served as lead counsel in trial and appellate courts nationwide, handling insurance disputes and claims involving hundreds of millions of dollars. Lee represents insurers in coverage disputes involving environmental and toxic tort, business tort, products liability, construction, and commercial claims. He also represents insurers in first party disputes.

Lee has appeared in every edition of the peer-nominated publication The Best Lawyers in America since 2008. He has been recognized in Best Lawyers for Bet-the-Company Litigation (since 2010), Commercial Litigation (since 2008), and Insurance Law (since 2010). In 2013, he was recognized by Best Lawyers as Baltimore Insurance Lawyer of the Year. Lee has appeared in every issue of Maryland Super Lawyers since 2007.

Lee is a 2015 recipient of the Daily Record's Leadership in Law Award. In 2013, he received the Champion of Justice Award from the Equal Justice Council of Maryland Legal Aid for his leadership in promoting equal access to justice.

Lee is the Co-Chair of the Equal Justice Council of Maryland Legal Aid. He formerly Co-Chaired the Equal Justice Council's Law Firm Campaign. Lee is also Chair of the Board of Directors for the Baltimore School for the Arts. He is a member of the Maryland Public Justice Center Advisory Council. He formerly served as Vice President of the Board and Chair of the Audit Committee of The Bryn Mawr School.

Lee is a member of the Maryland State Bar Association, American Bar Association, Public Justice Center Advisory Council and the American College of Coverage and Extracontractual Counsel.

Myles A. Parker
Carroll Warren & Parker PLLC
Chances Are … A Fortuity Case Study

Mr. Parker is an Equity Partner in Carroll Warren & Parker PLLC. He is admitted in Texas and Mississippi, and practices from offices in Houston, Texas and Jackson, Mississippi. His career spans more than 26 years, where he has served as lead counsel in numerous complex insurance coverage matters. He regularly represents quota share markets in major loss situations, guiding domestic and international insurers/reinsurers through the legal aspects of claims handling and coverage assessment.

Mr. Parker is a Fellow of the American College of Coverage and Extracontractual Counsel, and of the Litigation Counsel of America. He is AV rated by Martindale-Hubbell, and is recognized as a Leader in the Field by Chambers and Partners USA. He is a Member of the Million Dollar Advocates Forum, and is a Mid-South Super Lawyer. His professional accomplishments have been recognized by various other legal organizations, including his selection by Best Lawyers as one of the Best Lawyers in America, and by America's Top 100 Attorneys for its Lifetime Achievement award.

Mr. Parker is admitted in the U.S. Supreme Court; U.S. Courts of Appeal – Fifth, Sixth & Eighth Circuits; U.S. District Courts – Texas, Mississippi & Puerto Rico; and State Courts – Texas & Mississippi.

Sherilyn Pastor
McCarter & English
The Cobbler's Children Have No Shoes: Professional Liability Insurance

Sherilyn Pastor is Practice Group Leader of McCarter's Insurance Coverage Group. She is an experienced trial attorney, who has secured hundreds of millions of dollars in insurance for corporate policyholders. She litigates complex coverage matters throughout the country and abroad, and provides insurance coverage advice to clients assessing their potential risks, analyzing new insurance products, and considering the adequacy of their programs.

By way of example, Ms. Pastor defended Transamerica Corporation in a dispute with a former subsidiary (IMO Industries) regarding the $1.5 billion in insurance coverage. Transamerica had purchased for itself and its subsidiaries as part of a consolidated risk management approach. After a six-month trial for this policyholder, the court ruled in Transamerica's favor on all claims against it, entering declaratory judgment that Transamerica's decades old divesture agreement left its former subsidiary liable for its own asbestos losses. The court rejected that Transamerica was responsible for deductibles, retentions, or gaps in insurance coverage, or was effectively transformed into a "de facto" insurer because of its risk management efforts. The Appellate Division upheld all of the trial court's rulings in a 114-page decision, 81 pages of which it approved for publication, in September 2014. The N.J. Supreme Court refused to disturb them in July 2015, and order costs be paid in Transamerica's favor.

Ms. Pastor has shaped insurance law. She obtained summary judgment awarding Wakefern Food Corporation insurance for all its Northeast blackout losses, establishing New Jersey law that "physical damage" in a property and business interruption policy includes loss of use, value and function. She convinced a federal court that an employee's bill padding and kickback scheme was a direct and covered loss under a crime insurance policy. The court agreed with her, in awarding summary judgment to her client, that having the funds pass through an intermediary did not change the fundamental nature and effect of the employee's theft and unlawful taking of property. Ms. Pastor also helped Lucent Technologies Inc. (now Alcatel Lucent) recover its fiduciary liability coverage following various class action settlements with ERISA plaintiffs.

Ms. Pastor is on the Board of Regents of the American College of Coverage and Extracontractual Counsel (ACCEC), and Co-Chair of its Professional Liability Committee. She received the College's Thomas F. Segalla Award in 2015. Ms. Pastor is the Immediate Past Chair (Policyholder Side) of the ABA Litigation Section's Insurance Coverage Litigation Committee, having served as Vice-Chair from 2009-2012 and as co-chair of various ICLC subcommittees since 2002. Ms. Pastor was a member of the New Jersey Supreme Court's Professional Responsibility Rules Committee for over a decade, and a member of the New Jersey Supreme Court's Working Group on Ethical Issues Involving Metadata in Electronic Documents. She also serves as an Editorial Consultant to Law360: Insurance, and was on the Editorial Boards of the Insurance Coverage Law Bulletin, and a consultant on the New Appleman Insurance Law Practice Guide.

Martin C. Pentz
Foley Hoag LLP
Louisiana Hayride—Arceneaux and Pro-rata Defense Allocation—the New Trend

Martin C. Pentz is a partner in the Boston office of Foley Hoag LLP, where he chairs the firm's insurance recovery practice group. His practice focuses on the litigation and trial of insurance coverage disputes on behalf of policyholders. Mr. Pentz was lead counsel for the policyholder in such cases as Certain Underwriters at Lloyd's, London v. Chicago Bridge & Iron Co., 406 S.W.3d 326 (Tex. App.-Beaumont 2013, writ denied); EaglePicher Management Co. v. Zurich Amer. Ins. Co., 640 F.Supp.2d 1109 (D. Ariz. 2009); OneBeacon Insurance Co. v. Georgia-Pacific Corp., 474 F.3d 6 (1st Cir. 2007); Chicago Bridge & Iron Co. v. Certain Underwriters at Lloyd's, London, 59 Mass. App. Ct. 646 (2003); and Hakim v. Massachusetts Insurers Insolvency Fund, 424 Mass. 275 (1997). He is a co-author of Massachusetts Liability Insurance Manual (MCLE 2014).
Mr. Pentz is a Co-Chair of the COL/Excess Liability Insurance Committee of the ACCEC and a Co-Chair of the Insurance and Reinsurance Committee of the Insurance and Tort Litigation Section of the Boston Bar Association. He is listed in The Best Lawyers in America (Woodward/White, Inc.) and Massa.chusetts Super Lawyers, Insurance Coverage Litigation.

Neil B. Posner
Much Shelist
You Screwed Up: You Trusted Us!: Conflicts Among Insurers, Independent Counsel, and Insureds

Neil Posner successfully counsels his clients on the complexities of buying and maintaining insurance, and using insurance as part of an overall risk-management program. Chair of the firm's Policyholders' Insurance Coverage group, Neil focuses on insurance recovery and dispute resolution, risk management, loss prevention and cost containment. His clients include public and private companies, organizations, boards of directors, individual officers and other policyholders. Neil assists clients in analyzing, negotiating and enhancing a wide range of insurance policies and plans, including Directors' and Officers' Liability. Errors and Omissions/Professional Liability, Employment Practices Liability, Fiduciary Liability, Bankers Professional Liability and Financial Institution Bonds, Cyber Liability, E-Commerce, and Privacy Risks, Commercial Property, Intellectual Property Insurance, Construction Insurance, and Transportation, Transportation Broker, and Contingent Cargo Liability.

In addition to counseling clients with regard to ongoing and future insurance requirements, Neil helps policyholders resolve all types of insurance coverage disputes, through negotiation, litigation and other forms of dispute resolution, including mediation, arbitration and settlement. He has successfully obtained insurance coverage for defendants involved in a variety of class actions and other complex lawsuits. For example, when the former CEO of a bankrupt Chicago-area public company was named in a shareholder class action brought by the bankruptcy estate — alleging securities fraud and breach of fiduciary duty, and seeking to recover damage claims totaling nearly $400 million — Neil helped his client obtain effective insurance coverage.

Neil also practices extensively in the area of lawyer's professional liability, which includes counseling lawyers and law firms on professional responsibility and ethics matters. He has served as an expert witness in this area, and speaks and writes extensively on the subject. Neil is admitted to practice in Illinois and Wisconsin, the United States District Courts for the Northern District of Illinois and the Eastern District of Wisconsin, and the United States Tax Court.

Jay R. Sever
Phelps Dunbar LLP
Louisiana Hayride—Arceneaux and Pro-rata Defense Allocation—the New Trend

Jay Russell Sever obtained his undergraduate degree from the University of Maryland, B.S., 1986, and his J.D., 1991, from Tulane University Law School, where he served as the Senior Notes and Comments Editor, Tulane Law Review. He is admitted to practice in Louisiana and California.
Mr. Sever is a partner in the Insurance and Reinsurance group of Phelps Dunbar. He is also the Practice Coordinator for the Insurance and Reinsurance group in the New Orleans office. He serves as local, regional and national coverage counsel for both foreign and domestic insurance companies. He counsels clients, manages disputes and tries cases involving a wide variety of insurance coverage issues, including matters arising from bad faith, construction defect claims, third-party liability claims, first-party claims, professional liability claims, crane and rigging claims, racing and competitive sport claims, entertainment claims, transportation claims, environmental claims, general and toxic tort claims, advertising, copyright and trademark claims, media liability claims, multiple-year trigger and allocation issues, marine liability claims, Louisiana direct action claims and numerous others.

In addition to handling cases in Louisiana and California courts in which he is admitted, Mr. Sever also has acted as lead counsel in cases pending in Alabama, Florida, Georgia, Illinois, Indiana, Kentucky, Mississippi, New Jersey, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Texas, Virginia and Washington. Mr. Sever's practice, both litigation and counseling, involves attorneys from all of Phelps Dunbar's offices in the Gulf South and, where necessary, local counsel in states throughout the United States.

He has spoken on insurance coverage and litigation issues for multiple groups, including MC Consultants Inc. - Construction Litigation & Insurance Coverage Conference, Value Engineered Alternative Dispute Resolution (VEADR) Conference, HarrisMartin CAT Flood and Windstorm Litigation Conference, 8th Annual East Region Construction Litigation & Insurance Coverage Conference, Claims Legal Management (“CLM”) Conference, Federation of Defense and Corporate Counsel (“FDCC”), National Business Institute, New Jersey State Bar Association, and the University of Texas School of Law.

He is a member of the Louisiana State Bar Association, State Bar of California, Federal Bar Association, American Bar Association, Bar Association of the Fifth Federal Circuit, Federation of Defense & Corporate Counsel (FDCC), Defense Research Institute (DRI, The Voice of the Defense Bar), Claims and Litigation Management Alliance (“CLM”), and American College of Coverage and Extracontractual Counsel (ACCEC).

His recognition includes New Orleans Magazine - Top Lawyers: Insurance Law, AV© Preeminent Peer Review Rated by Martindale-Hubbell, and Louisiana Super Lawyers.

Elizabeth Stewart
Murtha Cullina
War and Peace (The Abridged Version): Application of the War and Terrorism Exclusions

Elizabeth Stewart is a trial lawyer, principally handling policyholder-side insurance coverage and complex commercial litigation. She recovers insurance proceeds and defense costs for policyholders facing large exposures and liabilities. The policies at issue have covered directors and officers, environmental, construction, products liability, property, business interruption, asbestos and employment claims.

Elizabeth is a Fellow of the American College of Coverage and Extracontractual Counsel and a member of the Insurance Coverage Litigation Committee of the American Bar Association and the Executive Committee of the Insurance Section of the Connecticut Bar Association. She also was appointed by Connecticut's Chief Justice to the Connecticut Civil Commission.

Elizabeth's Representative Insurance Coverage Cases:

- Won a bench trial awarding coverage to a Roman Catholic diocese for settlements of sexual misconduct claims. Hartford Roman Catholic Diocesan Corp. v. Interstate Fire & Cas. Co., 2016 U.S. Dist. Lexis 99369 (2016).
- Lead attorney for insulation installer on appeal on allocation issues for coverage for asbestos claims. New England Insulation Co. v. Liberty Mut. Ins. Co., 988 N.E. 2d 450 (Mass App. Ct. 2013), cert. denied, 991 N.E. 2d 188 (2013).
- Won a jury verdict against broker who failed to secure stop loss health insurance for approximately 2,000 employees and tribe members. Affirmed on appeal. Viejas Band of Kumeyaay Indians v. Lorinsky, 116 Conn. App. 144 (2009).

Elizabeth's Recent Speeches, Presentations and Publications on Coverage:

- Co-Author: "Insurance Bad Faith Litigation: Connecticut Law Developments," 89 Connecticut Bar Journal 285 (June 2016)
- Facilitator: Claims Handling Experts: How to Find Them, Manage Them and Win With Them (ABA Mar. 6, 2015)
- Speaker: Cover Yourself (And Your Client): Critical Insurance Considerations When Prosecuting and Defending Civil Actions (CBA Apr. 16, 2013)
- Speaker: Indemnification Clauses: A Practical Look at Everyday Issues (ACCA Westchester and Fairfield Chapter Apr. 1, 2011)
- Panelist: Oops, I Want That Back: Clawing Back Privileged Documents (ABA Mar. 6, 2009)
- Speaker: Bad Faith Claims Litigation: Policyholder and Insurer (CBA Oct. 27, 2008)

Elizabeth served as Murtha Cullina's Managing Partner from 2009 through 2014 and as Chair of the Firm's litigation department from 1998 through 2006.

Jeffrey Thomas
University of Missouri - Kansas City
Reflections on a Paradigm Shift for Extra-Contractual Liability in the Restatement of the Law, Liability Insurance

Jeffrey E. Thomas is the Daniel L. Brenner Faculty Scholar, Professor of Law, and Associate Dean for International Programs at the University of Missouri – Kansas City. He earned a Bachelor of Arts degree from Loyola Marymount University in 1983 (magna cum laude), and his Juris Doctor degree from University of California, Berkeley in 1986.

Insurance law is his primary research area. He served as the Editor-in-Chief of the New Appleman Library Edition, is co-author of the three-volume treatise Uninsured and Underinsured Motorist Insurance (with Alan Widiss), and his articles have been published in academic journals in the United States, China, Europe, India, Thailand, and the United Kingdom. He has served as President of the Asia Pacific Risk and Insurance Association, Chair of the Insurance Law Section of the Association of American Law Schools, a member of the Task Force on Federal Involvement in Insurance Regulation Modernization for the Tort Trial and Insurance Practice Section of the ABA, and as an Adviser to the American Law Institute's Restatement of the Law, Liability Insurance.

Professor Thomas practiced law with the firm of Irell & Manella before entering academia, where a significant portion of his practice involved insurance coverage and bad faith. He has served as an expert consultant and witness on insurance-related cases for policyholders, insurers and claimants. He is a member of the California Bar.

Dean Thomas previously taught at the University of Chicago as Bigelow Teaching Fellow, at Loyola Law School (Los Angeles) as an adjunct, at University of Connecticut as a summer visitor, and is a two-time Fulbright Fellow to China (1999-2000) and Russia (2010).

Sara Thorpe
Nicolaides Fink Thorpe Michaelides Sullivan LLP
Show Me the Money: Latest Developments in the Recovery of Attorneys Fees in Coverage and Bad Faith Litigation

Sara M. Thorpe is a founding partner of Nicolaides Fink Thorpe Michaelides Sullivan LLP. The firm's focus is on representing insurers in coverage disputes. From offices in California (San Francisco, Los Angeles, and San Diego), Chicago, and New York, Sara and her colleagues assist insurers with a wide-range of insurance policies and issues. Sara's experience includes over 25 years litigating complex coverage issues involving asbestos, environmental contamination, general liability, and professional liability, and defending against "bad faith" and unfair business practice claims.

Sara is AV rated by Martindale-Hubbell. Chambers reports that clients and peers describe Sara as a "bright and tough lawyer" who is a "vigorous advocate for her clients," "very thorough" and "very passionate."

Ellen M. Van Meir
Thompson Coe
Subrogation, Equitable Contribution, and Other Insurance: Untangling The Gordian Knot Without Prolonged Litigation

Ellen Van Meir represents commercial lines insurers in matters including questions of coverage, Stowers' liability and "bad faith." Ellen vigorously represents her carrier clients in cases throughout the country. Ellen has also handled appellate matters in various Texas appellate courts and the U.S. Court of Appeals for the Fifth, Eighth, Ninth and Tenth Circuits. She frequently counsels her clients in matters of policy contract rights and obligations, good faith duties to insureds and settlement and allocation issues involving single and multi-carrier cases. Ellen represents some of the largest and most sophisticated insurers in areas of liability, professional errors and omissions, property, umbrella and excess coverage.

Representative Experience

- Prevailed in Texas Federal Court on claims for breach of contract related to medical malfeasance and breach of civil liberties.
- Prevailed in Texas trial and appellate courts on claims for pollution coverage.
- Represented insurance carriers in several multi-million dollar "personal and advertising injury" claims in litigation.
- Represented a major insurance carrier in evaluating what is an "accident" or occurrence in the Tenth Circuit.
- Designated national coverage counsel for the Deepwater Horizon incident on behalf of a major insurance group.
- Representing an insurance carrier in coverage disputes involving international losses and Defense Base Act claims.
- Representing major insurers evaluating massive construction litigation claims in Arizona, California, Hawaii and Nevada.
- Represented a major insurance company in an appeal to the Eighth Circuit resolving issues of what is an "occurrence" under Arkansas law.
- Obtained a jury verdict and appellate decision in favor of major insurance company client in a case of allocation of covered damages between two insurers in a construction defect matter.
- Represented a major insurance company in an appeal in which the United States Court of Appeals in the Fifth Circuit affirmed the district court's judgment that the claims for trademark infringement and unfair competition did not state claims in "personal and advertising injury" in the insurance policy.
- Represented a major insurance company in an appeal in which the United States Court of Appeals for the Fifth Circuit affirmed the district court's judgment allocating a settlement to uncovered claims and requiring the insured to reimburse the carrier.
- Negotiated a settlement on behalf of major insurer to resolve a multi-million dollar dispute between major travel industries entities.
- Litigated a commercial indemnity case of first impression between major petrochemical companies.
- Prevailed in California Federal Court in personal and advertising injury case determining the scope of libel and slander offense coverage under 9th circuit law.
- Negotiated resolution of multi-insurer copyright infringement case involving horizontal allocation, primary/excess and personal and advertising injury issues regarding theft of architectural plans.
- Monitored and participated in resolving several multi-million dollar construction defect cases in South Texas in state and federal courts.
- Tried to judgment in client's favor advertising injury coverage disputes involving theft of trade names and trade secrets.

Joyce C. Wang
Carlson, Calladine & Peterson LLP
Master Class: Bad Faith Trial Tactics From the Best, For the Best

Joyce C. Wang is a founding partner of Carlson, Calladine & Peterson LLP and a nationally recognized litigator in the area of insurance coverage and bad faith. For over 30 years, she has represented national and international property and casualty insurers and reinsurers, as well as policyholders in complex commercial property and casualty insurance disputes. She is the head of the firm's cyber coverage practice and is admitted in California and Hawaii.

Ms. Wang's experience includes cases arising from catastrophes such as September 11, Hurricane Katrina, and the Honshu Tsunami, as well as large industrial and energy losses, cyber attacks and fraud. She also handles liability insurance disputes and has successfully obtained summary judgment on the grounds the conduct alleged was not an "accident" under a CGL policy. Her effective advocacy and professionalism enable her to successfully resolve many disputes before trial by way of dispositive motions. Through her extensive knowledge of insurance policies, case law, insurance regulations and statutes, she has earned a national reputation in the field.

Ms. Wang was instrumental in the 9th Circuit appeal in Northrop Grumman Corp. v. Factory Mutual Insurance Co., resulting in a ruling that the Policy's Flood exclusion clearly and unambiguously applied to hurricane storm surge. She subsequently obtained summary judgment on the bad faith, misrepresentation and fraud causes of action on the grounds that Factory Mutual's position was reasonable as a matter of law.

Ms. Wang is a past chair of the Property Insurance Law Committee (ABA) and an active member of the Federation of Defense and Corporate Counsel and the American College of Coverage and Extracontractual Counsel. She is a frequent panelist on insurance and bad faith law both here and abroad. California Lawyer Magazine voted her one of the 25 most influential lawyers in California after she argued before the California Supreme Court on behalf of a class of children affected by lead poisoning. She has been selected as a Northern California Super Lawyer every year since it began in San Francisco in 2004. Ms. Wang was recognized by San Francisco Magazine in 2012 as a Top Woman Attorney in Northern California, and by Fortune Magazine in 2013 as a Woman Leader in the Law.

Ms. Wang is admitted to all California State Courts, the U.S. District Court (Northern, Central and Eastern Districts of California), the Ninth Circuit Court of Appeals and all courts in the State of Hawaii.