
American College of Coverage Counsel
2020 Annual Meeting
September 10, 11, 24 & 25 | VIRTUAL

PAPERS

The Coronavirus' Impact on Business Interruption Coverage
Is "Direct Physical Loss" Being Redefined?

By: Rick Hammond, Partner
HeplerBroom, LLC, Chicago, Illinois

Background

Recent years have witnessed pandemic outbreaks of Ebola, H1N1, Avian flu and Legionnaires' disease, and now the world is reeling from the impact of the COVID-19 ("Coronavirus disease"). Pandemics occur when new viruses emerge which are able to infect people easily and spread from person-to-person in an efficient and sustained way. Currently, the number of people testing positive for Coronavirus is increasing in most areas of the world, at the same time that its impact on business is expanding its reach. Thus, there has been large-scale disruption of global supply chains, and possible forthcoming government-imposed closure orders. This situation is causing insurers and policyholders to closely examine whether their business insurance policies can be construed to provide coverage for the loss of business income associated with this developing pandemic.

Under that backdrop, this article will provide an overview of the underlying principles of business interruption insurance, discuss how courts may treat the business losses associated with the Coronavirus crisis, and examine whether the "direct physical loss or damage" requirement has been met when a business is impacted by this viral outbreak.

Scope of Coverage

Business interruption insurance is designed to protect the *prospective earnings* of a business. It is also designed to do for the insured, in the event of a loss, what the business would have done for itself if an interruption in the operation of the business had not occurred. Thus, business interruption insurance is designed to indemnify the policyholder for losses arising from a business's inability to continue its normal operations and functions. Coverage is generally triggered by the total or partial suspension of business operations due to the loss, loss of use, or damage to all or part of the buildings, plant, machinery, equipment, or other business personal property as the result of a covered cause of loss.

Coverage is generally provided for the "period of restoration," which is considered the period required to rebuild, repair or replace the damaged property at the described premises with reasonable speed and similar quality. It usually commences with the date of the property's

damage or destruction, and it is not generally limited by the date of the policy's expiration. Moreover, actual profits and business expenses covered by the policy are usually determined in a manner which gives due consideration for the character of the business along with the manner in which it conducts its activities.

Valuating a Business Interruption Loss

There is no prescribed or accepted formula for determining the actual loss of net profits and business expenses covered by business interruption insurance. The method employed, however, should test the insured's historical profitability, i.e., past experience and the probabilities of the future, and the loss should be determined in a practical way, having regard for the nature of the business and the methods employed in its operation.

Further, it should give practical effect to the intentions of the parties and the purpose of the insurance, as evidenced by the terms, conditions, and provisions of the policy. Thus, the insured's books and accounting system are not controlling in determining the recoverable loss under the policy of insurance. On the other hand, they are not irrelevant and should be given such weight as practical judgment dictates.

Coverage Requirements

Three separate components must be connected in order to satisfy the requirements of the typical business interruption insuring agreement:

1. A covered cause of loss must cause *direct physical loss* of or damage to the property *at the described premises*;

2 The covered loss must cause a *necessary suspension or interruption of operations*; and;

3. The *business income loss* must be caused by the suspension or interruption.

With respect to the "covered cause of loss" requirement, most commercial property policies are written on "all-risk" forms. An all-risk form covers all perils that are not specifically excluded; however, it does not cover every risk. The "causes of loss" section of an all-risk policy lists the perils that are excluded.

Because of prior pandemic outbreaks, many property policies now contain specific exclusions for property damage arising from viral or bacterial related losses. For those carriers that have incorporated the following Insurance Services Office's (ISO) language into their

commercial property policies, their exposure to Coronavirus related claims will likely be limited:

EXCLUSION OF LOSS DUE TO VIRUS OR BACTERIA
This endorsement modifies insurance provided under the following:
COMMERCIAL PROPERTY COVERAGE PART

STANDARD PROPERTY POLICY

A. The exclusion set forth in Paragraph B. applies to all coverage under all forms and endorsements that comprise this Coverage Part or Policy, including but not limited to forms or endorsements that cover property damage to buildings or personal property and forms or endorsements that cover business income, extra expense or action of civil authority.

B. We will not pay for loss or damage caused by or resulting from any virus, bacterium or other microorganism that induces or is capable of inducing physical distress, illness or disease. However, this exclusion does not apply to loss or damage caused by or resulting from "fungus", wet rot or dry rot. Such loss or damage is addressed in a separate exclusion in this Coverage Part or Policy.

C. With respect to any loss or damage subject to the exclusion in Paragraph B., such exclusion supersedes any exclusion relating to "pollutants".

D. The following provisions in this Coverage Part or Policy are hereby amended to remove reference to bacteria:

1. Exclusion of "Fungus", Wet Rot, Dry Rot And Bacteria; and
2. Additional Coverage – Limited Coverage for "Fungus", Wet Rot, Dry Rot And Bacteria, including any endorsement increasing the scope or amount of coverage.

E. The terms of the exclusion in Paragraph B., or the inapplicability of this exclusion to a particular loss, do not serve to create coverage for any loss that would otherwise be excluded under this Coverage Part or Policy.

CP 01 40 07 06 © ISO Properties, Inc., 2006.

Those insurers that have <u>not</u> added the above ISO exclusionary language or something similar to their property polices are likely to experience challenges and coverage questions

as to whether the Coronavirus is capable of triggering business interruption coverage under their policy forms. For those impacted carriers, one of the first threshold questions to be addressed is whether the Coronavirus can result in direct physical loss or damage to covered property. Thus, an employee who worked in and possibly infected a company's offices immediately before being tested positive for the Coronavirus seemingly leaves the insured property, i.e., the building and business personal property physically unchanged, *at least as to the naked eye*, thereby raising a coverage question regarding whether a policy's business interruption coverage has been triggered by a *direct physical loss*.

Whether a property has sustained physical loss or damage is open to question, and courts are not in complete agreement on this issue. Thus, some courts have held that the mere loss of use without physical alteration of property is not physical loss or damage *See, e.g., Newman Myers Kreines Gross Harris, P.C. v. Great Northern Ins. Co.*, 17 F.Supp.3d 323 (S.D.N.Y 2014) (holding that the policy language "direct physical loss or damage" requires some sort of actual, physical damage to the insured premises to trigger loss of business income and extra expense coverage); *Universal Image Productions, Inc. v. Chubb Corp.*, 703 F.Supp.2d 705 (E.D. Mich. 2010) (finding that intangible harms like strong odors and presence of mold/bacteria that did not alter the structural integrity of commercial property leased by the insured were not a "direct physical loss[es]").

On the other hand, other courts have found that the loss of use or inhabitability of insured property, under certain circumstances, can constitute "physical loss or damage." *See, e.g., Gregory Packaging, Inc. v. Travelers Property Cas. Co. of America*, 2014 WL 6675934 (D. N.J. 2014). (recognizing the split of authority as to whether the phrase "physical loss or damage" can include more than tangible damage to the structure of the insured property, and finding that temporary ammonia gas contamination constitutes "direct physical loss of or damage to" property and therefore, was covered by the policy).

In either case, the mere fact that *one* employee who worked in and, possibly, infected a company's offices immediately before being tested positive tests for the Coronavirus, is probably insufficient to render a company's offices as uninhabitable. However, given the current level of unease surrounding the Coronavirus, it is easy to imagine a scenario where an entire office building is argued to be unfit for occupancy and, therefore, deemed to have suffered a direct physical loss where *multiple* employees tested positive for the virus.

Along those lines, it is interesting to note a recent announcement issued by United Airlines:

Coronavirus (COVID-19): What we're doing to keep customers and employees safe

All aircraft are cleaned at a variety of touchpoints throughout the day.

- The cleaning procedure for flights includes a thorough wipe-down of all hard surfaces touched by customers and employees — including lavatories, galleys, tray tables, window shades and armrests.

- United uses an effective, high-grade disinfectant and multi-purpose cleaner.

When we are advised by the [Centers for Disease Control and Prevention] CDC and of an employee or customer who has traveled onboard and who is potentially exhibiting Coronavirus symptoms, that aircraft is taken out of service and sent through a full decontamination process that includes our standard cleaning procedures plus washing ceilings and overhead bins and scrubbing the interior.

It is not a stretch to foresee an argument forthcoming that the steps taken by United to decontaminate its equipment evidences a direct physical loss of some type.

Cyber Losses Have Set the Stage for Courts to Redefine "Physical Loss"

Losses arising out of a cyber event, e.g., a *virus* that infects a company's computer system and that causes a system shutdown is one of the more common type of business interruption claims being filed today. For many years, it was common for an insurer to exclude coverage for a claim of this type on the basis that electronic data was not considered a physical or tangible object that could be subject to loss or damage as defined by most policies.

However, recent decisions on this subject reflect that courts are beginning to broaden their opinion on the definition of "physical loss or damage." In that regard, the following cases may be precursor as to how a court might construe this term as it pertains to a business interruption claim arising out of the Coronavirus crisis:

Coverage Granted

In ***NMS Services Inc. v. Hartford***, 62 Fed. App'x 511 (4th Cir. 2003), a former employee of the insured's software development company installed two hacking programs on the insured's network systems. The hack caused the erasure of vital computer files and databases necessary for the operation of the company's manufacturing, sales, and administrative systems.

The insurer denied coverage and litigation ensued. The court upheld coverage for business interruption under policy language stating that the insurer would pay for the "actual loss of business Income" during the period of restoration. In that regard, the court noted that the suspension must be caused by "*direct physical loss of or damage* to property at the described premises." The court further found that the insured suffered damage to its property, specifically, damage to the computers it owned, which satisfied the requirement of direct physical loss of or damage to property.

In ***Lambrecht & Associates, Inc. v. State Farm Lloyds***, 119 S.W.3d 16 (Tex. App. 2003), the insured sought coverage for a loss of computer data and the related loss of business income after a virus caused the insured's computers to malfunction and eventually become completely useless. The insured's computer system had to be taken offline and its employees were unable to use their computers until the server was restored. The insurance policy at issue committed the insurer to pay for accidental direct physical loss to business personal property, and the actual loss of business income the insured sustained due to the necessary suspension of its operations during the period of restoration.

The court disagreed with the insurer's argument that the loss of information on the computer systems was not a physical loss because the data did not exist in physical or tangible form. The court held that the plain language of the policy dictated that the personal property losses alleged by the insured were physical as a matter of law.

In ***Landmark American Insurance Co. v. Gulf Coast Analytical Laboratories, Inc***., 2012 WL 1094761 (M.D. La. 2012), the insured provided chemical data analysis to the petrochemical industry and certain governmental agencies. Part of the insured's business involved analyzing chemical samples and storing the information as electronic data on a hard disk storage system. This system failed to read two hard disk drives, resulted in the corruption of data, and resulting in severe recovery costs to third-party vendors and losses in business income.

The insured sought coverage under its property policy. The policy covered risks of direct physical loss or damage including computer viruses, except those causes of loss and damage listed in the Exclusions. The insurer filed suit seeking a declaratory judgment from the court that electronic data is not susceptible to direct physical loss or damage. The insurer argued that electronic data is intangible in nature and thus not susceptible to "direct physical loss or damage" as a covered loss.

The court disagreed with the insurer and found that the insured's electronic data was "corporeal movable or physical in nature." The court further explained that the insured's

electronic data "has physical existence, takes up space on the tape, disc, or hard drive, makes physical things happen, and can be perceived by the senses."

Coverage Denied

In ***Source Food Tech., Inc. v. U.S. Fidelity & Guar. Co.***, 465 F.3d 834 (8th Cir. 2006), the insured argued that the closure of the United States/Canadian border as to its imported beef product, due to concerns of "mad cow" disease qualified as "direct physical loss" since it was unable to transport its product. The Eighth Circuit disagreed, finding that Source Food's inability to transport its beef product across the border did not constitute a product that was physically contaminated or damaged, and to hold otherwise would render the word "physical" meaningless.

In ***Ward General Insurance Services, Inc. v. Employers Fire Insurance Co.***, 7 Cal.Rptr.3d 844 (Cal. Ct. App. 2003), the insured suffered a computer crash during a system update that resulted in significant losses of electronically stored data. Restoration of the data came at great expense to the company in terms of lost productivity, commissions, and profits. When presented with the insured's claim, the insurer denied coverage because the loss did not result in "direct physical loss of or damage to" property.

In the resulting lawsuit, the court agreed with the insurer. In particular, the court noted that data is stored on a tangible medium and that the information itself remains intangible. The court concluded that an electronic data loss could not provide a basis for coverage under a first-party insurance policy because electronic data does not have a "material existence."

Supply Chain and Contingent Business Interruption Coverages

One of the biggest impacts of the Coronavirus crisis is supply chain disruption and the resulting interruption in business. For businesses that are dependent on supply chain production, contingent business interruption (CBI) insurance often provides coverage when a supplier suffers a *direct physical loss* to its property that impairs its ability to provide delivery of goods or materials to its customers.

CBI insurance may also cover economic losses, including increased costs from lost or reduced operations resulting from *physical damage* on the premises of a named or unnamed supplier. CBI policies may also cover loss of services to the insured business, such as loss of utility services or loss of markets for the business's own products. That said, CBI insurance likely includes the same conditions and exclusions found in a standard commercial property policy. In other words, the same issue remains regarding whether the Coronavirus can result in direct physical loss or damage to covered property.

Civil Authority Coverage

Many property policies extend business interruption coverage for losses arising from "civil authority" orders that impair or prohibit access to an insured's property. The scope and limitations of business interruption coverage under such endorsements vary based on whether a "direct physical loss" will be required. Note that insurers also may issue Civil Authority Coverage on a manuscript basis (custom designed for a particular insured), addressing specific needs based on expenses, geography, disease, calendar year, voluntary or mandatory orders, direct physical loss, a designated risk or other criteria.

The following cases may be instructive as to how a court might construe this term as it pertains to a business interruption claim that arises out of the Coronavirus:

Coverage Granted

In ***Southlanes Bowl, Inc. v. Lumbermen's Mut. Ins. Co.***, 208 N.W.2d 569 (Mich. Ct. App. 1973) Plaintiffs were engaged in the business of operating places of amusement consisting of bowling alleys, restaurants, taverns, snack bars, cocktail lounges and motels, and these establishments were covered by business interruption insurance. In the summer of 1967 and again after the assassination of Dr. Martin Luther King, Jr., in April of 1968, widespread riots and civil commotion accompanied by burning and looting erupted in and around the City of Detroit. However, none of the plaintiffs' businesses was physically damaged. On each occasion, the Governor declared a state of emergency, imposed a curfew, and closed all places of amusement within the cities of Detroit, Highland Park, Hamtramck, Ecorse, and River Rouge. In accordance with the Governor's order, the policyholders closed their establishments and as a result suffered a $49,687.69 net loss.

At trial, the policyholders asserted that the risk insured under the business interruption policies was the possible prohibition of access to their businesses by order of a civil authority arising from any of the enumerated perils, *e.g.,* riot, without any requirement of physical damage to the insured property. On the other hand, the insurer contended that under the terms of the business interruption policies, there is no coverage unless there has been direct physical loss and damage to the insured property; and inasmuch as no such damage was inflicted here, it was not liable to pay benefits for the policyholder's plaintiffs' losses. The trial court concurred and found for the insurer.

On appeal, the appellate court considered whether under the language of the business interruption policy, physical damage to the insured premises is a condition precedent to the insurer's liability to pay benefits. The court concluded that where the insured businesses were closed by order of a civil authority, physical damage to the insured premises was *not* a

prerequisite to the insurer's obligation to reimburse the insured for the net losses resulting therefrom. *Sloan v. Phoenix of Hartford Ins. Co.,* 207 N.W.2d 434 (Mich. Ct. App. 1973). (*Note: Very few courts have found that access was prohibited where the order of a civil authority required the insured's premises to close, thereby invoking coverage for business losses.)*

Coverage Denied

Courts have denied coverage under a Civil Authority policy provision in the following cases where the order only had an indirect effect of restricting or hampering access to the business premises.

54th St. Ltd. Partners, L.P. v. Fid. & Guar. Ins. Co., 306 A.D.2d 67, (N.Y. App. Div. 2003). No coverage where "vehicular and pedestrian traffic in the area was diverted, [but] access to the restaurant was not denied; the restaurant was accessible to the public, plaintiff's employees and its vendors."

Syufy Enter. v. Home Ins. Co. of Indiana, 1995 WL 129229, at *2-3 (N.D. Cal. 1995) (unpublished). The policy in this case required that access to plaintiff's premises be specifically prohibited by order of civil authority, and as a direct result of damage to or destruction of property adjacent to the premises. The court rejected the insured's claim for business interruption coverage for losses sustained during curfews imposed after the Rodney King verdict because curfews were imposed to prevent *potential* looting and rioting and not as a result of adjacent property damage.

Conclusion

It is very interesting to witness the evolution of business interruption coverage and how courts seem to be broadening their interpretation of these policies as more and more "non-physical property damage" losses become prevalent, such as, pandemics and cyber-related claims. That said, as more and more businesses come to realize that these types of losses pose a serious threat to their operations and contingency planning, the insurance industry will increasingly be called upon to develop new products and/or craft exclusions in an effort to address these loss exposures. For the time being, however, courts will continue to grapple and likely offer unpredictable opinions on how these policy terms, conditions and exclusions should be construed.

About the Author

Rick Hammond is a partner with HeplerBroom, LLC, and he serves as national counsel on matters relating to property insurance coverage, fire and explosion cases, and bad faith. He

also serves as an expert witness on insurance law, bad faith and coverage issues, and he is an adjunct professor on insurance law at Loyola University Law School.

Previously, Rick was the Assistant Deputy Director of the Illinois Department of Insurance's Chicago office, served as an Executive Director of a national insurance trade association, and held managerial positions in property claims and agency for two national insurance carriers.

Mr. Hammond is Past-President of the Illinois Association of Defense Trial Counsel and formerly served on the faculty and Board of Directors of the Insurance School of Chicago. He is a member of the Federation of Defense and Corporate Counsel and former Chair of their Property Insurance Law Committee. He is also the former Illinois State Representative of DRI, and he serves on the Board of Trustees of Loyola University Chicago.

Mr. Hammond was one of two attorneys in the country selected by the Lexis Nexis Insurance Law Center in 2008 to receive its "Insurance Lawyer of the Year Award." He is also a Fellow of the American College of Coverage and Extra-Contractual Counsel, an organization that includes some of the most preeminent coverage and extra-contractual attorneys in the United States and Canada.

Questions or comments can be directed to Mr. Hammond at the law firm of HeplerBroom, LLC, 30 North LaSalle, Suite 2900, Chicago, Illinois 60602, (312) 205-7743, or at the e-mail address of rick.hammond@heplerbroom.com.

Note: The author would like to thank and acknowledge the contribution and assistance of HeplerBroom associate attorney, ***Robert Hartzer****, who was instrumental in the research and preparation of this article*

Virus and Pollution Exclusions in Coronavirus-Related Business Interruption Claims: Magic Bullet or Major Battleground?

by

John Buchanan and Suzan Charlton
Covington & Burling LLP[1]

Some property/casualty insurers' public statements would suggest that virus and contamination exclusions universally bar coverage for claims arising from the coronavirus pandemic.[2] But not all policies contain such exclusions; and not all such exclusions are created equal. Some so-called virus exclusions may fail to capture the coronavirus unambiguously in their litanies of excluded perils; others may apply only to particular coverage grants; and others may contain exceptions allowing for express virus or pandemic coverage grants. Additionally, doctrines of regulatory estoppel, principles of public policy, or currently pending legislation may render even the broadest virus exclusions unenforceable as written. At the same time, however, policyholders whose policies lack any virus exclusions may still find that their insurers dispute coronavirus-related coverage by relying on their general pollution or contamination exclusions, even with no specific reference to viruses in their insurance contracts.

While we are still in the early days of coronavirus-related coverage litigation,[3] we explore here some of the arguments that policyholders and insurers have asserted to date regarding the application of virus and pollution exclusions to business interruption insurance claims.

I. Virus Exclusions

Some—but far from all—commercial property insurance policies contain exclusions for losses caused by viruses. The exact wordings of such exclusions, and their related definitions, vary. Some address viruses specifically, either alone or as one among other causes of loss such as bacteria, fungi, microbes, or microorganisms. Some expressly exclude SARS-CoV but not SARS-CoV-2. Some exclusions are phrased in terms of "communicable disease" or "pandemic," sometimes without using the word "virus." And some may purport to exclude "pollutants" or "contamination" in a form that is expressly defined to include "virus" as a "pollutant" or "contaminant." In addition, some virus exclusions are framed in anti-concurrent causation language, purporting to apply the exclusion regardless of other causes of loss or whether other causes acted concurrently or in any sequence with the excluded peril.

But not all virus exclusions apply to all losses.

A. Exceptions to Virus Exclusions[4]

Commercial property policies with virus exclusions might contain coverage *inclusions* (often with sublimits) that either expressly or implicitly negate the virus exclusion.

- ***Additional Coverage for Communicable Disease***

For example, some commercial property policies contain a contamination exclusion defining "contaminant" to include "virus"; however, these policies also contain additional coverage extensions for "Communicable Disease Response" coverage and "Interruption by Communicable Disease" coverage. If the coronavirus was actually present at an insured location, and that location is subject to a health authority order, then the policyholder should be entitled to coverage under this endorsement.

Insurers may argue that this coverage extension — which is often sublimited — provides the exclusive line of coverage for COVID-19-related losses. But many Communicable Disease coverage grants do not by their terms limit other coverage grants under the policy. Thus, for example, if the pandemic results in lost revenue or extra expense due to a plant shutdown or supply chain disruptions, business interruption or contingent business interruption coverage may not be subject to the communicable disease sublimits, but only to the policy's overall limits. Similarly, Civil Authority coverage might apply separately, to the extent that the cause of damage is deemed to be "of the type insured" and other requirements of that coverage grant are met.

As one case contesting the contamination/virus exclusion illustrates, policy wording is key. In *Thor Equities, LLC v. Factory Mutual Insurance Co*,[5] Factory Mutual ("FM") issued a commercial property policy with time element coverage that included "Interruption by Communicable Disease." According to the complaint, that policy provides coverage for business interruption due to an order regulating communicable disease and also contains a contamination/virus exclusion that defines contamination as a "condition of property" and includes "virus" among the causes of contamination:

> [A]ny condition of property due to the actual or suspected presence of any foreign substance, impurity, pollutant, hazardous material, poison, toxin, pathogen or pathogenic organism, bacteria, virus, disease causing or illness causing agent, fungus, mold or mildew.[6]

The insured in *Thor Equities* alleges that its losses are covered, not excluded, under this policy wording because the communicable disease coverage grant and the contamination exclusion are mutually exclusive:

> Thor's losses are covered under the other coverages and are not excluded by the Contamination Exclusion because the Contamination Exclusion only excludes costs due to contamination, not losses such as Time Element losses, and *the Contamination Exclusion cannot apply to anything defined as communicable disease because, as neither the Contamination Exclusion nor the communicable disease coverages reference each other*, if the Contamination Exclusion applies to communicable disease the communicable disease coverages are illusory.[7]

Further, the *Thor Equities* plaintiff alleges, coverage is not confined to the Communicable Disease extension, which is sublimited, but extends to all other business

interruption losses, because the contamination exclusion "only applies to costs incurred as a direct result of contamination, not costs incurred as a result of other causes."[8]

Thus, in policies with distinct property damage and time element coverages, separate communicable disease coverage, and a contamination/virus exclusion that is limited to "conditions of property," this particular virus exclusion may be limited to property damage losses and not preclude coverage for other elements of the claim.

- ***Additional Coverage for Fungi, Wet Rot, Dry Rot, and Microbes (including Viruses)***

In addition to the FM policy language at issue in *Thor Equities*, virus coverage may exist in other forms. For example, some business property policies contain coverage extensions for "fungi, wet rot, dry rot and microbe coverage," with a definition of "microbes" that expressly includes viruses. This additional coverage applies to property damage and time element losses, and expressly carves out an exception to the policy's fungi, wet rot, dry rot and microbe exclusion.[9] Where the virus or microbes are "the direct result of a covered peril" — *i.e.,* all risks other than those that are excluded — property losses and time element losses due to the coronavirus would be covered, though possibly subject to sublimits.

B. Virus Exclusion May Not Apply to All Causes of Loss

- ***Factors other than virus that cause physical loss***

When a loss is caused by something other than a virus, the virus exclusion does not apply: this axiomatic argument appears to lie at the heart of the complaints filed by Minor League Baseball (MiLB) teams, alleging "direct physical loss or damage" due to widespread shutdowns that have prevented them from fielding players and playing games.[10] The plaintiffs' alleged losses include physical loss and loss of use "to the teams' ballparks or elsewhere caused by the SARS-CoV-2 virus, the governmental response to it, or the MiLB teams' inability to obtain players."[11] Only one of these causes of loss is the virus; two are not; therefore, the plaintiffs assert, coverage still applies.[12]

- ***Civil Authority***

Some civil authority coverage claims may not be subject to virus exclusions. As the recently filed complaint in *Williams PLLC v. Cincinnati Ins. Co.* asserts, "None of the forms [in the insured's policy] exclude coverage due to a governmental action intended to reduce the effect of the ongoing global pandemic."[13] Similarly, in another recently filed complaint, Turek Enterprises alleges:

> The Covid-19 virus was not the direct cause of the property damage at issue. The State did not order Plaintiff, or any proposed class member, to suspend its operation because its premises needed to be de-contaminated from the Covid-19 virus. The State issued its Order to ensure the *absence* of the virus, or persons carrying the virus, from the Plaintiff's premises. And there is no evidence at all that the virus did enter Plaintiff's property or that it had to be de-contaminated.[14]

And the *Chattanooga* MiLB plaintiffs likewise contend that the governmental response to the pandemic is not itself due to "loss or damage caused by or resulting from any virus…."[15]

In sum, under this theory of coverage, the plaintiffs' losses were directly caused by the actions of a governmental authority, not by the virus. Further, the virus exclusion does not apply to the civil authority coverage, because the governmental closure orders do not require cleanup of viral contamination.[16]

In addition, some civil authority coverage grants extend to "imminent loss." Thus, exclusions that purport to bar coverage for "direct physical loss" or "the actual presence of any … virus" might be ineffective to preclude civil authority coverage where government shutdown orders are imposed to avoid or prevent "loss" or "imminent loss," as opposed to "physical damage."

Under an "all risk" policy, many courts require the policyholder only to demonstrate that its property has in some way been damaged or lost in order to satisfy its burden of proof.[17] If, as many policyholders contend, the inability to use property constitutes "direct physical loss or damage,"[18] and if the policyholder can demonstrate such a loss, then the burden shifts to the insurer to prove that an excluded peril caused that loss. Contamination/virus exclusions that use the phrase "conditions of property" or the word "actual" will present a more challenging burden of proof for insurers. If the exclusion requires the "actual presence of any … virus," the exclusion may be held inapplicable on its face to government orders that are based on merely suspected or imminent viral presence.

C. Regulatory Estoppel

Some policyholders contend that the virus exclusion itself is simply invalid. For example, in *1 S.A.N.T., Inc. d/b/a Town & Country v. Berkshire Hathaway, Inc.*,[19] the plaintiffs assert that principles of regulatory estoppel bar insurers from enforcing the virus exclusion.[20]

Regulatory estoppel is "a form of equitable estoppel whereby insurers are prevented, or 'stopped,' from asserting an interpretation of an insurance policy provision that is contrary to the insurer's explanation of that policy provision to state insurance regulators when the insurer originally sought approval of the policy form from the state department of insurance."[21] Here, the basis for Town & Country's assertion is that the insurance industry, when seeking approval for the new exclusion from state regulators in 2006, misrepresented its scope as merely clarifying rather than curtailing coverage. According to the complaint:

> 49. In their filings with the various state regulators (including Pennsylvania), on behalf of the insurers, ISO [the Insurance Services Office, Inc.] and AAIS [the American Association of Insurance Services] represented that the adoption of the Virus Exclusion was only meant to "clarify" that coverage for "disease-causing agents" has never been in effect, and was never intended to be included, in the property policies.
>
> ….

> 53. The foregoing assertions by the insurance industry (including Defendant), made to obtain regulatory approval of the Virus Exclusion, were in fact misrepresentations and for this reason, among other public policy concerns, insurers should now be estopped from enforcing the Virus Exclusion to avoid coverage of claims related to the COVID-19 pandemic.
>
> 54. In securing approval for the adoption of the virus exclusion by misrepresenting to the state regulators that the virus exclusion would not change the scope of coverage, the insurance industry effectively narrowed the scope of the insuring agreement without a commensurate reduction in premiums charged. Under the doctrine of regulatory estoppel, the court should not permit the insurance industry to benefit from this type of duplicitous conduct before the state regulators.[22]

A key issue in this regulatory estoppel litigation is whether ISO and AAIS did, in fact, misrepresent the coverage the exclusion was meant to "clarify." The complaint alleges that ISO represented, in a July 6, 2006 "Circular," that "property policies have not been a source of recovery for losses involving contamination by disease-causing agents," and that policyholders might try to "expand coverage to create sources of recovery for such losses…."[23] AAIS, in its own filing, similarly represented:

> Property policies have not been, nor were they intended to be, a source of recovery for loss, cost or expense caused by disease-causing agents. With the possibility of a pandemic, there is concern that claims may result in efforts to expand coverage to create recovery for loss where no coverage was originally intended . . .
>
> This endorsement clarifies that loss, cost, or expense caused by, resulting from, or relating to any virus, bacterium, or other microorganism that causes disease, illness, or physical distress or that is capable of causing disease, illness, or physical distress is excluded . . .[24]

But in fact, as the *Town & Country* complaint asserts, "[b]y 2006, the time of the state applications to approve the Virus Exclusion, courts had repeatedly found that property insurance policies covered claims involving disease-causing agents…."[25]

If the policyholder plaintiffs in *Town & Country* are correct, and the insurance industry representatives' 2006 representations to regulators are shown to be false, then the insurers may be barred from asserting that the exclusion applies to bar coverage for claims involving disease-causing agents, such as the coronavirus.

D. Public Policy Arguments

In at least one jurisdiction that has not formally adopted the regulatory estoppel doctrine, policyholders have instead relied on a public policy theory to overcome virus exclusions, alleging that their commercial property policies provide coverage for business interruption losses and that "any other construction of the language of the policies [is] void as against public policy…."[26]

These Texas policyholders allege that the exclusion is invalid because the insurers procured the state insurance department's approval by representing that the exclusion was narrower than these insurers now claim.[27] They seek discovery regarding "the meaning and scope and intended operation of the Virus exclusion," contending that:

> On information and belief, Defendant made admissions to insurance regulators that the exclusion was meant to apply only for decontamination costs claims, but not for losses from business interruption and civil authority orders.[28]

The insurers in these cases have moved to dismiss the complaints, including the claims based on the public policy argument. According to one insurer motion, public policy is in the insurers' favor, not the policyholders':

> To impose liability retroactively for an excluded peril … does not serve public policy, but would arbitrarily impose an inequitable burden on State Farm and other insurers to cover a risk that their policies explicitly and unambiguously informed policyholders was not covered and for which the insurers did not charge a premium.[29]

The court has not yet ruled on these motions as of this writing.

E. Proposed Legislation

Even if policyholder litigants' regulatory estoppel and public policy arguments were to fail in the courts, state and federal legislatures might nonetheless codify their positions, at least for small businesses. Legislation is currently under consideration in several states and in Congress, the effect of which would be to void virus exclusions and force insurers to pay certain claims under some circumstances.[30] None of the bills has yet passed.

II. Pollution/Contamination and Microbe Exclusions

A. Traditional Exclusions for "Pollutants" or "Contaminants" Omitting the Word "Virus."

If a policy lacks a standard-form virus exclusion that is commonly available in the marketplace, many courts would be reluctant to read the word "virus" into another exclusion where it does not appear.[31] Yet some insurers reportedly have attempted to do just that, arguing that garden variety pollution exclusions, phrased in terms usually reserved for environmental pollution, should apply to viruses, too. Both the case law and the regulatory history of the standard-form virus exclusion suggest that these insurance industry arguments may face stiff headwinds.

In the wake of the SARS pandemic of 2003, the insurance industry, through trade associations such as the Insurance Services Office (ISO) and the American Association of Insurance Services (AAIS), first sought regulatory approval in 2006 to add the virus exclusion (discussed above) to "all risk" commercial property policies, because the pollution exclusion did not expressly encompass viruses. The contemporaneous ISO Circular, as discussed above,

acknowledged exactly this point: that "viral and bacterial contamination," which are not mentioned in the standard pollution exclusion, "appear to warrant particular attention at this time." Thus, because policies with standard pollution exclusions left open the possibility of coverage for viruses, the insurance industry sought regulatory approval to close the door with a specific virus exclusion. Without the virus exclusion, ISO's commercial property policy's "physical loss of or damage to" requirement could be met by viral contamination, and the pollution exclusion would not apply.

This is essentially the plaintiffs' argument in *3 Squares LLC, et al. v. The Cincinnati Insurance Co.*,[32] a coverage case involving a policy that contains no virus exclusion, but only a standard exclusion for pollutants. The policyholders' complaint alleges:

> 15. Prior to the effective date of the Policies, ISO published and made available for use a standard virus exclusion form.
>
> 16. Defendant CIC chose not to include the ISO standard virus exclusion form in the Policies.
>
> 17. Other than reference to a computer virus, the Policies include no exclusion that references the word virus.[33]

Given the lack of an express virus exclusion, and allegations that otherwise meet the basic insuring agreement, the plaintiff policyholders seek a declaratory judgment that their claims (and those of class members with typical claims in common) are covered.

Among other defenses, the insurer in *3 Squares* is expected to raise its "pollutants" exclusion, which is written on standard ISO Form FM 101 05 16, as a defense to coverage. "Pollutants" is defined as "any solid… contaminant," including "substances which are generally recognized in industry or government to be harmful or toxic."[34] "Virus" is nowhere mentioned in this definition. Insurers nevertheless can be expected to argue that the coronavirus is a "solid irritant or contaminant" and that it is "harmful to persons," to support their denials of coverage.[35]

Case law in several states, involving analogous factual situations, supports policyholder arguments that such standard pollution exclusions do not bar coverage for losses caused by or resulting from a virus. In light of the environmental terms in these exclusions (e.g., "release, discharge, escape or dispersal of 'contaminants or pollutants'"), many courts have confined even "absolute" pollution exclusions to claims involving "traditional" environmental pollution, and declined to apply them to claims involving, for example, carbon monoxide, paint fumes, local workplace fumes, or ingestion of lead paint.[36] Under this interpretation, a cause that spreads a virus (such as a sneeze) would fall outside the exclusion.[37]

Some courts, however, have held that pollution exclusions encompass both traditional and non-traditional industrial pollution.[38] Given the stakes of pandemic-related coverage, insurers can be expected to argue that traditional pollution exclusions should be extended to the novel coronavirus, even when their policies otherwise lack express virus exclusions.

B. "Microbe" Exclusions

In its public statements regarding COVID-19, at least one insurer, CNA, has referenced its exclusions for "loss or damage caused by microbes, contaminants, or pollutants, among other perils."[39] A published version of CNA's "microbe" exclusion applies to the "presence, growth, proliferation, spread or any activity of Fungi, wet rot, dry rot or Microbes."[40]

In contrast to the "microbe" exclusion at issue in the *Thor Equities* case discussed above,[41] this version of the CNA exclusion defines "Microbe" without any mention of "virus":

> Any non-fungal microorganism or non-fungal, colony-form organism that causes infection or disease. Microbe includes any spores, mycotoxins, odors, or any other substances, products or byproducts produced by, released by, or arising out of the current or past presence of microbes.

Does the coronavirus that causes COVID-19 qualify as a "microbe" under a definition that is silent about viruses? Though a virus shares some of the characteristics of living things, it is not technically a life form[42]; therefore, it does not fall within the literal scope of the terms "organism" or "microorganism" in this definition of "Microbe." Most standard dictionaries also define "microbe" to mean a "microorganism," i.e., a living thing.[43] Nonetheless, due to the unique characteristics of viruses, usage of these terms may vary. For example, the NIH in its HIV/AIDS glossary says: "Although viruses are not considered living organisms, they are sometimes classified as microorganisms."[44]

In short, the terms "microbe" and "microorganism" may be deemed ambiguous as applied to viruses. Generally accepted principles of policy interpretation would dictate that if these terms appear in an exclusion, they must be construed narrowly—even if they have enjoyed a broader construction when they appeared elsewhere in a coverage grant.[45] Thus, standard rules of construction could result in differing conclusions as to whether the novel coronavirus falls within the term "microbe" or "microorganism," depending on whether the term in question appears in a coverage grant or an exclusion.

III. Conclusion

Coronavirus coverage litigation is in its earliest stages, with interpretation of exclusions and other substantive issues largely undecided. Courts should, of course, apply the rules of insurance contract construction to determine whether and to what extent each virus and pollution exclusion wording, in the context of the policy as a whole, applies to a particular fact pattern. In addition to plain language that unambiguously carves out exceptions allowing coverage in certain circumstances, real-world context—including past drafting and regulatory history and current political considerations—may also play a role in deciding whether or how virus and pollution exclusions should apply to business interruption insurance claims. Regardless of what the insurance industry's current public statements may suggest, these exclusions appear unlikely to provide insurers with a magic bullet against all coronavirus-related coverage claims in the courts.

[1] The views and opinions expressed in this article are those of the authors and shall not be cited or construed as reflecting the views or opinions of Covington & Burling LLP or of any firm client.

[2] *See, e.g.,* Leslie Scism, *Companies Hit by Covid-19 Want Insurance Payouts. Insurers Say No.*, WALL ST. J. (June 30, 2020), https://www.wsj.com/articles/companies-hit-by-covid-19-want-insurance-payouts-insurers-say-no-11593527047 (quoting Chubb Ltd. Chief Executive Evan Greenberg, in an April 2020 earnings call: "The industry will fight this tooth and nail."); *Travelers Letter to New York Property Insurance Policyholders*, TRAVELERS, https://www.travelers.com/about-travelers/covid-19-business-interruption (last visited July 2, 2020) ("[B]usiness interruption losses resulting from these types of events [cancellations, suspensions and shutdowns] do not present covered losses under our property coverage forms. Even if there has been direct physical loss or damage to property, your policy contains a number of exclusions that are likely to apply to business interruption losses. The most important exclusion to note is the exclusion for losses resulting from a virus or bacteria, which would include coronavirus."). *See also* FAIR, https://fairinsure.org/ (last visited July 2, 2020) ("Global pandemic risks are uninsurable. … The losses stemming from such an event were never intended to be protected by a business interruption policy.").

[3] As of the date of this publication, we are aware of just one coronavirus-related coverage decision, from a Michigan state trial court. There the judge, in an oral ruling from the bench, granted an insurer's motion for summary judgment on the ground that the policyholder, a restaurant group, had not alleged any direct physical loss of or damage to property; additionally the judge—apparently misapprehending the burden of proof on exclusions—stated that the policyholder had failed to establish the inapplicability of a virus and bacteria exclusion, which the judge found unambiguous. *See Gavrilides Mgmt. Co. v. Michigan Ins. Co.*, No. 20-2583b, Hearing on Oral Argument (Ingham Cty., July 1, 2020), https://www.youtube.com/watch?v=Dsy4pA5NoPw&feature=youtu.be.

[4] While beyond the scope of this discussion of commercial property and business interruption insurance, we note two additional virus exclusion issues. First, some policies either expressly include or exclude pandemic events. These provisions often contain a list of specifically enumerated "pathogens, mutations, or variations," including "Severe Acute Respiratory Syndrome-associated Coronavirus (SARS-CoV) disease." *See* Complaint, *SCGM, Inc. v. Certain Underwriters at Lloyd's* (S.D. Tex., filed April 3, 2020). When contained in a coverage grant, such a provision may reasonably be interpreted to apply to SARS-CoV-2, on the premise that it is a "variation" of SARS-CoV. Conversely, when such language appears in an exclusion, medical evidence highlighting the distinctions between SARS and COVID-19, and between the viruses that cause them, may lead courts to construe these terms more narrowly, requiring the exact virus to be named in order to be excluded. *See, e.g.,* Shibo Jiang, et al., *A distinct name is needed for the new coronavirus*, The Lancet (Vol 395, March 21, 2020) (coronavirus "is distinct from SARS-CoV in biological, epidemiological, and clinical features. Naming 2019-CoV as SARS-CoV-2 is therefore truly misleading."), https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(20)30419-0.pdf; *see generally, e.g., Affinity Living Grp. LLC v. Starstone Specialty Ins. Co*., No. 18-2376 (4th Cir., May 26, 2020) (interpreting same term "broadly … when used in a provision extending coverage but … more narrowly … when used in a provision excluding coverage.").

Second, general liability insurance policies commonly contain an express exception to the virus exclusion, carving out foodborne illness or human transmission of disease. An example of such an exception is phrased as follows:

> However, this exclusion does not apply to:
>
> i. any fungi or microbes that are, are on, or are contained in, a good or product intended for bodily consumption; or

ii. microbes that were transmitted directly from person to person.

CNA Paramount General Liability Fungi/Mold/Mildew/Yeast/Microbe Exclusion Endorsement, https://www.bidnet.com/bneattachments?/488376278.pdf. Such exceptions may become important for policyholders facing liability claims by customers or patients, visitors, independent contractors, certain employees, and others alleging that the policyholder caused injury or damage related to COVID-19 or the coronavirus.

[5] *Thor Equities, LLC v. Factory Mut. Ins. Co.*, No. 20-cv-3380, Complaint (S.D.N.Y., filed Apr. 30, 2020).

[6] Complaint ¶ 34, *Thor Equities* (quoting FM policy at 76).

[7] Complaint ¶ 56, *Thor Equities* (emphasis added).

[8] Complaint ¶ 56, *Thor Equities.*

[9] *See, e.g.*, CNA Paramount Business Property Form CNA62648 XX 10-15, http://serff.disb.dc.gov/DownloadPdf.ashx?id=CNAB-130040216.

[10] *Chattanooga Prof'l Baseball LLC v. Phila. Indem. Ins. Co.*, No. 2:20-cv-03032 (E.D. Pa., filed June 23, 2020), *voluntarily dismissed and ordered to be refiled on behalf of each individual defendant* (July 2, 2020); *7th Inning Stretch LLC d/b/a Everett AquaSox v. Arch Ins. Co*., No. 2:20-cv-08161 (N.J., filed July 2, 2020); *Nostalgic Partners LLC d/b/a Staten Island Yankees v. Phila. Indem. Ins. Co*., No. 200700054 (Pa. Com. Pls., Phila. Cty., filed July 7, 2020).

[11] Complaint ¶ 7, 69, *Chattanooga*, No. 2:20-cv-03032 (June 23, 2020 E.D. Pa.); Complaint ¶ 7, 69, *7th Inning Stretch*, No. 2:20-cv-08161 (N.J., filed July 2, 2020).

[12] *See* Jeff Sistrunk, *Minor League Baseball Teams Fight For COVID-19 Coverage*, Law360 (June 23, 2020), https://www.law360.com/articles/1285917/minor-league-baseball-teams-fight-for-covid-19-coverage ("These are three independent factors, all causing physical loss.") (quoting plaintiffs' counsel).

[13] Complaint ¶ 53, *Williams PLLC v. Cincinnati Ins. Co.*, No. 20-cv-02806 (N.D. Ill., filed May 8, 2020).

[14] Complaint ¶ 8, *Turek Enters., Inc. v. State Farm Mut. Auto. Ins. Co.*, No. 20-cv-11655 (E.D. Mich., filed June 23, 2020) (emphasis in original).

[15] *See* Complaint ¶ 83, *Chattanooga*, No. 2:20-cv-03032 (June 23, 2020 E.D. Pa.).

[16] *See* Complaint ¶ 47, *Turek*, No. 20-cv-11655 (E.D. Mich., filed June 23, 2020).

[17] *See, e.g., Fajardo Shopping Ctr. v. Sun All. Ins. Co*., 167 F.3d 1, 5 (1st Cir. 1999); *Living Word Bible Church, Inc. v. Travelers*, 2009 WL 2856127 (E.D. La. 2009) (same; citing cases); *Eveden Inc. v. N. Assur. Co*., 2014 WL 952643 (D. Mass. 2014) (same). *But see, e.g., Pentair Inc. v. Am. Guarantee & Liab. Ins. Co.*, 400 F.3d 613, 615 (8th Cir. 2005) (policyholder must still prove loss resulted from covered cause of loss under Minn. law to trigger coverage).

[18] The question of what constitutes "direct physical loss or damage" in the context of the coronavirus is the subject of a companion article in this issue of *Coverage*. [*See* _EDITORS PLEASE INSERT__.]

[19] *1 S.A.N.T., INC. d/b/a Town & Country v. Berkshire Hathaway, Inc.*, No. 2:05-mc-02025 (W.D. Pa., filed June 11, 2020), ECF No. 884.

[20] *See also* Complaint ¶ 83, *Chattanooga* ("T[he] Exclusion does not preclude the Teams' claims for coverage because, among other reasons, it is void, unenforceable, and inapplicable."); Complaint ¶ 10, *Turek* ("[T]he 'virus exclusion' is inapplicable, procured through fraud or misrepresentation, and therefore void.").

[21] *Regulatory Estoppel*, IRMI, https://www.irmi.com/term/insurance-definitions/regulatory-estoppel. *See, e.g., Morton Int'l, Inc. v. General Acc. Ins. Co. of America*, 134 N.J. 1, 75-76, 629 A.2d 831, 874 (1993) (applying regulatory estoppel to bar insurers from applying qualified pollution exclusion inconsistently from representations to insurance regulators)*; Sunbeam Corp. v. Liberty Mutual Ins. Co.*, 781 A.2d 1189, 1192-93 (Pa. 2001) (recognizing doctrine of regulatory estoppel and remanding issue for further evidentiary findings; additionally suggesting that evidence of representations to regulators might establish industry "custom and usage" of disputed terms in qualified pollution exclusion); *Simon Wrecking Co., Inc. v. AIU Ins. Co.*, 530 F. Supp. 2d 706, 714 (E.D. Pa. 2008) (holding that genuine issue of material fact existed as to regulatory estoppel and reserving issue for trial).

[22] Complaint at 10-11, *Town & Country*.

[23] Complaint ¶ 50, *Town & Country*.

[24] Complaint ¶ 51, *Town & Country*.

[25] Complaint ¶ 52, *Town & Country*.

[26] Second Amended Complaint ¶ 46, *Diesel Barbershop, LLC v. State Farm Lloyds*, No. 5:20-cv-00461-DAE (W.D. Tex., filed April 27, 2020), ECF No. 8; *see Vizza Wash, LP d/b/a The Wash Tub v. Nationwide Mut. Ins. Co.*, No. 5:20-cv-00680-OLG (W.D. Tex., filed June 5, 2020 after removal); *Slusher. Mid-Century Ins. Co.*, No. 5:20-cv-00607-FB (W.D. Tex., filed May 5, 2020).

[27] Plaintiff's Response to Defendant Nationwide's Motion to Dismiss at 8-9, *The Wash Tub*, No. 5:20-cv-00680-OLG (W.D. Tex. June 26, 2020), ECF No. 11.

[28] Plaintiff's Response to Defendant Nationwide's Motion to Dismiss at 9, *The Wash Tub*. *See also* Complaint ¶ 44, *Turek* ("[T]he standard form virus exclusion is … void as against public policy due to misrepresentation.").

[29] Defendant's Motion to Dismiss Plaintiffs' Second Amended Petition at 2-3, *Diesel Barbershop*, No. 5:20-cv-00461-DAE (W.D. Tex. May 8, 2020), ECF No. 9.

[30] *See* United Policyholders COVID Loss Recovery Initiative, https://www.uphelp.org/covid-loss-recovery-initiative, which tracks bills potentially affecting COVID-19 or pandemic coverage. States that have introduced such bills include Louisiana, Massachusetts, Michigan, New Jersey, New York, Ohio, Pennsylvania, Rhode Island, and South Carolina. Louisiana abandoned its proposed legislation upon adjournment of the 2020 Regular Session on June 1, 2020. The District of Columbia also introduced such a bill as part of an emergency package in April, but these provisions were deferred for potential future consideration and were not included in the final bill that the D.C. City Council passed in May 2020.

Congress is reviewing three federal proposals: the U.S. Pandemic Risk Insurance Act of 2020 (PRIA), H.R. 7011, 116th Cong. (introduced May 26, 2020); the Business Interruption Insurance Coverage Act of

2020, H.R. 6494, 116th Cong.; and the Never Again Small Business Protection Act of 2020, HR 6497, 116th Cong. All three have been referred to the House Committee on Financial Services.

[31] *See generally, e.g., Pan American World Airways v. Aetna Cas. & Sur. Co.,* 505 F.2d 989 (2nd Cir. 1974) (construing exclusion narrowly because "[v]arious exclusionary terms in use or being considered for use prior to the present loss would have excluded the loss had they been employed.")

[32] *3 Squares LLC v. Cincinnati Ins. Co.*, No. 1:20-cv-02690 (N.D. Ill., filed May 4, 2020).

[33] Complaint at 5, *3 Squares,* No. 1:20-cv-02690 (N.D. Ill. May 4, 2020).

[34] Complaint, Exhibit 1, ISO Form FM 101 05 16 at 39 of 40, *3 Squares*, ECF No. 1-1. The full exclusion reads as follows:

> any solid, liquid, gaseous or thermal irritant or contaminant, including smoke, vapor, soot, fumes, acids, alkalis, asbestos, chemicals, petroleum, petroleum products and petroleum by-products, and waste. Waste includes materials to be recycled, reconditioned or reclaimed. "Pollutants" include but are not limited to substances which are generally recognized in industry or government to be harmful or toxic to persons, property, or the environment regardless of whether injury or damage is caused directly or indirectly by the "pollutants"….

[35] At least one policy form of which we are aware contains such an expansive definition of "pollution and/or contamination" that literally *anything* could fall within the exclusion:

> (a) seepage of, or pollution and/or contamination by, anything, including but not limited to, any material designated as a 'hazardous substance' by the United States Environmental Protection Agency or as a 'hazardous material' by the United States Department of Transportation, or defined as a 'toxic substance' by the Canadian Environmental Protection Act for the purposes of part II of that Act, or any substance designated or defined as toxic, dangerous, hazardous or deleterious to persons or the environment under any other law, ordinance or regulation; and
>
> (b) the presence, existence, or release of anything which endangers or threatens to endanger the health, safety or welfare of persons or the environment.

Complaint, Exhibit A, ICAT Form SCOL 234 (07 09), Seepage and Pollution Exclusion Endorsement, *Alan Surure MD PA v. Certain Underwriters at Lloyd's London*, Filing No. 107829860 (Fla. Cir. Ct., Miami-Dade Cty., filed May 21, 2020), https://www.crowell.com/files/Alan-Serur-Complaint.PDF. In connection with this language, a Beazley underwriter has been quoted as saying, "Anything could be considered a pollutant if it's in the wrong place at the wrong time." Brooke Smith, *Pollution Protection*, Canadian Underwriter (Nov. 3, 2018), https://www.canadianunderwriter.ca/features/pollution-protection/. It remains to be seen whether a court would agree with an insurer's argument that its exclusion is so broadly and vaguely worded that it renders illusory the protection against most of the ordinary perils for which property policies are purchased.

[36] *See, e.g.,* **California**: *MacKinnon v. Truck Ins. Exch.*, 73 P.3d 1205 (Cal. 2003) (absolute pollution exclusion applies to releases of pollutants into the environment and not to claim arising out of the presence of poisons inside an apartment); **District of Columbia:** *Richardson v. Nationwide Mut. Ins. Co.*, 826 A.2d 310 (D.C. 2003) (pollution exclusion worded in terms of "byproducts of industrial pollution" did not apply to injuries arising from alleged carbon monoxide poisoning allegedly caused by a malfunctioning furnace in an apartment complex), *vacated pursuant to settlement*, 844 A.2d 344 (D.C. 2004); **Illinois:** *Am. States Ins. Co. v. Koloms*, 687 N.E.2d 72, 82 (Ill. 1997) (pollution "exclusion applies only to those injuries caused by traditional environmental pollution"); **Maryland:** *Clendenin Bros., Inc. v U.S. Fire Ins. Co.*, 889 A.2d

387, 398-98 (Md. App. 2006) (exclusion does not apply to welding fumes: "We conclude . . . that the current construction of the total pollution exclusion clause drafted by Insurer was not intended to bar coverage where Insureds' alleged liability may be caused by non-environmental, localized workplace fumes."); **New Hampshire:** *Weaver v. Royal Ins. Co.*, 674 A.2d 975, 977 (N.H. 1996) ("While courts freely apply the pollution exclusion to environmental contamination, they are generally unwilling to hold that its scope reaches other pollution-related injuries."); **New York:** *Belt Painting Corp v TIG Ins. Co.*, 795 N.E.2d 15, 20 (N.Y. 2003) ("the terms used in the exclusion to describe the method of pollution—such as 'discharge' and 'dispersal'—are terms of art in environmental law used with reference to damage or injury caused by disposal or containment of hazardous waste") (internal quotes omitted); **Ohio:** *Andersen v. Highland House Co.*, 757 N.E.2d 329, 330 (Ohio 2001) (holding that "[c]arbon monoxide emitted from a malfunctioning residential heater is not a 'pollutant' under [an absolute] pollution exclusion of a commercial general liability policy," and noting that "the genesis of the pollution exclusion" was to address environmental pollution); **Pennsylvania:** *Lititz Mut. Ins. Co. v. Steely*, 785 A.2d 975 (Pa. 2001) (absolute pollution exclusion did not extend to injuries from ingestion of lead paint).

[37] *See Johnson v. Clarendon Nat. Ins. Co.*, 2009 WL 252619, at *12 (Cal. App. Feb. 4, 2009) (unpub.) ("Does a policyholder pollute the environment by sneezing and passing a virus to their neighbor? A layperson would not reasonably interpret the exclusionary language to apply to the above scenarios.").

[38] *See, e.g.*, **Colorado:** *Mountain States Mut. Cas. Co. v. Roinestad*, 296 P.3d 1020, 1024-25 (Colo. 2013) (applying pollution exclusion to cooking grease dumped into sewer); **Florida:** *Deni Assocs. of Fla., Inc. v. State Farm Fire & Cas. Ins. Co.*, 711 So. 2d 1135, 1138 (Fla. 1998) (applying "absolute" pollution exclusion to fumes from an indoor ammonia spill, as well as spraying of chemical insecticide); **Nebraska:** *Cincinnati Ins. Co. v. Becker Warehouse, Inc.*, 635 N.W.2d 112, 120, 123 (Neb. 2001) (applying absolute pollution exclusion to xylene fumes, because the "pollution exclusion, though quite broad, is unambiguous" and "does not specifically limited excluded claims to traditional environmental damage"); **Virginia:** *TRAVCO Ins. Co. v. Ward*, 715 F. Supp. 2d 699, 716 (E.D. Va. 2010) (under Virginia law, pollution exclusion applies to release of household pollutants and is not limited to "traditional environmental pollution"); *PBM Nutritionals, LLC v. Lexington Ins. Co*., 283 Va. 624, 636, 724 S.E.2d 707, 714 (2012) ("In the instant case, none of the pollution exclusion endorsements reference any terms such as 'environment,' 'environmental,' 'industrial,' or any other limiting language suggesting that the exclusions are limited to 'traditional' rather than 'indoor' pollution.").

[39] *See* https://www.cna.com/web/wcm/connect/9f6a1393-65be-4c99-80ab-54b5cfd4da2a/Notice-to-NY-Commercial-Policyholders.pdf?MOD=AJPERES.

[40] Complaint, Exhibit B, *Ungarean v. CNA*, No. 60-20-6544, (Pa. Com. Pls., Phila. Cty., filed June 5, 2020), ISO Form SB-147083-B (Ed. 07/09), https://www.classaction.org/media/ungarean-v-cna-et-al.pdf.

[41] *See* text at n. 6, above.

[42] *See, e.g.*, Virus, https://www.britannica.com/science/virus ("Viruses should not even be considered organisms, in the strictest sense, because they are not free-living; i.e., they cannot reproduce and carry on metabolic processes without a host cell."); University of Bergen, Centre for Geobiology, What are microorganisms?, https://www.uib.no/en/geobio/56846/what-are-microorganisms#:~:text=Technically%20a%20microorganism%20or%20microbe,generally%20classified%20as%20non%2Dliving. ("The term microorganisms does not include viruses and prions, which are generally classified as non-living. . . . Most virologists consider them non-living, as they do not meet all the criteria of the generally accepted definition of life. For instance, most viruses do not respond to changes in the environment, which is a definitive trait for living organisms. In addition, viruses can replicate themselves only by infecting a host cell. They therefore cannot reproduce on their own.").

[43] *E.g.*, Merriam-Webster Dictionary, https://www.merriam-webster.com/dictionary/microbe (defining "microbe as "microorganism"); Cambridge English Dictionary, https://dictionary.cambridge.org/us/dictionary/english/microbe ("a very small living thing, esp. one that causes disease, and which is too small to see without a microscope"). As the Merriam-Webster entry for "microbe" explains (at https://www.merriam-webster.com/dictionary/microbe), "A hint of the Greek word *bios*, meaning 'life', can be seen in *microbe*. Microbes, or *microorganisms*, include bacteria, protozoa, fungi, algae, amoebas, and slime molds."

[44] *See* https://aidsinfo.nih.gov/understanding-hiv-aids/glossary/456/microorganism.

[45] *See, e.g.*, *Affinity Living Grp. LLC v. Starstone Specialty Ins. Co*., No. 18-2376 (4th Cir., May 26, 2020) (interpreting same term "broadly … when used in a provision extending coverage but … more narrowly … when used in a provision excluding coverage.").

Managing Crisis: The COVID-19 Pandemic and an Insurer's Duty of Good Faith
"Statutory Claims Handling Guidelines Remain in Effect!"
By: Rick Hammond, HeplerBroom, LLC*

Background

Numerous state governors have issued "shelter in place" orders that effectively close all "nonessential businesses," i.e., those companies that are not in a critical infrastructure industry as defined by the Department of Homeland Security, such as insurance and pharmaceutical companies, healthcare providers and food suppliers. The White House also issued an updated Coronavirus Guideline to essential businesses that states, "If you work, you have a special responsibility to maintain your normal work schedule." In some cases, essential business are also required to offer separate hours of operation for vulnerable populations.

With respect to the insurance industry, insurers are on the verge of being inundated with claim filings of historic proportions. It is projected that the bulk of these claims will relate to property insurance and the loss of business income associated with the large-scale disruption of global supply chains, interruptions of business operations, major events being cancelled, construction projects halted, and fallout from government-imposed closure orders. In tandem with increased claim volume, insurers have received notifications from a number of state regulatory agencies demanding that they comply with additional and more stringent claims handling requirements, and requiring insurers to submit advisory coverage opinions relating to COVID-19, before a claim is even filed.

Requirement for Advisory Opinions

Preliminary coverage opinions can expose a carrier to a breach of contract or bad faith allegation if their *actual* opinion on a specific claim differs from an earlier advisory opinion. Thus, even most courts will refuse to issue advisory opinions for the same reason, *i.e*., because each case differs! Nonetheless, the New York Department of Financial Services recently issued such a notice to insurers operating in that state:

> Given the potential impact of COVID-19 on business losses, particularly concentrated effects in local communities, DFS considers Insurers' obligations to policyholders a heightened priority. In the interest of the timely and equitable fulfillment of insurance contracts, Insurers must explain to policyholders the benefits under their polices and the protections provided in connection with COVID-19. Any Insurer that writes none of the business described herein should notify DFS in a statement signed by an officer or other authorized representative of the Insurer in lieu of complying with the provisions below.

- First, each Insurer should provide to DFS the volume of business interruption coverage, civil authority coverage, contingent business interruption coverage and supply chain coverage the Insurer wrote that has not lapsed as of the date of this letter, which should be expressed in amounts of direct premium, policy types and numbers of policies written of each type.

- Second, each Insurer should examine the policies it has issued and explain the coverage each policy offers in regard to COVID-19 - both presently and as the situation could develop to change the policyholder's status (i.e., is there any potential for coverage as a result of COVID-19).

- For each policy type, Insurers should prepare such information in a clear and concise explanation of benefits that is suitable for policyholder review. Insurers should then send such explanation to each of their policyholders of the applicable policy types. Insurers should also send copies of all such explanations to DFS, along with a representation that the explanations have been provided to the Insurer's policyholder.

- The explanation to policyholders should include all relevant information, including, without limitation:

    - What type of commercial property insurance or otherwise related insurance policy does the insured hold?

- Does the insured's policy provide "business interruption" coverage? If so, provide the "covered perils" under such policy. Please also indicate whether the policy contains a requirement for "physical damage or loss" and explain whether contamination related to a pandemic may constitute "physical damage or loss." Please describe what type of damage or loss is sufficient for coverage under the policy.

- Does the insured's policy provide "civil authority" coverage? If so, please describe what type of damage or loss is sufficient for coverage under the policy. Please also describe any relevant limitations under the policy. Please explain whether a civil authority prohibiting or impairing the policyholder's access to its covered property in connection with COVID-19 is sufficient for coverage under the policy.

- Does the insured's policy provide "contingent business interruption" coverage? If so, please describe what type of damage or loss is sufficient for coverage under the policy. Please provide the "covered perils" under such policy. Please also indicate whether the policy contains a requirement for "physical damage or loss" and explain whether contamination related to a pandemic may constitute "physical damage or loss."

- Does the insured's policy provide "supply chain" coverage? If so, is such coverage limited to named products or services from a named supplier or company? Please also indicate whether the policy contains a requirement for "physical damage or loss" and explain whether contamination related to a pandemic may constitute "physical damage or loss."

- For each instance of coverage described above, please provide the applicable waiting period under the insured's policy. Please also indicate whether the amount of time coverage remains in effect once becomes active for a given incident.

Demands for Insurers to Waive Policy Exclusions

In addition to the recent spate of regulatory mandates on insurers, there are ongoing legislative efforts seeking to require insurers to waive legitimate policy exclusions, and to cover pandemic-related claims where coverage does not exist. For example, HB 589 (Ohio) states that all existing insurance policies that provide coverage for loss of use and occupancy and business interruption shall be construed to include coverage for business interruption due to global virus transmission or pandemic during Ohio's state of emergency, which was declared on March 9, 2020. If passed, the bill would apply to businesses located in Ohio that employ 100 or fewer full-time employees.

Massachusetts introduced similar legislation in Bill No. SD.2888, which applies to companies that employ 150 or fewer full-time employees. While the Ohio bill does not expressly address the treatment of virus exclusions or the requirement that there be "direct physical loss or damage" to covered property, the Massachusetts bill is very clear on that point: "no insurer in the commonwealth may deny a claim for the loss of use and occupancy and business interruption on account of (i) COVID-19 being a virus (even if the relevant insurance policy excludes losses resulting from viruses); or (ii) there being no physical damage to the property of the insured or to any other relevant property."

The Massachusetts bill also provides that "[f]or the avoidance of doubt, this act is subject to Chapter 176D of the General Laws." Chapter 176D concerns Unfair Methods of Competition, and Unfair and Deceptive Acts and Practices in the Business of Insurance. By including this reference, the Massachusetts legislature is sending a very clear warning to insurers that the bill, if enacted into law, must be complied with fairly and in good faith.

Lastly, the Wisconsin Office of the Commissioner of Insurance recently ordered ("at no extra cost to policyholders") that:

(1) Insurers cannot deny a claim under a personal auto policy solely because the insured was engaged in delivery of food on behalf of a restaurant, until restaurants resume normal operations.

(2) GL Carriers must notify restaurant-insureds that hired and non-owned auto coverage is available and, if requested, must provide this coverage.

Interestingly, there was no mention by the Wisconsin Commissioner about any premiums that the insurance company is out of, i.e., whether the carrier should be entitled to collect back-premiums for being required to provide commercial coverage for future claims under a personal lines policy.

* * * * *

Under that backdrop, this article will discuss the various minefields that insurers must navigate during the COVID-19 pandemic in order to stay on the right side of good faith claims handling and avoid undue allegations of bad faith.

Reasonable Insurer's Test During a Pandemic

An onslaught of insurance claims of an extraordinary magnitude will likely result from the COVID-19 pandemic, taxing the industry's resources and challenge its efforts to reach timely coverage determinations and adjustments, especially if there is an ongoing need for social distancing. Under normal circumstances, if an insurer takes an unreasonable amount of time to investigate a claim and reach a coverage decision, there will be allegations of bad faith delay made against the carrier. However, the COVID-19 crisis is not a "normal circumstance." Therefore, the question becomes – what is "reasonable conduct" when examining whether an insurer acted in good faith while at the same time being besieged with an inordinate number of claims? Seemingly, the short answer is, "it depends." Most courts have held that whether an insurer's conduct is unreasonable or vexatious is generally a question of fact, not dependent upon any single factor or attitude, length of time, amount of money or situation of the policyholder. Thus, each case must be decided on its own facts.

In addition, it should not be overlooked that there are numerous instances where a good faith claims investigation requires face-to-face contact. Many of these investigatory tasks now must be curtailed, modified or delayed due to "social distancing" recommendations. Does any resultant delay caused by a need for social distancing create an exposure for bad faith? Moreover, lest not forget that policyholders also have obligations that they must fulfill as a precondition to coverage and that might be delayed for similar reasons. For example, most property policies state:

Duties In The Event Of Loss or Damage

a. You must see that the following are done in the event of loss or damage to Covered Property:

(1) Notify the police if a law may have been broken.

(2) Give us prompt notice of the loss or damage. Include a description of the property involved.

(3) As soon as possible, give us a description of how, when and where the loss or damage occurred.

(4) Take all reasonable steps to protect the Covered Property from further damage, and keep a record of your expenses necessary to protect the Covered Property, for consideration in the settlement of the claim. This will not increase the Limit of Insurance. However, we will not pay for any subsequent loss or damage resulting from a cause of loss that is not a Covered Cause of Loss. Also, if feasible, set the damaged property aside and in the best possible order for examination.

(5) At our request, give us complete inventories of the damaged and undamaged property. Include quantities, costs, values and amount of loss claimed.

(6) As often as may be reasonably required, permit us to inspect the property proving the loss or damage and examine your books and records. Also permit us to take samples of damaged and undamaged property for inspection, testing and analysis, and permit us to make copies from your books and records.

(7) Send us a signed, sworn proof of loss containing the information we request to investigate the claim. You must do this within 60 days after our request. We will supply you with the necessary forms.

(8) Cooperate with us in the investigation or settlement of the claim.

b. We may examine any insured under oath, while not in the presence of any other insured and at such times as may be reasonably required, about any matter relating to this insurance or the claim, including an insured's books and records. In the event of an examination, an insured's answers must be signed.

That said, courts rarely punish a policyholder because of an undue delay in complying with these duties and, in fact, many courts give leniency to an insured if it corrects the breach of duty. Conversely, however, as of this writing no legislative bills nor regulatory notices have been issued that seeks to relax an insurer's obligations to conduct a prompt investigation or disposition of claims or to lessen the penalties they suffer for any failure to do so, because of the pandemic.

Is a Hasty Investigation Unreasonable?

If the facts of a policyholder's loss and the law and policy are clear, is it unreasonable or bad faith for an insurer to make a quick decision to deny coverage? What if the denial of coverage was

correctly based on the policy's terms and conditions? A case on point was recently filed in the Northern District of Illinois.

In *Big Onion Tavern Group, LLC, et al. v. Society Insurance, Inc*., No. 1:20-cv-02005 (N.D. Ill. March 27, 2020), the plaintiffs include over a dozen owners and operators of Chicago area restaurants and movie theaters that were allegedly forced, by orders from the State of Illinois, to cease their operations as part of the State's efforts to slow the spread of the COVID-19 virus. The plaintiffs assert that Society Insurance failed to honor its obligations under their commercial businessowners insurance policies that included business interruption coverage for losses caused by a necessary suspension of their operations.

According to Society's denial letter that was attached as an exhibit to the complaint, the insureds' claim was denied because there was no covered cause of loss, i.e., no "Direct Physical Loss" suffered by the plaintiffs that was necessary to trigger coverage, under the terms of the policy. Society's denial letter further contends that a slowdown in business due to the public's fear of the coronavirus, or a suspension of business because a governmental authority (*i.e.*, the governor or the mayor) has ordered or recommended all or certain types of businesses to close is not a direct physical loss.

Society also stated that the policy's Civil Authority provision requires that a Covered Cause of Loss cause damage to property other than the property at the described premises, and that access to the area immediately surrounding the damaged property be prohibited by a civil authority. For those reasons, Society concluded that there is no coverage because:

- The Coronavirus is not a Covered Cause of Loss;
- A civil authority has not prohibited access to the insured's business because of a Covered Cause of Loss that caused damage to a premises other than the described premises; and
- The actual or alleged presence of the coronavirus is not a Covered Cause of Loss.

The plaintiffs contend, however, that Society issued blanket denials of coverage to plaintiffs for any losses related to the closure orders — often within hours of receiving plaintiffs' claims — without first conducting any meaningful investigation. In that regard, Society's denial letter reflects that it was issued three days after the loss was reported. The insureds also allege that, upon receipt of the claims, Society "immediately denied the claims (either verbally or through cursory emails) without conducting any investigation, let alone a 'reasonable investigation based on all available information' as required under Illinois law."

Further, the plaintiffs claim that Society *prospectively* concluded that Society's policies would likely not provide coverage for losses due to a governmental-imposed shutdown due to COVID-19, when the insurer circulated a memorandum to its agency partners, before the plaintiffs even submitted their claims to Society. That memorandum -- "This is how various coverages would likely respond to COVID-19 claims" states:

FIRST-PARTY CLAIMS

Business Income coverage: Whether it be a full shutdown of business, a partial suspension of operations or an alteration in business operations that remain open, Business Income coverage must be due to a suspension caused by *direct physical loss of or damage to covered property at the described premises. The loss or damage must be caused by or result from a Covered Cause of Loss*.

Extra Expense coverage also requires the same coverage triggers. In general, a quarantine of any size, or brought about by a governmental action without a Covered Cause of Loss, would likely not trigger Business Income or Extra Expense coverages under our policies.

Civil Authority coverage: Civil Authority additional coverage pays for actual loss of Business Income and Extra Expense caused by an action of civil authority that prohibits access to the described premises when *a Covered Cause of Loss causes damage to property other than property at the described premises*. A widespread governmental imposed shutdown due to COVID-19 (coronavirus) would likely not trigger the additional coverage of Civil Authority.

The plaintiffs allege that Society's policies did not include an exclusion for loss caused by a virus and that this led the plaintiffs to expect that the insurance included coverage for property damage and business interruption losses caused by viruses like COVID-19. Alleging that Society could have issued policies with a virus exclusion, but chose not to do so, the plaintiffs claim that Society is now "try[ing] to limit its exposure on the back-end through its erroneous assertion that the presence of the coronavirus is not 'physical loss' and therefore is not a covered cause of loss under its policies."

Because of prior pandemic outbreaks, many property policies now contain specific exclusions for damage arising from viral or bacterial related losses. For those carriers that have incorporated the following Insurance Services Office's (ISO) language into their commercial property policies, their exposure to Coronavirus related claims will likely be limited:

EXCLUSION OF LOSS DUE TO VIRUS OR BACTERIA
This endorsement modifies insurance provided under the following:
COMMERCIAL PROPERTY COVERAGE PART

STANDARD PROPERTY POLICY

A. The exclusion set forth in Paragraph B. applies to all coverage under all forms and endorsements that comprise this Coverage Part or Policy, including but not limited to forms or endorsements that cover property damage to buildings or personal property and forms or endorsements that cover business income, extra expense or action of civil authority.

B. We will not pay for loss or damage caused by or resulting from any virus, bacterium or other microorganism that induces or is capable of inducing physical distress, illness or disease. However, this exclusion does not apply to loss or damage caused by or resulting from "fungus", wet rot or dry rot. Such loss or damage is addressed in a separate exclusion in this Coverage Part or Policy.

C. With respect to any loss or damage subject to the exclusion in Paragraph B., such exclusion supersedes any exclusion relating to "pollutants".

D. The following provisions in this Coverage Part or Policy are hereby amended to remove reference to bacteria:

1. Exclusion of "Fungus", Wet Rot, Dry Rot And Bacteria; and

2. Additional Coverage – Limited Coverage for "Fungus", Wet Rot, Dry Rot And Bacteria, including any endorsement increasing the scope or amount of coverage.

E. The terms of the exclusion in Paragraph B., or the inapplicability of this exclusion to a particular loss, do not serve to create coverage for any loss that would otherwise be excluded under this Coverage Part or Policy.

CP 01 40 07 06 © ISO Properties, Inc., 2006.

In addition to allegations for breach of contract, the plaintiffs in *Big Onion Tavern Group, LLC, et al. v. Society Insurance, Inc.* seek statutory penalties under the Illinois Insurance Code, 215 ILCS 5/155 based on among other things, Society's alleged coverage disclaimers issued "without conducting reasonable investigations based on all available information." It is important to note, however, that Illinois courts have stated on numerous occasions that a claim for violation of Section 155 is not available in the absence of coverage under the policy, *i.e.*, "where the policy is not triggered, there can be no finding that the insurer acted vexatious and unreasonably in denying the claim." *Rhone v. First Am. Title Ins. Co.*, 401 Ill. App. 3d 802, 815 (1st Dist. 2010). In other words, a defendant cannot be liable for section 155 relief where no benefits are owed. *Martin v. Illinois Farmers Ins*., 318 Ill. App. 3d 751, 764 (1st Dist. 2000) (internal citations omitted).

Therefore, if Society is successful in proving that coverage was properly denied, the plaintiffs' allegations of vexatious conduct against the insurer should seemingly be dismissed, unless the trial or appellate court elects to use this case as a basis to consider making new law in Illinois, as is the case in a few other states.

For example, in *Coventry Associates v. American States Insurance Co.,* 136 Wash. 2d 269 (1998), the insurer conceded that it conducted a bad faith investigation into a loss. Nonetheless, the trial court granted summary judgment for the insurer on the coverage question and granted its

motion to dismiss the bad faith claim. The court of appeals affirmed, but the Washington Supreme Court reversed.

The court reasoned that under Washington law, insurers have not only a general duty of good faith, but also a specific duty to act with reasonable promptness in investigating and communicating with their insureds following notice of a claim and tender of defense. The court further reasoned that the duty of good faith is broad, all-encompassing and not limited to an insurer's duty to pay, settle or defend.

> The implied covenant of good faith and fair dealing in the policy should necessarily require the insurer to conduct any necessary investigation in a timely fashion and to conduct a reasonable investigation before denying coverage. In the event the insurer fails in either regard, it will have breached the covenant and, therefore, the policy.

Similarly, note the court's holding in *Zilisch v. State Farm Mut. Auto. Ins. Co.*, 196, Ariz. 234 (2000): "if an insurer acts unreasonably in the manner in which it processes a claim, it will be held liable for bad faith without regard to its ultimate merits." *Id* at 236. Also, see *LeRette v. American Medical Security*, Inc., 705 N.W.2d 41, 48-49 (Neb. 2005). The court reasoned that where facts supporting a bad faith claim differ from those supporting a breach of contract claim, an insured need not prevail on the breach of contract claim in order to prevail on the bad faith claim. Nor does ultimate payment of the claim defeat a bad faith claim. Finally, note the court's holding in *Nelson v. Hartford Underwriters Ins. Co.*, 177 N.C. App. 595, 609 (2006):

> [N]othing in the case law… *requires* that the tortious conduct be accompanied by a breach of the contract, even though most, if not all, of the cases have as a factual background the insurance company's refusal to pay. We do not believe an action for punitive damages from tortious conduct is precluded when the company eventually pays, if bad faith delay and aggravating conduct is present." *Robinson v. N. Carolina Farm Bureau Ins. Co.*, 86 N.C. App. 44, 49-50 (1987). Thus, even if an insurance company rightly denies an insured's claim, and therefore does not breach its contract, as here, the insurance company nevertheless must employ good business practices which are neither unfair nor deceptive.

Only a small number of states have established a cause of action for bad faith in the absence of coverage. Therefore, insurers should exercise caution, particularly in those states, before reaching a hasty coverage decision where evidence might suggest a less than thorough claims investigation prior to a rightful denial of a coverage.

Statutory Claims Handling Guidelines are not Relaxed During a National Emergency

Some courts have held that statutory claims handling guidelines, including timeliness requirements, remain in effect during worst-case scenarios. For example, under Louisiana law,

insurers have "an affirmative duty to adjust claims fairly and promptly and to make a reasonable effort to settle claims with the insured or the claimant." La. R.S. 22:1220. They risk statutory penalties of up to two times the damage incurred if claims are not paid within 60 days of receipt of a valid proof of loss. Notably, these penalties can be imposed even absent a finding of bad faith, and there is no exception in the law if the insurer's resources are taxed.

Notably, in *Maloney Cinque, LLC v. Pacific Ins. Co.*, 89 So.3d 12 (La. App. 4th Cir. 2012), plaintiffs owned several truck stops in the New Orleans area that were damaged as a result of Hurricane Katrina. Settlement of the claim was delayed by Pacific's calculation of a coinsurance penalty as well as scheduling difficulties. Allegedly, Pacific not only failed to timely pay the claim, it failed to timely pay the undisputed damages. The plaintiffs filed suit, arguing that while the claim was ultimately paid, it was not paid timely as required by law.

After trial in May 2010, the district court entered judgement in favor of the plaintiffs (with the exception of attorney fees), ultimately issuing a written opinion awarding $2,386,354.50 in statutory late payment penalties alone. It applied, and later discounted the coinsurance provision. On appeal, and after a rehearing on the coinsurance issue, the court found that the coinsurance provision was inapplicable because the insurer had breached the insurance contract by delaying payment. The appellate court recast the judgement against the insurer as follows: (1) $290,903 for extra expense damages and a penalty of $72,725.75 for late payment of extra expense damages; (2) a penalty of $151,580.50 for late wind-damage payments; (3) $782,241.75 in lost profits and $ $1,173,362.62 in penalties for late payment; (4) a penalty of $50,000 for late payment of claimed business income. Notably, the insurer was not found to have acted in bad faith but it was still punished to the tune of $1,447,668.87 for its delays.

* * * * *

Insurers operate under a continuing duty of good faith and fair dealing, even during extraordinary circumstances such as disasters and national emergencies. In *Sher v. Lafayette*, 988 So.2d 186 (La. 2008), plaintiff's filed a claim for property damage to his five-unit apartment building after Hurricane Katrina and was only partially paid. Lafayette determined that most of the buildings damage was due to poor maintenance, disrepair, and flooding. They paid the plaintiff a total of $2,755.08 sometime after a November 2005 inspection. Plaintiff sued Lafayette and among the charges in the complaint was a count for bad faith; i.e., Louisiana law requires payment of a claim within 30 days where an insured provides satisfactory proof of loss to the insurer.

The jury returned a verdict against Lafayette and awarded plaintiff $553,615.00, and $184,538.00 of the judgment was for Lafayette's breach of their statutory duty of good faith for failing to pay promptly. The jury found Plaintiff's contention that the loss was reported to Lafayette in the first two weeks of September 2005 more believable than Lafayette's contention that they first received notice of the loss in October of 2005. What is important to note, however, is that the appellate court did not view the insurer's taxed resources as a basis to relax the statutory requirement for the insurer to initiate loss adjustment within the required 30 days.

Conclusion

Bad faith suits against insurers arising out of the COVID-19 pandemic will probably run the gamut, i.e., allegations that the insurance company was too quick to deny coverage, or took too long to investigate a claim and reach a coverage decision. To strengthen its defense in this area, insurers should emphasize to their claims staff the importance of:

– Maintaining a well-documented claims file that outlines the steps of an investigation and which explains the basis for any delays;

– Conducting a reasonable, good faith and prompt investigation;

– Ensuring that "red flags" used to justify a lengthy investigation are material and relevant to the circumstances of the claim;

– Adhering to the contractual and regulatory timelines for reaching a coverage decision on a claim; and

– Ensuring that all coverage rights are properly reserved and that communication with the insured is maintained during the course of an investigation.

About the Author

Rick Hammond is a partner with HeplerBroom, LLC, and he serves as national counsel on matters relating to property insurance coverage, fire and explosion cases, and bad faith. He also serves as an expert witness on insurance law, bad faith and coverage issues, and he is an adjunct professor on insurance law at Loyola University Chicago Law School.

Previously, Rick was the Assistant Deputy Director of the Illinois Department of Insurance's Chicago office, served as an Executive Director of a national insurance trade association, and held managerial positions in property claims and agency for two national insurance carriers.

Mr. Hammond is Past-President of the Illinois Association of Defense Trial Counsel and formerly served on the faculty and Board of Directors of the Insurance School of Chicago. He is a member of the Federation of Defense and Corporate Counsel and former Chair of their Property Insurance Law Committee. He is also the former Illinois State Representative of DRI, and he serves on the Board of Trustees of Loyola University Chicago.

Mr. Hammond was one of two attorneys in the country selected by the Lexis Nexis Insurance Law Center in 2008 to receive its "Insurance Lawyer of the Year Award." He is also a Fellow of the American College of Coverage Counsel, an organization that includes some of the most preeminent coverage and extra-contractual attorneys in the United States and Canada. Questions or comments can be directed to Mr. Hammond at the law firm of HeplerBroom, LLC,

30 North LaSalle, Suite 2900, Chicago, Illinois 60602, (312) 205-7743, or at the e-mail address of rick.hammond@heplerbroom.com.

Note: The author would like to thank and acknowledge the contribution and assistance of HeplerBroom associate attorneys,* ***Robert G. Hartzer and William E. Parrish**, who were instrumental in the research and preparation of this article.*

The Basic Elements of Civil Authority Coverage

By: Stephen E. Goldman
Robinson & Cole LLP

Presented to the American College of Coverage Counsel

September 9-11, 2020

"Basic" business interruption coverage provides coverage for loss of "Business Income" (net profit plus continuing expenses or gross profit minus non-continuing expenses) if that loss was caused by a suspension of the operations of the insured business and if the suspension was caused by direct physical loss of or damage to property at the insured premises if that direct physical loss or damage was caused by a "Covered Cause of Loss" (usually defined as a risk of loss not otherwise excluded).

Coverage for loss of business income caused by an order of civil authority usually appears in property insurance policies as an extension of basic business interruption coverage and covers certain instances when a business loses income as the result of an order prohibiting access to the insured premises. Although the language of a grant of civil authority coverage varies from one policy to another, the most common elements to the coverage are: 1) A governmental order that prohibits access to the insured premises; 2) The Order must be the result of (caused by) loss of or damage to off-site property caused by a covered cause of loss; and 3) the claimed loss of income must have been caused by the prohibition of access.

I. Did Order Prohibit Access?

Initially, the insured must establish that the order relied upon prohibited access to the insured premises. In *Commstop v. Travelers Indem. Co. of Conn.*, CIV.A. No. 11-1257, 2012 WL 1883461, * 9 (W.D. La. May 17, 2012), the court held that the phrase "prohibit access" means access to the insured premises is "totally and completely prevented— *i.e.*, made impossible" by action of civil authority. In *Comstop*, the court held that plaintiff's claim for business income loss due to restricted road access did not trigger coverage under the policy's civil authority provision. Another court refused to find a "prohibition of access" when state or local advisories request the public to stay off streets. *Kean, Miller LP v. Nat'l Fire Ins. Co. of Hartford*, CIV.A. No. 06-770-C, 2007 WL 2489711, at *5 (M.D. La. Aug. 29, 2007) (holding that a civil authority order recommending residents to remain off the streets did not "prohibit" access to the insured's premises, and thus the insured's claim for business loss were not covered under the policy's civil authority clause). In *Ski Shawnee, Inc. v. Commonwealth Ins. Co.*, CIV.A. No. 3:09-CV-02391, 2010 WL 2696782, * 4 (M.D. Pa. July 6, 2010) the court found no coverage involving the Pennsylvania Department of Transportation's closure of main route to insured's ski resort did not prevent some customers from accessing resort through alternate routes. In *Abner, Herrman & Brock, Inc. v. Great N. Ins. Co.*, 308 F. Supp. 2d 331, 335-36 (S.D.N.Y. Mar. 12, 2004), following the World Trade Center attacks, the court found that the civil authority provision coverage applied only when civil authority actually and completely prohibits access to the insured premises and not during subsequent days when other traffic restrictions made access to the premises more difficult. In *54th St. Ltd. Partners, L.P. v. Fid. & Guar. Ins. Co.*, 306 A.D.2d 67, 763N.Y.S.2d 243 (1st Dep't 2003), the court held that a civil authority provision applied only to the two days when access to the premises was denied and did

not apply to the days thereafter because although vehicle and pedestrian traffic to the premises was diverted, access was not denied to the public, employees, or vendors, as there was not a "total interruption or cessation" of business. In *St. Paul Mercury Ins. Co. v. Magnolia Lady, Inc.*, CIV.A.No.297-CV-153, 1999 WL 33537191, at *3 (N.D. Miss. Nov. 4, 1999), the court found no coverage when state authorities hampered access to claimant's casino-hotel by closing damaged bridge, because "casino-hotel was accessible during the period of time the bridge was under repair." A similar result was obtained when the FAA Ground Stop Order restricted air travel after the September 11th attack on the World Trade Center, but did not prohibit all access to airports and their associated businesses. *See Paradies Shops, Inc. v. Hartford Fire Ins. Co.*, No. 1:03-CV-3154-JEC, 2004 WL 5704715, at *7 (N.D. Ga. Dec. 15, 2004) ("The Court sees no reasonable means of construing [the] order to ground all aircraft as an order specifically forbidding access to plaintiff's premises" in airport terminal stores"); *Philadelphia Parking Auth. v. Fed. Ins. Co.*, 385 F. Supp. 2d 280, 289 (S.D.N.Y. 2005) (finding no coverage where the order "may have temporarily obviated the need for plaintiff's parking services, [but] it did not prohibit access to Plaintiff's garages and therefore cannot be used to invoke coverage").

II. Was the Order caused by Covered Loss of or Damage to Property?

As noted, the insured must also prove that the Order itself was caused by property damage. This invokes two questions: a) was the presence of a virus in a building "loss of or damage to property"?; if so, is the claimed loss caused by an excluded cause of loss; and b) if so, is that loss or damage caused by a covered cause of loss?

A. Was the Presence of Virus in a Building "Loss of or Damage to Property?

The question of whether the presence of a virus on a surface within a building constitutes "direct physical loss of or damage to" the building or property within it is the subject of ongoing litigation. Three of four courts that have considered the issue have rejected the insured's argument that a "loss of use" or "loss of functionality" of the premises constituted "direct physical loss of or damage to property." *See Diesel Barbershop*, 2020 WL 4724305, at *5; *Rose's 1 LLC et al. v. State Farm Lloyds*, 2020 WL 4589206, *2 (D.C. Super.Ct. Aug. 6, 2020); *Gavrilides Management Co. v. Michigan Ins. Co*., Case No. 20 258 CB, Mich. Cir. Ct for Ingram County, Tr. Of July 1, 2020 Hearing tr. at 18-20. *But see. Studio 417, Inc. v. Cincinnatti Ins. Co*., No. 20 CV 03127 SRB, 2020 WL 4692385 (W.D. Mo. Aug. 12, 2020)(finding that discovery was needed to determine the nature and extent of the presence of the virus).

B. Is the Claimed Loss Excluded?

Even if a court were to conclude that a virus in an off-site building constitutes direct physical loss of or damage to property within the geographical scope contemplated by the policy language, an insured must also prove that the physical loss or damage to the off-site property was the result of (i.e., caused by) a covered cause of loss. Many policies have virus exclusions that make "virus within a building" out of coverage even if it is found to be physical loss or damage to that building. *See Diesel Barbershop, LLC et al v State Farm Lloyds*, 2020 WL 4724305, at *6 (W.D. Tex. Aug. 13, 2020) (holding that virus exclusion applied because "it was the presence of COVID-19 in Bexar County and in Texas that was the primary root cause of Plaintiffs' businesses temporarily closing"); *Gavrilides Management Co. v. Michigan Ins. Co*., Case No. 20 258 CB, Mich. Cir. Ct for Ingram County, Tr. Of July 1, 2020 Hearing at 21 (concluding that the virus exclusion "supplies a completely workable, understandable, usable definition of the word

virus," and "the plaintiff has not supported that [the virus exclusion] doesn't apply"). Many policies have other exclusions that are also potentially applicable, such as contamination exclusions and pollution exclusions.

C. Was the Claimed Loss of or Damage to Property the Cause of the Order?

If the insured can overcome the burden of proving that loss of or damage to off-site property caused by a covered cause of loss occurred, the insured must also establish that the property damage identified was the cause of the Order. This is particularly important in the context of the Stay at Home Orders issued by many state and municipal governments, where the orders were issued to create the social distancing needed to prevent the spread of the virus, and were not the result of the short term presence of a virus in a building. The simple need to avoid future human infection or property damage at other premises does not establish the required causation between the alleged damage to off-site property and the issuance of the order. Simple fear of future contamination of people or property is not sufficient. *See United Air Lines, Inc. v. Ins. Co. of State of Pa.*, 439 F.3d 128, 134 (2d Cir. 2006) (holding that civil authority coverage did not apply where "the government's subsequent decision to halt operations at the Airport indefinitely was based on fears of future attacks" on September 11, 2001, not because of property damage to adjacent property); *Paradies Shops, Inc. v. Hartford Fire Ins. Co.*, CIV.A. No. 1:03-CV-3154, 2004 WL 5704715, *7 (N.D. Ga. Dec. 15, 2004) (Secretary of Transportation grounded air traffic due to fear of future terrorist attacks using airplanes, not because of physical damage that occurred in Manhattan, Washington D.C., or Shanksville, PA); *Dickie Brennan & Co. v. Lexington Ins. Co*., 636 F.3d 683, 687 (5th Cir. 2011) ("the 'due to' language in [the] policy required a close causal link by its plain terms."); *Syufy Enterprises v. Home Ins. Co. of Indiana*, No. 0756 FMS, 1995 WL 129229 (N.D. Cal. 1995)(curfews imposed

to avoid "potential looting" were not caused by damage to adjacent property); Two Ceasars Corp. v. Jefferson Ins. Co., 208 A.2d 305 (D.C. Cir. 1971)(governmental objective of avoiding civil unrest did not create causal nexus between property damage and curfew order).

Finally, if the insured can establish all of the elements of coverage, it must still prove that its claimed loss of income was caused by the prohibition of access to its premises, not the losses of its customers or suppliers, and not by a general loss of market.

COVID-19 Coverage Litigation Update

Will Your Claim be Batched with Others for Resolution?

By Robert Lane, Alliant Specialty in collaboration with Linda Kornfeld, Blank Rome

So far, traditional first-party property insurers have taken hardline "no coverage" positions for COVID-19 business interruption claims. As a result, policyholders nationwide (and even around the world) have been left to contemplate whether to press their coverage claims through litigation, or stay on the sidelines and watch as others develop the issues. Those policyholders already in coverage litigation or considering filing suit should be aware of the debate between policyholders and their insurers regarding how to manage the coverage suits that have been filed in many different courts in many different states around the country. To be sure, there are currently nearly 700 lawsuits pending in federal and state courts nationwide (most of which thus far involve small businesses) seeking rulings regarding whether business interruption losses associated with COVID19 are covered by traditional first-party property policies. Of those 700 cases, almost 200 of them are identified as putative class actions.

Recently, some of the policyholder-side lawyers representing restaurants, bars, theaters and other retail establishments across the country in already filed suits have sought to consolidate all federal court cases into one lawsuit and, thus, create a multi-district lawsuit commonly known as an "MDL." Essentially, when federal court litigants request an MDL, a panel of federal judges is convened to hear and decide whether to grant the MDL request. Here, more than 30 insurers and several dozen policyholders have challenged the MDL effort by arguing that the cases are not similar enough to be batched together for purposes of full or even partial resolution, and that consolidation will in fact slow the path to resolution for many policyholders.

Since April, when claimants in both Pennsylvania and Illinois lawsuits first presented the MDL request, much has been written about the rationale for supporting or opposing this MDL approach. The debate took an important step toward resolution on July 30th when an MDL panel heard oral argument via a Zoom call with attorneys on all sides of the issue.

The insurer-side lawyers arguing against consolidation, referred to consolidation as a "nightmare" and instead posited that "it would make most sense for the judges currently overseeing the proposed class actions to evaluate each individual motion for class certification on the merits."

Policyholder-side lawyers pushing for consolidation argued that many insurers have

asserted the same argument against coverage; namely that COVID-19 did not cause requisite "direct physical loss or damage" to the insured property. Those "five simple words," the policyholder lawyers argued, constitute a "common thread" running through all the cases thus warranting consolidation. Other policyholder attorneys have argued against an MDL, observing that (a) historically no insurance coverage cases have been batched into an MDL, (b) coverage litigation often centers on the nuances of the insurance laws of the particular state where litigation is filed, (c) forcing policyholders to litigate in the context of an MDL can result in insureds losing "control" of their individual case if their lawyers are not designated as "lead counsel" in the MDL, and (d) the process can result in many inefficiencies. Some of those lawyers again used the "nightmare" characterization of the proposed consolidation effort here. The issues presented by all sides at the hearing are now "under submission," and it is expected that the panel will render an opinion soon.

The upshot of the MDL debate: if you or your client is considering how best to address insurer denials of COVID-19 business interruption claims, and litigation is on the list of options, a key component of that evaluation should include "where" to file suit—in which state, and in federal or state court. The consolidation options for the MDL panel are multiple and should be considered as part of an ultimate resolution strategy.

Once the court rules, we will update this discussion with specifics about the ruling and provide thoughts about its impact on going-forward decisions involving COVID-19-related coverage claims.

For more information contact:

Robert N. Lane, Esq.
Executive Vice President,
Alliant Specialty Group
Robert.Lane@alliant.com
O (949) 660 5902
C (949) 258 2242

Linda Kornfeld, Blank Rome
Vice Chair,
Insurance Recovery
LKornfeld@BlankRome.com
(424) 239 3859

"Is the Best Defense a Good Offense?" An Insurer Perspective

American College of Coverage Counsel
2020 Annual Meeting

Virtual Conference
September 10-11 & 24-25, 2020

Laura A. Foggan
Crowell & Moring LLP
Washington, DC
lfoggan@crowell.com

An Insurer Perspective: Introduction

Consistent with the approach of numerous courts across many jurisdictions, an insurer has no duty to prosecute affirmative counterclaims as part of its duty to defend. This rule is consistent with the policy language, the weight of authority, and the interests of both policyholders and insurers.

Under widely-used insurance contract terms, an insurer has no duty to a policyholder to prosecute a policyholder's counterclaims. The basic meaning of the duty to defend and the plain and ordinary meaning of the term "defense" compels the conclusion that the prosecution of counterclaims is not part of an insurer's defense obligations. Affirmative counterclaims are inherently offensive and prosecutorial, and not defensive. Expanding the duty to defend to include the prosecution of affirmative counterclaims would impermissibly expand the insurance policy beyond the contractual bargain.

The "in for one, in for all" rule followed in many jurisdictions does not compel a different result. That rule requires that an insurer provide a complete defense against a plaintiff's complaint. In light of the plain and ordinary meaning of "defense," the complete defense rule does not extend "defense" to encompass the prosecution of affirmative counterclaims.

Furthermore, there are strong public policy reasons to adhere to the majority view and refuse to embrace a murky exception for affirmative counterclaims that somehow are "inextricably intertwined" with the defense of an action. *See Spada v. Unigard Ins. Co.*, 232 F.

Supp. 2d 1155, 1163-64 (D. Or. 2002), *aff'd in part on affirmative counterclaim issue,* 80 F. App'x 27 (9th Cir. 2003) (noting that the "inextricably intertwined" test "has been repeatedly called into question, disagreed with, and not followed"). Recognizing the straightforward rule that there simply is no duty to prosecute affirmative counterclaims benefits the insurance system by promoting the certainty on which insurers depend in underwriting risk.

I. Under the weight of authority nationwide, an insurer has no duty to "defend" an affirmative counterclaim.

A. The duty-to-defend is a contractual duty to defend a policyholder for a claim made against it.

The rule that the defense obligation does not require prosecution of affirmative counterclaims is rooted in the basic meaning of the duty to defend: a contractual obligation and right by an insurer to defend a policyholder for a claim made against it.

The insurance contract requires the insurer to cover "Defense Costs," or the "reasonable and necessary legal fees and expenses incurred by [the insurer], or by any attorney designated by [the insurer] to defend [the insured], resulting from the investigation, adjustment, defense, and appeal of a Claim."[1] Nowhere is there any mention of an obligation to prosecute affirmative counterclaims. Imposing that result would impermissibly contort the duty to defend beyond what is provided for under the plain policy terms.

Widely-used insurance contract language provides that the insurer has a duty to defend

[1] The duty to defend is a contractual duty and right undertaken by an insurer. *See Herbert A. Sullivan, Inc. v. Utica Mut. Ins. Co.*, 439 Mass. 387, 397 (2003).

any "claim or suit, i.e., 'any proceeding initiated ***against*** [the insured]'" (emphasis added). Where the policy provides that the insurer has a "duty to defend any claim or suit," the policyholder is not entitled to reimbursement for legal fees incurred in the prosecution of affirmative counterclaims, because an "[insurer's] obligation [to the policyholder] stem[s] from the insurance policy, which provid[e]s for a legal defense." *See Goldberg v. Am. Home Assur. Co.*, 80 A.D.2d 409, 411 (N.Y. App. Div. 1981). The policy language does not include a promise to pay legal fees for claims asserted by the policyholder.

The duty to defend does not expand to include prosecution of counterclaims because a policyholder "bargained only for the insurer to pay for defending the insured against litigation[;] [it] did not bargain for legal representation where the insured is the plaintiff." *Red Head Brass, Inc. v. Buckeye Union Ins.* Co., 735 N.E.2d 48, 57 (Ohio Ct. App. 1999). *See also* Allan D. Windt, *Insurance Claims and Disputes*, § 4:41 (5th ed.) ("An insurer, being obligated only to defend claims brought 'against' the insured, is not required to bear the cost of prosecuting a counterclaim on behalf of the insured.").

B. An affirmative counterclaim is not a claim made against the policyholder.

In asserting a counterclaim, a defendant acts as a plaintiff. "A counterclaim is a 'claim for relief, just like a claim in the complaint." *See* Hon. Amy St. Eve & Michael A. Zuckerman, *The Forgotten Pleading*, 7 Fed. Cts. L. Rev. 152, 176 (2013). A claim brought by a policyholder is, at its core, offensive and prosecutorial, not defensive.

In federal actions, counterclaims are subject to the pleading requirements for all affirmative claims set by the federal rules and the Supreme Court in *Ashcroft v. Iqbal* and *Bell Atlantic Corp. v. Twombly. See id.; see also Tyco Fire Prods. LP v. Victavlic Co.*, 777 F. Supp. 2d 893, 904 (E.D. Pa. 2011) (discussing the pleading standards of affirmative counterclaims). Likewise, states' rules of civil procedure, modeled after the Federal Rules of Civil Procedure, generally construe counterclaims, whether compulsory or permissive, as offensive, prosecutorial claims. *See, e.g., Hermanson v. Szafarowicz,* 457 Mass. 39, 49 (2010) ("We generally follow the Federal courts' interpretation of Federal rules of civil procedure in construing our own identical rules.").

C. The duty to defend has a clear, unambiguous meaning: to deny or oppose the validity of the plaintiff's suit.

There is a basic, unambiguous meaning of "defense" in this context. To provide a "defense" is to deny or oppose the validity of the plaintiff's suit on behalf of the party being sued. *See, e.g., Red Head Brass, Inc.,* 735 N.E.2d at 57 (the "plain and ordinary meaning" of the terms "defend" and "defense" is "to deny or oppose the right of a plaintiff in regard to (a suit or wrong charged)[,]" or "the act of defending [as] opposed to attack[,]" and "a defendants denial, answer, or plea: opposing or denial of the truth or validity of the plaintiff's case;" "defend" "does not include prosecution of one's legal claim against another") (internal citations omitted).

Applying the plain and ordinary meaning of policy terms, like the term "defense," ensures that both insurers and policyholders understand the insurance contract and the available coverage. An affirmative counterclaim is not a proceeding initiated by a third•party against a

policyholder that implicates coverage under a policy. *Shoshone First Bank*, 2 P.3d at 516 (even where "duty to defend" and "claim" were undefined in the policy, holding that if an "insurance policy fails to specify coverage for prosecuting counterclaims, the policy language will not be 'tortured' to create an ambiguity" in order to provide coverage).

D. The weight of authority nationwide recognizes that a duty to defend is a contractual duty to defend a policyholder for a claim made against it.

The majority of courts that have considered the issue have held that an insurer has no duty to prosecute a policyholder's affirmative counterclaims. Commentators agree, noting the general rule that "[a]n insurer, being obligated only to defend claims brought 'against' the insured, is not required to bear the cost of prosecuting a counterclaim on behalf of the insured." Allan D. Windt, *Insurance Claims and Disputes*, § 4:41 (5th ed.).

Indeed, courts in numerous jurisdictions across the nation hold that the duty to defend does not encompass prosecution of affirmative counterclaims. *See, e.g.,* **California,** *James 3 Corp. v. Truck Ins. Exch.*, 111 Cal. Rptr. 2d 181, 188 (Cal. Ct. App. 2001) (no duty to prosecute counterclaims because "there is nothing in the policy that contractually obligates [the insurer] to fund and prosecute an insured's affirmative relief counterclaims or cross•complaints"); *Barney v. Aetna Cas.* & *Sur. Co*., 230 Cal. Rptr. 215, 219-20 (Cal. Ct. App. 1986) (no duty to prosecute counterclaims, noting that "[the insurer] had no duty under the policy to file a cross-complaint on [the insured's] behalf, for nothing in the policy provisions imposes upon the insurer the duty to prosecute claims of the insured against third parties"); *Silva* & *Hill Constr.* Co. *v. Emp'rs Nut.*

Liab. Ins. Co., 97 Cal. Rptr. 498, 506 (Cal. Ct. App. 1971) ("The duty to defend could not extend to requiring the insurer to take affirmative action [.]"); **Massachusetts,** *Mount Vernon Fire Insurance Company v. VisionAid, Inc.*, No. SJC-12142 (June 22, 2017) (finding no duty to defend counterclaim); **Ohio,** *Red Head Brass, Inc.*, 735 N. E. 2d at 57 (finding that under the "plain meaning to the words of the contract[,] . .. the contract did not require [the insurer] to pay for the prosecution of [the policyholder's] counterclaim"); **Oregon,** *Spada v. Unigard Ins. Co.*, 232 F. Supp. 2d 1155, 1164 (D. Or. 2002), *aff'd in part on affirmative counterclaim issue*, 80 F. App'x 27 (9th Cir. 2003) (finding chat "policy language 'to provide a defense' does not encompass a duty to prosecute affirmative counterclaims and cross-claims for relief"); **New Jersey,** *Morgan, Lewis* & *Bockius LLP v. Hanover Ins. Co.*, 929 F. Supp. 764, 773 (D.N.J. 1996) (no coverage for counterclaim filed by policyholder because "[t]he insurance policies do not cover affirmative claims asserted by the insured...."); **New York,** *Goldberg v. Am. Home Assur. Co.*, 80 A.D.2d at 410-11 (N.Y. App. Div. 1981) (insurer "was under no obligation to represent [the policyholder] in his counterclaim against [the claimant]..." because "[the insurer's] obligation to [the policyholder] stemmed from the insurance policy, which provided for a legal defense"); *Reynolds v. Hartford Acc.* & *Indem. Co.*, 278 Supp. 331, 333 (S.D.N.Y. 1967) ("As the insurance contract never contemplated the obligation to bring affirmative claims on behalf of its assured and the prosecution of counterclaims would no doubt entail extra expenditures on the part of the insurance carrier, to imply an obligation on its part to bring counterclaims would be manifestly unfair"); **Maine,** *Bennett v. St. Paul Fire* & *Marine Ins. Co.*, No. 04-cv-212-GNZ, 2006 WL 1313059, at *4, n.10 (D. Me. May 12, 2006) (citing *Carey v. Indian Rock Corp.*, 863

A.2d 289, 290 (Me. 2005) (Maine case law suggested that Maine courts would take the view that there is no duty to prosecute counterclaims as part of an insurer's duty to defend); **Minnesota,** *St. Paul Fire & Marine Ins. Co. v. Nat'l Computer Sys., Inc.*, 490 N.W.2d 626, 632 (Minn. Ct. App. 1992) (insurer not obligated to pay for the costs of a counterclaim raised by the policyholder in answering the complaint); **North Carolina,** *Duke Univ. v. St. Paul Mercury Ins. Co.*, 384 S.E.2d 36, 46 (N.C. Ct. App. 1989) ("An insurer, being obligated only to defend claims brought 'against' the insured, is not required to bear the cost of prosecuting a counterclaim on behalf of the insured."); **Wisconsin,** *Towne Realty, Inc. v. Zurich Ins. Co.*, 548 N.W.2d 64, 69 (Wis. 1996) (finding that even where the prosecution of a counterclaim is necessary to defend a suit, there is no duty to prosecute an affirmative counterclaim where "[t]he insurance contract simply does not establish an obligation on the part of [the insurer] to indemnify the Insureds for the pursuit of counterclaims"); **Wyoming,** *Shoshone First Bank v. Pac. Emp'rs Ins. Co.*, 2 P.3d 510, 516 (Wyo. 2000) ("We invoke our rule that if an insurance policy fails to specify coverage for prosecuting counterclaims, the policy language will not be 'tortured' to create an ambiguity."). These cases make clear the widespread agreement on this rule.

E. "In for One, In for All" is consistent with the rule that there is no duty to prosecute affirmative counterclaims.

Courts agree that the contractual duty to defend, under widely-used policy language and the usual and ordinary sense of the term "defense," does not include coverage for the prosecution of affirmative counterclaims, which are, by definition, offensive. Indeed, as the United States District Court for the District of Massachusetts in *Barletta Heavy Division, Inc. v. Travelers*

Insurance Co. explained, the duty to defend limits an insurer's duty to "defending against claims and does not encompass lawsuits launched offensively. "*Barletta Heavy Div., Inc. v. Travelers Ins. Co.*, No. 12-11193-DPW, 2013 WL 5797612, at *10 (D. Mass. Oct. 25, 2013) (internal quotations omitted). Counterclaims are claims for relief, like claims asserted in a complaint.

Further, the "in for one, in for all" or complete defense rule is fully consistent with the majority rule that counterclaims are not a "defense." The "in for one, in for all" rule requires that an insurer provide a defense for the entire complaint even if coverage is unavailable for certain causes of action asserted against the policyholder. *See GMAC Mortg., LLC v. First Am. Title Ins. Co.*, 464 Mass. 733, 739 (2013). While this rule may require a "complete defense" against the claimant's action, it does nothing to support an expansion of the duty to defend to include the prosecution of affirmative counterclaims, because such claims are inherently offensive.

Notably, the "in for one, in for all" rule is consistent with the approach of most jurisdictions across the country with respect to the duty to defend. *See generally,* Steven Plitt et al., *14 Couch on Insurance §* 200:19 (3d ed. 2016) ("A duty to defend any of the claims against an insured usually requires the insurer to defend the entire suit."). The weight of authority recognizing that there is no duty to prosecute affirmative counterclaims is fully consistent with this widely-accepted "complete defense" principle because, as discussed, the assertion of affirmative counterclaims is not part of a policyholder's defense.

F. Adopting the rule that there is no duty to prosecute affirmative counterclaims benefits both policyholders and insurers.

The assertion of counterclaims in civil litigation is ubiquitous. Both the Federal Rules of Civil Procedure and state rules of civil procedure allow defendants to plead any counterclaim in the answer to a complaint, in the same way a plaintiff would assert a claim. *See* Fed. R. Civ. P. 13(b). The liberal assertion of counterclaims is encouraged by the American judicial system as a means to promote judicial economy. *See* Douglas D. McFarland, *In Search of the Transaction or Occurrence: Counterclaims*, 40 Creighton L. Rev. 699, 732 (2007) (joinder devices such as counterclaims "permit as many controversies as possible to be settled in a single lawsuit, and joinder rules should promote judicial economy and efficiency").

The United States District Court for the District of Massachusetts in *Barletta Heavy Division, Inc. v. Travelers Insurance Co.* noted the problem of extending coverage to affirmative suits by policyholders. "Finally, there are good policy reasons for declining to extend the coverage of an insurer's duty to defend to voluntary suits initiated by the insured," it said. *Barletta Heavy Div.*, 2013 WL 5797612 at *10. The court recognized that:

> To do so would risk spawning marginal litigation; an insured would have every incentive-and little disincentive-to file suit, knowing that it could reap the benefits of success-however unlikely-while transferring the costs of an otherwise predictably unsuccessful suit onto its insurer.

Id.

If the defense duty were to be interpreted to encompass affirmative counterclaims, insurers would incur increased litigation costs that were not contemplated in the underwriting

process. Thus, expanding an insurer's duty to defend beyond the defense of claims asserted against a policyholder to affirmative counterclaims would create greater litigation risk and uncertainty for insurers long-run, this would not serve the interest of Massachusetts policyholders.

Insurance is a carefully defined, risk-for•premium exchange, calculated by an exacting actuarial science. *See N. River Ins.* Co. *v. Cy Thompson Transp. Agency, Inc.*, 840 F.2d 139, 142 (1st Cir. 1988) (recognizing that coverage is tailored to the risks defined in the insurance policy). Insurers price their policies based on an assumption of risk of claims asserted by third-parties against the policyholder. Coverage for affirmative counterclaims, and the high likelihood that they will be asserted, would negate the clear meaning of the policy's defense provisions, and add an additional factor in the underwriting process. As courts and commentators repeatedly have recognized, expanding insurers' coverage obligations beyond the explicit policy terms leaves "ordinary insureds to bear the expense of increased premiums necessitated by the erroneous expansion of their insurers' potential liabilities."[2]

II. Public policy supports adherence to the rule that the duty to defend only extends to claims asserted against a policyholder.

Adherence to the rule that defense does not include the prosecution of affirmative counterclaims is in accord with the basic meaning of the duty to defend. This rule is consistent with the policy language, the weight of authority, and the public interest. This longstanding rule

[2] *Garvey v. State Farm Fire* & *Cas. Co.*, 770 P.2d 704, 711 (Cal. 1989); *see also Moradi-Shalal v. Fireman's Fund Ins. Cos.*, 758 P.2d 58, 66 (Cal. 1988) (legal rules which increase insurance litigation costs will "result in higher premiums" to the general public) (internal citations omitted).

is a tested, straightforward standard for determining an insurer's defense duties.

An exception would undercut the straightforward rule that a defending insurer simply is not required to prosecute a counterclaim. In particular, the murky exception that a few courts have found to exist for affirmative counterclaims that somehow are "inextricably intertwined" with the defense of an action is suspect and undesirable. *See Spada*, 232 F. Supp. at 1163-64 (D. Or. 2002) (noting that *Safeguard Sci.'s, Inc. v. Liberty Mut. Ins. Co.*, 961 F.2d 209 (3d Cir. 1992), which advocates for the "inextricably intertwined" test "has been repeatedly called into question, disagreed with, and not followed"). An "inextricably intertwined" or similar carve-out would inject unnecessary and undesirable confusion into a clear rule. Requiring a defense of *some* counterclaims under such a rule would create undesirable ambiguity regarding an insurer's defense obligations. *See, e.g., Barletta Heavy Div.*, 2013 WL 5797612, at *10. It would unduly complicate the coverage analysis and encourage coverage disputes over whether a particular counterclaim is "inextricably intertwined" with the defense of the action.

Requiring insurers to pay for affirmative claims that would potentially benefit a policyholder would fundamentally alter an insurer's defense obligations under the policy.[3] It would negate the clear meaning of widely-used insurance policy terms and sweep in all kinds of unforeseeable activity. For instance, would defending a faulty workmanship case require an insurer to also prosecute suits for any amounts that customers have withheld due to complaints

[3] To the extent that the insured suggests that thebest defense to the claims against him is an affirmative counterclaim, it should be noted that there is already a pleading mechanism that allows a defendant to assert affirmative matters defeating claims against him - affirmative defenses.

about inadequate workmanship? Would an insurer defending a company in a wrongful termination case be required to finance counterclaims concerning alleged theft of trade secrets? Incorporating these types of obligations to pursue affirmative claims as part of a "defense" would go well beyond providing a policyholder a simple "collateral benefit."

Such obligations are not part of the insurer's contractual duty to provide a defense within the plain meaning of the term. *See Towne Realty, Inc.*, 48 N.W.2d at 69 (quoting dissent in lower court opinion that although "[i]t may be true that a good defense is a good offense, that does not create an obligation beyond the terms of the insurance policy. Courts should adhere to the settled rule, and refuse to introduce confusion into an insurer's duty to defend its policyholder in third-party suits brought against it.

Conclusion

An insurer does not owe a duty to prosecute an insured's counterclaim(s) for damages, or for affirmative counterclaims generally, as part of its duty to defend under the provisions of the insurance contract related to providing a defense or under an "in for one, in for all" rule.

THE BEST DEFENSE MAY BE A GOOD OFFENSE: A POLICYHOLDER'S PERSPECTIVE

American College of Coverage Counsel
2020 Annual Meeting

September 2020

Marion B. Adler
Adler Law Practice, LLC
Chicago, Illinois
madler@adlerlawpractice.com

Lyndon F. Bittle
Carrington, Coleman, Sloman
& Blumenthal, LLP
Dallas, Texas
lbittle@ccsb.com

THE BEST DEFENSE MAY BE A GOOD OFFENSE: A POLICYHOLDER'S PERSPECTIVE

MARION B. ADLER
ADLER LAW PRACTICE, LLC
madler@adlerlawpractice.com
708-948-7391
www.adlerlawpractice.com

LYNDON F. BITTLE
CARRINGTON, COLEMAN, SLOMAN & BLUMENTHAL, LLP
lbittle@ccsb.com
214-855-3096
www.ccsb.com [1]

When an insurer has a duty to defend or to pay a policyholder's defense costs, the majority of courts hold that the insurer also must fund the policyholder's pursuit of "affirmative claims," at least when those affirmative claims are either:

(a) inextricably intertwined with the claims against the policyholder for which the insurer has a defense obligation;[2] and/ or

(b) defensive in nature, in that the affirmative claims may eliminate or reduce the insured's liability to the claimant.[3]

---

[1] Marion Adler and Lyndon Bittle both regularly represent commercial policyholders in coverage disputes. The views expressed in this paper are theirs alone and do not necessarily represent the views of their firms or clients.

[2] *See, e.g., Safeguard Scientifics, Inc. v. Liberty Mut. Ins. Co.*, 766 F. Supp. 324, 334 (E.D. Pa. 1991), *aff'd mem.*, 1992 U.S. App. LEXIS 38473 at *14-15, 1992 WL 12915247 (3d Cir. 1992) (unpublished order under F.R.A.P. 32.1).

The term "defense obligation" is used to encompass situations in which the insurer either (i) has a duty to defend, or (ii) has the duty to pay defense costs incurred by the policyholder, who controls its own defense.

[3] *See, e.g., Oscar W. Larson Co. v. United Capitol Ins. Co.*, 845 F. Supp. 458, 461 (W.D. Mich. 1993), *aff'd on other grounds*, 64 F.3d 1010 (6th Cir. 1995).

Very few courts adopt a bright line rule that an insurer who has a duty to defend or fund the defense never has a duty to pay for pursuing affirmative claims.[4] Rather, when the insurer prevails in such disputes, it is typically because the court concludes that:

(a) the affirmative claims are not defensive in nature; and/ or

(b) because the insurer has accepted the defense of the claims asserted against the policyholder, the insurer is entitled to control the defense, including whether to pursue the affirmative claims as a defense strategy.[5]

Broadly speaking, the question of whether the insurer has a duty to fund affirmative claims arises in two distinct circumstances. Most frequently, the "affirmative claims" are asserted as counterclaims, cross-claims, or third-party claims in the lawsuit in which the policyholder was named as a defendant.[6] Less often, the policyholder seeks to hold the insurer responsible for the litigation expense of an entirely separate lawsuit, often in situations where the policyholder sues preemptively so as to seize the initiative in a long-simmering dispute.[7] Conceptually, it is simpler for the policyholder to frame the affirmative claims as "defensive" if they are asserted as a counterclaim, cross-claim, or third-party claim in response to a suit against the policyholder. Even when the affirmative claims are pursued in a separate lawsuit, however, a policyholder may be able characterize them as "defensive"–e.g., if the affirmative lawsuit is filed to obtain a more favorable forum.[8]

Alternatively, a policyholder may be able to recoup the costs of affirmative claims from its insurer under "allocation" theories. Courts typically require an insurer to pay all fees for legal services that are reasonably related to the claims within the insurer's defense obligation, even where that work may also benefit claims outside the insurer's defense duties.[9] As discussed below, however, this general rule

---

[4] *But see Mt. Vernon Fire Ins. Co. v. VisionAid, Inc.*, 477 Mass. 343, 347, 354 (2017).

[5] *See, e.g., Bennett v. St. Paul Fire & Marine Ins. Co.*, ME Civil No. 04-CV-212-GNZ, 2006 U.S. Dist. LEXIS 29017 at *14-15, 2006 WL 1313059 at *4 (D. Me. May 12, 2006) (relying upon both reasons to deny policyholders' effort to force insurer to fund affirmative claims).

[6] *See., e.g., Great West Cas. Co. v. Marathon Oil Co.*, 315 F. Supp. 2d 879 (N.D. Ill. 2003).

[7] *See, e.g., Great Am. E&S Ins. Co. v. Power Cell, LLC*, 356 F. Supp. 3d 730 (N.D. Ill. 2018).

[8] *IPB, Inc. v. Nat'l Union Fire Ins. Co.*, 299 F. Supp. 2d 1024, 1026 (D.S.D. 2003).

[9] *See generally Safeway Stores, Inc. v. Nat'l Union Fire Ins. Co.*, 64 F.3d 1282, 1289 (9th Cir. 1995) (although insurer had no duty to defend corporate defendant, insurer

is subject to exceptions and qualifications, especially where the policy language dictates specific allocation procedures.

A. Insurer's Duty to Pay for Counterclaims, Cross-Claims, Third-Party Claims

There are a large number of cases that address whether an insurer must pay for the legal costs of counterclaims, cross-claims, or third-party claims asserted by the defendant-insured in response to a suit for which the insurer owes a defense obligation. The following list is not exhaustive, but is illustrative of the reasoning typically offered in support of or against requiring the insurer to fund such claims.

1. Case law holding that costs of counterclaims, cross-claims, and third-party claims are within the scope of an insurer's defense obligation

The following cases are among those where courts have upheld a policyholder's right to the payment by the insurer of the fees associated with a counterclaim, cross-claim, or third-party claim that has been joined to a suit against the policyholder for which the insurer has a duty to defend.

In ***Safeguard Scientifics, Inc. v. Liberty Mut. Ins. Co.*, 766 F. Supp. 324 (E.D. Pa. 1991), *aff'd mem.*, 1992 U.S. App. LEXIS 38473, 1992 WL 12915247 (3rd Cir. 1992) (unpublished)**, the insured was the president of a corporation, which sued him for alleged acts of corporate malfeasance, including alleged defamation of the corporation. The defamation claims entitled the officer to a defense under the Personal Injury Coverage of a CGL policy. The insured counterclaimed, alleging misconduct by the corporation, including breach of contract, fraud, and breaches of the duty of good faith and fair dealing. The court held the allegations of the counterclaim were inextricably intertwined with allegations of the claims asserted against the officer and therefore the insurer was required to fund the cost of the counterclaim.

The insured in ***Oscar W. Larson Co. v. United Capitol Ins. Co.*, 845 F. Supp. 458, 461 (W.D. Mich. 1993), *aff'd on other grds.*, 64 F.3d 1010 (6th Cir. 1995)**, was named as a third-party defendant in a multi-party suit involving the clean-up of a polluted site. The insured asserted a counterclaim against the defendant who had impleaded the insured into the action, and cross-claims against other parties for their role in contributing to the pollution. The court agreed with the insured that the costs of prosecuting the counterclaims and cross-claims were within the duty to

---

was required to pay entirety of defense bills because sums incurred in defending corporation were reasonably related to defending directors and officers, who were entitled to defense under policy terms).

defend because they "are actually defensive in nature and prosecuted to limit or defeat plaintiff's liability in the state court action." 845 F. Supp. at 461. Cases that have followed *Oscar Larson* in the context of environmental actions include ***Great West Cas. Co. v. Marathon Oil Co.*, 315 F. Supp. 2d 879, 882 (N.D. Ill. 2003)** ("'Defense' is about avoiding liability. Claims and actions seeking third-party contribution and indemnification are a means of avoiding liability just as clearly as is contesting the claims …."); and ***Emhart Indus., Inc. v. Home Ins. Co.*, C.A. No. 02-53S, 2006 U.S. Dist. LEXIS 63144 at *7, 2006 WL 2460908 at *2 (D.R.I. Aug. 2, 2006)** ("[T]he duty to defend encompasses fees and costs incurred in counterclaims or third-party actions aimed at shifting liability for the claim as to which the duty to defend exists.").

***TIG Ins. Co. v Nobel Learning Communities, Inc.*, NO. 01-4708, 2002 U.S. Dist. LEXIS 10870, 2002 WL 1340332 (E.D. Pa. June 19, 2002**), was more procedurally complex. First, the insured filed a "Declaratory Action for Copyright Ownership" against the seller of certain assets acquired by the insured. The asset seller then asserted a copyright-infringement counterclaim against the insured. After ruling that the insurer had a duty to defend the infringement counterclaim, the court also held that TIG was required to pay the policyholder's litigation expenses in pursuing its affirmative claims – i.e., the declaratory action that the insured had filed first. The court reasoned that those affirmative claims were "inextricably intertwined" with and "necessary to the defense of the [copyright infringement] litigation as a strategic matter." 2002 U.S. Dist. LEXIS 10870 at *39.[10]

In ***Ultra Coachbuilders, Inc. v. General Security Ins. Co.*, 229 F. Supp. 2d 284 (S.D.N.Y. 2002) (Cal. law)**, the policyholder was sued for claims of trademark infringement, for which the insurer owed a defense. The policyholder brought a counterclaim, which included claims sounding in unfair competition and interference with competitive advantage. The court held that the insurer had a duty to pay the expenses of the counterclaim pursuant to the "inextricably intertwined" test from *Safeguard Scientifics* because the counterclaims mirrored the policyholder's defense of "unclean hands" in opposition to the underlying plaintiff's efforts to enjoin the policyholder's use of the marks. *Id.* at 288.[11]

---

[10] However, the court did hold the insurer's duty to pay for the affirmative claims only incepted after the asset seller had filed its infringement counterclaim. It is unclear whether the policyholder had sought to recover its costs of the affirmative claims predating the counterclaim. *See* 2002 U.S. Dist. LEXIS 10870 at *41.

[11] Intermediate appellate courts in California have declined to apply the "inextricably intertwined" test in applying California law. *See, e.g., James 3 Corp. v. Truck Ins. Exch.,* 111 Cal. Rptr. 2d 181, 188-89 (Cal. Ct. App. 2001) (criticizing *Safeguard Scientifics*); *Gray v. Underwriters at Lloyd's, London*, No. A096189, 2002 Cal. App. Unpub. LEXIS 6621, 2002 WL 1587925 at *9 (July 19, 2002). The California Supreme Court evidently has not spoken on this issue.

In ***Hartford Fire Ins. Co. v. VitaCraft Corp.*, 911 F. Supp. 2d 1164, 1183 (D. Kan. 2012)**, the insured's competitor sued it for a variety of IP-related claims, including claims that insured's patent infringed its senior patent, trade secret misappropriation, and claims of unfair competition, including trade disparagement. The court held the disparagement claims were within the Personal Injury coverage of the policy, obligating the insurer to defend the entirety of the suit. The insured counterclaimed to invalidate the plaintiff's senior patent based on misconduct before the Patent Office. The court held the insurer had a duty to defend the counterclaim both because it was inextricably intertwined with principal action and because it was defensive in nature.

***D.R. Horton, Inc.–Denver v. Mountain States Mut. Cas. Co.*, 69 F. Supp. 3d 1179 (D. Colo. 2014)**, arose from an underlying construction dispute, in which the general contractor was named as an additional insured to general liability policies issued to each subcontractor. The general contractor and the subs were sued for alleged defects in the construction project. In addition to upholding the general contractor's right as an additional insured to a defense under the subcontractors' policies, the court held that those insurers were required to fund the general contractor's cross-claims for contribution and indemnity against the subcontractors who were the named insureds. Similar to the coverage disputes involving environmental claims, the court reasoned that the cross-claims were intended to eliminate or reduce the general contractor's liability and therefore were defensive in nature. *Id.* at 1198-1200. The court reached this conclusion even though it resulted in the insurers being required to fund both the general contractor's prosecution and subcontractors' defense of the cross-claims. *Id.* ***See also Nationwide Mut. Ins. Co. v. D.R. Horton, Inc.–Birmingham*, 15-351-CG-N, 2016 U.S. Dist. LEXIS 160148, 2016 WL 68282 (S.D. Ala. Nov. 18, 2016)** (In a parallel coverage action brought by a different insurer, the court followed the District of Colorado's holding that the insurer was required to pay the litigation expense of cross-claims asserted by the general contractor as additional insured against the named insured/sub).

2. Case law declining to require an insurer to fund the costs of counterclaims, cross-claims, and third-party claims.

Few courts follow an absolute, bright line rule that an insurer's defense obligations never encompass a duty to pay for the affirmative counterclaims, cross-claims, or third-party claims. Massachusetts is one of those few. *See* ***Mt. Vernon Fire Ins. Co. v. VisionAid, Inc.*, 477 Mass. 343 (2017).** The policyholder was sued by a former employee, alleging that he was terminated on account of age discrimination, as well as asserting common law claims for wrongful termination. *Id.* at 346. The insurer appointed panel counsel to defend the policyholder; the defense entailed establishing the employer had legitimate grounds for terminating the employment based on poor job performance and misappropriation of the employer's funds. *Id.*

However, the insurer refused to fund a counterclaim seeking to recover the misappropriated funds. On certified questions from the First Circuit, the Massachusetts Supreme Judicial Court held that neither the duty to defend nor the duty to pay defense costs required the insurer to fund the misappropriation counterclaim, based on dictionary definitions of the term "defend," which the court held unambiguously did not encompass prosecuting a counterclaim. *Id.* 347-54. The court specifically declined to adopt the test applied by some courts that looked to whether the counterclaim was "inextricably intertwined" with the insured's defense. The court rejected the "inextricably intertwined" standard based upon both the absence of such language in the policy and on public policy grounds–i.e., that the "inextricably intertwined" approach would "result in extensive preliminary litigation to determine what claims are sufficiently intertwined." *Id.* at 351.

Massachusetts is not alone in its hard-line position. Federal courts construing Texas law have held that the "duty to *defend* the entire suit does not give rise to a duty to prosecute claims helpful to or even inextricably intertwined with that defense." ***Aldous v. Darwin Nat'l Assur. Co.*, 851 F.3d 473, 483 (5th Cir. 2017) (citing *Mustang Tractor & Equip. Co. v. Liberty Mut. Ins. Co.*, No. H-91-2523, 1993 U.S. Dist. LEXIS 21277, 1993 WL 566032 at *9 (S.D. Tex. Oct. 8, 1993)** (denying insured's request for recovery of cost of prosecuting indemnity and contribution claim against third party, rejecting argument that "the 'best defense' against [covered] claim was a 'good offense'" against the third party), *aff'd*, 76 F.3d 89 (5th Cir. 1996)).

Similarly, the Supreme Court of Wyoming has held that "if an insurance policy fails to specify coverage for prosecuting counterclaims, the policy language will not be 'tortured' to create" such a duty, "no matter how factually intertwined the claims may be." ***Shoshone First Bank v. Pac. Employers Ins. Co.*, 2 P.3d 510, 516-17 (Wyo. 2000).**

However, most of the recently-decided cases (i.e., within the last 20 years) in which the courts have refused to impose a duty on the insurer to fund counterclaims, cross-claims, and/or third-party claims have done so on more narrow grounds – either because the affirmative claims are not "defensive" and/or because the insurer accepted the defense of the suit, which entitled it to dictate defense strategy, including whether to assert "defensive" affirmative claims. For example:

Similar to *VisionAid*, in ***International Ins. Co. v. Rollprint Pckg. Prod., Inc.*, 312 Ill. App. 3d 998 (2000)**, the underlying suit was brought by a former employee who alleged he had been subjected to employment discrimination and wrongful termination. The insurer refused to defend the suit, and this declaratory action ensued. While upholding the policyholder's position that the insurer had a duty to defend the claims asserted by the former employee, the court declined to order the insurer to pay the cost of a counterclaim, which sought to restrain the former

employee from using the employer's trade secrets. The court distinguished the situation from *Oscar Larson* because the trade secret counterclaim was not "defensive" as it did not seek merely "to limit a defendant's potential liability." *Id.* at 1015. Although *Rollprint* represented a loss for the policyholder in that case, subsequent courts treat *Rollprint* as supporting the broader proposition that affirmative claims that are "defensive" in nature are within the scope of an insurer's defense obligation. *See, e.g.,* ***Great West v. Marathon*, 315 F. Supp. 2d at 882** (discussed *supra* at pp. 3-4); ***Selective Ins. Co. v. Creation Supply, Inc.*, 2017 IL App (1st) 161899-U ¶¶ 44-47, 2017 Ill. App. Unpub. LEXIS 1368 at *21-*23, 2017 WL 2855984 (June 30, 2017)** (unpublished order).[12]

In ***Bennett v. St. Paul Fire & Marine Ins. Co.*, ME Civ. No. 04-CV-212-GNZ, 2006 U.S. Dist. LEXIS 29017, 2006 WL 1313059 (D. Me. May 12, 2006)**, the policyholder was a divorce attorney who was sued by the ex-husband of his former client for an order of protection for alleged harassment. The attorney's malpractice insurer accepted the defense of that claim. However, the policyholder also wanted to pursue both (a) a counterclaim against the ex-husband for his harassment of the attorney, and (b) a collection action against the former client's uncle, who had reneged on his agreement to pay the fees incurred in representing his niece. The insurer declined to fund either affirmative claim. The court agreed with the insurer, holding that neither affirmative claim was defensive in nature because neither would eliminate or reduce the policyholder's liability for alleged harassment of the ex-husband. 2006 U.S. Dist. LEXIS 29017 at *14-15. In this regard, it was not enough that the counterclaim would put pressure on the ex-husband to abandon suit or settle for less. Rather, the substance of the counterclaim must be "inextricably intertwined" with the principal action asserted against the insured. *Id.* at *14. Moreover, even if the affirmative claims had been "defensive," given that the insurer had accepted the defense of the claims asserted against the policyholder, the insurer controlled the defense, including whether to pursue the affirmative claims. *Id.* at *15. *See also James 3 Corp. v. Truck Ins. Exch.,* 111 Cal. Rptr. 2d 181, 188 (Cal. Ct. App. 2001) (insurer defending without reservation of rights controls defense, including decisions about affirmative claims).

***Spada v. Uniguard Ins. Co.*, 232 F. Supp. 2d 1155, 1163-64 (D. Ore. 2002), *aff'd on other grounds*, 80 F. App'x 27 (9th Cir. 2003)** (unpublished), entailed coverage for claims stemming from landslides that occurred on adjoining lots – one owned by the insureds and the other by "the McCormicks." The City sent a series of

---

[12] Although Illinois Supreme Court Rule 23(e) forbids the citation in Illinois proceedings of unpublished appellate orders, that rule does not prevent citation in non-Illinois proceedings. A recent decision by the U.S. District Court for the Northern District of Illinois in fact cites the unpublished *Creation Supply* order to support a holding that an insurer owed a duty to defend "affirmative" claims. *See Great Am. E&S Ins. Co. v. Power Cell LLC*, 356 F. Supp. 3d 730, 749 (N.D. Ill. 2018).

demand letters to the insureds instructing them to stabilize their lot so as to prevent future damage. The McCormicks sued the insureds, alleging that the insureds were responsible for damage to their lot. The insurer accepted the defense of that suit. The insureds then counterclaimed against the McCormicks and impleaded the City as a third-party defendant, employing their own counsel when the insurer refused to fund the affirmative claims. The district court held that the insurer had no duty to fund the affirmative claims because it had accepted the defense of the principal action, and therefore was entitled to control the defensive strategy. On appeal, the Ninth Circuit affirmed the district court judgment but on different grounds – to wit, that the counterclaims were not defensive and thus there was no need to reach the broader question of whether an insurer must fund the prosecution of defensive counterclaims. 80 Fed. App'x at 29-30.

***National City Bank v. N.Y. Central Mut. Fire Ins. Co.*, 6 A.D.3d 1116, 775 N.Y.S.2d 679 (4th Dept. 2004),** likewise held that an insurer had no duty to fund prosecution of cross-claims by the insured against its co-defendants where the insurer had accepted the defense of the suit brought against the insured and therefore had the right to control the defense strategy.

B. Insurer's Duty to Pay for Anticipatory or Parallel Suits Filed by the Insured

Occasionally, policyholders are more ambitious in the "affirmative" claims for which they seek insurer funding, contending that preemptive or parallel suits that they initiate are essentially "defensive" to covered claims being asserted against the policyholder. As a policyholder seeking to obtain such funding, the actual wording of the insurance policy may be important. Whereas occurrence-based policies typically impose a duty to defend "suits," the defense obligation in claims-made policies typically applies to "claims." Where the insured has been the target of pre-suit demands – sufficient to constitute a "claim" under the policy definition – then a preemptive suit filed by the policyholder is rightfully understood as a "defense" to that "claim," even under the literalist definition of "defend" applied by cases like *VisionAid*.

We describe below some examples of case law addressing an insurer's obligation to fund parallel or anticipatory suits filed by the policyholder.

1. Case law holding that the costs of anticipatory or parallel suits are within the scope of the insurer's defense obligation

In ***Creation Supply, Inc. v. Selective Ins. Co.*, No. 14 C 08856, 2019 U.S. Dist. LEXIS 195456, 2019 WL 5892193 (N.D. Ill. Nov. 12, 2019), *app. dismissed*, No. 19-3430, 2019 U.S. App. LEXIS 39358, 2019 WL 9048966 (7th Cir. Dec. 26, 2019)**, the court upheld an insured's right to payment by its insurer of the costs of two lawsuits that the insured filed in the Northern District of Illinois in response to

a trade dress infringement action filed against it and its CEO in the District of Oregon. The Illinois suits consisted of (a) a declaratory action of non-infringement against the Oregon plaintiff, and (b) a suit against the insured's vendor that supplied the implicated products, seeking indemnity for the infringement claim.[13] The insured presumably was seeking a strategic advantage in having the dispute adjudicated in Chicago where it was headquartered; in fact, its initial response to the Oregon action was to seek dismissal for lack of personal jurisdiction. Ultimately, the Illinois federal court transferred the two underlying lawsuits to the District of Oregon, which then consolidated them with the earlier-filed suit against the insured. Meanwhile, the insured had filed a counterclaim and third-party claim in the Oregon suit that paralleled the suits it had filed in Illinois. In this coverage suit filed in the Northern District of Illinois, the court held the insurer was required to pay the fees incurred by the insured in Illinois before those actions were transferred to and consolidated with the Oregon action. *See* 2019 U.S. Dist. LEXIS 195456 at *8-*9. This result makes sense if you accept that an insurer has a duty to pay the fees for affirmative claims that are defensive in nature – i.e., that will reduce or eliminate the insured's liability in the principal action. Here, part of the insured's defense entailed objecting to

---

[13] The procedural history of both the underlying litigation and the coverage dispute is complex, involving a series of rulings by the Northern District of Illinois and the District of Oregon in the underlying litigation and by both the Illinois Appellate Court and the Northern District of Illinois in the coverage dispute. As none of these decisions contains a comprehensive summary of the proceedings, the proceedings described in the text above is pieced together from these various decisions, including:

Creation Supply, Inc. v. Alpha Art Materials, Co., 2013 U.S. Dist. LEXIS 151292, 2013 WL 57299709 (D. Ore. Oct. 22, 2013) (denying insured's summary judgment against vendor in underlying third-party action seeking indemnity).

Too Markers Prod., Inc. v. Creation Supply, Inc., 2014 U.S. Dist. LEXIS 106226, 2014 WL 3818675 (D. Ore. Aug. 4, 2014) (denying vendor's motion for summary judgment in underlying third-party action filed by insured).

Selective Ins. Co. v. Creation Supply, Inc., 2015 IL App (1st) 140152-U (insurer had duty to defend claims asserted against insured in Oregon suit).

Selective Ins. Co. v. Creation Supply, Inc., 2017 IL App (1st) 161899-U (insured had right to recoup litigation expense from insurer of third-party claim prosecuted in Oregon).

See also other decisions issued in the Northern District coverage action: 2015 U.S. Dist. LEXIS 196400 (Aug. 15, 2015) (denying insurer's motion for summary judgment on bad faith and breach of contract claims); 2017 U.S. Dist. LEXIS 22614, 2017 WL 661587 (Feb. 17, 2017) (granting summary judgment to policyholder on breach of contract claim for failure to defend underlying Oregon suit); 2018 U.S. Dist. LEXIS 234977, 2018 WL 10498545 (Dec. 20, 2018) (findings of fact and conclusions of law on bad faith claims).

personal jurisdiction in Oregon, to force the infringement action to proceed in its home state of Illinois. This is a legitimate defensive strategy (even if unsuccessful).

The coverage dispute in ***IPB, Inc. v. Nat'l Union Fire Ins. Co.*, 299 F. Supp. 2d 1024, 1026 (D.S.D. 2003)**, arose in the context of a sale of a business. The insured seller was sued in Arkansas by the buyer to rescind the transaction based upon alleged fraudulent inducement. Meanwhile, a shareholder's suit had been filed in Delaware in which the insured and the buyer were both defendants. In lieu of actively defending the Arkansas action, the insured filed a cross-claim against the buyer in the Delaware suit. The buyer then counterclaimed against the insured in the Delaware action, raising essentially the same claims as it asserted in the Arkansas suit. The Delaware court's ruling included detailed findings, rejecting the buyer's claims of fraud and finding that the buyer's principal motivation for seeking rescission was remorse for the price paid, which precluded the buyer from pursuing its claims in the Arkansas action. The court in the coverage action rejected the insurer's effort to escape payment of the fees incurred by the insured in Delaware, noting that even one of the insurer's representatives agreed that Delaware was a more favorable forum than Arkansas for litigating the dispute.

In ***Great Am. E&S Ins. Co. v. Power Cell LLC*, 356 F. Supp. 3d 730, 749 (N.D. Ill. 2018)**, the insured, "Zeus," was the supplier of batteries used by "SWF" to manufacture battery-operated window shades. There were a series of customer complaints and incidents relating to electrical failures of the shades, including explosions, which led to SWF's recalling the shades. Correspondence between Zeus and SWF ensued, in which SWF blamed the recall and explosions on faulty batteries supplied by Zeus, while Zeus contended that the problems arose from SWF's faulty design of the shades. Zeus sued SWF preemptively, seeking a declaratory judgment that its batteries were not defective and for defamation arising out of the content of SWF's recall notices, blaming Zeus for the product failures. SWF then counterclaimed against Zeus, based on alleged defects in the batteries. Zeus's insurer refused to even defend SWF's claims against Zeus, based upon the policy definitions of "property damage" and "occurrence," and late notice. Not only did the court reject those coverage defenses as to the insurer's duty to defend Zeus against SWF's claims, it also held that the duty to defend encompassed the fees incurred by Zeus in its affirmative claims – including those that pre-dated the filing of SWF's counterclaim.

2. Case law holding that the costs of anticipatory or parallel suits are outside the scope of the insurer's defense obligation

***Post v. St. Paul Travelers Ins. Co.*, 691 F.3d 500, 522 (3rd Cir. 2012)**, adopted a bright-line rule that an insurer never has a duty to pay an insured's litigation expense for a separate lawsuit even if that separate suit is "defensive" of a claim within the scope of the insurer's defense obligations. The court adopted this rule while simultaneously recognizing that the insurer would have a duty to pay the cost of a defensive counterclaim asserted by the insured in an action for which the

insurer did owe a defense. *Id.* The court was persuaded by and followed the reasoning of ***Amquip Co. v. Admiral Ins. Co.*, 2005 U.S. Dist. LEXIS 5462 at *26-*27, 2005 WL 742457 at *7 (E.D. Pa., Mar. 31, 2005)**:[14]

> If courts were to consider the costs an insured incurred by instituting its own action for the purpose of bringing pressure on the other party under the guise of a litigation defense, it would encourage and endorse multiplicity of litigation. This is much different than requiring the insurer to reimburse the insured for the cost of prosecuting counterclaims raised in the same action.

Like *Post*, the court in *Amquip* adopted this bright-line rule against an insurer's duty to fund "defensive" parallel lawsuits while simultaneously recognizing that the insurer would have had a duty to pay the cost of a counterclaim as a "necessary litigation defense that is intertwined with the defense of the underlying complaint." 2005 U.S. Dist. Lexis 5462 at *26.

At least one California court likewise has held there is no duty to fund an offensive action in another court, even if it's "the best defense." ***Gray v. Underwriters at Lloyd's, London*, No. A096189, 2002 WL 1587925, *9 (Cal. App. July 19, 2002) (unpublished).** The court cited several cases for the proposition that "California cases have not imposed a duty to assert affirmative claims on an insurer who is defending an action." *Id.*

***Weinstein & Riley, P.S. v. Westport Ins. Corp.*, No. C08-1694JLR, 2011 U.S. Dist. LEXIS 26369, 2011 WL 887552 (W.D. Wash. Mar. 14, 2011)**, entailed a coverage dispute over a convoluted pair of underlying cases, arising out of a stock-sale of a business, "B-Line," in which the attorney/insured served as CEO, held an minority interest, and served as B-Line's outside attorney. The first underlying suit was filed in Oregon by B-Line's majority shareholders to compel the attorney to tender his shares, as well as asserting claims for breaches of contractual and fiduciary duties against him. 2011 U.S. Dist. LEXIS 26369 at *4. Subsequently, B-Line – now controlled by the acquiring shareholders – filed suit against the insured in Washington for both attorney malpractice and breach of fiduciary duties as CEO. *Id.* at *8-12. His malpractice carrier concluded that most of the claims in the Washington suit were outside the scope of coverage – because some arose from the insured's role as CEO and coverage for most of the attorney malpractice claims were barred by an exclusion arising from the insured's ownership stake in B-Line. However, the insurer concluded that one claim was potentially within the scope of coverage because it arose from the insured's refusal to follow the client's instructions to withdraw as its attorney, occurring after he no longer owned shares B-Line (the "failure-to-withdraw"

[14] The Third Circuit's opinion in *Post* incorrectly cites to a subsequent *Amquip* decision, reported at 231 F.R.D. 197, for this proposition.

claim). *Id.* at *13-16. The insurer therefore agreed to defend the Washington suit subject to a reservation of rights and subject to an allocation of fees between the failure-to-withdraw claim and the non-covered claims. *Id.* at *15-17. Meanwhile, the insured filed a third-party claim against B-Line in the Oregon action, mirroring the claims asserted by B-Line against the insured in Washington, including the failure-to-withdraw claim. *Id.* at *26-27. The insured then tried to bootstrap the inclusion of the failure-to-withdraw claim in the Oregon action to impose a duty on the insurer to fund the entirety of his fees in that suit. The coverage court denied this effort, holding that the third-party failure-to-withdraw claim in the Oregon action was "not inextricably interrelated" to the other claims in the Oregon suit, but rather a "discrete, stand-alone claim" and there were no claims asserted against the insured in the Oregon suit for which the insurer owed a defense. *Id.* at *39, *48-49. However, as discussed in the following section, the court did allow the insured, under allocation theories, to recoup a limited amount of the fees incurred in the Oregon action as reasonably related to his defense of the failure-to-withdraw claim asserted in the Washington suit.

C. The Back Door: Even if the Insurer has no Duty to Fund Affirmative Claims, Fees for such Claims May be Recoverable Under Allocation Theories.

Many courts follow the rule that, when the fees incurred in connection with non-covered claims represent legal services that were also reasonable and necessary to the defense of the covered claims, the entirety of those fees are within the scope of the covered defense costs. *See, e.g., Safeway Stores* (cited in footnote 9 *supra.*) Not all courts follow this rule, however. And, even as to courts that generally do, an exception is made when the policy contains explicit language dictating an allocation of fees between covered and non-covered fees, which is increasingly common. A full-blown discussion of court decisions addressing general principles for allocation of defense costs is beyond the scope of this paper.[15]

In jurisdictions where the rule is accepted that the insurer must pay all legal fees that were reasonably related to defense of covered claims, even if those fees also advanced the insured's position as to non-covered claims, the policyholder has a strong argument for requiring the insurer to pay fees incurred for affirmative claims, even if the court does not consider the affirmative claims themselves within the scope of the insurer's defense obligation. For example, in ***Potomac Elec. Power Co. v. California Union Ins. Co.*, 777 F. Supp. 980, 984 (D.D.C. 1991)**, the court held

[15] The subject of allocation of defense costs was discussed in a paper and presentation at the 2019 ACCC annual meeting. *See* F. Cordell, J. Bryan, M. Hamilton & S. Charlton, *"'Allocation – Is That a Thing?' – Navigating Disputes Over Allocation of Covered and Uncovered Claims,"* at 1-10 (ACCC 2019 Annual Meeting, Chicago, IL, May 8-10, 2019).

that the fees incurred by the insured in filing a "preemptive" action against the State Attorney General were fully recoverable from the insurer if the policyholder could show that those expenses "were reasonably related to the [defense of the] PCB civil suit," for which the insurer did owe a defense.[16]

Similarly, ***Etchell v. Royal Ins. Co.*, 165 F.R.D. 523, 563 (N.D. Cal. 1996)**, upheld the policyholder's right to recover the cost of a non-covered cross-claim asserted in a trespass action for which the insurer owed a defense obligation because

> [t]here was a great deal of overlap in the underlying action between the evidence and law made relevant by the claims in the Blasis' complaint and the evidence and law made relevant by the claims in the Etchells' cross-complaint. …
>
> In this setting, California courts would permit Safeguard to escape liability for fees or costs incurred in prosecution of the cross-complaint only if Safeguard could adduce undeniable evidence that the challenged fees or costs would not have been incurred but for the filing of the cross-complaint.

Accord ***MGA Entertainment, Inc. v. Hartford Ins. Group*, No. ED CV 08-0457-DOC(RNBx), 2012 U.S. Dist. LEXIS 24000 at *58-68 (C.D. Cal. Jan. 24, 2012)** (although fees incurred by insured in counterclaim did not constitute covered defense costs, insurer may not seek reimbursement from policyholder for those fees unless the insurer can show that "the fees and costs incurred for an insured's affirmative claims and defenses are separable and those fees and costs are allocated *solely* to the affirmative claims"); ***Amquip*, 2005 U.S. Dist. LEXIS 5462 at *27** (leaving open for trial a determination whether the insured "incurred costs common to both the defense of the Ohio action [for which the insurer owed a defense obligation] and the prosecution of the [parallel] Pennsylvania action [which was outside the insurer's defense obligation).

On the other hand, when the insurer is able "to separate the fees associated with preparing and asserting an affirmative counterclaim from other defensive fees," rules of allocation may defeat the policyholder's efforts to recoup the costs of pursuing affirmative claims in situations where the affirmative claims are outside the scope of the insurer's defense obligations. ***See Sullivan v. Am. Family Mut. Ins. Co.*, A06-1285, 2007 Minn. App. Unpub. LEXIS 750, 2007 WL 2106142 at *2 (July 24,**

[16] In addition to holding the insurer responsible for the fees incurred in its "preemptive" affirmative civil suit, the court relied upon the same allocation principles to hold the insurer responsible for its fees incurred in criminal grand jury proceedings. *See* 777 F. Supp. at 984.

2007) (quoting ***St. Paul Fire & Marine Ins. Co. v. Nat'l Computer Sys., Inc.*, 490 N.W.2d 626, 632 (Minn. App. 1992))**.

Further, even when the court follows the general rule that an insurer may be liable for the costs of non-covered affirmative claims where the legal services also overlapped and advanced the defense of covered claims, the court may deny or reduce the insured's recovery if those fees were disproportionate to the insured's exposure for the covered claim. This is illlustrated by ***Weinstein & Riley*, 2011 U.S. Dist. LEXIS 26369 at *57-68**, in which the court awarded a mere $40,000 out of the $1.8 million that the insured claimed as fees incurred in the separate Oregon lawsuit that were reasonably related to defense of the covered failure-to-withdraw claim asserted in the Washington action. Among the reasons cited by the court was that the "$1.8 million in attorney's fees is 'excessively disproportionate' to the [insured's] risk of liability on the 'failure to withdraw' malpractice claim," given that the underlying plaintiff had abandoned the failure-to-withdraw claim after concluding that the damages "would be negligible." *Id.* at *66-67

Conclusion

Courts that limit the insurer's obligation to fund affirmative claims, even where necessary for a complete defense, often rely on the perceived "plain meaning" or "common usage" of the word "defend." The Massachusetts court in *VisionAid* held "the plain meaning of the word 'defend' is clear" and does not obligate the insurer "to prosecute an affirmative counterclaim on behalf of its insured," based upon two selected dictionary definitions of the word. *See* 477 Mass. at 348-49 (quoting Webster's Third New Int'l Dictionary 591 (1993)); *see also Red Head Brass, Inc. v. Buckeye Union Ins. Co.*, 135 Ohio App. 3d 616, 628 (1999) (same).

There are, however, other definitions and common usages that suggest a less restrictive meaning for the "defend." For example, the word is also defined as "to act as attorney for" someone,[17] or to "represent the defendant."[18] This meaning is particularly apropos to the insurance context, as the insurer can only satisfy its duty to defend by retaining attorneys. And "to act as an attorney" logically includes taking actions a reasonable defense attorney would take—which in an appropriate case will include counterclaims or third-party claims.

As the dissenting justices in *VisionAid* observed, courts should "focus on what it means to defend a proceeding, which is the duty the insurer agreed to assume."

---

[17] WEBSTER'S SEVENTH NEW COLLEGIATE DICTIONARY, at 216 (1971). *Accord Merriam-Webster.com Dictionary*, https://www.merriam-webster.com/dictionary/defend (accessed July 13, 2020). *See also* RANDOM HOUSE WEBSTER'S UNABRIDGED DICTIONARY, at 522 (2d ed. 1998) ("to serve as attorney for").

[18] BLACK'S LAW DICTIONARY, at 377 (5th ed. 1979).

> Because the duty to defend a "claim" under the contract means to defend the insured in any proceeding where a wrongful act is alleged, … the broader view of the duty to defend includes the duty to prosecute compulsory counterclaims that are intertwined with the insured's defense. This broader view is consonant with what any reasonable attorney representing the insured would do to defend a proceeding; the narrower view [adopted by the court] is not.

477 Mass. at 358 (Gants, C.J., dissenting).

More broadly, in common usage, "defend" means to "protect from attack," as in "you have the right to defend yourself if you are being attacked."[19] Defense in this example is obviously not limited to fending off blows or crouching in a defensive position. Self-defense includes striking back. Britain's airstrikes on Germany in 1940 were an integral part of Churchill's defense of the island.[20]

Indeed, the *VisionAid* court begs the question by declaring that "the essence of what it means to defend is to ***work to defeat*** a claim that could create liability against the individual being defended." 477 Mass. at 348-49 (emphasis added). On its face, "work[ing] to defeat a claim" may very well include offensive and preemptive actions. And, surely "defeat[ing] a claim" includes taking steps to "diminish liability," as was pointedly made clear in *Great West v. Marathon Oil*:

> "Defense" is about avoiding liability. Claims and actions seeking third-party contribution and indemnification are a means of avoiding liability just as clearly as is contesting the claims alleged to give rise to liability.

315 F. Supp. at 882.

---

[19] *Macmillan Online Dictionary*, https://www.macmillandictionary.com/us/dictionary/american/defend (accessed July 13, 2020).

[20] *See* ERIK LARSON, THE SPLENDID AND THE VILE 306 (Crown 2020).

10 Cases in 45 Minutes

American College of Coverage Counsel
2020 Annual Meeting

Virtual Conference
September 10-11 & 24-25, 2020

Robert D. Chesler, Esq.
Anderson Kill
Newark, NJ
rchesler@andersonkill.com

Anthony B. Leuin, Esq.
Shartsis Friese LLP
San Francisco, CA
aleuin@sflaw.com

Suzanne Midlige, Esq.
Coughlin Duffy
Morristown, NJ
smidlige@coughlinduffy.com

MAJOR INSURANCE DEVELOPMENTS OF 2019

Robert Chesler and Nicholas Insua

In the early 1980's, when insurance coverage litigation was in its infancy, most practitioners expected that courts would quickly resolve the key issues. No one expected that they would still be debating basic coverage issues in 2019. This past year did not see any decisions addressing truly novel issues. Rather, with the exception of cyber insurance, the year's decisions shed clarity on existing issues with which coverage litigators long have grappled.

Cyber Insurance

The Eleventh Circuit, applying Georgia law, held that a phishing loss constituted a direct loss resulting from a fraudulent transfer. *Principle Solutions Group LLC v. Ironshore Indemnity Inc.,* 944 F.3d 886 (11th Cir. 2019). The meaning of 'direct' has long been a source of contention.

Principle Solutions concerned a classic phishing case. The company's controller received a message supposedly from the company's managing director, advising her to wire $1,700,000 pursuant to instructions that the controller would receive from an attorney. The purported attorney then contacted the controller and gave her instructions to wire the money to a bank in China. The transferring bank, Wells Fargo, asked for verification that the wire transfer was legitimate, which the controller confirmed. Wells Fargo then released the funds. The next day, the managing director told the controller that he never gave the instruction.

Ironshore first argued that the phishing loss did not constitute a covered fraudulent transfer pursuant to the insurance policy, an argument that the court found was unpersuasive. Ironshore next asserted that the loss was not 'direct' as required by the fraudulent transfer coverage because there was no "immediate link between the instruction and the loss." Id. Again the court disagreed. It found that the Georgia standard was proximate cause, which included "all of the natural and probable consequences" of the act "unless there is a *sufficient and independent* intervening cause." (Cite omitted) (Emphasis in original.) Id. The court held that the intervening acts between the initial message and the wiring of the money were not sufficient to break the causal chain.

Principle Solutions is the third circuit court decision to find coverage for phishing losses under a business crime policy.

Illusory Coverage

Policyholders often assert to a court that if it adopts the policy interpretation proffered by the insurance company, it would render coverage illusory, but the case law shows that this assertion has met with only limited success. However, cases from 2019 may breathe new life into this argument.

Crum & Forster Specialty Ins. Co. v. DVO, Inc., 939 F.3d 852 (7th Cir. 2019) concerned a professional liability policy issued to a company that had contracted to design and build an 'aerobic digester,' designed to convert cow manure to electricity. After an accident, the insurance company denied coverage on the basis of a breach of contract exclusion. Since the underlying claim arose from DVO's breach of contract, the insurance company asserted the application of the exclusion.

The trial court agreed, but the Seventh Circuit reversed. The court found that all of DVO's work was performed pursuant to a contract, and to enforce the breach of contract exclusion would render the coverage illusory.

In *Starr Surplus Lines Ins. Co. v. Star Roofing,* No. CA-CV18-0642, 2019 WL 5617575 (Ariz. Ct. App. Oct. 31, 2019), Starr issued a policy to a roofing company. An employee of the building's tenant passed out from roofing fumes and broke her arm. The insurance company denied coverage on the basis of the pollution exclusion, and the court's decision centered on its holding that the absolute pollution exclusion only applied to traditional environmental pollution. However, the court also addressed illusory coverage: "The scope of interpretation requested by Starr Surplus would result in illusory coverage for the ordinary commercial business activities of the insured…." Id. at *35. See also, *McGraw-Hill Education v. Illinois National Insurance Co.*, Case No. 655708/16, 2019 WL 6869010 (Ill App. Div. 1st Dept., Dec. 17, 2019) (applying fortuity defense to copyright infringement coverage "would render that portion of the policy illusory.") Id. at *1.

Bad Faith

Bad faith is another cause of action often pressed by policyholders with only mixed success. However, two decisions from 2019 may provide a roadmap to policyholders on such claims.

In *Yahoo! Inc. v. National Union Fire Ins. Co. of Pittsburgh, PA*, No. 5:17-cv-00489 (N.D. Cal. May 17, 2019), National Union moved for judgment as a matter of law on Yahoo's bad faith claim. To oppose, Yahoo relied on such evidence as (1) National Union's denial letter cited to an exclusion not found in the policy, (2) National Union used an incomplete copy of the policy to determine coverage, (3) National Union did not construe "the allegations of the underlying suits in a manner that would favor a finding of coverage," (4) National Union did not reconsider its coverage position, and (5) National Union did not conduct a thorough investigation, among others. Id. at *3.

The court found that the jury could rule for National Union and find that its "coverage decisions were not unreasonable." However, it also found that "there is a legally sufficient evidentiary basis for a jury to find that National Union acted or failed to act without proper cause." As a result, the court denied National Union's motion.

Prucker v. American Economy Ins. Co., No. CV186013630S, 2019 WL 2880369 (Conn. Sup. Ct. May 31, 2019) involved a homeowners' claim of deteriorating conditions in its basement walls caused by a contaminant in the concrete, apparently a common complaint. The insured brought causes of action in bad faith, and pursuant to the Connecticut Unfair Trade Practices Act ("CUTPA") and the Connecticut Unfair Insurance Practices Act ("CUIPA"). The insurance company moved to strike these counts.

The court allowed the bad faith claim to remain because the insured alleged that the insurance company "knew of and chose to ignore the rulings by state and federal courts in Connecticut that similar damage should be covered under similar policy language." Id. at *4. The court stated that this essentially alleged that the insurance company had no reasonable basis to deny coverage. The court found that if these decisions were confirmed by the Connecticut Supreme Court and Harleysville knew that its coverage position was incorrect, a bad faith claim was plausible.

The CUTPA and CUIPA counts required by statute a general business practice of unfair trade practices by the insurance company. The plaintiff alleged the insurance company's "systematic and uniform denial" of similar claims, and pointed to a putative class action on the same issue. The court found that the plaintiff had alleged a sufficient general business practice, and denied the insurance company's motion to strike. Id. at *7.

Yahoo and *Prucker* indicate that courts will look to evidence of claims handling practices in determining bad faith. This could be a fertile field for policyholders.

War Risk Exclusion

The war risk exclusion has received much attention with respect to cyber-attacks of late. *Universal Cable Productions, LLC v Atlantic Specialty Ins. Co*., 929 F.3d 1143 (9th Cir. 2019) concerned a more traditional conflict – that between Israel and Hamas in Gaza. Universal was filming near Gaza and had to move and cease production because of the outbreak of fighting between the parties. This resulted in a business interruption loss. The insurance policy had two war risk exclusions upon which the insurance company relied to deny coverage. The district court held that the conflict was a war within the ordinary understanding of that term and denied coverage, and the Ninth Circuit reversed.

First, the court rejected the application of contra proferentem, because of Universal's broker's role in drafting the insurance policy. The court next rejected the district court's reliance on the 'ordinary understanding' rule. It cited to the California Civil Code, which stated that the ordinary meaning applied to policy terms *"unless a special meaning is given to them by usage, in which case the latter must be followed."* (Emphasis in court's decision.) Id. at 1153. The court then found that in the insurance context, 'war' was understood only to be a conflict between two sovereign states. It therefore held that since neither Hamas nor Gaza were sovereign states, the exclusions did not apply.

War and terrorism exclusions have become much broader in many policies. Policyholders and their brokers or consultants should review them carefully and see if they need to be scaled back.

Late Notice

Late notice is a crucial issue on which jurisdictions differ dispositively. A majority of states hold that late notice of a claim will only foreclose coverage under a general liability policy if the late notice has prejudiced the insurance company – although states differ on what constitutes prejudice. A minority of states hold that late notice of a claim will foreclose coverage as a matter of law.

Pitzer College v. Indian Harbor Ins. Co., 447 P.3d 669 (Cal. 2019) concerned a California insured suing in California on an insurance policy that contained a New York choice of law provision. Pitzer gave late notice of an environmental claim to Indian Harbor, which denied coverage on the basis of late notice. Under California law, late notice will only foreclose coverage if the insurance company can demonstrate substantial prejudice, while under New York law, with respect to the insurance policies at issue, late notice is fatal to coverage. Pitzer argued that the court should not enforce the choice of law provision because the prejudice rule constituted California fundamental public policy. The Ninth Circuit certified the case to the California Supreme Court.

The California Supreme Court held that even in the absence of a legislative pronouncement, the prejudice rule was a fundamental public policy of California that overrode the contractual choice of law provision. The court relied on several factors. Id. at 99.

Asbestos Insurance Coverage

Apocryphally, someone once asked a Lloyd's representative what would be the next asbestos, and he replied – asbestos. The Connecticut Supreme Court's decision in *R.T. Vanderbilt v.Hartford Acc. & Indem. Co.,* 216 A.3d 629 (Conn. 2019) reflects the persistence of asbestos in the insurance (and other) contexts. The court addressed four important issues.

Most importantly, the court confirmed that Connecticut was a continuous trigger state. Under that rule, the insurance company on the risk when the first exposure to asbestos exposed, and insurance companies continued on the risk until manifestation of an asbestos illness. The court affirmed the lower court's refusal to permit expert testimony by an insurance company to establish that in fact, an asbestos injury does not take place until the final cellular mutation that caused the disease to develop.

The court also adopted the 'unavailability rule,' holding that the insurance company and not the insured was responsible for those years on the risk when insurance coverage was not available in the marketplace. The court ruled that indoor exposure to asbestos was not

pollution, adopting, as in *Starr Surplus,* the rule that the pollution exclusion only applied to traditional environmental pollution. The court then granted a significant victory to insurance companies, holding that an 'occupational disease' exclusion applied not only to the insured's only employees but to any employee. Since almost all asbestos claimants suffered exposure in the course of their employment, this holding practically vitiates coverage under any policy containing such an exclusion.

Assignment

Ever since the decision by the California Supreme Court in *Henkel Corp. v. Hartford Acc. & Ind. Co*., 62 P.3d 69 (Cal. 2003), insurance companies have carefully reviewed claims by successor companies under their predecessors' policies to see if the parties had properly assigned the policies. In *The Premcor Refining Group, Inc. v. ACE Ins. Co. of Illinois,* No. 5-18-0210, 2019 Ill. App. (5th) 180210-u (Ill. App. Ct. 5th Dist., Aug. 12, 2019), the successor corporation failed to do so.

Premcor purchased assets from Apex. As a result, Premcor found itself subject to environmental litigation stemming from those assets. Premcor sought coverage under the Apex policies in place when the contamination occurred. The insurance companies denied coverage, asserting that the asset purchase agreement ("APA") had not assigned those policies to Premcor. Moreover, Apex intervened, joining the insurance companies and denying that it had assigned the policies to Premcor.

The court ruled that the APA did not include an assignment of those policies in dispute. It found that while the APA did specifically assign certain policies, it did not assign the earlier policies. The court stated, "a valid assignment must describe the subject of the assignment with sufficient particularity." Id. at *4. In some similar disputes, successor companies have argued that a general assignment of contractual rights includes rights under insurance policies. Query whether such an argument would survive the Premcor test of 'sufficient particularity.' See also, *PCS Nitrogen, Inc. v. Continental Casualty Co.*, N. 5699 (S. Car. App. 2019) (court held that company was not a successor and did not receive an assignment).

Loss of Use

The definition of property damage in a general liability policy includes 'loss of use of tangible property that is not physically injured.' Many policyholders do not realize how broad this coverage is. In *Thee Sombrero, Inc. v. Scottsdale Ins. Co.*, 28 Cal. App. 5th 729 (Cal. App. Ct. 2019), the court stretched this coverage probably as far as it can go.

After a shooting, the city canceled Thee Sombrero's nightclub license, although the club could still be used as a banquet hall. The Sombrero sued the security company at the night club. That company defaulted, and Thee Sombrero sued the company's insurance company

directly. The trial court dismissed the claim, finding that the loss was not for property damage but for economic loss.

The appellate court reversed. It held that Thee Sombrero suffered the loss of use of the property as a nightclub, which was an element of the definition of property damage. The court then found that the proper measure of damages was the loss in value of the property.

Relationship Back

Under claims-made policies, and particularly D&O policies, a later claim can relate back to a prior claim and be covered under the policy in place at the time of the earlier claim. This 'relationship back' doctrine has produced a large and bewildering morass of case law. *Emmis Communications Corp. v. Illinois National Ins. Co*., 323 F. Supp. 3d 1012. (S.D. Ind. 2018) may help both policyholders and insurance companies navigate their way on this issue.

Emmis has both an unusual fact pattern and procedural history. The relationship back doctrine can aid either the policyholder or the insurance company depending on the circumstances. However, it is more frequently used by insurance companies to argue that a latter claim relates back to an earlier claim that the policyholder did not report, thereby foreclosing coverage for the latter claim because of late notice.

In *Emmis*, the insurance company sought to relate the later action back to the prior one. The district court disagreed and ruled in favor of the policyholder. At first, the Seventh Circuit reversed. However, it then granted a petition for rehearing, withdrew its prior opinion, and adopted the decision of the district court. The district court had adopted a relation back standard of "operative facts…that is, facts that form the basis of the causes of action asserted in the lawsuits." Id. at 1027. The court found that the related facts relied upon by the insurance company were just "window dressing," and held that the actions were not related.

D&O Issues

Delaware courts were active in addressing D&O issues in 2019, issuing five important decisions.

The Delaware Supreme Court handed a victory to insurance companies in *In re Verizon Insurance Coverage Appeals*, No. 558, 560, 561, 2018, 2019 WL 5616263 (Del. Sup. Ct. Oct. 31, 2019). Verizon had spun off a company, which quickly entered bankruptcy. The bankruptcy trustee sued Verizon, alleging violation of fraudulent transfer statutes, payment of unlawful dividends in violation of Delaware corporate statutes, and common law counts of breach of fiduciary duty, promoter liability, and unjust enrichment. While Verizon successfully defended the suit, it incurred $48 million in attorneys' fees. Verizon sought coverage under its D&O policy, which defined a security claim in relevant part as a claim

"alleging a violation of any federal, state, local or foreign regulation, rule or statute regulating securities." Id. at *1.

The trial court held that the definition of 'security claim' was ambiguous and that contra proferentem applied, and found coverage. The Delaware Supreme Court reversed, holding that the definition was unambiguous. It found that the broad definition of "regulations, rules or statutes" enunciated by the lower court "would encompass a variety of non-security related claims." Id. at *3.

In *Conduent State Healthcare, LLC v. AIG Specialty Ins. Co*., No. N18C-12-074, 2019 WL 3337216 (Del. Super. Ct. June 24, 2019), the insured received a civil investigation demand ("CID") from the Texas attorney general demanding documents. The insurance company sought partial summary judgment, arguing that the CID was only a request for information and not a 'claim' under the insurance policy. The court denied the motion, holding that the demand for documents was a claim because it was a demand for non-monetary relief.

In *IDT Corp. v. U.S. Specialty Ins. Co*. No. N18C-03-032, 2019 WL 413692 (Del. Super. Ct. Jan. 31, 2019), the court held that the insurance company had to defend the chairman of the board of the corporation. The insurance company asserted that the underlying complaint did not allege a 'wrongful act' necessary to trigger coverage against the chairman. The court found that the definition of 'wrongful act' was unambiguous It held that 'wrongful act' had a broad meaning not limited to the breach of fiduciary duty, and found coverage.

However, the court also held that the corporate spin-off that was the basis of the claim was not a securities claim, so that the corporation itself did not have coverage. It found that a security claim had to be brought by a subsidiary, and that, following a spin-off, the former subsidiary that sued IDT was no longer a subsidiary, despite its central role.

In *Arch Ins. Co. v. Murdock*, No. N16C-01-104, 2019 WL 2005750 (Del. Super. Ct. May 7, 2019), the court held that settlement payments by the company to its shareholders were not an excluded 'increase in the consideration paid' but a covered loss.

In *Solera Holdings v. XL Specialty Ins. Co*., No. N18C-08-315, 2019 WL 4733431 (Del. Super. Ct. Sept. 26, 2019, the court faced the novel issue of whether an appraisal action constituted a covered securities claim, and held that it did.

Conclusion

Insurance law is state law, which means that the parties can litigate each issue fifty times. Hopefully, this year's decisions will be normative and help to reduce future litigation on these issues. However, if the past is any indicator, we can expect that we have not heard the last word.

Bob Chesler and Nick Insua are shareholders in the Newark office of Anderson Kill, where they represent policyholders.

The Impact of Delaware's Sudden Dominance in D&O Coverage Disputes

American College of Coverage Counsel
2020 Annual Meeting

Virtual Conference
September 10-11 & 24-25, 2020

Leslie Ahari
Clyde & Co.
Washington, D.C.
Leslie.Ahari@clyde.us

Seth Lamden
Neal, Gerber & Eisenberg, LLC
Chicago, IL
slamden@nge.com

Mike Manire
Manire Galla Curley LLP
New York, New York
mmanire@maniregallacurley.com

The Impact of Delaware's Sudden Dominance in D&O Coverage Disputes

Long dominant in business and corporate governance litigation, the Delaware state courts have recently garnered significant attention for their decisions in director & officer liability insurance coverage disputes. In the past few years, the Delaware Superior Court has issued a number of pro-corporate policyholder rulings that are distinctly more favorable to insureds compared to decisions in other jurisdictions on the same or similar issues. The result has been an increased level of D&O insurance coverage litigation generally, and in Delaware in particular. This paper addresses several of the most significant decisions issued to date on critical issues, including choice of law, public policy limitations on coverage, the scope of Securities Claim coverage, related wrongful act issues, and allocation between covered and uncovered loss.

I. Delaware Choice of Law and Forum Related Issues

In the absence of a choice of law clause, the choice of law rules in most states require the forum court to determine which state has the most significant relationship with the insurance coverage dispute. More often than not, the most significant relationship test results in application of the insurance law of the state where the named insured corporation has its primary business location, particularly if the policy itself is issued and delivered to the insured in that jurisdiction. *See, e.g., Certain Underwriters at Lloyd's, London v. Foster Wheeler Corp.*, 36 A.D.3d 17 (N.Y. App. Div. 1st Dep't 2006), aff'd, 9 N.Y.3d 928 (2007) (under "center of gravity" test, applicable law is the location of the insured's principal place of business where insurance policies cover risks in multiple states).

The Delaware Supreme Court likewise applies the most significant relationship test to decide choice of law for insurance policies. *See Certain Underwriters at Lloyd's, London v.*

Chemtura Corp., 160 A.3d 457 (Del. 2017); *Travelers Indem. Co. v. CNH Indus. Am., LLC*, No. 420, 2018 WL 3434562 (Del. July 16, 2018) (TABLE). However, in a little-noticed decision in 2010, Delaware Superior Court Judge Fred Silverman, in a discussion that appears to be *dicta*, expressed why he thought Delaware law should apply to an insurance coverage dispute under a D&O policy issued to a company headquartered in Virginia but incorporated in Delaware. *See Mills Limited P'ship v. Liberty Mut. Ins. Co.*, No. 09C-11-174, 2010 Del. Super. LEXIS 563, 2010 WL 8250837 (Del. Super. Ct. Nov. 5, 2010). The coverage issue in *Mills* was an exhaustion question arising out of the settlement of a securities fraud claim. The court had actually found that a Virginia court would apply the same coverage standard as a Delaware court, and noted that "if the laws would produce the same decision, there is no real conflict and a choice of law analysis would be superfluous." *Id*. at * 11 (citing *Great Am. Opportunities, Inc. v. Cherrydale Fundraising, LLC*, No. 3718, 2010 Del. Ch. LEXIS 15 (Del. Ch. Jan. 29, 2010). The court nevertheless addressed choice of law. The court noted that an optional arbitration clause in the policy provided that any arbitrators would "give due consideration" to the law of the insured's state of incorporation, and concluded that the parties "probably expected Delaware law to apply." *Id*. at *14. The court noted that "a fundamental policy of contract law is protecting the parties' expectations." *Id.* at *11. The court then cited the Restatement (Second) Conflicts of Law and listed the contacts set forth in §188 as considerations for determining applicable law when an insured risk involves multiple jurisdictions and is not "located" in a particular state. Those contacts included the places of contracting and of negotiation of the contract, but the court made no mention of a factual record or analysis in that regard. Instead, the court stated, without citing any precedential authority:

> When the insured risk is the directors' and officers' "honesty and fidelity" to the corporation, and the choice of law is between headquarters or the state of incorporation, the state of incorporation has the most significant relationship.

Id. at *17-18.

The *Mills* decision drew little attention at the time.

In 2018, however, Judge Eric Davis of the Delaware Superior Court, in *Arch Insurance Co. v. Murdock*, 2018 Del. Super. LEXIS 96; 2018 WL 112911 (Del. Super. Ct. March 1, 2018) ("*Arch v. Murdock 2018*"), adopted and applied the *Mills* analysis in holding that the law of Delaware, rather than California, governed the construction of a D&O policy issued in California to Dole Food Company, Inc. The matter in dispute was coverage for a settlement of a Delaware Chancery Court action arising out of Dole CEO and controlling stockholder David Murdock's acquisition of 100% of Dole's publicly-traded stock. Dole was a Delaware corporation whose headquarters was in California. The primary defendants, Murdock and Dole's former general counsel, were located in California, and the insurers presented evidence that the relevant conduct of the parties had taken place in California, the policies were issued and delivered in California, and the policies contained California amendatory endorsements to conform the policies to California's insurance regulatory requirements. The policies contained no choice of law provision and no ADR clause like that in *Mills*. The court nevertheless applied Delaware law.

The court acknowledged that "[i]n complex insurance cases with risks in multiple states such as this one, Delaware courts have generally held that the most significant factor for the conflict-of-law analysis is the principal place of business of the insured because it is 'the situs which link[s] all the parties together,'" citing cases including *Liggett Group, Inc. v. Affiliated FM Ins. Co.,* 788 A.2d 134 (Del. Super Ct. 2001). *See Arch v. Murdock 2018*, 2018 Del. Super. LEXIS 96, at *22. *Liggett* contained an in-depth choice of law analysis applying the law of the

state of the insured's headquarters to a general liability policy insuring risks in multiple states. Judge Davis observed that *Liggett* "is a very well-reasoned opinion and strong authority on the issue of choice of law in complex insurance coverage situations." *Id.* at *24. But the court found *Mills* to be the "better authority" for a D&O policy, citing Judge Silverman's dicta that the state of incorporation has the "most significant relationship" to a D&O policy, which insures directors' and officers' "honesty and fidelity" to the corporation. *Id.*

The Delaware Supreme Court rejected the Dole D&O insurers' application for certification of Judge Davis's decision for interlocutory appeal. The coverage litigation has since been resolved, but one of the insurer parties reserved the right to appeal the choice of law ruling (and others) to the Delaware Supreme Court. The insurer's opening brief was filed under seal on July 7, 2020. The case caption is *RSUI Indemnity Company v. David H. Murdock, et al.*, No. 154,2020, in the Supreme Court of Delaware.

The Delaware Superior Court made several other controversial rulings in *Arch v. Murdock*, two of which are discussed later in this paper. But the impact of the choice of law decision to date has been significant. Since the court's March 1, 2018 decision, at least two courts have expressly adopted and applied the choice of law principle discussed in *Mills* and applied in *Arch v. Murdock I*, one characterizing the principle as a "consistent" holding of Delaware courts. *See Pfizer, Inc. v Arch Ins. Co.*, No. N18C-010310, 2019 WL 3306043, 2019 Del. Super. LEXIS 345 at *19 (Del. Super. Ct. July 23, 2019) ("[A]pplying Delaware law here accords with this Court's consistent application of Delaware law to resolve disputes over insurance coverage of directors' and officers' liability."); *Calamos Asset Mgmt. v. Travelers Cas. & Sur. Co. of Am*, No. 18-1510, 2020 U.S. Dist LEXIS 111895 (D. Del. June 25, 2020). Other Delaware Superior Court judges have acknowledged the principle in *dicta*. *See IDT Corp. v.*

U.S. Specialty Ins. Co., 2019 Del. Super. LEXIS 55*; 2019 WL 413692 (Del. Super. Ct. Jan. 31, 2019) (noting there was no conflict of laws in the case and that a Delaware court should therefore "avoid a choice-of-law analysis altogether," but then noting "one more thing"—"Delaware courts have consistently held" (citing only *Mills*) that Delaware law should apply to a Delaware corporation's D&O policy); *Ferrellgas Partners, L.P. v. Zurich Am. Ins. Co*., 2020 Del. Super. LEXIS 41, at *8; 2020 WL 363677 (Del. Super. Ct. Jan. 21, 2020) (finding no need to choose between Texas and Delaware law, but asserting that Delaware courts "consistently" have held (citing *IDT* and *Mills*) that Delaware law applies to D&O insurance disputes with Delaware corporations.).

It remains to be seen whether *Mills* and *Arch v. Murdock I* approach will be upheld by the Delaware Supreme Court or followed by other jurisdictions. Indeed, a New York trial court recently rejected the *Mills* analysis in connection with a series of D&O coverage disputes arising out of the American Realty Capital accounting fraud. In *XL Specialty Insurance Co. et al. v. AR Capital, LLC, et al*, No. 650018/2019 (Sup. Ct., NY Cty., NY) the court applied New York law over Delaware law to a D&O policy issued to a Delaware-incorporated insured, AR Capital, LLC, with a principal place of business in New York. *See* Transcript of Hearing at 45-49, attached to Decision + Order on Motion (Jan. 31, 2020), *XL Specialty Ins. Co. et al. v. AR Capital, LLC, et al*, No. 650018/2019 (Sup. Ct., NY Cty., NY). The insureds had asserted counterclaims against excess D&O insurers for breach of contract and bad faith and argued for application of Delaware law based on *Mills* in opposing a motion to dismiss those claims. The New York court rejected that argument, distinguishing the choice of law analysis in an insurance coverage case from that in an "internal affairs doctrine" case – such as breach of fiduciary or other duties to shareholders by corporate officers – "where you look at the state of

incorporation." *Id.* at 8. Specifically, the court ruled that a contract choice of law analysis should apply, even if the underlying claim for which the insured seeks coverage is an "internal affairs" matter.

> This case is not about whether the defendants breached their fiduciary duties to the shareholders of their WREIT [sic]. It's about -- that claim is already settled. The question here is about insurance coverage and interpretation of the insurance contract.

Id. at 46. Consistent with New York's "center of gravity" test, the court ruled that the insured's "state of domicile should be the driving force" in the choice of law analysis. *See* Transcript at 46.

The American Realty Capital insurance dispute resulted in other Delaware Superior Court rulings on *forum non conveniens*, personal jurisdiction and comity, all of which have taken on greater significance in light of the *Mills* and *Arch v. Murdock 2018* decisions. The issues arose because of a race to the courthouse in which the insurers filed in New York and the insureds filed in Delaware a day later.

First, the Delaware Superior Court rejected the insurer's motion to dismiss the second filed Delaware action on *forum non conveniens* grounds. The court found that the Delaware and New York cases would be deemed contemporaneously filed, with no "first-to-file" preference. The court applied a *forum non conveniens* analysis and held that the insurer defendants failed to establish they would suffer "overwhelming hardship" if required to litigate in Delaware and that the so-called *Cryo-Maid* factors (balancing of the parties' interests)[1] did not "tip in favor of"

[1] *See Gen. Foods Corp. v. Cryo-Maid, Inc*., 198 A.2d 681 (Del. 1984). One of the *Cryo-Maid* factors is whether Delaware substantive law would apply to the case. The defendant insurers argued that New York law would apply, but the plaintiff insureds' asserted there was no conflict between the relevant laws of the two states. The court made no ruling on choice of law and treated it as a neutral factor. *Id.* at *16-17.

staying the Delaware litigation in deference to the New York forum. *See AR Capital, LLC v. XL Specialty Ins*. Co., 2019 Del. Super. LEXIS 216, at *20, 2019 WL 1932061 (Del. Super. Ct. April 25, 2019), *reh'g denied* 2019 Super. LEXIS 288 (May 29, 2019).

Meanwhile, the New York trial court denied the insureds' motion to dismiss the New York case in favor of the Delaware forum, based on New York's strong interest in the dispute and application of the "first filed" rule. On appeal, the First Department affirmed the decision. *See XL Specialty Ins. Co. v. AR Capital, LLC*, 181 A.D.3d 546 (NY App. Div. 1st Dep't 2020).

Second, the Delaware Superior Court addressed personal jurisdiction with respect to certain Difference in Conditions ("DIC") insurers that had been sued in Delaware but were not involved in the New York litigation. The DIC insurers sought dismissal for lack of personal jurisdiction because their policies had been issued to a different named insured headquartered in New York and incorporated in Maryland, and that insured had no place of business in Delaware. The court granted the jurisdiction motion as to the DIC insurers, holding that under recent United States Supreme Court case law, in order for the court to exercise general personal jurisdiction over the DIC insurers, they would either have to be incorporated or have their principal place of business in Delaware, which they did not. *Id.* at *8. The court ruled that personal jurisdiction also was lacking, and found inadequate the insureds' allegations that the DIC insurers are licensed to do business and in fact transact business in Delaware, and that they write insurance policies covering Delaware citizens. *Id.* at *13. Those connections, according to the court, were "outside the context of this lawsuit," and the cause of action asserted against the DIC insurers did not arise from their conduct in Delaware. *Id.*

The AR Capital coverage litigation proceeded simultaneously in two jurisdictions for over a year and a half, with the parties coordinating discovery between the two cases. However, on a second round of dismissal motions filed in the Delaware action, the insurers again asked the Delaware Superior Court to dismiss or stay the Delaware litigation in deference to the New York action. Although the Delaware court again rejected the *forum non conveniens* argument, it decided to stay the litigation on principles of comity. This was based on the substantive rulings that had been reached in the New York litigation by the trial court, and affirmed by the Appellate Division, that New York was a logical forum and New York had a legitimate interest in the litigation,. *See AR Capital, LLC v. XL Specialty Ins. Co.,*, No. N19C-01-024, 2020 WL 4907990 (Del. Super. Ct. Aug. 3, 2020).

II. Coverage for Settlement Reached After Trial Court Decision Finding Fraud

The *Arch v. Murdock* case also raised a unique question regarding the primary D&O policy's conduct exclusion and the insurability of fraudulent conduct under Delaware law. As noted above, the underlying claim against Murdock and others arose out of Murdock's taking Dole private in a November 2013. The price and other terms of the transaction were approved by a special committee of the Dole board and a narrow majority of disinterested stockholders. *See In re Dole Food Co. Stockholder Litig*., No. 8703, No. 9079, 2015 Del Ch. LEXIS* 223 (Del. Ch. August 27, 2015) (the "Chancery Court Decision"), at *73-80. Dole stockholders sued Murdock and others in Delaware Chancery Court, alleging breaches of fiduciary duty that had artificially deflated the market value of Dole's stock and had allowed Murdock to acquire the stock at an unfair price. *See id.* at *2-7. After a full bench trial, Vice Chancellor Travis Laster found that Murdock, the General Counsel, and Murdock's holding company DFC Holdings were jointly liable for breach of their duties of loyalty to the selling stockholders, specifically

finding and repeatedly characterizing Murdock's and the General Counsel's as conduct as "fraud." *See, e.g.*, *id.* at *155 ("Murdock and Carter's pre-proposal efforts to drive down the market price and their fraud during the negotiations reduced the ultimate deal price by 16.9%."); *see also Arch Ins. Co. v. Murdock*, 2018 Del. Super. LEXIS 96 *; 2018 WL 112911 (Del. Super. Ct. March 1, 2018) ("*Arch v. Murdock 2018*"), at *17 ("Vice Chancellor Laster specifically found that 'Murdock and Carter's conduct throughout the Committee process . . . demonstrated that their actions were not innocent or inadvertent, but rather intentional and in bad faith.'"). Vice Chancellor Laster found that Murdock and the two other responsible defendants were liable to Dole stockholders in the amount of over $148 million. *See Dole* Chancery Court Decision, 2015 Del Ch. LEXIS* 223, at *158.

Shortly after the Chancery Court Decision was issued, before the issuance of a final order and without the Dole D&O Insurers' written consent, the *In re Dole* parties reached a settlement in which Murdock agreed to pay 100% of the Chancery Court's award against him and the other defendants (the "Dole Settlement"). Murdock then sought coverage for the Dole Settlement from the Dole D&O insurers. In the subsequent *Arch v. Murdock* insurance coverage action, the insurers asserted – among other defenses to coverage for the Dole Settlement – both the primary policy's conduct exclusion and the uninsurability of fraud as a matter of public policy.

The D&O primary policy's conduct exclusion stated that the policy would provide no coverage for any Loss on account of a Claim;

> based upon, arising out of or attributable to … [a]ny profit … or financial advantage to which the Insured was not legally entitled; or [a]ny willful violation of nay statute or any deliberately … fraudulent act, error or omission by the Insured, ***if established by a final and non-appealable adjudication adverse to such Insured in the underlying action.***

Arch v. Murdock I, at *8 (emphasis added). The Superior Court granted the insureds' motion to dismiss the insurers' claim based on the exclusion. *See Arch Ins. Co. v. Murdock*, 2016 Del. Super. LEXIS 645, 2016 WL 7414218 (Del Super. Ct. Dec. 21, 2016) ("*Arch v. Murdock 2016*"). The court did not question that the underlying court's findings of fraud and deliberate conduct, and indeed ultimately ruled that the insureds were collaterally estopped from denying those findings. *See Arch v. Murdock 2018,* 2018 Del. Super. LEXIS 96, at *18. The court also acknowledged that the underlying settlement and the subsequent Chancery Court order approving were "carefully crafted to mitigate the findings of" the Chancery Court Decision, possibly for the purpose of "maintain[ing] insurance coverage." *Id.* at *20. But the court found that the conduct exclusion did not bar coverage for the settlement, because "the [Chancery Court Decision] was not a final and non-appealable decision," *Id.* at *21.

The Superior Court's written opinion did not comment on the primary case law relied on by the insurers in their briefing: *In re IBP, Inc. S'holders Litig. v. Tyson Foods, Inc.,* 793 A.2d 396 (Del. Ch. 2002) ("*IBP*"), *appeal dismissed in part sub nom. Tyson Foods, Inc. v. Aetos Corp.*, 809 A.2d 575 (Del. 2002) ("*Tyson*"), and *aff'd Tyson Foods, Inc. v. Aetos Corp.*, 818 A.2d 145 (Del. 2003). In *IBP*, a party who entered and obtained court approval of a case after a post-trial decision returned to the court and moved to vacate the interlocutory order. Then-Vice Chancellor Strine rejected the motion, ruling that under Chancery Court rules, the interlocutory order *became* a final and non-appealable judgment as a result of the court's approval of the settlement. *IBP,* 793.A.2d at 400. The Delaware Supreme Court affirmed Vice Chancellor's Strine's ruling, explaining that when parties settle and waive any right to appeal, an interlocutory ruling "achieves finality" and becomes a "final and non-appealable adjudication." *Tyson*, 809 A.2d at 580.

The *Arch v. Murdock* court nevertheless found that the "plain, unambiguous language" of the conduct exclusion did not apply because (i) the Chancery Decision did not constitute a final and non-appealable adjudication, and (ii) the Chancery Court's "Settlement Order and Final Judgment did not make findings regarding fraudulent acts by an insured." *Arch v. Murdock 2016*, 2016 Del. Super. LEXIS 245, at *21.

The Delaware Supreme Court's treatment of this issue on appeal will be worth watching, for reasons beyond the Superior Court's failure to address the *IBP* and *Tyson* decisions. A year later in the same case, the *Arch v. Murdock* court held that the same Chancery Court Decision was "finally adjudicated" for purposes of collateral estoppel. *See Arch v. Murdock 2018,* 2018 Del. Super. LEXIS 96 *at *17-18.* The court cited the *Tyson* decision that it did had not addressed in the *April v. Murdock 2016* decision on the conduct exclusion. *Id.* at *16. For collateral estoppel purposes, the court found that the Chancery Court Decision "is sufficiently definite to be a final judgment on the merits," *id.* at *18, and ruled that "the Court will employ collateral estoppel against the Insureds on factual issues determined in the [Chancery Court Decision] to the extent those factual issues are relevant to issues in this civil action." *Id.* at *18-19. The court distinguished its holding from its earlier one on the conduct exclusion, quoting its own dicta from that earlier decision that there is a "big difference between [a collateral estoppel finding and] finding that contractually you agreed to a final non-appealable order. . . ." *See id.* at *16 n.91, *quoting Arch v. Murdock 2016*, 2016 Del. Super. LEXIS 96 at *15-16.

The collateral estoppel issue was before the *Arch v. Murdock* court because the insurers were seeking summary judgment on their defense that allowing Murdock to obtain insurance reimbursement for his payment in the Dole Settlement would violate Delaware public policy, as it would allow a Delaware director or officer to profit from conduct that a Delaware Chancery

Court had found to be a fraud against Dole's stockholders. The court rejected that defense in the same decision. The court acknowledged that it could not enforce an insurance provision that is contrary to Delaware public policy, but stated that Delaware courts may not "void an otherwise valid contract provision 'in the absence of clear indicia that such a policy actually exists.'" *See Arch v. Murdock 2018,* 2018 Del. Super. LEXIS 96, at *26-27, *citing Whalen v. On-Deck, Inc*., 514 A.2d 1072, 1074 (Del. 1986). The court stated that it could not find a Delaware decision holding that a corporation cannot obtain directors and officers insurance that covers breach of loyalty based on fraud. *See id.* at *27. The court cited *Whalen*, noting that the Delaware Supreme Court held that there was no Delaware public policy against insurance coverage for punitive damages. *See id.* The court also observed that § 145(g) of the Delaware General Corporation Law gives corporations the power to purchase insurance coverage for directors and officers "against any liability that could be asserted against him. *See id*. Finally, though acknowledging that "it may strain public policy to allow a director to collect insurance on a fraud," the court denied the insurers' motion, holding that Delaware public policy did not "clearly prohibit the Insurers from indemnifying the Insureds' fraud." *Id*. at *28.

The *Arch v. Murdock* decision on coverage for fraud is a striking example of the potential impact of the same court's decision on application of Delaware law to a D&O policy. The insurers sought application of the law of California, which includes a statutory provision barring insurance coverage for willful misconduct. S*ee* California Ins. Code § 533. Application of that California statute to the *Arch v. Murdock* coverage dispute might well have changed the outcome.

The Dole Settlement also raised the question whether Murdock's payment of additional consideration for the Dole shares he purchased constituted insurable "Loss". The court granted

the insureds' summary judgment motion on that issue, finding that the Dole Settlement fell within the primary policy's definition of Loss, which expressly included "settlement amounts." *Arch Ins. Co. v. Murdock*, 2019 Del. Super LEXIS 227, at *24, 2019 WL 2005750 (Del. Super. Ct. May 7, 2019) (*Arch v. Murdock III*). Although the policy's Loss definition expressly did not include "amounts representing the increase in the consideration paid … by the Policyholder in connection with its purchase of any securities," the court found that language did not apply because Murdock, rather than Dole (the policyholder), paid the Dole Settlement. *Id*. The court made no specific finding regarding whether Delaware public policy barred coverage for the Dole Settlement as disgorgement or restitution, but in light of his earlier decision on public policy and its reliance on the Delaware Supreme Court's *Whalen v. On-Deck, Inc*. decision in *Arch v. Murdock 2018*, the court's views on that specific issue were evident. A Delaware Superior Court had already ruled in 2015 that a restitutionary settlement was covered under a similarly worded D&O policy because of the policy's inclusion of "settlements" in is definition of Loss and a final adjudication condition in its illegal profit exclusion. *See Gallup, Inc. v. Greenwich Ins. Co*., 2015 Del. Super., LEXIS 129, 2015 WL 1201518 (Del. Super Ct., February 25, 2015).

The *Arch v. Murdock* decisions on the conduct exclusion and Delaware public policy on insuring fraud are on appeal in *RSUI Indemnity Company v. David H. Murdock, et al.*, No. 154,2020, in the Supreme Court of Delaware.

III. Coverage For a Shareholder Appraisal Action

Under most public company D&O policies, entity coverage is available only for a "Securities Claim." In 2019, Delaware courts issued two rulings regarding what constitutes a D&O insurance "securities claim." The first of these rulings found, as a matter of first impression, that a shareholder appraisal action pursuant to 8 Del. C. § 262 constitutes a

"Securities Claim," which the D&O policy at issue in that case defined as "any actual or alleged violation of any federal, state or local statute, regulation, or rule or common law regulating securities . . . ." *Solera Holdings, Inc. v. XL Specialty Ins. Co.*, 213 A.3d 1249, 1254 (Del. Super. Ct. 2019).[2]

By way of background, section 262 of the Delaware General Corporation Laws confers upon any stockholder holding shares at the time of certain types of mergers or consolidations the right to demand an appraisal by the Delaware Court of Chancery of the fair value of the shares. See 8 Del. C. § 262. *See also Verition Partners Master Fund, Ltd. v. Aruba Networks, Inc.,* 210 A.3d 128 (Del. 2019) (discussing valuation standards applicable to a section 262 appraisal action). No allegations of wrongdoing are required to plead an appraisal action.

The underlying claim in *Solera Holdings* was an appraisal action brought against Solera, the insured, following a merger between Solera and another company. *See id*. at 1252. The underlying plaintiffs claimed that the fair market value of their shares at the time of the merger was greater than the agreed merger price. The appraisal action did not allege any claims against Solera other than a request for an appraisal. *See id.* Solera requested coverage from its D&O insurer, which denied coverage on the basis that an appraisal action is not a claim for a "violation" of any law, as required by the policy definition of "Securities Claim," because "a 'violation' of law must involve wrongdoing, and allegations of wrongdoing are not required in an appraisal action." *Id*. at 1253. The D&O policy did not define the term "violation." *See id*. at 1255.

[2] The Superior Court's ruling in *Solera Holdings* is currently pending on appeal before the Delaware Supreme Court.

In response, Solera argued that the term "violation" does not require any wrongdoing; it merely requires an alleged violation of a legal standard. *See id*. at 1255. Accordingly, Solera argued, the appraisal action alleges a violation of law because an appraisal action "inherently alleges a violation of the statutory obligation to provide shareholders fair value for their shares when they are cashed out of their position." *Id*. at 1255.

Agreeing with Solera, the Delaware Superior Court held that a shareholder appraisal action against an insured entity is a "Securities Claim" because it alleges a violation of a law or rule regulating securities. *See id*. at 1255-56. The stockholders have a legal right to receive fair market value for their shares, reasoned the court, and the basis for an appraisal action is an allegation that the stockholders did not receive fair market value. *See id*. at 1256. In so ruling, the court rejected the insurers' argument that an appraisal action is not a Securities Claim because the appraisal action did not allege violations of law involving wrongdoing. As the court explained, the plain and ordinary meaning of the term "violation" is not limited to wrongdoing – a violation is, "among other things, a breach of the law and the contravention of a right or duty." *Id*. at 1256. The court also noted that if the insurer "intended to limit coverage to claims alleging wrongdoing, the Policy could have used limiting language." *Id*. at 1256.

The *Solera Holdings* court also held that the appraisal action sought "Loss," even though the only relief sought in the appraisal action was the fair market value of the shares and pre-judgment interest. The D&O policy at issue defined "Loss" to include "damages, judgments, settlements, pre-judgment and post-judgment interest or other amounts . . . that [Solera] is legally obligated to pay." *Id*. at 1256-57. Although the parties agreed that the fair market value of the shares did not constitute covered "Loss," the underlying claimants also sought pre-judgment interest. *See id*. at 1256. The court rejected the insurer's argument that pre-judgment interest

only constitutes "Loss" if it is awarded on covered damages, noting that the insurer did not cite any supporting case law and could have drafted the policy to limit coverage for pre-judgment interest awarded on covered damages if it had so desired. *See id*. at 1257. Although it found that pre-judgment interest constitutes "Loss," the court nevertheless denied Solera's motion for summary judgment regarding coverage for the pre-judgment interest due to factual issues and concerns that other policy exclusions could eliminate coverage. *See id.*

IV. "Securities Claim" Coverage For Claims Under Laws That Do Not "Regulate" Securities

In the second case addressing the meaning of "Securities Claims" in a D&O Policy, the Delaware Superior Court ruled in favor of the policyholder that the "Securities Claim" coverage for the company under a D&O Policy extended to breach of fiduciary duty, unlawful payment of dividends and fraudulent transfer counts asserted against it. On appeal, the Delaware Supreme Court reversed, holding that "Securities Claim" as defined by the policy did not include a claim against an insured for alleged common law and violations of state and federal laws that do not specifically "regulate securities." *See In re Verizon Ins. Coverage Appeals*, 222 A.3d 566 (Del. 2019), *reh'g denied* (Nov. 18, 2019).

This coverage dispute arose out of Verizon's 2006 spin-off of its print and electronic directories business into a newly formed subsidiary, Idearc Inc. Verizon transferred the directories business to Idearc in exchange for 146 million shares of Idearc common stock, $7.1 billion in Idearc debt, and $2.5 billion in cash. Verizon distributed the common stock to its shareholders. Idearc then launched as an independent, publicly traded company with $9.1 billion in debt. In 2009, Idearc filed for Chapter 11 bankruptcy. U.S. Bank, the Litigation Trustee, filed suit against Verizon and certain of its officers, alleging that they had loaded Idearc with

excessive debt. The Litigation Trustee's complaint alleged counts for (i) breach of fiduciary duty; (ii) payment of an unlawful dividend in violation of the Delaware Code; and (iii) fraudulent transfer under the U.S. bankruptcy code and the Texas Uniform Fraudulent Transfer Act. The Trustee sought to recover approximately $14 billion in damages.

Verizon incurred more than $48 million in defense costs, which it sought to recover from its insurers under its D&O policies. The insurers denied coverage on the basis that the trustee action did not constitute a "Securities Claim," defined in relevant part to mean a claim "alleging a violation of any federal, state, local, or foreign regulation, rule or statute regulating securities (including, but not limited to, the purchase or sale or offer or solicitation of an offer to purchase or sell securities)." Verizon then filed a coverage action against the insurers in Delaware Superior Court.

In the coverage litigation, the parties cross-moved for summary judgment on whether the U.S. Bank action was a "Securities Claim." The insurers argued that the "rules" and "regulations" referenced in the definition should be understood to refer to federal securities laws and state Blue Sky laws. By contrast, Verizon argued that the insurers' interpretation was too narrow and the word "rule" should be read to encompass judicial rules of law or common law rules that "must be followed to properly engage in a securities transaction." The Superior Court held that the definition of "Securities Claim" was ambiguous, and that the doctrine of *contra proferentem* required it to adopt Verizon's interpretation of "Securities Claim." As it stated: "Nothing in the policies' definitions of securities claims purports to exclude common-law rules or to limit coverage to only those claims alleging violations of enumerated state or federal securities statutes and regulations." *Verizon Commc'ns Inc. v. Illinois Nat'l Ins. Co.*, No. CVN14C06048WCCCCLD, 2017 WL 1149118, at *10 (Del. Super. Ct. Mar. 2, 2017).

On appeal, the Delaware Supreme Court disagreed and reversed. The Supreme Court determined that the "Securities Claim" definition was unambiguous and the Trustee's action did not assert a "Securities Claim" within the meaning of the policies. *See In re Verizon Ins. Coverage Appeals*, 222 A.3d at 580. The Supreme Court concluded that "regulations, rules, or statutes," as used in the definition of "Securities Claim" "must be directed specifically towards securities laws for 'regulating securities' to have meaning." *Id.* at 575. The Supreme Court also observed that none of the legal causes of action in the trustee suit were "specifically directed" towards securities laws or even necessarily involved securities. The Supreme Court rejected Verizon's argument that the "Securities Claim" definition encompassed claims for any unlawful conduct committed during a securities-related transaction, finding that Verizon's interpretation would cast "too broad a net." *Id.* at 579. It therefore held that Verizon was not entitled to coverage for its defense costs. The Supreme Court reversed and ordered the Superior Court to enter judgment in favor of the insurers. In November 2019, the court denied Verizon's request for a rehearing.

V. Related Wrongful Acts and Related Claims Issues

The Delaware Superior Court recently has adopted an interpretation of common wording in D&O Policies regarding "Related Wrongful Acts" that differs significantly from other jurisdictions. In interpreting policy language regarding whether Wrongful Acts and Claims are related and the application of the Prior Notice and Prior and Pending Litigation exclusions, the Delaware Superior Court requires a showing that claims are "fundamentally identical" in order to be considered related. *See Pfizer*, *Inc. v Arch Ins. Co.*, No. N18C-01-310, 2019 Del. Super. LEXIS 345, 2019 WL 3306043 (Del. Super. Ct. July 23, 2019).

The underlying lawsuit in *Pfizer* was a securities class action captioned *Morabito v. Pfizer, Inc.* Pfizer's D&O insurer denied coverage for the *Morabito* suit based on two exclusions: (1) a "Related Wrongful Acts" exclusion that excluded coverage for Claims "alleging, arising out of, based upon or attributable to the facts alleged, or to the same or related Wrongful Acts alleged or contained in any Claim which has been reported . . ." under a prior policy; and (2) two "Specific Litigation Exclusions" that excluded coverage for Claims "alleging, arising out of, based upon, attributable, or in any way related directly or indirectly" to the underlying facts, circumstances, acts or omissions alleged in an earlier lawsuit captioned *Garber v. Pharmacia*, and Interrelated Wrongful Acts. *Id*. at *5-*6. The insurer argued that there was no coverage for the *Morabito* suit because it was related to the *Garber* suit, which had been brought during a prior policy period.

In interpreting the policies, the *Pfizer* court cited *United Westlabs, Inc. v. Greenwich Ins. Co.*, No. 09C-12-048, 2011 WL 2623932 (Del. Super. Ct. July 1, 2011), which the court stated examined an "indistinguishable" definition of Interrelated Wrongful Acts. In *United Westlabs*, the court initially stated that it need not determine whether Delaware or California law governed the policy, because the laws between the two states did not differ. The court then rejected the insured's argument that two sets of wrongful acts were unrelated because they were based on separate injuries and events and separated over two year time period. As a factual matter, the court found that the two sets of wrongful acts in that case were "fundamentally identical" for the purpose of holding (in the insurer's favor) that the matters were considered a single claim in the same policy period because they involved the same subject and common facts, circumstances, transactions, events and occurrences, notwithstanding the addition of other parties to the later filed counterclaim. *Id.* at *11.

In a footnote, the *Pfizer* court also cited *Medical Depot, Inc. v. RSUI Indem. Co.*, No. N18C-01-310, 2016 WL 5539879 (Del. Super. Ct. Sept. 29, 2016). *Id.* at *9 & n. 82. In *Medical Depot*, the court held that two actions were not related and therefore not considered a single Claim, where one was an individual wrongful death and products liability case for injuries caused by a body sling, and the second was a class action under California's unfair trade practices statute seeking redress for having purchased the sling, but did not allege physical injury. Without citation, the court stated that the two suits were not "fundamentally identical" and therefore the class action did not relate back to the personal injury suit.

Based on these precedents, the *Pfizer* court more broadly held that under Delaware law, "similar 'relatedness' or 'arising out of' policy language is interpreted as precluding coverage only where two underlying actions are 'fundamentally identical." *Id.* at *7. *See also id.* at *9. It then concluded that the *Morabito* and *Garber* suits were not "fundamentally identical." Although the suits shared some similarities, the court found there were notable differences. First, although both were securities fraud class actions, the *Morabito* suit was brought by the shareholders of Pfizer and the Garber suit was brought by shareholders of Pharmacia before it was acquired by Pfizer. Second, although both suits alleged that the defendant had made false representations and omissions regarding health risks allegedly caused by the drug Celebrex, the *Morabito* suit involved alleged cardiovascular risks and the *Garber* suit involved gastrointestinal risks. *See id*. at *10. Additionally, the *Morabito* suit alleged false representations regarding a second drug, Bextra. *See id*. As the court concluded, "[i]n short, while there may be some thematic similarities, the Underlying Actions are truly, in all relevant respects, different." *Id*. at *10. In so ruling, the court found significant that these suits "involved entirely distinct misrepresentations of very different health risks associated with Celebrex." *Id*.

A year later, the *Pfizer* court issued a second decision, applying the "fundamentally identical" standard to a prior notice exclusion. *See Pfizer, Inc. v. U.S. Specialty Ins. Co.*, No. N18C-01-310, 2020 WL 5088075 (Del. Super. Ct. August 28, 2020). Based on its earlier decision, the court held that the prior notice exclusion did not apply because the *Morabito* and *Garber* actions were not "fundamentally identical."

VI. Allocation and the Larger Settlement Rule

The *Arch v. Murdock* court issued yet another controversial decision just before the case was finally settled in 2020, in this instance on allocation. For purposes of trial, the D&O insurers argued that the Dole Settlement would have to be allocated in accordance with the primary policy's allocation clause. Among other things, they asserted, defense cost payments had been made by underlying insurers for uninsured defendants, and there were insurable capacity issues with respect to Murdock and the other defendants in the Chancery Court Decision. *See* Transcript of Oral Argument, *Arch Ins. Co. v. Murdock*, No. N16C-01-104 (Del. Super Ct. Aug. 27, 2019). The primary policy contained the following allocation clause:

> If in any Claim, the Insureds who are afforded coverage for such Claim incur Loss jointly with others (including other Insureds) who are not afforded coverage for such Claim, or incur an amount consisting of both Loss covered by this Policy and loss not covered by this Policy because such Claim includes both covered and uncovered matters, then the Insureds and the Insurer agree to use their best efforts to determine a fair and proper allocation of covered Loss. The Insurer's obligation shall relate only to those sums allocated to matters and Insureds which are afforded coverage. In making such determination, the parties shall take into account the relative legal and financial exposures of the Insureds in connection with the defense and/or settlement of the Claim.

See Arch Ins. Co. v. Murdock, No. N16C-01-104, 2020 Del. Super. LEXIS 156, at *6-7 (Super. Ct. Jan. 17, 2020) ("*Arch v. Murdock IV*").

The insureds, on the other hand, sought a summary judgment ruling that any allocation of Loss under the D&O policies would be governed by the "larger settlement rule," and that the insurers would be unable to establish that any uncovered liability had increased the amount of the Dole Settlement. *See Arch v. Murdock IV*, 2020 Del. Super. LEXIS 156, at *12-*13.

The court granted the insureds' motion to apply the larger settlement rule, finding that the Allocation Clause did not apply to the circumstances of the Dole Settlement.

Judge Davis first acknowledged that no Delaware court had ever applied the rule. *See id*. at *18. He cited cases from the Ninth and Seventh Circuits as the source of the rule: *Safeway Stores, Inc. v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA*, 64 F.3d 1282, 1287 (9th Cir. 1995); *Nordstrom, Inc. v. Chubb & Sons, Inc*., 54 F.3d 1424, 1433 (9th Cir. 1995); *Caterpillar, Inc. v. Great Am. Ins. Co.*, 62 F.3d 955 (7th Cir. 1995); and *Harbor Ins. Co. v. Continental Bank Corp.*, 922 F.2d 357, 368 (7th Cir. 1990). *Id*. *17-18. The judge observed that the rationale for the rule, as he perceived it, was consistent with the coverage provided by the primary D&O policy, which when read "as a whole" was intended to provide the insured with "a complete indemnity for Loss regardless of who else might be at fault for similar actions." *Id.* at *18-19.

The court analyzed the Dole allocation clause but read the "relative legal and financial exposures" standard to apply only in the specific context of the insurers' and insureds' agreement "to use their best efforts to determine a fair and proper allocation of covered Loss." The court read the provision to mean that if the parties were unable to agree on allocation despite those efforts, the stated standard would no longer apply and the larger settlement rule would take over. *See id*. at *20-21. The insurers would not be deprived of their "economic deal" under the policy, the court reasoned, because they would still have the protection of subrogation. *Id.* at *21.

The *Arch v. Murdock IV* decision is troubling for D&O insurers, as it arguably renders clauses like the Dole allocation clause meaningless. The larger settlement rule developed at a time when D&O policies did not include an allocation requirement. The rule was viewed as largely favorable to insureds, and insurers adopted allocation clauses to provide for specific standards like relative exposure. *See* 23-146 Appleman on Insurance Law & Practice Archive § 146.5[E][1]. If *Arch v. Murdock IV* stands as good law in Delaware, the ability of the parties to reach agreement on allocation between covered and uncovered loss will be negatively impacted.

The larger settlement decision in *Arch v. Murdock IV* is under appeal in *RSUI Indemnity Company v. David H. Murdock, et al.*, No. 154,2020, in the Supreme Court of Delaware.

Sorting Out the Rules & Responsibilities Of Primary and Excess Carriers in the Defense of "Bet the Company" Litigation

American College of Coverage Counsel
2020 Annual Meeting

Virtual Conference
September 10-11 & 24-25, 2020

Michael W. Huddleston
Munsch Hardt Kopf & Harr, P.C.
Dallas, Texas
mhuddleston@munsch.com

I. Defense

A. Primary Has The Duty to Defend

The primary carrier has the duty to defend. Thus, unless the excess carrier agrees to accept tender of the primary limits or decides to associate in the defense, all costs of the defense are carrier by the primary carriers. Many of the solutions to problems with the quality of the defense provided by the primary carrier are solved with practical and sometimes unorthodox solutions.

1. Independent counsel?

In situations where the insured is allowed or required to select independent counsel, the excess carrier may have the same concerns regarding the quality of the defense. But again, so long as the defense is being provided under the primary policy, there is little the excess carrier can do that will not result in it spending money on the costs of defense and counsel.

2. Multiple primaries

a. Who picks the lawyer?

In cases where there are multiple primary policies sharing the costs of defense, there may be a conflict over who picks the lawyer to defend the case. Sometimes, both carriers will try to select co-counsel, which is simply a train-wreck.

b. *Keene* approach to tagging the line by the carrier

In jurisdictions allowing the insured to select the line or tower of coverage where multiple policies are available, the insured can pick a carrier who has a more preferable approach to who is defending. It is then left to the carriers to work out who will pay for what and how costs are allocated.

3. Fee sharing and defense agreements among carriers

In toxic tort cases, the carriers will often enter into sharing or allocation agreements. This does not change the right of the excess carrier to have the costs of defense covered by the primary carriers. Often, the excess carriers are at least consulted on questions such as whether a national coordinating counsel should be selected.

4. Problems

a. Inadequate defense

The inadequacy of the defense can take many forms. First and foremost is whether the defense counsel has experience in cases of similar complexity and exposure. Is this someone who has been involved with a "bet the company" case before? Also, importantly, does defense counsel have adequate appellate support? These types of cases typically involve several key legal issues that will be the subject of an appeal. Involvement of appellate counsel in briefing and litigation support pre-trial and at trial can make all of the difference. In Texas, for example, much of the mining for appellate error comes in the jury charge phase. Appellate counsel should be involved throughout the trial phase to assure preservation and also continuity in terms of the presentation of motions for directed verdict and post-verdict motions.

(1) Quality of defense counsel

Experience and reputation of defense counsel are critical. Also, is the defense counsel someone who has the time to devote to the project or is it going to be delegated to other partners and associates? Is there a fall-off from the lead lawyer in terms of approach, experience and ability.

(2) Captive counsel

As incomprehensible as it sounds, there are cases where the primary carrier seeks to defend with a captive counsel from its own staff. This should create a conflict of interest in that, at least in Texas, captive counsel cannot be used where there is a conflict of interest. Coverage issues obviously can raise a conflict, especially if the coverage issue overlaps with liability issues or facts. Moreover, bet the company cases always involve risk of a verdict in excess of policy limits. Often, internal company policy will be to have outside counsel involved if there are potential duty to settle within limits issues likely to arise.

In *Unauthorized Practice Of Law Committee v. American Home Assurance Company, Inc.*, 261 S.W.3d 24, 42-43 (Tex. 2008), the court held that the use of captive counsel in the face of a conflict of interest would amount to the unauthorized corporate practice of law by the insurer. The court explained:

If an insurer's interest conflicts with an insured's, or the insurer acquires confidential information that it cannot be permitted to use against the insured, or an insurer attempts to compromise a staff attorney's independent, professional judgment, or in some other way the insurer's and insured's interests do not have the congruence they have in the many cases in which they are united in simple opposition to the claim, then the insurer cannot use a staff attorney to defend the claim without engaging in the practice of law.

Id. The court refused to adopt a rule presuming a disqualifying conflict in every instance where a demand within limits was made, noting that whether captive counsel was sufficiently loyal to the insured would have to depend on more than just the offer itself. The court explained:

> An insurer has a so-called *Stowers* duty to accept a claimant's reasonable offer to settle within policy limits or stand to an excess judgment. The Committee argues that sometimes staff attorneys are restricted by their employer in whether they may apprise an insured of the insurer's *Stowers* obligation and are sometimes required to obtain management approval before making or responding to settlement offers that implicate that duty. The Committee argues that a staff attorney cannot be expected to dis-regard the insurer's policies on such matters, even when it would be in the insured's best interest to do so, because of fear of reprisal in employment . . . As we have noted, defense counsel, whether private or on staff, owes the insured unqualified loyalty. It is possible that counsel will fail to render that loyalty, but we cannot presume that a staff attorney is more likely to do so, especially absent any evidence of a complaint ever having been made.

Id. at 41. Simply put, for the policyholder concerned about captive defense counsel, loyalty needs to be judged and documented early. Also, it would be helpful to ask and know about any internal insurance company policies governing captive counsel in *Stowers* situations. All of this can be used to negotiate a change in counsel, either in cooperation with the excess carrier or not.

B. Does the Primary Have A Duty To Give Notice To The Excess Carrier?

1. Varied Answers

This is a question that greatly depends on the jurisdiction. The primary carrier is not a party to and is not itself bound by the excess policy, but it is the agent of the insured in handling the defense and litigation. The duties regarding notice are clearly placed on the insured. But, the nature of the defense obligation could alter that answer, depending on the jurisdiction. Inter-company practices and guidelines have sometimes been referenced as a source of an obligation to give notice. Finally, the recognition of a duty of good faith on the part of the primary carrier could be used as a basis for imposing such a duty.

In *G.A. Stowers Furniture Co. v. American Indemnity Co.*, 15 S.W.2d 544, 547 (Tex. Comm'n App. 1929, holding approved), the court noted:

> As shown by the above-quoted provisions of the policy, the indemnity company had the right to take complete and exclusive control of the suit against the assured, and the assured was absolutely prohibited from making any settlement, except at his own expense, or to interfere in any negotiations for settlement or legal proceeding without the consent of the company; the company reserved the right to settle any such claim or suit brought against the assured. Certainly, where an insurance company makes such a contract; it, by the very terms of the contract, assumed the responsibility to act as the exclusive and absolute agent of the assured in all matters pertaining to the questions in litigation, and, as such agent, it ought to be held to that degree of care and diligence which an ordinarily prudent person would exercise in the management of his own business . . . .

Id. The court added that the primary carrier acts as "the sole and exclusive agent of the assured, in full and complete control. Such exclusive authority to act . . . does not necessarily carry with it the right to act arbitrarily." *Id.*

Most excess policies trigger notice on the point when the underlying claim is determined to potentially involve the excess layer of coverage. Some have automatic triggers, especially professional liability policies, regarding specific types of claims triggering a duty to notify. Who knows best if the underlying case may involve the excess layer? Clearly, the primary carrier who is controlling the defense of the case knows best as to whether the excess carrier may need to be involved. Unfortunately, any such duty rubs against the primary carrier's desire in some cases to hold a hard line on settlement below its limits. If it involves the excess carrier itself, then such action would seem to admit the case could go in a bad direction and result in a judgment in excess of the primary limits.

In 1974, the Claim Executive Council of the American Insurance Association, the American Mutual Insurance Alliance and some unaffiliated insurers recommended to their member companies some guiding principles concerning the settlement and trial decisions in which both a primary and an excess insurer are potentially involved. One of the recommendations was as follows:

> 5. If at any time, it should reasonably appear that the insured may be exposed beyond the primary limit, the primary insurer *shall give*

prompt written notice to the excess insurer, when known, stating the results of investigation and negotiation, and giving any other information deemed relevant to a determination of the exposure, and inviting the excess insurer to participate in a common effort to dispose of the claim.

6. Where the assessment of damages, considered alone, would reasonably support payment of a demand within the primary policy limit but the primary insurer is unwilling to pay the demand because of its opinion that liability either does not exist or is questionable and the primary insurer recognizes the possibility of a verdict in excess of its policy limit, it shall *give notice of its position to the excess insurer* when known. It shall make available its file to the excess insurer for examination, if requested.

Guiding Principles at para. 5-6 (emphasis added).

The Guiding Principles were utilized by the court in *American Centennial Ins. Co. v. Warner-Lambert Co.,* 293 N.J. Super. 567, 576, 681 A.2d 1241, 1246 (Ch. Div. 1995). Both the primary and excess carrier had been signatories to the "The Guiding Principles for Primary and Excess Insurance Companies." The court noted that these Guidelines specifically states that the primary must inform the excess of a claim in certain circumstances. The *Warner-Lambert* court used these principles in developing an *industry standard* of sorts for when a primary insurer must notify the excess carrier of a claim. In short, the court found that if the excess may also be responsible for coverage, then the primary carrier has a duty to notify the excess carrier. *But see Lemuel v. Admiral Ins. Co.*, 414 F. Supp. 2d 1037, 1057 (M.D. Ala. 2006), *aff'd sub nom. Lemuel v. Lifestar Response of Alabama, Inc.*, No. 06-11155, 2007 WL 57097 (11th Cir. Jan. 9, 2007)(refusing to extend the burden of notice to the primary carrier as a matter of equity and fairness).

In *Monarch Cortland v. Columbia Casualty Company*, 626 N.Y.S.2d 426 (1995), the court held that an insurer who did not sign on to the Guiding Principles was not bound by them. But, the court recognized the principles were an indication of industry practice and that they might in effect apply even if the two carriers involved were not signatories. *See also American Centennial Ins. Co. v. Warner-Lambert Co.*, 681 A.2d 1241 (N.J. Ch. 1995)(using the Guiding Principles to create a direct duty to settle on the part of the primary carrier).

One commentator notes:

> Stemming from the implied duty of good faith, numerous jurisdictions have accepted the fact that the primary insurer has the duty to notify the excess insurer of potential excess exposure. However, it may be the case that the failure to provide notice must be found to be in "bad faith" to be actionable. Monarch. In other jurisdictions, the excess insurer may be required to show prejudice to bring suit for failure to notify.

Minkoff, D. & Tulli, L., "Duties Owed to the Excess Insurer by the Insured and the Primary Insurer, and Theories of Recovery Upon Breach of Those Duties," https://webcache.googleusercontent.com/search?q=cache:IPSMNvy6WsUJ:https://www.cozen.com/news-resources/publications/2007/duties-owed-to-the-excess-insurer-by-the-insured-and-the-primary-insurer,-and-theories-of-recovery-upon-breach-of-those-duties-aba-insurance-coverage-litigation-committee-seminar+&cd=3&hl=en&ct=clnk&gl=us.

C. Excess carrier protections from the primary or lower tiered excess defending and controlling the defense?

1. Introduction:

The excess carrier is empowered by most policies to either associate in the defense or take over the defense of the case. The costs of such action must, however, be carrier by the excess carrier. That does not mean that compromises cannot be made with the primary or lowered tiered carrier defending the case. The excess carrier is also protected in most jurisdictions with either a direct duty regarding settlement owed by the primary carrier to the excess carrier or an equitable subrogation claim against the primary or lowered tiered defending carrier/s.

2. Issues and considerations related to monitoring counsel

- What is the difference between monitoring counsel and counsel retained to participate/associate in the defense?
- Is there a difference in monitoring counsel and coverage counsel? Do some monitoring counsel avoid coverage issues?
- Who does the monitoring counsel represent—is it always the excess carrier?
- If the monitoring counsel represents the excess carrier, and coverage issues have been reserved, does the insured and/or its

defense counsel waive the privilege to any information provided to the monitoring counsel?

- Does that answer change if the monitoring counsel does not become involved in coverage issues?

- If the privilege is not waived by the insured providing the reports/communications to the monitoring counsel because the monitoring counsel and the defense have a common interest, is the privilege waived if the monitoring counsel provides the reports/communications to the carrier if that carrier has reserved rights?

3. Considerations Regarding Counsel Retained by the Excess Carrier to Associate/Participate in the Defense

- Does this necessarily involve appearing as counsel of record for the insured?

- Does the excess carrier waive coverage defense if it does not issue an reservation of rights when it retains counsel to participate in the defense in some fashion?

- If the defense counsel retained by the excess carrier appears as counsel of record, who has the right to control the defense--primary carrier or excess?

- What happens if the counsel participating in the defense and counsel retained by the primary carrier disagree on trial strategy?

- What happens if the participating defense counsel and the excess carrier recommend certain experts be retained or other costs be incurred, but the primary carrier and the counsel it retained say that expense is not necessary?

- What can the primary carrier share with the defense counsel retained by the excess carrier without waiving the privilege?

- What can the defense counsel retained by the excess carrier share with the excess carrier without waiving the privilege?

- What are the implications of disagreements in settlement value and settlement strategy?

- Does an excess carrier ever have a duty to retain high-powered defense counsel to participate in the defense?

D. The flow of information to the excess carrier

1. Assuming notice has been given, who has a duty to keep the excess insurer informed of developments in the defense of the case?

The policyholder practically must take the lead in making sure the excess carrier has the information it needs to handle the case. The policyholder must work with the primary carrier and defense counsel to get critical pleadings, motions, depositions, written and documentary discovery and case evaluations into the hands of the excess carrier. Reminders to defense counsel of the need to serve the true client, the policyholder, usually provides sufficient information to get cooperation.

E. Issue of privilege in communications with the excess carrier

1. Not defending per se.

The extent of the privilege varies by jurisdiction. It is not certain in many jurisdictions. If an excess carrier is not defending, then in some states this can lead to arguments that the attorney-client privilege does not apply. Work product should certainly apply regardless.

2. Special considerations in additional insured conflicts

Additional conflict of interest and thus privilege issues can arise where there is additional insured coverage involved. This stems primarily from the fact many companies collapse responsibility for the named insured and the additional insured into the same adjuster.

3. Solutions?

Consideration should be given to joint defense agreements with all concerned with a multi-carrier claim. In order to assure protection, we often urge carriers to accept a "defense" role in order to improve potential protection from controlling caselaw.

F. Appeals with multiple insurance layers

Bonding in multi-insurer cases can become difficult and contentious. In many jurisdictions, the amount required to be bonded is capped. In Texas, the cap is $25 million. If there is a tower of insurance at least exceeding this amount even if slightly, then the carriers will likely try to allocate among themselves the costs of the bond and any collateralization considerations.

Where there are coverage disputes, commitment to pay the full judgment where some or all of that judgment may not be covered is going to likely be contested. It is tantamount to a waiver of the coverage defense. If the appeal is unsuccessful and the insured insolvent, the carrier could be left paying a partially uncovered claim

II. Claims Handling and Coverage Issues For The Excess Carrier

A. Does the excess carrier have to reserve its rights?

Many jurisdictions impose no common law duty unless an insurer is defending. Statutory requirements of fair claims acts regarding the reservation of rights are not limited to defense and thus may impose an earlier obligation to reserve rights.

For example, in Texas an attempt was made to require a reservation of rights on the part of an excess carrier in *Arkwright-Boston Manufacturers Mutual Ins. Co. v. Aries Marine Corp.*, 932 F.2d 442, 447 (5th Cir. 1991). The duty to reserve at common law was based on the carrier defending, having a conflict and thus an incentive to steer the case. In *Arkwright,* the policyholder sought to impose the "defense exception" for imposing estoppel in the absence of a reservation to an excess carrier. The district court agreed, noting that the excess carrier orchestrated settlement and was in effect defending, without technically providing the legal defense. *Id*. at 1450. The court emphasized that in the case before it the insurer made no attempt to inform the insured of the coverage issues or the insured's intent to settle the underlying claim and then seek reimbursement from the insured.

The Fifth Circuit Court of Appeals reversed the decision of the district court, holding that there was no authority for the proposition that "an insurer's participation in settlement negotiations, where the insured has retained independent counsel, is tantamount to assuming the assured's defense." *Id*. at 445-46. The court held that there was not an assumption of the "defense" sufficient to bring the defense exception into play where the insurer was not actually defending the suit and the insured was fully aware of the settlement negotiations and failed to object in any way to the participation of the excess carrier in question. *Id*. (citing 16C J. Appleman, *Insurance Law & Practice*, § 9365 p.

559 (1981).

B. Does the use or hiring of monitoring or partially participating counsel alter the obligation?

Certainly, the more an attorney is involved in the defense, monitoring or otherwise, the more like a reservation is required.

C. If the case if actually going to be tried, can the insured, as a predicate, force or convince the excess carrier to reserve?

The insured needs to know what the excess coverage position is in planning for what will happen if the case is tried and a judgment entered. Coverage positions can change whether a policyholder wants to settle or go forward with trial. If the insured is led to believe there is no coverage defense being asserted, then the raising of such a coverage defense at or after trial can prejudice the insured. This then brings the case within statutory requirements to reserve within a reasonable time. If the insured is damaged by the failure to reserve, the damages are recoverable in Texas under the Insurance Code.

D. Should the excess carrier be added to any declaratory actions involving the primary carrier?

Because many forms of excess policy are following form, the excess carrier certainly has an interest in the litigation sufficient that it can be added. It is, however, another group of lawyers for the policyholder to fight. Since the primary has an interest in defending shared coverage defenses, then one would reasonably conclude the excess carrier would be bound by the decision in a case brought by or against the primary carrier.

III. Settlement

A. Duty of the Excess Carrier

In *G.A. Stowers Furniture Co. v. American Indemnity Co.*, 15 S.W.2d 544, 547 (Tex. Comm'n App. 1929, holding approved), the court predicated the duty to settle on the "control" given to and exercised by the carrier under the policy terms:

> The provisions of the policy giving the indemnity company ***absolute and complete control of the litigation***, as a matter of law, carried with it a corresponding duty and obligation, on the part of the indemnity company, to exercise that degree of care that a person of ordinary care and prudence

> would exercise under the same or similar circumstances, and a failure to exercise such care and prudence would be negligence on the part of the indemnity company.

Id.; *see also Rocor Int'l v. Nat'l Union Fire Ins. Co. of Pittburgh, PA,* 77 S.W.3d 253, 263 (Tex. 2002) (noting the *Stowers* decision is based in part "upon the insurer's control over settlement"). Stated another way, an insurer whose policy does not permit its insured to settle claims without its consent owes to its insured a common law "tort duty." *Ford v. Cimarron Ins. Co., Inc.,* 230 F.3d 828, 831 (5th Cir. 2000)(citing *G.A. Stowers Furniture Co. v. Am. Indem. Co.,* 15 S.W.2d 544 (Tex. Comm'n App. 1929, holding approved)).

Apparently, according to some authorities, the excess carrier must also have taken over the defense of the case in order to have a duty to settle. *See Keck, Mahin & Cate v. Nat'l Union Fire Ins. Co.,* 20 S.W.3d 692, 701-02 (Tex. 2000). Thus, the failure of the excess carrier in *Keck* to respond to the initial settlement demand of $3.6 million could not be used as contributory negligence in the excess carriers direct action against the primary carrier where the offer came prior to tender of the primary limits and prior to takeover of the defense. *Id.*

The *Keck* court held that even if the excess carrier was negligent in failing to "explore coverage issues more diligently, reserved its rights . . . investigated the merits of the third-party claim more thoroughly, hired independent counsel to monitor the third-party claim, supervised its claim adjuster more closely, and demanded to settle the claim months before trial," it was not actionable because it was based on conduct prior to the tender of the primary limits and because in this pre-tender situation the *excess carrier has no duty to defend or indemnify*. *Id.* The court added that pre-tender, the excess carrier had no duty to monitor the defense or to anticipate that the defense was being mishandled by the primary carrier and the defense counsel selected by the insured, noting the general tort rule that a party has no duty to anticipate the negligence of another. *Id.*

In some other jurisdictions, the courts have recognized that an excess carrier has a duty to settle once the primary limits or any self-insured retention have been tendered, regardless of whether the excess carrier is defending or not. ALLAN D. WINDT, INSURANCE CLAIMS & DISPUTES: REPRESENTATION OF INSURANCE COMPANIES & INSUREDS, sec. 5:26 (Database updated March 2011). In Texas, however, at least some courts have recognized that the tort duty to settle under *Stowers* does not apply unless the excess carrier is defending. *Emscor Mfg., Inc. v. Alliance Ins. Group,* 879 S.W.2d 894, 909 (Tex. App.—Houston [14th Dist.] 1994, writ denied)(holding that excess insurer can never have a duty to settle). The court in *Emscor* observed: "[W]e note that ***the Stowers doctrine . . . has never***

been applied to an excess carrier . . . ." *Id.* at 901(emphasis added). The *Emscor* court added: "There is simply no authority in this State establishing a cause of action by an insured against its **excess** insurer for negligence, bad faith, or for unfair and deceptive practices in the handling of a claim brought by a third-party." *Id.* at 909; *accord West Oaks Hosp., Inc. v. Jones,* No. 01-98-00879-CV, 2001 WL 83528, at *10. The court reasoned:

> The *Stowers* doctrine has been applied in Texas in only two circumstances—to the insured's right to sue a primary carrier for wrongful refusal to settle a claim within policy limits, *see G.A. Stowers Furniture Co. v. American Indem., Co.,* 15 S.W.2d 544, 547–48 (Tex.Comm'n App.1929, holding approved), and to an excess carrier's right to sue a primary carrier, under the theory of equitable subrogation, to protect the excess carrier from damages for a primary carrier's wrongful handling of a claim, *see American Centennial Ins. Co. v. Canal Ins. Co.,* 843 S.W.2d 480, 483 (Tex.1992). Neither of those circumstances are present in the instant case.
>
> . . . .
>
> Under *Stowers,* the insurer's duty to the insured, extends to the full range of the agency relationship as expressed in the policy**.** *See Ranger County Mut. Ins. Co. v. Guin,* 723 S.W.2d 656, 659 (Tex.1987). [emphasis added]. That duty may include investigation, preparation for defense of the lawsuit, trial of the case, and reasonable attempts to settle. *See American Physicians Ins. Exchange v. Garcia,* 876 S.W.2d 842, 849 (Tex.1994) (opinion on motion for rehearing). Here, ***Alliance had no duty to investigate, negotiate or defend Emscor*** under the terms of the excess policy or at law, and ***never undertook those responsibilities on its own.*** *See Emscor,* 804 S.W.2d at 197–99. Therefore, Alliance had no duty under *Stowers* and Emscor has failed to state a *Stowers* cause of action.

879 S.W.2d at 909 (emphasis added).

One commentator has noted:

> Commentators agree that the Texas courts have not yet found an excess carrier subject to the duty outlined in *Stowers.* Nevertheless, most agree that it is likely the court will eventually adopt some version of that duty where the primary carrier has tendered the underlying limits. Note that the above cases indicate that the excess carrier may also need to be *defending the*

case in order for a *Stowers* duty to apply, but the Supreme Court decision in *Keck* appears to treat the defense as a separate duty or concept:

> An insurer's duty to settle is independent of its duty to defend. 14 COUCH ON INSURANCE 3 rd §§ 203:12-203:13; 1 WINDT, *supra* § 5.26, at 350. An excess insurer owes its insured a duty to accept reasonable settlements, but that duty is also not typically invoked until the primary insurer has tendered its policy limits. 1 WINDT, *supra* § 5.26; *Cf. Employers Nat'l Ins. Co. v. General Accident Ins. Co.,* 857 F.Supp. 549, 554-55 (S.D.Tex.1994)(when excess liability is likely, an excess insurer may interject itself into settlement negotiations before tender by the primary insurer).

Keck, 20 S.W.3d at 701. Nevertheless, the Court also observed that the excess carrier in that case "did not assume control of the defense before INA tendered its limits and had no duty to evaluate the $3.6 million settlement demand until after that tender." *Id.* at 701. The Court additionally observed: "National had no duty to act until INA tendered its limits and surrendered the defense to National. *See* 1 WINDT, *supra* § 2.01, at 31." *Id.* at 702.

As one commentator notes: "Still, it seems counter-intuitive that an insured has no recourse against an excess carrier that refused to respond to a demand that exceeded the primary limits but could have been settled within the excess carriers limits, but was not and verdict is eventually entered that exceeds the combined limits of both the primary and excess policies. There should be some balance in the process." R. Brent Cooper, "*Triggering Stowers Under Multiple Policies,*" 5th Annual Insurance Law Symposium, p. 6 (2010). Justice Hecht noted the uncertainty of Texas law in this area in a concurring opinion in *Keck:*

> I am not persuaded that an excess insurer never has a duty to defend or settle a claim against its insured before primary coverage is exhausted. An excess carrier that has the right to intervene in the defense may be obligated to do so to protect itself and its insured when it is clear that the liability claim will exceed primary coverage.

> *Keck, supra,* at 705. Thus, the outline of exactly how the *Stowers* duty would apply is uncertain. Most believe that it will eventually be found to apply to excess carriers in some form. Undoubtedly a tender by the primary would be required, and possibly the additional fact that the excess carrier has a duty to defend and/or is defending.

O'Quinn, M., *Stowers,* MEALY'S INSURANCE LITIGATION REPORTER, at 1-2.

B. Phased or Bifurcated Offers to Multiple Carriers

With a primary ($1m) and two excess carriers ($5m each), you have a problem making an effective unconditional demand within policy limits. A bulk offer to settle for $1.1 is in excess of the primary limits. As to the first level primary, it is conditional as to tender of the primary limits and still exceeds the first level excess' limits. The second level excess can say the same, the demand is for more than their individuals limits and is conditional. But, a phased offer, required phased tendering of limits of the primary and then the first level excess has some chance of being effective. If the primary or first excess refuses, they can be clearly identified and targeted because they halted the opportunity to settle. As the second level excess, the target is clearly placed on them once the other two have tendered. The offer is then no longer conditional and requires only payment of the limits of the second level excess carrier. Working through the *Maldonado* decision, which involved bulk offer exceeding limits to the primary and the insured is instructive.

A conditional offer can become valid under *Stowers* if the condition is satisfied in time for the carrier to respond to the offer. Thus, a so-called bifurcated offer can become valid. Offers requiring a contribution by the insured and the carrier are problematic if simply combined. In other words, if you offer to settle for $1.2 million, with $200,000 from the insured and the limits from the carrier, the insured would have to tender before the offer would be unconditional as to the carrier. The offer to the carrier is conditioned on the insured tendering their portion. Timing it so that the carrier gets time to respond once the condition is satisfied is critical. Bifurcating the offer so that the condition comes first and then the carrier portion follows once the condition is satisfied, with a separate time for responding, avoids the difficulties experienced in published cases.

Again, one cannot make a bifurcated offer without making a conditional offer. For example, if the offer to the carrier is contingent on the insured kicking in some of its own money, then the offer is conditional. Can it never be a valid *Stowers* demand? Yes.

The Supreme Court certainly suggested in *Maldonado* that proof that the carrier was informed of the insured's willingness to satisfy the terms of the "condition" would

likely be sufficient to trigger the carrier's duty to settle. In that case, of course, the carrier did not receive sufficient notice.

One approach to this problem is to make the bifurcated offer in such a fashion that the insured is given a certain amount of time to consider whether it wishes to contribute as requested, and if the insured agrees, it then must notify the carrier, whose own duty will run a specified number of days from the date of the insured's notice to the carrier of its acceptance of the terms.

The goal is to make clear that there is in fact a conditional requirement, provide the mechanism for its satisfaction and then allow a reasonable time after the condition is satisfied for the carrier to accept. This is intended not fit the rule that even when an offer is conditional, it will be binding when the specified conditions have occurred. *Webster*, 906 S.W.2d at 77.

A similar approach can be taken with excess carriers. In other words, the offer needs to clearly state what is expected from the primary carrier and what is expected from the excess carrier. The mechanism for the satisfaction of the condition that the primary carrier tender limits should be part of the demand. Without a tender, the excess carrier has no duty to settle, generally. For example, the following offer could be made:

Plaintiff A and B agree to provide a complete release, including the release of any liens or other encumbrances, for the following consideration:

1. $1 million paid by Slippery Rock Ins. Co. (primary);

2. $5 million paid by Mondo Excess Ins. Co. (excess).

This offer will remain open to Slippery Rock for thirty days. If Slippery Rock agrees to the tender of the designated amount as part of a total settlement of $6 million, it will then provide notice to the insured and/or Mondo Ins. Co. The offer will then remain open to Mondo to accept this offer for the additional amount of $5 million for a term of 15 days.

The thought obviously is that while the offer is initially conditional, the satisfaction of the condition sets the stage for an unconditional offer. The communication and time enlargement provisions seek to solve problems such as those in *Maldonado*.

A similar difficulty exists where there is a self-insured retention or sizeable deductible. A bifurcated offer may be required in such settings, particularly where the coverage above is not invoked until there is a tender or exhaustion of the deductible/SIR.

C. Special problems with self-insurance and fronting policies

1. The Self-Insured Retention

a. What is it?

At its core, a self-insured retention ("SIR") is a mechanism that allows the insured to reduce the total premiums it pays in exchange for less overall coverage. In essence, the insured becomes a partner with its insurers, and retains a portion of its own risk instead of shifting the entirety to its carriers.

With large and sophisticated business, liability claims are not so much of a risk as they are a cost of doing business. *See* DOUGLAS R. RICHMOND, *Self-Insurance and the Decision to Settle*, 30 TORT & INS. L. J. 987 (1995). The larger the enterprise is, the more likely it will be to have accidents that result in costly claims. Thus, the insured can effectively gamble that the money it saves in premiums will be more than the losses it expects to absorb.

The self-insured retention can either be the functional equivalent of a primary layer of coverage, or it can be excess. Where, for example, the insured retains the first $1 million of losses, its insurers providing coverage above $1 million are excess to the SIR. Alternatively, it may be that the insured retains some intermediate portion of the coverage, say for example, a first-layer excess in between the primary and second-level excess layer.

Regardless of what form the SIR takes, knowing when it applies and what the terms of the SIR agreement require is a complex issue for courts, litigants and their attorneys today. Thus, this section of the paper will attempt to provide the reader with a guide to resolving some of these problems.

To facilitate the discussion, the following scenario will be utilized:

> The Insured has a liability policy with limits of $10 million. However, the first $2 million in losses are covered by the SIR. Therefore, the carrier actually provides coverage for losses ranging from $2,000,000.01 up to and including $10 million.
>
> Further still, the policy provides that the Insured has a duty to settle claims within the SIR when liability is reasonably

clear. Otherwise, it has a duty to tender the SIR when a given claim exceeds the $2 million SIR limit.

With this background, the issues surrounding the application of these coverage tools will be examined.

b. Dresser

In *International Ins. Co. v. Dresser Indus., Inc*., 841 S.W.2d 437 (Tex. App.--Dallas 1992, writ denied), the insured had a "fronting policy" as the primary layer of coverage, and it also retained the duty to defend. The court refused to engraft a contractual duty to protect the excess carrier by requiring reasonable attempts to settle within the SIR if possible. *Id.* at 442. Also, the court rejected arguments that there was any such common-law duty, and refused to allow such an action. *Id.* at 444-45.

Importantly, however, the clause only requires the insured to settle within the SIR where "liability is reasonably clear." This, of course, is a higher threshold than *Stowers* which only requires settlement when it is reasonable to do so, and it does not require liability to be reasonably clear.

c. What happens when . . .

Returning the above scenario, what happens when a given claim exceeds the SIR limit, but the policy requires the insured to settle a claim within the SIR where possible? Nothing. The "duty to settle" clause is not triggered because the claim cannot be settled within the SIR. Thus, the insured must still contribute the SIR to a settlement effected by the excess carrier so long as the settlement was reasonable under the circumstances.

Absent contrary policy language, the insurer usually controls the SIR in settlement. See W. T. BARKER, *Combining Insurance and Self- Insurance: Issues for Handling Claims*, 61 DEF. Counsel J. 352, 357 (July 1994). When a loss exceeds the SIR, the insured must contribute its SIR to the payment of settlement or judgments. This result is dictated by the terms of the coverage it purchased. *See, e.g. H.E. Butt Grocery Co. v. National Union Fire Ins. Co.*, 150 F.3d 526, 528, 535 (5th Cir. 1998); *see also Vesta Ins. Co. v. Amoco Prod. Co.*, 986 F.2d 981, 988 (5th Cir. 1993); *Arkwright-Boston Mfrs. Mut. Ins. Co. v. Aries Marine Corp*., 932 F.2d 443, 447 (5th Cir. 1991). This result obtains, even over the insured's objections, and most cases hold that the insurer's decision will be given considerable deference by the courts. *Id.* at 358.

There are several reasons that support giving the insurer control over the SIR and compelling payment so long as the settlement is a reasonable one. First, it is usually contractually required that the insured contribute its SIR when necessary. Policies contain language such as:

> We'll pay damages and defense costs of all covered claims or suits in excess of your self insured retentions up to the limits of coverage . . .; or
>
> The self insured retentions . . . fix the amount you'll be responsible for before the limits of coverage of this agreement will apply.

These clauses make clear that the SIR must be paid prior to the triggering of the excess layers.

Second, such a rule ceding control to the insurer promotes the public policy favoring settlement. *See, e.g. Dear v. Scottsdale Ins. Co.*, 947 S.W.2d 908 (Tex. App.--Dallas 1997, writ denied); *Brightwell v. Rabeck*, 430 S.W.2d 252 (Tex. Civ. App.--Fort Worth 1968, writ ref'd n.r.e.).

At least one California court has addressed a factually similar situation. In *Harbor Ins. Co. v. City of Ontario*, 231 Cal. App.3d 927, 282 Cal. Rptr. 701 (1991), the insured told the carrier that it had permission to settle the case, but also that it did not agree to the settlement for purposes of committing the SIR amount. *Id.* at 930-31. The court held that the insured's allowing the settlement to go forward *in any respect* amounted to *agreement as a matter of law*. *Id.* at 934-35. The court found that to allow the insured to reap the benefit of settlement going forward and then try to avoid paying the retention "would afford the insured the power unilaterally and arbitrarily to negate the SIR feature of the policy in those instances where the insurer wished to settle because the projected damages exposure penetrated the floor of the excess coverage." *Id.* at 935. This would be inconsistent with the reduced nature of the coverage purchased, including the related premiums for this reduced coverage. *Id.*

Thus, where a policy requires the insured to attempt settlement for claims falling within its SIR, it usually only does so where liability is "reasonably clear." But, when an insured purchases a policy with an SIR, it takes the risk that the entirety will be paid towards settlement. If a given claim reaches above the SIR limits, then the insured must contribute those limits toward the settlement. So long as the settlement is a reasonable one, the insured cannot otherwise complain about the excess carrier's decision to settle.

Therefore, for claims that exceed the SIR, the test is whether the settlement itself was reasonable, not whether liability was reasonably clear.

D. Responsibilities of Primary to Excess—finding and exploiting downward pressure on the primary

1. Various Theories

The courts in the various jurisdictions have adopted a number of approaches in dealing with the obligations regarding settlement owed by a primary carrier to an excess carrier. The theories can be summarized as follows:

(A) Direct duty. *Excess Liability: Rights and Duties of Commercial Risk Insureds and Insurers* § 6:5 (citing cases in California, Colorado, Illinois, Arizona, Louisiana, New York, North Carolina, and Wisconsin). Often based on a duty of good faith. *Camelot by the Bay Condominium Owners' Association, Inc. v. Scottsdale Ins. Co.,* 27 Cal.App.4th 33, 32 Cal. Rptr.2d 354 (1994); *Baen v. Framers Mutual Fire Ins. Co. of Salem County*, 723 A.2d 636, 639 (N.J. Super. Ct. App. Div. 1999). The primary is said to owe the excess carrier the same duty owed to the insured. *New England Ins. Co. v. Healthcare Underwriters Mut. Ins. Co.,* 352 F.3d 599 (2nd Cir. 2003); *accord American Centennial Ins. Co. v. Warner-Lambert Co.*, 681 A.2d 1241 (N.J. Ch. 1995)(involving primary allowing the insured to control the defense and negotiation of settlement)[1]; *Estate of Penn v. Amalgamated General Agencies,* 372 A.2d 1124, 1127 (N.J. Super. Ct. App. Div. 1977); *Hartford Accident & Indemnity Co. v. Michigan Mutual Ins. Co.*, 93 A.D.2d 337 (N.Y. App. Div. 1983), *aff'd*, 463 N.E.2d 608 (N.Y. 1984).

(B) Triangular reciprocity based on the duties shared among the primary, the insured and the excess carrier. *Transit Casualty v. Spink Corp.,* 156 Cal. Rptr. 360 (Ct. App. 1979).

(C) Equitable subrogation, allowing several different theories available directly to the insured to be used by the excess carrier.

(D) Assignment from the insured.

[1] This case is of particular interest to those excess carriers with a fronting policy below. Often with fronting policies. The insured is allowed to completely control the defense and settlement of the case at least within the fronting policy limits.

2. Equitable subrogation—

a. The Texas Experience—American Centennial v. Canal

In *American Centennial Ins. Co. v. Canal Ins. Co.*, 843 S.W.2d 480, 483 (Tex.1992), the insured had a typical coverage scheme -- a primary layer with two levels of excess on top. In this case, Canal provided primary coverage up to $100,000; First State provided first-level excess coverage from $100,000 to $1 million; and American Centennial provided second-level excess coverage from $1 million to $4 million. *American Centennial Ins. Co. v. Canal Ins. Co.*, 843 S.W.2d 480, 481 (Tex. 1992).

The insured, General Rent-a-Car, was sued in a wrongful-death action resulting from a blowout of an allegedly defective tire on one of its rental cars. *Id.* Canal investigated and defended the underlying lawsuit, retaining outside counsel to represent the insured. However, the defense was allegedly botched by insurance defense counsel, thus forcing the insurers to settle the case for $3.7 million. *Id.* In response, the two excess carriers sued the primary carrier and the defense lawyers, on a variety of theories.

The court framed the issue as "whether an excess insurance carrier has a cause of action against a primary carrier and trial counsel for mishandling a claim." *Id.* Initially, the court noted that *Stowers* allows an insured to sue a primary carrier for negligently failing to settle a claim within policy limits. Further, the court also noted that equitable subrogation was a vehicle by which the excess carrier could sue the primary on a *Stowers* claim. Also, the court recognized that equitable subrogation was valid under Texas law, but that it had never been raised in this context. *Id.* at 482.

The *American Centennial* court noted that many states allow an excess carrier to pursue a primary carrier for botching the defense of the underlying lawsuit and that a majority of these states do so through the vehicle of equitable subrogation. *Id.* at 482-83, nn. 2-3. The court noted that allowing such an action encourages fair and reasonable settlements of lawsuits. *Id.* at 482. Also, absent such a right, the primary would have less incentive to settle within the policy limits, and thereby cause an increase in the premiums of excess coverage. *Id.* at 483. Although the court did not expressly state as much, the concept of protecting the insured is furthered by the court's holding. By failing to treat the excess carrier as the insured, then the insured would be less able to purchase excess coverage at a discounted rate. Thus, the insured is an indirect beneficiary of the court's protection of excess carriers. Finally, the court noted that this would help to ensure a fair and equitable distribution of losses among primary and excess carriers.

In one of the more important points supporting equitable subrogation rights, the court noted that it did not want to relieve the primary carrier of its *Stowers* obligations simply because the insured contracted for excess coverage. *Id.*

Finally, the excess carriers urged the court to allow a direct action against the primary carrier, rather than through the derivative nature of a subrogation claim. The court noted that the advantage sought by such a rule would allow the excess carrier to ignore any policy defenses against the insured. Because the insurer must "stand in the insured's shoes," then any defense valid against the insured is also valid against the insurer seeking to recover on the insured's claim. The court noted that only a few jurisdictions allow such an action and that the case could be resolved without reaching the issue. Thus, the court refused to recognize a direct right at that time, but did leave the door open to reconsider the issue in a proper case. *Id.*

Damages in the equitable subrogation action by the excess carrier against the defense counsel and the primary carrier appear to clearly be based on a legal fiction. If there is excess coverage, and it pays, the insured is protected and suffers no harm. *American Centennial* clearly holds that public policy favoring protection of excess carriers and their low cost/high limits coverage and the need to make sure that offending primary carriers and defense lawyers do not escape punishment justifies this approach to damages. That being said, the assumption of damages is still based on a fiction. The Supreme Court has since indicated in other contexts that damages should be real and not fictional. *State Farm Fire & Cas. Co. v. Gandy*, 925 S.W.2d 696 (Tex. 1996).

One ponders whether a direct action or duty rule would be more realistic and logically accurate. If the excess carrier could sue directly based on duties owed by the primary carrier to it, then the amount it pays is in fact a damage to it and not some fictional harm. The reality is that *American Centennial* reflects a blending of direct duty and equitable subrogation concepts. One need look no further than the rule that the excess carrier is subject to defenses applicable to both it and the insured in whose shoes it stands.

The opinion in *American Centennial* was a plurality opinion. In a concurring opinion joined by a majority of the court, Justice Hecht wrote that recovery in an equitable subrogation case did not include a right to recover by the excess carrier "in its own right or for statutory or punitive damages." *Id.* at 485. The concurring opinion states that the *Stowers* action would be the only one allowed and that the excess carrier would not be permitted to bring statutory or punitive damages claims. The opinion goes on to state that the majority opinion refers only to negligence/*Stowers* claims and thus must hold that these claims were the only ones available.

The Supreme Court next discussed whether the excess carrier could pursue a malpractice claim against the defense lawyers hired by the primary carrier. After initially noting that Texas recognizes the defense of privity to a legal malpractice claim, the court observed that none of these cases involved a subrogation action, rather than a direct assignment. *Id.* at 484.

The court noted that it did not want to needlessly interfere with the lawyer-client relationship, but that allowing a subrogation action in this instance would only allow the excess carrier to assert the insured's existing rights, rather than creating new ones. *Id.* at 485. As with primary carriers, the court did not want to relieve the defense lawyers of their duties to the insured simply because the insured has chosen to purchase excess coverage. Thus, it allowed a subrogation action against the defense lawyers.[2] *Id.*

b. Birmingham

Birmingham represents a classic inter-carrier dispute. After settling the underlying judgment, the excess insurer filed suit against the primary carrier, among others. *Birmingham Fire Ins. Co. v. American Nat'l Fire Ins. Co.*, 947 S.W.2d 592 (Tex. App.–Texarkana 1997, no writ).

Birmingham involved a claim by an excess carrier against a primary carrier. Initially, the court discussed whether the primary carrier had a duty to negotiate with the claimant(s), and held that under *Garcia*, a carrier has no duty to "negotiate in good faith the settlement of a case." *Id.* at 596-97. "'Negotiation' is the 'process of submission and consideration of offers until [an] acceptable offer is made and accepted.'" *Id.* at 597. The carrier likewise has no duty to even "solicit settlement offers from a third-party plaintiff." *Id.* (citing *Insurance Corp. of Am. v. Webster*, 906 S.W.2d 77, 79 (Tex. App.–Houston [1st Dist.] 1995, writ denied)).

The court also noted the fact that the "ultimate issue" according to *Garcia* is whether a reasonable demand to settle within limits was presented to the insurer. *Id.* at 598. Thus, the carrier has no duty whatsoever to negotiate or initiate settlement discussions. *Id.* at 598-99.

---

[2] Importantly, the court noted that it was not deciding whether assignment of a legal malpractice claim was permissible, but rather that it was simply allowing the excess carrier to enforce the insured's action through equitable subrogation. *Id.* at 484 n.6.

Most important for the purposes of this paper is that the *Birmingham* court also held that a comparative negligence defense may be raised against an excess carrier who negligently provided damaging information to the claimant's counsel. *Id.* at 596. This seems to be a case that invokes *Canal's* warning that an insurer could be held liable for its own negligence under certain circumstances prior to the triggering of its duty to defend.

c. *Keck*—The Next Step

In *Keck, Mahin & Cate, Grant Cook v. National Union Fire Ins. Co. of Pittsburgh, P.A.*, 20 S.W.3d 692 (Tex. 2000), the court's holding sets forth a number of rulings critical to suits between carriers. The court also appears to have halted to some extent the contraction of other available tort theories, albeit without discussion of *Garcia, Guin, Traver, or Head.*

In *Keck,* the insured was sued for damages allegedly caused by improper processing and marketing of shrimp. *Id.* at 695. The insured retained the law firm of Keck, Mahin & Cate ("KMC") to defend it in the lawsuit. Subsequently, KMC tendered the defense to the insured's carriers, National Union and Insurance Company of North America ("INA"). INA was the primary insurer, with policy limits of $1 million. National Union provided excess coverage from $1 million to $10 million. *Id.*

During the underlying suit, the plaintiff's made a demand for $3.6 million, which was rejected by both carriers and the insured. *Id*. KMC advised that it believed the case could probably be settled for less than half this amount. During trial, however, the case settled for $7 million, with INA contributing its $1 million and National Union paying the remaining $6 million. *Id.*

Subsequently, National Union filed suit against INA and KMC for allegedly mishandling the defense of the suit, and it sought reimbursement of the $6 million it paid to settle the case. *Id.* National Union's claims were based on the equitable subrogation theory announced in *Canal*, *supra*. *Id.*

The appellate history of this case is worth brief mention. The 14th Court of Appeals decided the case in October, 1997. The Supreme Court initially denied review in June, 1998. However, on rehearing, the court granted review in July, 1999.

(1) An Evolving Doctrine

Keck is a significant case for a number of reasons. It represents the evolving nature of a newly created right of action. In *Keck*, the Supreme Court was faced with delineating

the contours of the rule from *Canal*. The court was faced with deciding what defenses are available, how they should be applied, and other issues to define the scope of the equitable subrogation doctrine in this context.

First and foremost, *Keck* presented an opportunity for the Supreme Court to reexamine its holdings in *Canal*. The court affirmed the validity of the subrogation rights it announced in *Canal* with little discussion. After reiterating *Canal's* basic holding, the court noted that Justice Hecht's concurring opinion, joined by a majority of the court, also stated that a defendant to an equitable subrogation claim was entitled to "any defense available against either the insured or the excess carrier, including the excess carrier's unreasonable refusal to cooperate in the defense and settlement of the action." *Id.* at 700 (quoting *Canal*, *supra*, at 486). Thus, like any subrogation claim, any defenses good against the subrogor are also good against the subrogee.

Secondly, after reaffirming *Canal,* the court went on to more fully elaborate on the true nature of the equitable subrogation action. The defendants raised a number of defenses against the excess carrier, including comparative fault and voluntary payment. Below is a detailed discussion of the court's treatment of each issue.

(2) Comparative Fault

KMC argued a number of points asserting that the excess carrier could not recover due to its own negligence. KMC argued that National Union was negligent respecting its duty to defend. Initially, the court noted that an excess carrier's duty to defend generally is not triggered until the primary carrier tenders its policy limits. *Id.* at 700-01. Thus, the court held that any alleged negligence of National Union for failing to participate in the defense prior to the tender of the primary policy limits was irrelevant to KMC's claims of comparative fault. *Id.* However, the court also noted that ***the excess carrier could not affirmatively disrupt or harm the insured's defense.*** KMC alleged that National Union failed to appear at a deposition in the underlying case. The court held that if KMC could prove that this harmed the insured's defense, then such evidence would be relevant to a comparative fault defense. *Id.* Thus, a mere failure to aid the insured's defense is not a viable defense to a subrogation claim, but ***affirmative*** conduct which actually hurts the insured's defense can be a valid defense to a subrogation claim.

Next, KMC argued that the $7 million settlement was excessive and that National Union should be held responsible for failing to settle the case for less when it had the opportunity to do so prior to trial. However, the court rejected this theory, noting that the excess carrier's duty to settle is also not typically invoked until the primary policy limits are tendered. *Id.* at 701. Since the $3.6 million offer had occurred prior to that

point, then the failure of National Union to respond to that offer was irrelevant because the offer had been revoked by the time the primary policy limits were tendered. *Id.*

The primary carrier also argued comparative fault principles. It asserted that National Union should have protected itself better by doing such things as exploring the coverage issues more thoroughly, reserving rights, investigating the underlying claim more diligently, and other similar acts. *Id.* at 702. For the reasons above, the court also rejected this argument, noting once again, that National Union's pre-tender conduct was irrelevant. *Id.* Specifically, the court stated:

> [W]e agree with the court of appeals that National's pre-tender conduct is irrelevant to the issue of comparative responsibility unless there is evidence that National interfered with the insured's defense or assumed control of the defense at some earlier point in time.

Id. at 702. Thus, in the typical case, an excess carrier will not be liable for pre-tender conduct. But, if it chooses to interfere with the claim or assume control, it should be prepared to accept responsibility for its conduct.

(3) Volunteer Doctrine/Defense

KMC also argued that the payment by National Union amounted to a voluntary choice—one that National Union was not legally obligated to perform. The court of appeals elaborated on this issue. In the court of appeals, the primary carrier argued that "National [Union] paid the $6 million as a 'volunteer', and therefore, it could not recover under an equitable subrogation theory." *National Union Fire Ins. Co. of Pittsburgh, P.A. v. Insurance Co. of N. Am.*, 955 S.W.2d 120, 124-25 (Tex. App.--Houston [14th Dist.] 1997). Unfortunately, the court did not further address the issue. However, in the discussion of whether *Canal's* holding entitles an excess carrier to recover punitive damages, the court held that it could not, stating that "[a]s a general rule, subrogation gives indemnity and no more." *Id.* at 133. Importantly, the court elaborated as follows:

> In other words, a party who successfully brings suit based on the doctrine of equitable subrogation can only recover ***the amount he was required to pay*** because of the actions of the defendant.

Id. (emphasis added).

At the Supreme Court, KMC argued that "had National thoroughly investigated the underlying claim it would have discovered that its excess policy did not provide coverage for the [underlying claim]." *Keck*, 20 S.W.3d at 702. The court noted initially that an insurer who pays a liability claim is not a volunteer if the payment is made ***in good faith and under a reasonable belief that the payment is necessary for its protection.*** *Id.* (citing *Arkwright-Boston Mfrs. Mut. Ins. Co. v. Aries Marine Corp*., 932 F.2d 442, 447 (5th Cir. 1991)). Further, the court noted that Texas courts have taken a liberal stance towards payments made by insurers to settle liability claims against their insureds. *Id.* Thus, an excess carrier's payment "has been said to be *presumptively involuntary for subrogation purposes*." *Id.* (emphasis added).[3]

The Supreme Court rejected the approach urged by KMC, observing that it would increase conflict between insurers and insureds and that it would discourage insurers from paying or settling disputed claims. Thus, the court held that this was bad public policy and they declined to adopt the volunteer doctrine as framed by KMC. *Id.*

(4) Causation

---

[3] As a very general rule, a voluntary payment by a carrier bars later claims for reimbursement. The carrier should make clear in writing to other carriers and to the insured that amounts paid for defense or settlement are subject to the right to seek reimbursement pursuant to subrogation. *See, e.g., Commercial Union, supra, at* *5 (holding that where carrier had equal duty to defend but failed to raise "other insurance" issue, equitable subrogation was not permitted). Providing a defense subject to a reservation of rights, if the carrier in fact had a duty to defend, does not make a carrier a volunteer. *Texas Prop. & Cas. Ins. Guar. Ass'n v. Southwest Aggregates, Inc.*, 982 S.W.2d 600, 608-09 (Tex. App.-- Austin 1998, no writ).

An insurer is not a volunteer merely by paying a contingent claim, or by paying more than its proportionate share of a given loss. *Foremost County*, *supra*. The court noted that so long as the monies were paid on behalf of the insured, then the carrier was deemed not to be a volunteer. *Id.* However, it does have limits. Merely protecting the insured's interest is insufficient to avoid the volunteer defense. *Id.* at 762. As the Texas Supreme Court later noted, it has to be an effort to protect the payor's own interest. *See Keck Mahin & Cate, infra*, 20 S.W.3d at 702. There, the court noted that an insurer who pays a liability claim is not a volunteer if the payment is made in good faith and under a reasonable belief that the payment is necessary for its protection. *Id.* (citing *Arkwright-Boston Mfrs. Mut. Ins. Co. v. Aries Marine Corp*., 932 F.2d 442, 447 (5th Cir. 1991)). Further, the court noted that Texas courts have taken a liberal stance towards payments made by insurers to settle liability claims against their insureds. *Id.* Thus, an excess carrier's payment "has been said to be *presumptively involuntary for subrogation purposes*." *Id.* (emphasis added).

Further, the volunteer issue is unaffected regardless of whether the insurer seeking recovery does so through either conventional or equitable subrogation. *Foremost County*, *supra*. However, the presence of an "other insurance" clause may impact this analysis. *See Traders & General Ins. Co. v. Hicks Rubber Co.*, 140 Tex. 586, 597, 169 S.W.2d 142 (1943)(where both policies limited the liability to a proportionate share of the loss, recovery cannot be had for amounts paid in excess of that insurer's proportionate share).

Finally, the court dealt with the issue of causation. All the parties agreed that the settlement was excessive, but the dispute arose concerning who was at fault for the bad settlement results. The court noted that National Union had a heavy task -- it had to prove that the settlement was excessive in the abstract, but also reasonable under the circumstances. Thus, in order to recover, it had to have damages (i.e. a settlement figure higher than the case was actually worth), but at the same time, its actions had to be reasonable (i.e. the amount paid was reasonable in light of the circumstances). The court concluded:

> National's entitlement to damages will thus depend on proof that the true value of [the underlying claim] was less than $7 million but that KMC's malpractice inflated its value. Assuming such proof, National may then recover as damages the difference between the true and inflated value less any amount saved by the settlement.

Id. at 703.

(5) Implications of *Keck*, *Mahin & Cate*

The *Keck* decision may have broad implications for the rights afforded by *Canal.* Under *Canal*, an excess carrier was allowed to sue the primary carrier for mishandling the defense. *Canal*, *supra*. But, *Canal* was decided in 1992. Eight years later, *Keck* maintained this right of action.

In *Keck,* the Supreme Court left of a number of stray comments and holdings in the context of a claim by an excess carrier against the primary carrier and the defense attorneys (selected by the insured) that seem at odds with *Traver, Head* and a number of other decisions regarding theories of liability regarding settlement-related conduct. In that case, the claimant offered to settle for amounts in excess of the primary policy, but within the limits of the excess policy. The case was prematurely pushed to trial and the lawyers were unable to obtain a continuance. The primary carrier immediately tendered its policy limits. The excess carrier eventually settled the suit for almost twice the original demand from the claimants.

After *Traver*, one would have thought that an excess carrier, in an equitable subrogation action, could not bring a suit against a primary carrier for "mishandling" the insured's defense. Apparently not, according to *Keck. This is precisely the nature of the suit brought in that case.* The court held that the excess carrier could recover if it proved that the primary insurer or the defense attorneys "mishandled the defense," and that a

judgment in excess of the cases' true value would have resulted. *Id.* at 703. *But see Westchester Fire Ins. Co. v. American Contractors Ins. Co.,* 1 S.W.3d 872 (Tex. App.–Houston [1st Dist.] 1999, no pet.)(refusing to recognize a claim that the primary carrier negligently handled the settlement where the basic *Stowers* requirements were not satisfied).

Justice Hecht stated in a concurring/dissenting opinion that he was not sure that an excess carrier has ***no duty to defend or settle a claim against the insured until the primary policy is exhausted.*** Justice Hecht urges careful examination of the duties of excess carriers.

Moreover, the *Keck* court held that an excess carrier bringing an equitable subrogation suit is subject to a comparative responsibility defense based on any conduct by it that is shown to have interfered with or controlled before the tender of the limits by the primary carrier. *Keck*, 20 S.W.3d at 702. The court in *Keck,* noted that in the *American Centennial* concurring opinion, to which a majority of the court agreed, the court noted that a primary carrier should have as a defense any defense "available against either the insured or the excess carrier, including the excess carrier's unreasonable refusal to cooperate in the defense and settlement of the action." The *Keck* court also cited the opinion in *Birmingham Fire Ins. Co. v. American Nat'l Fire Ins. Co.,* 947 S.W.2d 592, 596 (Tex. App.–Texarkana 1997, writ denied), which held that a comparative negligence claim may be brought against an excess carrier who negligently provided damaging information to the claimant's counsel.

One must ask what the excess carrier's negligence has to do with a subrogation claim brought in the name of the insured? Of course, a contribution claim could be brought against the excess carrier itself for its actions in causing the harm for which its is bringing the subrogation case. Thus, this distinction may be of little apparent, practical difference. However, a claim for contribution may not be brought if the true plaintiff, the insured in a subrogation action, could not bring the claim. As the court later holds, an excess carrier that is not in the process of defending the insured has no duty to defend.

The court held that an excess carrier has no duty to settle until the primary carrier has tendered the primary limits. *Id.* ***Apparently, the excess carrier must also have taken over the defense of the case.*** *Id.* Thus, the failure of the excess carrier in *Keck* to respond to the initial settlement demand of $3.6 million could not be used as contributory negligence where the offer came prior to tender of the primary limits and prior to takeover of the defense. *Id.*

The court thus held that even if the excess carrier was negligent in failing to "explore coverage issues more diligently, reserved its rights . . . investigated the merits

of the third-party claim more thoroughly, hired independent counsel to monitor the third-party claim, supervised its claim adjuster more closely, and demanded to settle the claim months before trial," it was not actionable because it was based on conduct prior to the tender of the primary limits and because in this pre-tender situation the *excess carrier has no duty to defend or indemnify*. *Id.* The court added that pre-tender, the excess carrier had no duty to monitor the defense or to anticipate that the defense was being mishandled by the primary carrier and the defense counsel selected by the insured, noting the general tort rule that a party has no duty to anticipate the negligence of another. *Id.*

As a very general rule, a voluntary payment by a carrier bars later claims for reimbursement. The carrier should make clear in writing to other carriers and to the insured that amounts paid for defense or settlement are subject to the right to seek reimbursement pursuant to subrogation. *See, e.g., Commercial Union, supra, at* *5 (holding that where carrier had equal duty to defend but failed to raise "other insurance" issue, equitable subrogation was not permitted). Providing a defense subject to a reservation of rights, if the carrier in fact had a duty to defend, does not make a carrier a volunteer. *Texas Prop. & Cas. Ins. Guar. Ass'n v. Southwest Aggregates, Inc.*, 982 S.W.2d 600, 608-09 (Tex. App.-- Austin 1998, no writ).

An insurer is not a volunteer merely by paying a contingent claim, or by paying more than its proportionate share of a given loss. *Foremost County*, *supra*. The court noted that so long as the monies were paid on behalf of the insured, then the carrier is deemed not to be a volunteer. *Id.* However, the rule does have limits. Merely protecting the insured's interest is insufficient to avoid the volunteer defense. *Id.* at 762. As the Texas Supreme Court later noted, the excess carrier must act as well to protect the payor's own interest. *See Keck Mahin & Cate, infra*, 20 S.W.3d at 702. There, the court noted that an insurer who pays a liability claim is not a volunteer if the payment is made in good faith and under a reasonable belief that the payment is necessary for its protection. *Id.* (citing *Arkwright-Boston Mfrs. Mut. Ins. Co. v. Aries Marine Corp*., 932 F.2d 442, 447 (5th Cir. 1991)). Further, the court noted that Texas courts have taken a liberal stance towards payments made by insurers to settle liability claims against their insureds. *Id.* Thus, an excess carrier's payment "has been said to be *presumptively involuntary for subrogation purposes*." *Id.* (emphasis added).

d. Westchester

Westchester Fire Ins. Co. v. Admiral Ins. Co., 152 S.W.3d 172, 180 (Tex. App. – Fort Worth 2004, pet. denied), assumed without detailed discussion that the excess insurer can sue the primary insurer as the insured's equitable subrogee to recover its settlement

payment over and above the primary insurer's policy limits. Indeed, the case involved a legal malpractice claim by the excess insurer that settled before the trial of the *Stowers* action against the primary insurer. As the insured's equitable subrogee, *Westchester's ability to recover damages on [the insured]'s* Stowers *claim was limited to [the insured]'s ability to recover damages. See Am. Centennial, 843 S.W.2d at at 483*; *Nat'l Union Fire Ins. Co. v. Ins. Co. of N. Am*., 955 S.W.2d 120, 134 (Tex. App.--Houston [14th Dist.] 1997), *aff'd sub nom*., *Keck*, 20 S.W.3d at 704.

One of the central issues in *Westchester* was whether the excess insurer voluntarily made the settlement payment. Claims for equitable subrogation can be defeated if the subrogee voluntarily paid. Under the analysis in *Keck v. Nat'l Union Fire Ins. Co.*, 20 S.W.3d 692, 702 (Tex. 2000), a payment is not "voluntary" if made in good faith under the reasonable belief that the payment is necessary for its protection. *See also Peachtree Constr*., 647 F.3d at 256. Texas courts presume that a payment is involuntary. *Id.* Westchester's payment was involuntary because it in good faith reasonably believed at the time its payment was necessary for its protection. Accordingly, it was equitably entitled to maintain a cause of action against the primary insurer as if it were the insured. *See id*. at 702-03; *Argonaut Ins. Co. v. Allstate Ins. Co*., 869 S.W.2d at 542.

In discussing the concept of equitable subrogation, the court observed generally that the excess insurer, as equitable subrogee of the insured, "may bring *any cause of action* against [the primary insurer] that [the insured] could have brought." Although caution is required before putting too much stock in such a general observation, it nevertheless reveals that the court did not generally perceive any limitation on the *type* of cause of action that could be asserted, provided it was one the insured itself could have advanced. The Fifth Circuit has accepted the settlement-based claim of an excess carrier against a primary carrier in a *Stowers*-like situation arising from Louisiana law that is materially indistinguishable from *Stowers*. *RSUI Indem. Co. v. Am. States Ins. Co.*, 768 F.3d 374, 381-82 (5th Cir. 2014). A district court has looked to this decision as confirming *Westchester* and its predecessors in permitting an excess carrier to sue for *Stowers* violations as the insured's equitable subrogee. *Am. Empire Surplus Lines Ins. Co. v. Occidental Fire & Cas. of N.C*., No. 2:14-CV-456, 2015 U.S. Dist. LEXIS 95095, *5 (S.D. Tex. July 22, 2015). The ability of the excess insurer to prosecute a *Stowers* claim against a primary insurer has been upheld again as recently as last year in *Westport Ins. Corp. v. Pa. Nat'l Mut. Cas. Ins. Co*., 2018 U.S. Dist. LEXIS 170179, *71-73 (S.D. Tex. Aug. 18, 2018).

e. Waiver of Subrogation

Under Texas law, subrogation rights of the carrier under the contract may be waived or altered by contract. *Lancer v. Murillo,* 909 S.W.2d 122, 127 (Tex. App.–San

Antonio 1995, no writ). In an amazing, and in the authors' opinion erroneous, decision, the Dallas Court of Appeals held that a following form clause in an umbrella policy that stated that the umbrella policy's coverage was subject to the "same coverage limitations" as the insured's underlying policy effectively incorporated a waiver of subrogation provision from the primary policy. *St. Paul Fire & Marine Ins. Co. v. Reliance Nat'l Ins.*, No. 05-98-00031-CV, 2000 WL 1036320 (Tex. App.–Dallas, July 28, 2000, pet. pending). Obviously, a waiver of subrogation clause is a provision that destroys the affirmative rights of the carrier and does not amount to a "coverage limitation." Moreover, it is indeed curious how a subrogation clause from one primary carrier could be used to bar subrogation against another, unscheduled/unlisted primary carrier with respect to whom the named insured on the umbrella policy was an additional insured. Interestingly, this opinion was issued without oral argument, despite a request for the same, over two years after the appeal was filed and the opinion was based on an argument that was not previously raised at the trial court or in the appellate briefs.

3. Limitations of scope of suit—ie, extra-contractual

It is worth noting that *Am. Centennial* also reserved any decision whether the excess insurer could assert through equitable subrogation or otherwise claims for violations of the DTPA and Insurance Code because those actions were barred by limitations before the excess insurer instituted its suit against the primary insurer. *Am. Centennial*, 843 S.W.2d at 483. Even Justice Hecht in his concurring opinion recognized that the excess insurer as equitable subrogee could bring *any* action that the insured could have asserted against the primary insurer. *Id.*, at 486 (Hecht, J., concurring).

Justice Hecht recognized that the type of action that could be asserted by the excess insurer as the insured's subrogee has been extended beyond negligence claims. This recognition has been frequently repeated without challenge. It seems to be part of the broader conventional wisdom that the scope of actions to which an excess insurer may be subrogated for purposes of asserting against the primary insurer includes any action the insured could have asserted against the primary insurer, whether the action was based in equity, statute or contract. *Cantu*, 234 S.W.3d at 774; *see also Peachtree Constr.*, 647 F.3d at 256. This declaration is consistent with the reasoning provided in *Hicks*, *Transportation Ins.*, and *Mid-Continent.*

The reasoning of these recent decisions reinforces the viability of more than just common-law actions in the hands of excess insurer suing on behalf of the insured. When cases such as *Am. Centennial* and *Mid-Continent* were decided, the accepted view was that the only way the insured could recover damages for failure to accept a reasonable settlement offer was through a *Stowers* action. Since then, the Texas Supreme Court

decided *USAA Texas Lloyds Co. v. Menchaca*, 545 S.W.3d 479, 498 (Tex. 2018)(op. on reh'g). There it held that an insured could recover policy benefits under the Insurance Code when "the insurer's statutory violation causes the loss of [policy] benefits" to which the insured was or would have been entitled but for the statutory violation. The insured can also recover damages for losses independent of the loss of policy benefits resulting from the insurer's statutory violation.

As a result, the underpinning of the rule restricting equitable subrogation to the insured's common-law negligence claims against the insurer are no longer, if they ever were, justified. To the extent that an insured could have obtained relief under the Insurance Code under *Menchaca*, then it stands to reason that the concept of equitable subrogation means that the excess insurer should likewise be able to assert a claim under the Insurance Code to recover the losses it incurred on the insured's behalf.

This conclusion necessarily follows from the nature of equitable subrogation itself as "the *substitution* of one party for another such that the new party may assert the rights of the substituted party." *Associated Int'l Ins. Co. v. Scottsdale Ins. Co.*, 862 F.3d 508, 510 (5th Cir. 2017)(applying Texas law). If so, then "standing" is automatically satisfied so long as the party whose rights are being asserted by the subrogee had standing. As the court explained in *Frymire Eng'g Co. ex rel. Liberty Mut. Ins. Co. v. Jomar Int'l, Ltd.*:

> The doctrine of equitable subrogation allows a party who would *otherwise lack standing* to step into the shoes of and pursue the claims belonging to a party with standing.

259 S.W.3d 140, 142 (Tex. 2008); *followed, e.g., by Tex. Lone Star Petroleum Corp. v. Chesapeake Operating Inc.*, No. 2:14-CV-331, 2016 U.S. Dist. LEXIS 156866, 2016 WL 6677939, at *9-10 (S.D. Tex. Nov. 14, 2016). The concept of derivative standing was the basis of the ruling in *Am. Centennial Ins. Co. v. Canal Ins. Co.*, 843 S.W.2d 480, 483 (Tex. 1992), that equitable subrogation allowed the excess insurer to assert the insured's rights under the primary policy against the primary insurer.

Ethical Issues that May Arise in Multi-client Representations[1]

American College of Coverage Counsel
2020 Annual Meeting

Virtual Meeting
September 2020

Tracy Alan Saxe
Saxe Doernberger & Vita, P.C.
tas@sdvlaw.com

Laura Hanson
Meagher & Geer, PLLP
lhanson@meagher.com

Timothy Wilson Burns
Burns Bowen Bair LLP
tburns@bbblawllp.com

[1] Paper authored by Tracy Alan Saxe and Ashley D. McWilliams, Saxe Doernberger & Vita, P.C.

EXECUTIVE SUMMARY

The ethical rules impose on every attorney the duty to deal fairly, honestly and with undivided loyalty, including avoiding conflicts of interest, maintaining confidentiality, and honoring the client's interests over his or her own. The issue explored in this paper is whether coverage counsel can engage in multi-client representation when the clients are not directly adverse in the coverage dispute, but coverage counsel later learns of information about the underlying case that each client may wish to keep confidential from the other. The specific type of multi-client representation discussed here involves two entities engaging a single law firm for representation in a coverage dispute against their respective separate insurers under their respective separate policies to obtain coverage from a common single occurrence involving litigation in which both entities are co-defendants (the "Underlying Action").

Coverage counsel is not precluded from representing both clients even where counsel becomes aware of information in the multi-client representation that one or both clients would not want to be disclosed to the other if: a.) the information will not materially interfere with counsel's ability to represent each client competently, and b.) coverage counsel prevents any disclosure of confidential information.[2]

HYPOTHETICAL SCENARIO[3]

Two unrelated entities are co-defendants in an underlying action. Both entities engage the same law firm to serve as coverage counsel in disputes against their respective insurers under separately acquired insurance policies. Each client has separate defense counsel. Coverage counsel attends mediation in the Underlying Action where coverage counsel learns of separate confidential settlement demands and offers with the underlying plaintiff that is not intended to be shared among the co-defendants.

ANALYSIS

I. No conflict of interest if no material interference with counsel's independent legal advice and advocacy.

At the outset of each engagement, lawyers need to assess the potential ethical issues under the relevant Rules of Professional Conduct. Model Rule 1.7 provides guidance for the lawyer-client relationship where there is a potential conflict of interest among current clients.[4] Here, a determination is needed as to whether there is a material

---

[2] This paper focuses solely on ethical considerations under the Model Rules of Professional Conduct (the "Model Rules"), with special attention to conflicts of interest and confidentiality. Other potential lines of analysis, e.g., attorney disqualification, attorney malpractice liability, etc., are not addressed.

[3] The scenario in this hypothetical is fictitious, but representative of such situations. Nothing in this paper should be taken as a representation of real-life events or attorney- client interactions of the law firms represented on the panel.

[4] MODEL RULES OF PROF'L CONDUCT r. 1.7 (ABA 2019) provides in relevant part:

> "(a) A lawyer shall not represent a client if the representation involves a concurrent conflict of interest. A concurrent conflict of interest exists if:

limitation on coverage counsel's ability to provide competent independent advice and advocacy concerning each client's dispute with their respective insurers due to the multi-client representation.

Although coverage counsel's *clients are directly adverse* in the Underlying Action, coverage counsel does not represent them in that controversy, and each of the coverage counsel's clients has separate defense counsel for those issues.[5] However, Section (a)(2) of the Model Rules of Professional Conduct states that a conflict of interest can still arise even if there is no direct adversity.[6] On the other hand, one state Supreme Court determined that there was not a material limitation on the lawyer's representation of either client when the goals of the two clients were essentially identical.[7] In all situations, a conflict of interest may exist if there is a significant risk that a lawyer's ability to consider, recommend, or carry out an appropriate course of action for either client will be materially limited as a result of the lawyer's representation and other responsibilities to the other client.[8]

In our hypothetical multi-client representation, coverage counsel simultaneously represents both clients in what is very similar, but, in some sense, mostly unrelated legal work. Each client has a contractual dispute under their respective policies, which are separate independent contracts (even if with the same insurer). Coverage counsel's legal strategy will be formulated based on independently assessed factors, including the specific, possibly unique, language of each client's policy, the potentially unique triggering event under each client's respective insuring agreement, potentially unique exclusions, endorsements, deductibles and sublimits, each insurance carrier's reason for denial or reservation of rights, and each client's unique relationship with their own insurer.

The clients in our scenario, however, as co-defendants in the Underlying Action, may have adverse economic interests. This would certainly be true if either client's defenses in the Underlying Action lead to increased liability for the other client. This will also be true if settlement with the underlying plaintiff will be accomplished jointly, and a reduction in the share of one client's payment results in a greater payment by the other. In a Florida case, *Orchid Island Golf & Beach Community Ass'n, Inc. v. Palm Coast Development of Vero Beach, Inc.* No. 312008CA013188, 2011 WL 13201792, at *3 (Fla.Cir.Ct. Nov. 22, 2011), the court determined the issue of whether a law firm should

---

> (1) the representation of one client will be directly averse to another client; or
> (2) there is a significant risk that the representation of one or more clients will be materially limited by the lawyer's responsibilities to another client, a former client or a third person or by a personal interest of the lawyer."

[5] For purposes of this paper, MODEL RULES OF PROF'L CONDUCT r. 1.7(a)(1) is not at issue.

[6] Direct adversity means representing two clients on opposite sides of the litigation or transaction. Direct adversity may also arise if the lawsuit requires cross – examination of another client. See *Smith v. Smith,* 2019 WL 1312867, at *4 (Ohio Ct. App. Mar. 21, 2019).

[7] *Saline Mem'l Hosp. v. Berry,* 321 Ark. 588 (1995) (Holding that the representation of insurer would not materially limit firm's representation of hospital and no appearance of impropriety was created as would require disqualification.)

[8] MODEL RULES OF PROF'L CONDUCT r. 1.7, Cmt. 8 (ABA 2019).

be disqualified due to a conflict of interest between two current clients. The court decided in favor of the law firm and held that the law firm should not be disqualified because the evidence did not support a conclusion that when the law firm undertook representation, the representation would be directly adverse to an existing client. The dispute between the existing clients involved a breach of contract due to non-payment of fees by one client to the other. The plaintiff asserted that a partner at the firm once advised it on the implementation and validity of the fees and thus should be disqualified from representing the defendant.

The Florida court applied Rule 4-1.7 of the Rules Regulating the Florida Bar,[9] and relied on the comments to resolve the existing client conflict issue. The comment states, "[S]imultaneous representation of clients whose interests are only economically adverse, such as representation of competing enterprises in unrelated litigation, does not ordinarily constitute a conflict of interest."[10]

In *Orchid Island*, in addition to arguing that the defendant's counsel should be removed pursuant to the rule 4-1.7 of the Rules Regulating the Florida Bar, the plaintiff argued, that an actual violation of the Rules Regulating the Florida Bar is not necessary for the Court to disqualify defendant's counsel where there is an appearance of impropriety.[11] The court held "that it is unrefutable *[sic]* that the subject matter of the fee was discussed… there was no testimony or evidence to suggest that Quinn [counsel] ever undertook any research or examination of impact fees or rendered any formal opinion."[12]

The critical question to coverage in multi-client representation is whether the economically adverse interests of the clients will eventuate and, if it does, whether it will materially interfere with the lawyer's independent professional judgment in considering

---

[9] *R. Regulating Fla. Bar 4-1.7* provides in relevant part:

> (a) Representing Adverse Interests. Except as provided in subdivision (b), a lawyer must not represent a client if:
>
> (1) the representation of 1 client will be directly adverse to another client; or
>
> (2) there is a substantial risk that the representation of 1 or more clients will be materially limited by the lawyer's responsibilities to another client, a former client or a third person or by a personal interest of the lawyer.
>
> (b) Informed Consent. Notwithstanding the existence of a conflict of interest under subdivision (a), a lawyer may represent a client if:
>
> (1) the lawyer reasonably believes that the lawyer will be able to provide competent and diligent representation to each affected client;
>
> (2) the representation is not prohibited by law;
>
> (3) the representation does not involve the assertion of a position adverse to another client when the lawyer represents both clients in the same proceeding before a tribunal; and
>
> (4) each affected client gives informed consent, confirmed in writing or clearly stated on the record at a hearing.

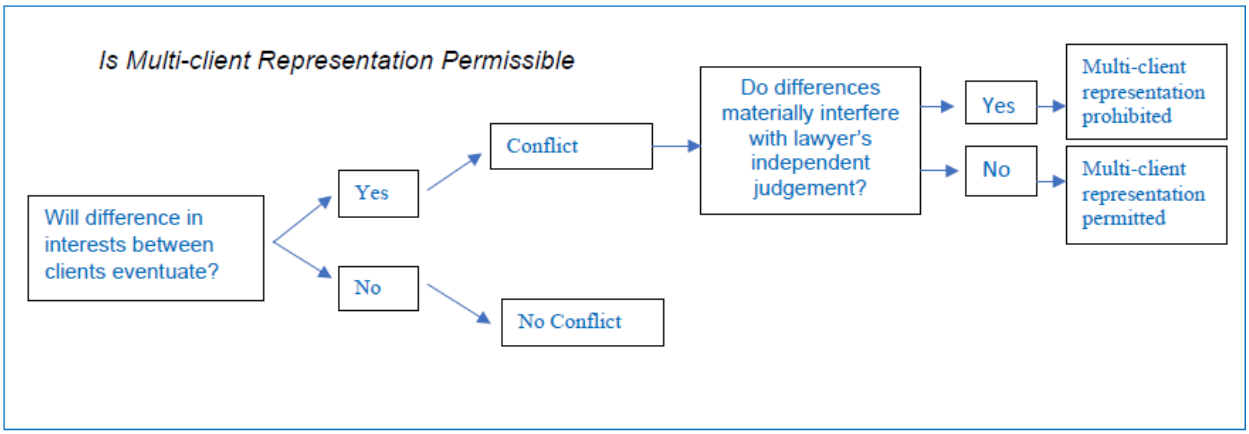
[10] *R. Regulating Fla. Bar 4-1.7* cmt.

[11] *Orchid Island Golf & Beach Community Ass'n, Inc.,* 2011 WL 13201792, at *8.

[12] *Id.* at 9.

alternatives or foreclose courses of action that reasonably should be pursued on behalf of the client.[13] If so, coverage counsel shall not engage in the multi-client representation.

The law firm in *Orchid Island* was not disqualified despite the existing client conflict because it did not take any affirmative action to prejudice its other client. In multi-client representation, coverage counsel must perform its due diligence and create a legal strategy best fit for each client. In the hypothetical, the parties are seeking coverage under separate insurance policies. Each denial may have its own rationale. All unique circumstances require evaluation, but nothing in this hypothetical scenario appears to indicate that a material interference with coverage counsel's independent judgement will arise. This conclusion does not change even if the rationale for each insurer's denial is similar.[14]



If a material limitations conflict arises, the conflict is not waivable. A non-consentable material limitation exists if a disinterested lawyer would conclude that the client should not agree to the representation under the circumstances.[15] If a disinterested lawyer would conclude that the client should not agree to representation, then the lawyer cannot properly ask the client to consent to representation.[16] Under the facts presented in the hypothetical, coverage counsel can represent each client with independent judgement. The outcome of one coverage dispute is not dispositive of the other. For these reasons, a disinterested attorney could conclude that it is acceptable for the clients to participate in the multi-client representation.

---

[13] MODEL RULES OF PROF'L CONDUCT 1.7, Cmt. 8 (ABA 2019); *Iowa Supreme Court Attorney Disciplinary Bd. v. Willey*, 889 N.W.2d 647 (Iowa 2017); *In re Opinion No. 17-2012 of Advisory Comm. on Prof'l Ethics*, 107 A.3d 666, 672 (2014).

[14] It is worth noting that it may be to both clients' economic benefit if coverage counsel's increased efficiency leads to a lower fee for each by having one attorney represent them.

[15] See *Albert M. Greenfield & Co. v. Alderman*, 2001 WL 1855056, at *1 (Pa. Super. Ct. May, 14, 2001); See also *Times Fiber Commc'ns, Inc. v. Trilogy Commc'ns, Inc.,* No. CV 950552603S, 1996 WL 698016, at *3 (Conn. Super. Ct. Nov. 29, 1996) (Discussing disqualification of a patent attorney pursuant to rule 1.7 of Connecticut Rule of Professional Conduct which adopted rule 1.7 of the Model Rules of Professional Conduct).

[16] *Albert M. Greenfield & Co.*, 2001 WL 1855056, at *6.

The Court of Appeals of Ohio, in *Smith v. Smith* 2019 WL 1312867, at *1 *(Ohio Ct. App. Mar. 21, 2019)* provided a little guidance on the meaning of a "material limitation conflict".[17] The court decided to disqualify the attorney under Ohio's rule 1.7 due to a conflict under part (a)(1) direct adversity and (a)(2) material limitation. When analyzing whether a material limitation existed pursuant to part (a)(2) of the rule, the *Smith* court determined that a conflict arises "if there is a *substantial risk* that the lawyer's ability to consider, recommend, or carry out an appropriate course of action for that client will be materially limited by the lawyer's responsibilities to another client." *Smith v. Smith 2019 WL 1312867, at *4.* The court in *Smith* relied on the rule's comments that a material limitation exists if a decision for which the lawyer must advocate on behalf of one client in one case will create a precedent likely to severely weaken the position taken on behalf of another client in another case. *Id.*

Coverage counsel in our hypothetical multi-client representation will not advocate for a position that will create a precedent to the detriment of the other client. Because the clients share a common single occurrence in the Underlying Action and are pursuing coverage from their respective insurers, counsel's coverage position may be the same for each client. Thus, a favorable outcome for one client is likely advantageous for all clients. Indeed, a winning precedent in one case may bolster the likelihood of a favorable judgment in the other client's favor or an increased likelihood that the other insurer will make a prompt and fair offer to settle the coverage dispute.

II. Coverage Counsel in multi-client representation must maintain each client's confidences and prevent disclosure relating to the representation.

Coverage counsel engaged in multi-client representation must maintain each client's individual confidences and prevent disclosure of information related to the representation of each client. Pursuant to rule 1.6 of the Model Rules of Professional Conduct, a lawyer has a duty not disclose information related to the representation unless the client gives informed consent. The disclosure is impliedly authorized, or the disclosure falls within an exception.[18] Counsel must make reasonable efforts to prevent inadvertent

---

[17] The court evaluated Ohio Rules of Professional Conduct rule 1.7; Conflict of Interest: Current Clients. Ohio's rule 1.7 is substantially similar to rule 1.7 of the Model Rules of Professional Conduct .OHIO RULES OF PROF'L CONDUCT, r. 1.7(2020) provides in relevant part:

> "(a) A lawyer's acceptance or continuation of representation of a client creates a conflict of interest if either of the following applies:
>
> (1) the representation of that client will be directly adverse to another current client;
>
> (2) there is a substantial risk that the lawyer's ability to consider, recommend, or carry out an appropriate course of action for that client will be materially limited by the lawyer's responsibilities to another client, a former client, or a third person or by the lawyer's own personal interests."

[18] See MODEL RULES OF PROF'L CONDUCT r. Rule 1.6 (ABA 2019) provides in relevant part:

> "(a) A lawyer shall not reveal information relating to the representation of a client unless the client gives informed consent, the disclosure is impliedly authorized in order to carry out the representation or the disclosure is permitted by paragraph (b).
>
> …
>
> (c) A lawyer shall make reasonable efforts to prevent the inadvertent or unauthorized disclosure of, or unauthorized access to, information relating to the representation of a client."

or unauthorized disclosure or unauthorized access to information relating to the representation of his or her client.

Coverage counsel in multi-client representation is tasked with maintaining the confidences of multiple clients who have distinct coverage disputes but are co-defendants in an underlying lawsuit. Multi-client representation is not joint representation. Coverage counsel is not required to disclose to independent, unrelated clients, and counsel is prohibited from voluntarily divulging any information related to the other client, absent implied authorization or a waiver of confidentiality between the clients. No client is entitled to information regarding the other's coverage dispute.

Additionally, coverage counsel must act competently and use reasonable measures to safeguard all information related to the representation of all clients.[19] Because the multi-client representation involves some overlap of information, there is a possibility that information from one client can inadvertently be shared with the other. Coverage counsel must be especially cautious that information learned while present at a mediation on behalf of more than one client is not mistakenly revealed to an unintended client.[20]

If information is inadvertently shared, coverage counsel is not automatically in violation of the rules of professional conduct if counsel has made reasonable efforts to prevent the access or disclosure. Comment 18 of rule 1.6 *Confidentiality of Information* of the Model Rules of Professional Conduct states the factors to be considered in determining the reasonableness of the lawyer's efforts which include, but are not limited to, sensitivity of the information, the likelihood of disclosure if additional safeguards are not employed, the cost of employing additional safeguards, the difficulty of implementing the safeguards, and the extent to which the safeguards adversely affect the lawyer's ability to represent clients.[21]

III. Best Practices

Multi-client representation presents challenging ethical questions that do not have clear answers under the Model Rules of Professional Conduct. Although we conclude that the Model Rules do not preclude coverage counsel from multi-client representation, we suggest best practices to avoid an ethical violation.

First, coverage counsel should thoroughly evaluate the multi-client representation from the perspective of a disinterested attorney. If counsel concludes that representation

---

For purposes of this paper the information obtained by coverage counsel does not fall within an exception.

[19] MODEL RULES OF PROF'L CONDUCT r. Rule 1.6(c) (ABA 2019) (stating "lawyer shall make reasonable efforts to prevent the inadvertent or unauthorized disclosure of, or unauthorized access to, information relating to the representation of a client.")

[20] An accidental disclosure is not an automatic violation of Model Rule 1.6(c) if counsel exercises due care to avoid the disclosure and protect the client's confidences.

[21] MODEL RULES OF PROF'L CONDUCT r. 1.6, Cmt. 18 (ABA 2019).

of any client will impair the ability to represent another client, consider withdrawing from representation of one of the clients. This should be done at the earliest possible time so that counsel does not become disqualified from representing all clients arising out of this common occurrence.

Second, inform the client fully. Coverage counsel should clearly communicate the scope of representation and why multi-client representation will not impair coverage counsel's ability to represent the client. Informed consent requires that each affected client be aware of the relevant circumstances and of the material and reasonably foreseeable ways that the conflict could affect the interests of the client.[22] When representation of multiple clients is undertaken, the information must include the implications of the common representation, including possible effects on loyalty, confidentiality, and the attorney-client privilege and the advantages and risks involved. Multi-client representation is not joint representation, but due to the similarity in interest and co-defendant status in the underlying case, it is easy for a client to conflate the two. Therefore, it is imperative that coverage counsel engages in clear communication with each client and distinguishes the role of coverage counsel from that of their respective defense counsel in the Underlying Action.

Third, confirm in writing separately, with each client that coverage counsel has advised the client of the scope of representation, and that the client has no concerns with the multi-client representation or any concerns of the client have been adequately addressed.

Finally, reevaluate regularly. If at any stage in the representation coverage counsel concludes that a material impairment has or will arise, inform the client, take all necessary steps to protect the interests of all clients, and consider withdrawing from representation of one or all of the clients.

[22] MODEL RULES OF PROF'L CONDUCT r. 1.7, Cmt. 18 (ABA 2019).

YOU DID . . . WHAT!

Looking at post-breach settlements under the light of a torch passed to third-party claimants

American College of Coverage Counsel
2020 Annual Meeting

Virtual Conference
September 10-11 & 24-25, 2020

Bill Ford, Moderator
Collins Ford LLP
Tarzana, California
william.ford@fordlawfirm.com

Jean M. Lawler
Lawler ADR Services
El Segundo, California
jlawler@lawleradr.com

Wendy L. Feng
Covington & Burling, LLP
San Francisco, California
wfeng@cov.com

Ellen Van Meir
Thompson Coe
Dallas, Texas
EVanMeier@thompsoncoe.com

YOU DID …. WHAT!

Looking at Post-Breach Settlements Under the Light of a Torch Passed to Third Party Claimants

The Hypothetical:

D purchased a $1 million general liability insurance policy from GOT-U INS. CO.

D is sued by P.

P's complaint aggressively alleges many factual claims. Some of the claims, while not true, are at least potentially covered, thereby giving rise to GOT-U'S duty to defend the entire suit. Some of the claims are true but would never be even potentially covered. The uncovered claims create an exposure of at least $1.5 million, not including punitive damages.

D timely notifies GOT-U of P's suit. D requests a defense. However, GOT-U both denies coverage and fails to defend D, pointing to the claims that are not even potentially covered (ignoring the others).

D lacks the financial resources to defend itself and enters into a reasonable and non-collusive "Settlement, Assignment, and Limited Recourse Agreement" ("Settlement") pursuant to which (a) D settles with P for $1.5 million, (b) D assigns all assignable rights and claims against GOT-U to P and (c) P agrees that its sole recourse for collection will be limited to the recovery of assigned claims against GOT-U, not D's assets.[1]

P, as assignee, sues GOT-U.

Now, P alleges breach of contract and breach of the implied covenant of good faith and fair dealing arising out of GOT-U's breach of its duty to defend D. P claims, among other damages, the full amount of the Settlement, $1.5 million.

GOT-U conducts certain discovery including depositions of both D and P. GOT-U obtains facts which establish the falsity of P's claims that were at least potentially covered.

GOT-U'S defenses include the following:

[1] This hypothetical stipulates that emotional distress and punitive damages are not assignable at law. The assignability of punitive damages is dependent on the jurisdiction. See, United Heritage Property and Cas. Co. v. Farmers Alliance Mut. Ins. Co. (D. Idaho, Feb. 9, 2012, No. CIV. 1:10-456 WBS) 2012 WL 442881, at *5 ("Other states to have addressed this question have similarly held that claims for punitive damages can be assigned when they are based on otherwise assignable causes of action").

1. That breach of its duty to defend D, if any, did not "cause" the Settlement or the amount thereof;

2. The assignable damages are limited to fees and costs paid or incurred by D or, at best, are capped at policy limits subject to any retention;

3. That because D paid no money and was "immunized" against collection by the limited recourse term of the Settlement, D suffered no detriment or loss and P has no claim;

4. Relying on evidence obtained during discovery, GOT-U contends the Settlement was not "covered;" hence, P has no claim against GOT-U.

The Argument

I. First Defense: The insurer's breach of its defense obligation was not the legal cause of the Settlement

A. D had a right to mitigate GOT-U's breach by its settlement

It is widely recognized that when an insurer wrongfully fails or refuses to provide a defense to its insured, the insurer has materially breached the insurance contract, and the abandoned insured is entitled to enter into a reasonable and non-collusive post judgment settlement with the plaintiff and then maintain an action against the insurer to recover the amount of the settlement.[2] In addition, the majority of courts have recognized the insured's right to assign its action against the insurer in exchange for a covenant not to execute.[3]

One clear implication from the majority rule is that a contractual breach of the defense obligation "entitles" the insured to make a reasonable settlement. This means the causal link between breach of the defense obligation and settlement is a given. As explained by one court, "the unacceptable alternative would be to compel the insured, following the insurer's breach, invariably to force the dispute to trial and thus to risk additional (and

[2] See generally, D. Richmond, The Consent Judgment Quandary of Insurance Law, 48 TTIPLJ 537 (2013); C. Wood, *Assignments of Rights and Covenants Not to Execute in Insurance Litigation,* 75 Tex. L.Rev. 1373 (1997); J. Harris, *Judicial Approaches to Stipulated Judgments, Assignments of Rights, and Covenants not to Execute in Insurance Litigation,* 47 Drake L.Rev. 853 (1999).

[3] *Ibid., Strahin v. Sullivan,* 220 W.Va. 329, 342; 647 S.E.2d 765, 778 (2007) (explaining the majority of jurisdictions recognize the validity of a third-party's claim arising from a post-breach settlement with an assignment and covenant not to execute).

perhaps uninsured) exposure and to incur unnecessary expenditure of the insured's own money and of the state's overtaxed judicial resources."[4]

B. The anatomy of an *Isaacson* reimbursement claim

California recognizes an insured's post-breach right to enter into a reasonable, non-collusive settlement pre-judgment.[5] The anatomy of an *Isaacson* claim is made up of 4 points:

Point 1 - If an insurer, with notice of the pendency of the underlying action, wrongfully denied coverage or improperly refuses to provide its insured with a defense, the insured is entitled to make a reasonable settlement of the claim in good faith and then maintain an action against the insurer to recover the amount of the settlement.[6]

Point 2 - In a later action against the insurer, based upon a breach of the contractual obligation to provide a defense, a reasonable settlement made by the insured to terminate the underlying claim may be used as *presumptive evidence* of the [1] insured's liability on the underlying claim, and [2] the amount of such liability.[7]

Point 3 – To rely on the presumptions, an insured is required to establish three basic or foundational facts: (1) the insurer wrongfully failed or refused to provide coverage or a defense, (2) the insured thereafter entered into a settlement of the litigation which was (3) reasonable in the sense that it reflected an informed and good faith effort by the insured to resolve the claim.[8]

Point 4 – Once the insured presents these basic facts then the insured is entitled to an evidentiary presumption (under California Evidence Code §605), which affects the burden of proof at trial.[9]

Point 1 establishes causation. Point 2 makes clear the insured's presumed liability and amount of that liability flow from a reasonable settlement. This means the insured is never required to prove either his own liability or the amount thereof. Point 3 makes clear that a

---

[4] *Pruyn v. Agricultural Ins. Co.,* 36 Cal. App. 4th 500, 529 (1995).

[5] *Isaacson v. California Ins. Guarantee Assn.* 44 Cal.3d 775 (1988); *Xebec Development Partners, Ltd. v. National Union Fire Ins. Co.,* 12 Cal.App.4th 549 (1993); and *Pruyn v. Agricultural Ins. Co.,* supra, 36 Cal. App. 4th 500.

[6] *Pruyn, supra,* 36 Cal.App.4th at 515 (citing and quoting *Isaacson,* 44 Cal.3d at 791).

[7] *Ibid.*

[8] *Pruyn, supra,* at 528.

[9] *Pruyn* at 529.

settlement is established as reasonable by the same kind of evidence as would support a good faith determination by the court that the settlement was in the "ball-park."[10] Point 4 makes clear that the insurer has an opportunity to challenge the settlement by showing that the settlement amount was unreasonable or fraudulent or collusive as not reached at arm's length.

II. Second Defense: The assignable damages are limited to fees and costs paid or incurred by D or, are capped at policy limits subject to any retention.

Upon breach of the defense obligation, the better-reasoned view is that there is no "cap" to limit damages to defense fees and costs paid or incurred

GOT-U's Second defense reflects perhaps the "majority view" that "[w]here there is no opportunity to compromise the claim and the only wrongful act of the insurer is the refusal to defend, the liability of the insurer is ordinarily limited to the amount of the policy plus attorneys' fees and costs."[11]

Recently, the Nevada Supreme Court, in response to a certified question submitted by the U.S. District Court for the District of Nevada, embraced the "minority view" as the better approach, *i.e.*, that damages for a breach of the duty to defend are not automatically limited to the amount of the policy; instead, the damages awarded depend on the facts of each case.[12]

In *Century Surety* the court held the majority view places an "artificial" limit to the insurer's liability. It reasoned that whereas a limits "cap" on damages is based on the duty to indemnify, "[a] duty to defend limited to and coextensive with the duty to indemnify would be essentially meaningless: insured's pay a premium for what is partly litigation insurance

---

[10] *Tech-Bilt, Inc.v. Woodward-Clyde & Associates,* 38 Cal.3d 488 (1995) (provides trial courts with guidance in determining motions for good faith settlement under Cal. C. Civ. Proc. §877.6 which cuts off certain contribution rights of non-settling defendants). The *Tech-Bilt* court used the expression "ball park" to provide a short hand reference to a more specific, factor driven analysis for trial courts to follow when determining whether the settlement was "in the ball park" – motion granted; or when the settlement "out of the ball park" – motion denied. The factors to consider include a rough approximation of plaintiffs' total recovery, the amount of the settlement, the parties' financial conditions, and the existence of collusion, fraud or tortious conduct aimed to injure the interests of non-settling defendants. See, *Tech-Bilt, supra,* 38 Cal.3d at 499.

[11] *Comunale v. Traders & General Ins. Co.*, 50 Cal.2d 654, 659-60 (1958) (*Comunale*); see also *Emp'rs Nat'l Ins. Corp. v. Zurich Am. Ins. Co. of Ill.,* 792 F.2d 517,520 (5th Cir. 1986).

[12] See, *Century Surety Company v. Andrew,* 134 Nev. 819,823 citing, *Burgraff v. Menard, Inc.*, 367 Wis.2d 50, 875 N.W.2d 596, 608 (2016).

designed to protect . . . the insured from the expense of defending suits brought against him."[13]

Policyholders (or their assignees, like P) should consider the following arguments in opposition to the so-called majority view: First, to the extent *Comunale* ever was a statement of the majority view, it is now fragile. The flawed premise, quoted above, was *dictum.* So, the musing went, ***if*** the insured employs competent counsel there would be no ground for concluding that a judgment against the insured would have been for a lesser sum had the defense been conducted by the insurer's counsel. *Comunale's* 1958 *dictum* cannot be reconciled with the same court's later landmark *holding,* in *Gray v. Zurich Ins. Co.*[14] Recall, *Gray* held a breaching insurer liable for the full amount of a judgment against its insured.[15] Like GOT-U, the insurer in *Gray* tried to argue it only had to reimburse the insured's expenses in defending the third-party action, but not payment of the judgment. *Id.* at 279-80. The court rejected any such hard-and-fast rule because it would "impose upon the insured 'the impossible burden' of proving the extent of the loss caused by the insurer's breach." *Id.* at 280. Thus, the law's thoughtful evolution in just *eight short years* progressed rapidly from hypothesizing that an abandoned insured's counsel might not make a judgment "lesser" than insurer-selected counsel, on the one hand, to an adamant refusal to impose the "impossible burden" of proving the extent of loss, on the other.

Second, "[C]ourts have for some time accepted the principle that an insured who is abandoned by its liability insurer is '***free***' to make the best settlement possible with the third-party claimant, including a stipulated judgment with a covenant not to execute."[16] The analysis is not one of causation.

Third, GOT-U's suggestion that only defense expenses are recoverable upon breach of the defense obligation would contradict decades of established that law post-breach settlements give rise to presumptions of insureds' *liability* and the *amount* thereof. These presumptions would be meaningless if damages were limited to defense expenses.

---

[13] *Century Surety Co. v. Andrew, supra,* 134 Nev. 819, 825.

[14] 65 Cal. 2d 263, 419 P.2d 168 (1966).

[15] *Gray, supra,* at 263.

[16] *Pruyn, supra,* 36 Cal. App. 4th at 515; also, *Samson v. Transamerica Ins. Co*., 30 Cal. 3d 220, 240-242 and *Isaacson v. California Ins. Guar. Assn*., 44 Cal. 3d 775, 791.

Finally, consistent with general contract principles, the insured should be entitled to consequential damages resulting from the insurer's breach of its contractual duty to defend.[17]

As case law has made plain, the proper measures of damage for contractual or tortious breaches of the defense obligation, codified in California by Civil Code §§ 3300 and 3333 respectively, apply so that the amount of a reasonable and non-collusive post-breach settlement is always sufficient to establish and quantify damage without any reference to "coverage."

III. Third Defense: Because the limited recourse agreement immunized D from having to fund the settlement, D suffered no detriment or loss and thus P has no claim

A. Policyholders should argue the "hypothetical of the innocent insured" to demonstrate why requiring "coverage" for post-breach settlements would eliminate incentives for settlement and waste judicial resources

Recall, P's numerous, aggressive allegations against D were ***not true*** with respect to the claims that were at least potentially covered. Put another way, given D's factual innocence, there was little or no chance GOT-U would ever be required to pay an adverse judgment against D pursuant to indemnity coverages.

It can be seen that if GOT-U'S position was ever written into the law so that reasonable post-breach settlements nonetheless had to be "covered," no just results would follow. There would be an obvious chilling effect on settlements: litigants would lose, courts would lose, and only insurers would "win."

P would have no incentive to settle, except for cash, because the assigned claims would have little value to the extent P, as assignee, had to prove "coverage."

If D was unwilling or *unable* to defend, the underlying P v. D lawsuit would proceed to default judgment. The insurer, having breached its defense duty, would lie-in-wait for prosecution of D's assigned claims, knowing it had saved money by not defending and ready to put some of its savings to use against P's assigned claims.

[17] See *Century Surety, supra,* at 825 (citing Restatement of Liability Insurance Sec. 48 (Am. Law Inst., Proposed Final Draft No. 2, 2018)).

Judicial resources would always be wasted either on the underlying P v. D suit that was forced to default or on trial of P's assigned claim, wherein P would be forced to the impossible burden of proving "coverage" for the post-breach settlement.

Thus, setting aside that P's second suit would be both pointless *and* virtually impossible to manage, GOT-U'S proposed rule would effectively remove *assignments with covenants not to execute* as established means of self-protection. Abandoned insureds, like D, innocent of alleged covered wrongdoing, would be far less able to settle actions because their Third-Party adversaries would be disinclined to accept assignments without potential value. At bottom, only insurers win—courts and insureds lose.

B. D, as Assignor of its rights against GOT-U, suffered a loss; that D made no actual Payment to P and is "insulated" from Personal Liability is irrelevant

GOT-U may argue that P has no bad faith claim against it. So it would go, because D paid no actual money and was "insulated" against personal liability by the post-breach settlement, he suffered no cognizable loss or detriment.

P's response should be simple and straightforward.

P should correctly acknowledge that breach of the implied covenant of good faith and fair dealing (bad faith) occurs if the insurer "acts unreasonably and without proper cause in failing to investigate a claim, refusing to provide a defense, or either delaying or failing to pay benefits due under the policy."[18] Also, P can readily concede "[Bad faith] is '*actionable'* because such conduct causes financial loss to the insured, and it is the financial loss or risk of financial loss which defines describing the unreasonable withholding of a policy benefit as a financial loss or risk of financial loss which defines the cause of action."[19]

However, the insured's right to a defense is a policy benefit, *to say the least*; it's also a primary right as important as the insured's right to indemnity and California courts have been consistently solicitous in the insured's expectations on this score. [20]

---

[18] *Richards v. Sequoia Ins. Co.*, 195 Cal. App. 4th 431, 438 (2011).

[19] *Gourley v. State Farm Mut. Auto.*, 53 Cal.3d 121, 123.

[20] *Montrose Chem. Corp. v. Superior Court*, 6 Cal. 4th 287, 295-296 (1993); *Buss v. Superior Court*, 16 Cal. 4th 35, 45 (1997).

In the post-breach settlement D assigned its claims against GOT-U to P and "[a] thing in action is a right to recover money or other personal property by a judicial proceeding."[21] "A thing in action, arising out of the violation of a right of property, or out of an obligation, may be transferred by the owner."[22]

D's property rights, its claims against GOT-U, assigned to P, were not "gifted;" they were assigned in consideration of the limited recourse agreement (or covenant not to execute). D's economic loss was the transfer (assignment) of its claims including for breach of GOT-U's defense obligation and related bad faith—the amount of D's detriment or loss or damage, however described, will always equal the amount of P's recovery, if any, which will only be determined in the P v. GOT-U suit.

IV. FOURTH DEFENSE: Got-U's New Evidence, obtained in discovery conducted post-breach and post-settlement, tends to show P's potentially covered claims would never have been actually covered; hence the post-breach settlement is not "covered"

A. After violating its duty to defend, an insurer cannot by "hindsight" resort to newly discovered evidence that the post-breach settlement is not "covered"

1. The newly discovered facts are irrelevant because "coverage" measured by a standard applicable to indemnity is never at issue with respect to post-breach settlements

For a host of compelling reasons, actual "coverage," measured by the indemnity standard applicable to *judgments,* is completely irrelevant to post-breach settlements. As discussed in this paper, Policyholders (or their Assignees, like P) should argue as follows:

Point 1: Upon breach of the defense obligation, the insured had a right to enter into a reasonable, non-collusive post-breach settlement; the settlement established and quantified the insured's loss, detriment or damage as reflected by the presumptions that the settlement reflected the fact of its liability and that the amount was reasonable;

Point 2: The Insured's claim (or its Assignee's claim, like P's) for reimbursement of the amount of the post-breach settlement is not in the nature of a claim

[21] *Cal. Civil Code* § 953.

[22] *Cal. Civil Code* § 954.

for "indemnity," i.e., it is not a claim to collect on a judgment; hence, there is no basis upon which to apply principles of collateral estoppel—there is no judgment and no findings;

Point 3: The duty to indemnify, on the one hand, and the duty to defend, on the other, cannot be collapsed or made interchangeable; they differ in purpose; they differ in triggers; they differ in substance; and they differ in scope. Hence, there is no rational basis to apply an "indemnity" standard to a post-breach settlement. Related to this point:

a. The "purposes" are different; whereas the purpose of the duty to defend is to "avoid or at least minimize liability" *before* liability has been established, the purpose of the duty to indemnify is to "resolve liability" *after* it has been established;

b. The "triggers" are different; the duty to defend may arise as soon as damages are "sought" in some amount—the duty to indemnify can only arise after damages are "fixed" in some amount;

c. The "substance" of each is different; the duty to defend entails the rendering of a service, namely, the mounting and funding of a defense, the indemnity obligation entails the payment of money; and

d. The "scope" of each is different; the duty to indemnify may be broad but the duty to defend is perforce broader still—where there is a duty to defend, there may be a duty to indemnify; but where there is no duty to defend, there cannot be a duty to indemnify.[23]

Point 4: Having breached its duty to defend, GOT-U cannot point to any viable "Reservation of Rights," therefore, there is no basis upon which to assert grounds for non-coverage of the post-breach settlement; in effect, GOT-U cannot cloak itself with the same rights and prerogatives available to an insurer that honored its defense obligation while properly reserving rights to later dispute or disclaim coverage.[24]

[23] See, the California Supreme Court's scholarly opinion in *Certain Underwriters at Lloyd's of London v. Superior Court (Powerine),* (2001) 24 Cal. 4th 945, 951, 975, wherein each sub-part of Point 3 is set forth in greater detail.

[24] This point is discussed herein at IV.D.

2. Aside from being irrelevant, an insurer's newly discovered evidence to the effect a post-breach settlement may not be "covered" violates public policy

Through the years, in different contexts, courts have consistently rejected, as unfair and against public policy, various efforts by insurers to justify "non-coverage" results by "hindsight." In California, for example, *Mullen v. Glens Falls Ins. Co.*[25] illustrates the concept. There, an insurer refused to defend or indemnify, contending the underlying action was based on an intentional assault which was excluded from coverage. The refusal to defend was wrongful because, at the time of the refusal, there was a potential for coverage. The insured hired his own counsel; the ensuing verdict against him was based on intentional assault, thus the insurer would have been "vindicated" in its belief of non-coverage.

However, the insured was entitled to seek not only his costs of defense but also the full amount of the judgment. The court's decision was based on the notion an insurer may not deny an insured a defense at a time when it has reason to believe there is a potential for coverage and then, later, rely on the results of the lawsuit and/or subsequent factors to prove that there was in reality no potential liability in the first place. *Mullen v. Glens Falls Ins. Co.*[26] Public policy "alone" drove the ruling in *Mullen*. The court reasoned that "otherwise an insurance carrier could refuse to defend its insured on the slightest provocation and *then resort to hindsight for the justification.*"[27] The rule of *Mullen* is that the amount of judgments—including even judgments that, upon adjudication, turn out to be not covered—equate with and constitute detriment to support a damage claim for an insurer's failure or refusal to defend.

Mullen is not unique or aberrational. The purpose and rationale of other "no-justification-by-hindsight" rules have been deeply woven into the fabric of coverage law for decades. For example, in *Gray*,[28] explicit to the court's landmark decision was a rejection of the insurer's "argument that the duty to defend dissolves simply because the insured is unsuccessful in his defense and because the injured party recovers of the basis of a finding of the assured's willful conduct."[29] Hindsight was not available to the breaching insurer, Zurich Insurance Company, left pointing to an "uncovered" judgment.

---

[25] 73 Cal. App. 3d 163 (1977)

[26] 73 Cal. App. 3d at 173.

[27] *Id.* at 173 (emphasis added).

[28] 65 Cal. 2d 263.

[29] *Gray* at 278.

Regarding *Gray*, it may help to pause and appreciate that the world *will never know* from the uncertain judgment in *Gray* whether, fifty plus years ago, Dr. Gray was acting "negligently" (covered) or "willfully" (not covered). It doesn't matter. The California Supreme Court removed any unfair "wait-and-see" option from Zurich, which it determined to be liable for the full amount of the judgment whether covered or not covered.

Other "no hindsight" rule formulations, are instructive. Consider the rule that a declaratory judgment of "no coverage," either by summary judgment or after trial, never retroactively relieves the insurer of the duty to defend. It only prospectively relieves the insurer of the obligation to continue to defend after the declaration. See, *Montrose Chemical Corp. v. Superior Court.*[30]

Yet another example of "no justification by hindsight" can be seen in *Haskel, Inc. v. Superior Court*.[31] There, the court held that in a declaratory relief action to determine coverage, that insurers enjoy no right to delay adjudication of their defense obligations until they can "develop" sufficient evidence through discovery to retroactively justify their earlier refusal to provide that defense.[32]

Another example of no justification by hindsight" is implicit in *Buss v. Superior Court*, ("*Buss*").[33] Recall, in a "mixed" action, in which some of the claims are at least potentially covered and others are not, the insurer has a contractual duty to defend as to claims that are at least potentially covered, having been paid premiums by the insured therefor, but does not have a contractual duty to defend as to those that are not, having not been paid therefor. The *Buss* court justified the insurer's duty to defend the entire "mixed" action prophylactically, as an obligation imposed by law:

> To defend meaningfully, the insurer must defend immediately. [citation] To defend immediately, it must defend entirely. It cannot parse the claims, dividing those that are at least potentially covered from those that are not.[34]

---

[30] 6 Cal. 4th 287, 295 (1993); see also, *Buss v. Superior Court, supra,* 16 Cal. 4th at 46 ("before [being extinguished] it had a duty to defend; after, it does not have a duty to defend further").

[31] 33 Cal. App. 4th 963, 977 (1995)

[32] *Id*. at 977.

[33] 16 Cal. 4th at 48-49.

[34] *Ibid.*

Allowing non-defending insurers to look back at a post-breach settlement and demand evidence of "coverage" would contradict the reasoning and policy expressed in *Buss.*

The *Buss* court held ***defending*** insurers could seek reimbursement for defense costs provided they can be allocated solely to the claims that are not even potentially covered.[35]

The point here is that GOT-U's "*new* facts" were obtained in discovery that was *after the fact of breach* and *after the fact of settlement*. There are two principles that can be argued: First, on a basic level, post-breach settlements can never be "tested" for "coverage" because they are not judgments, hence, indemnification plays no analytical role; and second, equally important, facts newly "discovered" by insurers, are unavailable except as relevant to whether the post-breach settlement was reasonable and not collusive (and in a proceeding where such issue was raised).

B. Post-breach Judgments based on Principles of Collateral Estoppel are distinguishable from post-breach settlements

GOT-U seeks to manufacture a convenient "one-size-fits-all" rule whereby it can scrutinize P's reasonable, non-collusive post-breach *settlement* for "coverage." GOT-U may attempt to rely on certain California Supreme Court cases to support the general notion that, "like post-breach *judgments*," post-breach settlements must be "covered" by the same indemnity standard.[36]

The *rationale* of these post-breach *judgment* cases matters. *Geddes* was squarely based on established principles of ***collateral estoppel***. The very words convey, without question, the application of collateral estoppel principles. Here are the words:

> An insurer that has been notified of an action and refuses to defend on the ground that the alleges claim is not within the policy coverage is *bound* by a judgment in the action, in the absence of fraud or collusion, as to *all material findings of fact essential to the judgment of liability* of the insured. The insurer is not *bound*, however, as to issues *not necessarily adjudicated*

[35] *Id*. at 54.

[36] Cases such as *Geddes & Smith, Inc. v. St. Paul-Mercury Indemnity Co*. (1959) 51 Cal. 2d 558 ("*Geddes*") and *Hogan v. Midland National Ins. Co.* (1970) 3 Cal. 3d 553 ("*Hogan*")

> *in the prior action* and can still present any defenses not inconsistent with the judgment against the insured. [37]

The court in *Geddes* cited and relied upon the Restatement of Judgments, § 107a, pp. 513-518.[38] By 1959, when *Geddes* was published, collateral estoppel had been well-established in California jurisprudence.

In *Bernhard v. Bank of America*[39] the Supreme Court pointed out that the doctrine of res judicata not only bars re-litigation of the same cause of action once a final determination has been made by a court of competent jurisdiction, it also precludes a reexamination as between the parties or their privies of any ***issue*** necessarily decided if the issue is involved in any subsequent lawsuit brought on a different cause of action. [40]

Thus, in *Geddes*, the high court faithfully applied collateral estoppel principles and ruled that in a suit on a judgment to enforce the policy an insurer may or may not be "bound" by a judgment depending on whether coverage issues were litigated to finality.[41] The reasoning in *Geddes* does not extend to settlements.

Geddes was followed by *Hogan* in 1970 which *also* applied collateral estoppel principles. Factually, *Hogan* involved a "mixed" or "severable" judgment. The resolution of factual matters in the underlying action allowed the court to determine that some damages were covered and some were not.

P would do well to observe four (4) common threads that run through *Geddes* and *Hogan*:

(1) In each case there was a breach of the duty to defend;

(2) In each case the insured provided for his own defense;

(3) In each case there was a post-breach judgment which included factual findings that either did, or did not, permit the court to apply collateral estoppel principles so as to "bind," or not, the insurer; and

---

[37] *Geddes, supra,* 51 Cal. 2d. at 561.

[38] *Id.,* at 562.

[39] 19 Cal.2d 807 (1942)

[40] *Id.,* at 810.

[41] See, *Geddes, supra,* 51 Cal. 2d at 561.

(4) In each case the claim was for indemnity "on" a judgment to enforce a policy's terms and provisions.[42]

Hogan was no different.

> [O]ne of the consequences of an insurer's failure to defend is that it may be bound, in a subsequent suit to enforce the policy (or in a direct action under Ins. Code §11580), by the express or implied resolution in the underlying action of the factual matters upon which coverage turns.[43]

As seen, the rule of *Geddes* and *Hogan* is squarely based on principles of collateral estoppel. Those principles *only* apply to indemnity claims on a judgment or direct statutory actions on a judgment for indemnity coverage.

The collateral estoppel rule applicable to certain post-breach *judgment*s, exemplified by *Geddes* and *Hogan*, cannot be "crazy glued" to post-breach *settlements* or even to *all* post-breach judgments.

The seminal case of *Gray v. Zurich Ins. Co.*[44] is instructive here. The suit Zurich *should* have defended arose out of an altercation between Dr. Gray and Mr. Jones. Jones sued in Missouri aggressively alleging an assault, seeking both actual and punitive damages.[45] Zurich refused to defend on the ground the complaint alleged an intentional tort which fell outside the coverage of the policy. *Id*. Dr. Gray thereafter unsuccessfully defended on the theory of self-defense; he suffered a judgment of $6,000 actual damages although no punitive damages were awarded. *Id.*

Gray sued Zurich for *damages* for failure to defend. *Id.*, at 267. Zurich's defenses included that "the judgment in the third-party suit upholding the claim of an intentional bodily injury operates to [collaterally] 'estop' the insured from recovery."[46]

---

[42] Regarding the *last* point, the claim in *Geddes* was for *indemnity.* The first sentence says so: "Plaintiff appeals from a judgment for defendant *in an action to recover on an insurance policy* issued by defendant to [insured]." *Geddes, supra,* 51 Cal.2d at 561. Thus, the court had to compare the material findings essential to the judgment with the terms and conditions of an insurance policy.

[43] *Pruyn v. Agricultural Ins. Co.,* 36 Cal. App. 4th 500, 514 n. 15 (1995) (J. Croskey's characterization of *Hogan.*)

[44] *Gray, supra,* 65 Cal. 2d 263.

[45] *Id*., at 267.

[46] *Id*. at 269. In *Gray*, the "judgment" in the underlying case was ***not clear.*** That's an understatement. The record on appeal included a mishmash of Dr. Gray's offer of proof (rejected by the trial court), exhibits introduced at trial

The court rejected Zurich's argument that if the judgment in a third-party suit goes against the insured it operates as "res judicata or collateral estoppel in the insured's action or proceeding against the insurer."[47]

Gray stands for the proposition that ". . . the insurer [who wrongfully fails to defend] is liable [for the amount of the judgment against its insured] whenever the trial in the underlying action involved a theory of recovery within the coverage of the policy and it was not clear whether the jury's verdict was based upon that theory."[48]

Why did the court in *Gray* determine that an "unclear," post-breach judgment was not susceptible to collateral estoppel? For one thing, an "unclear" judgment from which no one can intuit whether Dr. Gray was negligent (covered) or acting intentionally (not covered) could not "bind" the insurer under collateral estoppel principles. However, that was not the end the analysis. Based on *public policy*, the non-defending insurer, Zurich, was held liable for the amount of the unclear, post-breach judgment because it had subjected or exposed its own insured to the risk of that adverse judgment. The court reasoned: "If he [the insured] is to be required to finance his own defense and then, only if successful, hold the insurer to its promise by means of a second suit for reimbursement, we defeat the basic reason for the purchase of the insurance."[49]

Recall, the four (4) suggested threads running through the G*eddes/Hogan* rule. Applying those to *Gray*, while there ***was*** a breach of the defense obligation and while Dr. Gray ***did*** provide for his own defense, there were ***no factual findings*** in the judgment clear enough to "bind" the insurer; *and*, Dr. Gray's claim was ***not for indemnity*** "on" the judgment in any event. Dr. Gray's claim was for damages.

Similarly, in *Mullen v. Glens Falls Ins.* Co.,[50] the insurer wrongfully refused to defend or indemnify even though at the time of the refusal it was aware of facts giving rise to the potential for coverage. The insurer was not permitted to point to the "uncovered" judgment in the third party's action against the insured to show the absence of actual or

---

consisting of pleadings and the verdict in the Missouri suit and a copy of the subject insurance policy. The parties waived findings of fact and conclusions of law. *Id.* at 267.

[47] *Id.* at 278.

[48] See, e.g., *Hogan v. Midland Nat. Ins. Co., supra,* 3 Cal. 3d at 566; also, *Pruyn v. Agricultural Ins. Co., supra,* 36 Cal. App. 4th at 514, n. 15.

[49] *Gray, supra,* 65 Cal. 2d at 278.

[50] 73 Cal. App. 3d 163 (1977).

potential coverage.[51] Again, as *Mullen* illustrates, an "uncovered" judgment was deemed not susceptible to collateral estoppel based on *public policy*.

Amato v. Mercury Casualty Co.[52] ("*Amato*") followed the holding in *Mullen*. *See, Amato,* at 832. It also followed *Gray. Amato,* at 833.

In *Amato* a post-breach judgment was clearly uncovered because the jury found by special verdict that Ms. Sutton did reside with Mr. Amato; hence, the "Resident Relative Exclusion" would have negated coverage. See, *Id.* at 830 (re the special verdict) and at 837 (re the exclusion). However, that was not the result. In *Amato* the appellate court found the insurer liable for the full amount of the uncovered judgment. The court drew a clear and powerful distinction between Mr. Amato's claim for breach of the defense duty, on the one hand, and Ms. Sutton's direct-action claim for coverage under *California Ins. Code* §11580, on the other. Recall, the court's teaching:

It may seem 'quixotic' that Sutton is denied recovery on her direct action on the policy but Amato is entitled to recover for Mercury's failure to defend. However, the distinction is explainable by the ***difference in nature of their respective claims***. Sutton's claim depends on the contract terms of the coverage provisions of the insurance policy, whereas Amato's claim is based on the judicially expanded duty to defend. It is well established in California that 'an insurer that wrongfully refuses to defend is liable on the judgment.[53]

Recall, again, the four (4) threads running through *Geddes/Hogan.* In a post-breach *settlement* situation, the "third" and "fourth" threads are always absent. There is neither a judgment nor any "factual findings" upon which collateral estoppel might be based, not even theoretically. Also, and importantly, the nature of a post-breach settlement claim is never for "indemnity." It never seeks payment "on" a judgment and it is never a direct action under §11580. It is always a claim for damages based on the judicially expanded defense obligation.

---

[51] See, *Mullen v. Glens Falls Ins. Co., supra,* 73 Cal. App. 3d at 173-174 (explaining that ". . . a contrary holding would force the insured to finance his own investigation and the defense of the lawsuit, and then to seek reimbursement in a second lawsuit against the insurance company. . . [T]his could deprive [the insured] of the expertise and resources available to the carriers in making prompt and competent investigations as to the merits of lawsuits filed against their insureds"). The echo of *Gray* is unmistakable.

[52] , 53 Cal. App. 4th 825 (1997)

[53] See, *Amato v. Mercury Cas. Co., supra,* 53 Cal. App. 4th at 839 (emphasis added).

C. Permitting GOT-U to Challenge "Coverage" with respect to a post-breach settlement ignores that GOT-U breached an implied-in-law duty to ***also*** defend those claims that were not potentially covered

Virtually all courts agree that in a "mixed" action, that is, an action that contains claims that are at least potentially covered along with claims that are not, the insurer must defend the entire action.[54] In such a mixed action, the insurer has a contractual duty to defend as to claims that are at least potentially covered, having been paid premiums by the insured therefor, but does not have a contractual duty to defend as to those that are not, having not been paid therefor.

In *Buss v. Superior Court*,[55] the California Supreme Court ruled that in a "mixed" action, in which some of the claims are at least potentially covered and others are not, there is a *contractual* duty to defend the claims at least potentially covered and an *implied-in-law* duty to defend, prophylactically, claims that are not. [56]

It follows that where an insurer fails or refuses to defend a "mixed" action, it necessarily breaches two (2) separate and distinct defense obligations. In the hypothetical, D, the abandoned insured, was not only exposed to claims that were at least potentially covered but also to claims that were not.

Post-breach settlements obviously resolve *all* claims, potentially covered and otherwise. GOT-U would have no reason based in logic or the law why it must be allowed to locate a covered "pearl" that may, or may not be buried in "mixed" sands. The damage to D, the insured, is the amount fixed by a reasonable post-breach settlement—not simply the amount, if any, that might be allocated to a "portion" of D's detriment.

It bears mention that a *pointless* search for the "covered" pearl in mixed sands would also be impossible in any event. GOT-U seeks to impose on courts and litigants two (2) separate tasks: First, trying to identify or reconstruct which alleged facts supported claims that were potentially covered, and Second, trying to determine whether these alleged facts might have been proven, had the insurer not breached.

The search is not only pointless—it's unfair. GOT-U, in breach, should not be allowed to divert money otherwise available for defense of D into a convenient war chest with which to defeat P's (assigned) claims for reimbursement. Also, GOT-U should not be

---

[54] RLLI, §14, Reporter's Note, b. *The duty to defend the whole action.*

[55] 16 Cal. 4th 35 (1997)

[56] *Id.,* 48-51.

allowed to use post-breach "discovery" to garner hindsight evidence regarding "non-coverage" of the post-breach settlement, as discussed above.

The court in *Buss* justified the insurer's duty to defend the entire "mixed" action prophylactically, as an obligation imposed by law:

> To defend meaningfully, the insurer must defend immediately. [citation] To defend immediately, it must defend entirely. It cannot parse the claims, dividing those that are at least potentially covered from those that are not.[57]

At the heart of the *Buss* decision is the concept that ***by defending*** the entire "mixed" action, as they are obligated in law to do, insurers were entitled to look back retroactively for allocation and reimbursement. It is hard to imagine the California Supreme Court, applying the logic of *Buss*, would tolerate a rule whereby GOT-U, a ***non-defending*** insurer would be permitted to look back at a post-breach settlement and demand evidence of "coverage."[58] The "look back" prerogative whereby insurers can seek reimbursement for settlements always presumes and is conditioned upon there having been no antecedent breach of the defense obligation.

D. GOT-U failed to defend; thus, it had no viable "Reservation of Rights" with which to later disclaim coverage even in the event of an adverse judgment against D; in the context of a post-breach *settlement,* GOT-U has no greater rights

Recall, GOT-U did not defend. It follows that GOT-U did not (and could not) "reserve" any rights to dispute or disclaim coverage even in the event of an adverse judgment against D. In the context of a post-breach settlement, setting aside that "coverage" is irrelevant, GOT-U's position seems even less tenable.

If a liability insurer's reservation of rights is to have any useful meaning, it must be in the context of its performance of its duty to defend or settle. It is universally understood that an insurer may accept defense of a lawsuit without raising any objection to coverage, but, by so doing, it waives its right to contest coverage at a later date.[59] In most jurisdictions, a

---

[57] *Buss v. Superior Court, supra,* 16 Cal. 4th at 49, 939 P.2d at 775.

[58] The same observation could be made about yet another Supreme Court case, *Johansen c. Calif. State Auto. Assn. Inter-Ins. Bur*., 15 Cal. 3d 9, 19 (1975) (stating that "if, having reserved its right to assert a defense of non-coverage and having accepted a reasonable [settlement] offer, the insurer subsequently established the non-coverage of its policy, it would be free to seek reimbursement of the settlement payment from its insured").

[59] *Truck Ins. Exchange v. Superior Court,* 51 Cal.App.4th 985, 993; 59 Cal.Rptr. 2d 529 (1996).

wrongfully non-defending insurer that purports to issue a reservation of rights is be deemed to have waived its "reserved" defenses to coverage.[60] The implied or deemed waiver rule discourages insurers who defend without reserving rights. They pose a potential risk of unfair prejudice to the insured who may be denied the right to protect its coverage interests.[61]

It's worth mentioning, Washington takes no back seat when it comes to strong pronouncements:

> We therefore hold that when an insurer wrongfully refuses to defend, it has voluntarily forfeited its ability to protect itself against an unfavorable settlement, unless the settlement is the product of fraud or collusion.[62]

The California Supreme court in two landmark cases provides that an insurer's defense under reservation of rights preserves an insurer's "due process" rights to later contest both its defense obligation and allows it, in the proper circumstances, to contest its settlement obligations.[63]

A rule allowing a wrongfully non-defending insurer to attempt to allocate a settlement (or judgments) discourages insurers from defending under reservation of rights. The liability insurer's reservation of rights exists to protect both the insurer and the insured by allowing an insurer who is under of its obligations under the policy to undertake a defense while reserving its rights to ultimately deny coverage.[64]

---

[60] See RLLI, §15, Reporter's Note a ("Although the requirement that the insurer must reserve its rights was originally grounded in estoppel, 'a review of the case law reveals it has since developed into a distinct doctrine that stands on its own.'" [citations omitted]); see also, Couch on Insurance, Third Edition, §239:107 ("It must be generally be shown by the party claim a waiver that the person against whom the waiver is asserted had, at the time, knowledge, actual or constructive, of the existence of his or her rights or all the material facts upon which they depended, and the same requirement applies to equitable estoppel").

[61] See RLLI, §15, Comment a; but see, *Standard Mut. Ins. Co. v. Lay*, 989 N.E.2d 591 (Ill. 2003) (rejecting "presumed prejudice" and requiring proof of prejudice to the insured).

[62] Thus stated the Supreme Court of Washington in *Truck Ins. Exchange v. VanPort Homes, Inc.* 147 Wash. 2d 751, 765-6 (2002).

[63] See, *Buss v. Superior Court (Transamerica Ins. Co.),* 16 Cal.4th 35 (1997) (preserving equitable right of defending insurer under reservation of rights to seek reimbursement of defense fees for clearly uncovered claims in mixed actions); *Blue Ridge Ins. Co. v. Jacoobsen*, 25 Cal. 4th 489 (2001) (preserving the equitable right of a settling insurer under reservation of rights to seek reimbursement of uncovered settlement amounts from the insured).

[64] *R.T. Vanderbilt Company, Inc. v. Hartford Accident & Indemnity Co.,* 156 A.3d 539, 621 (Conn.App. 2017).

V. Conclusion

As Insurers have known for decades, there are risks or perils to breaching the defense obligation. This paper addresses ***one*** such peril—perhaps the greatest peril in actual fact.

The thesis here is that upon breach, the insured has the right to enter into a reasonable and non-collusive settlement. The settlement creates presumptions of the insured's liability-in-fact and the amount thereof. The post-breach settlement should not be challenged on the basis it is not "covered" for the many compelling reasons explained above. The post-breach settlement established and quantified the insured's damages—period, full stop to the analysis.

That the insured's post-breach settlement included an assignment of all assignable at law claims against the insurer in consideration of a limited recourse provision or covenant not to execute is of no consequence. This is so because the assignment was not a "gift" to the third party claimant—it was a necessary transfer of property to resolve the dispute.

Insurers can and should self-protect by defending with reservations of rights. By so doing they will not be estopped from later disputing coverage in the event of an adverse judgment nor can they be deemed to have waived any right to do so.

Finally, recognizing that post-breach settlements need not be established as "covered" is fair and just. The judicial system can ill-afford countless "second suits" by insureds or their assignees wherein and whereby they are forced to prove an irrelevant or perhaps even impossible thing, namely, that a post-breach settlement is "covered." Insurers should not deprive their insureds of defenses which were contractually promised—nor should they use money "saved" as convenient war chests to defeat the pointless second suits. Finally, universal recognition of the "peril" of post-breach settlements will provide an appropriate incentive against breaches of the duty to defend.

AFTERWORD

The well-articulated issues and researched positions presented in the substantive paper are (mostly) presented from the policyholder perspective. The insurer side of these same issues, in and out of California, undeniably comes to very different conclusions on the public policy and legal premises presented. We leave the reader with certain comments and ideas for thought to aid a hopefully robust discussion at the May meeting.

The duty to defend and the duty to indemnify are separate obligations evaluated under different standards.[65] While a defense is owed for a claim potentially covered based on the allegations asserted, the duty to indemnify is a separate contractual obligation based on the actual facts. Under the hypothetical proposed, the assignee claimant stands in the shoes of the insured and is therefore entitled, under a breach of contract theory, to no greater coverage than the insured would have been entitled to receive. And, at least under some states' laws, "even if a liability insurer breaches its duty to defend, the party seeking indemnity still bears the burden to prove coverage if the insurer contests it."[66] Said differently, the doctrines of waiver and estoppel cannot be used to create insurance coverage where none exists under the terms of the policy. [67]

The *Pruyn* case cited in the paper does not say that an insurer must pay for non-covered damages. Rather it says that the insurer should pay for amounts that "cannot be attributed to uncovered claims." [68] Moreover, while settlement reached without the insurance carrier's consent may create a presumption of the insured's underlying *liability* in a situation in which the insurer breached its duty to defend, this presumption does not address whether such liability is for a covered event. California precedent, starting with *Lamb v. Belt Cas. Co.*,[69] has required proof of coverage for settled damages. [70]

Upon proof of a breach of the duty to defend, the insured or assignee is entitled to damages including defense costs but may not be entitled to the policy limit or amount of stipulated judgment unless there is first proof that the judgment is for a covered claim.[71] Of course, in California those costs may include the costs of *Cumis* counsel, the amount of the settlement for which there is coverage for such damage under the terms of the policy and

---

[65] *See King v. Dallas Fire Ins. Co*., 85 S.W.3d 185, 187 (Tex. 2002); *Trinity Univ. Ins. Co. v Cowan*, 945 S.W.2d 819, 821 (Tex. 1997).

[66] *Utica Nat. Ins. Co. v. American Indem. Co*., 141 S.W.3d 198 (Tex. 2004).

[67] *See, e.g., Texas Farmers Ins. Co. v. McGuire*, 744 S.W.2d 601, 602-03 (Tex. 1998).

[68] *Pruyn v. Agric. Ins. Co*., 36 Cal.App.4th 500, 42 Cal.Rptr.2d 295, 303 (1995), citing *Samson v. Transamerica Ins. Co*., 30 Cal.3d 220, 178 Cal.Rptr. 343, 636 P.2d 32, 44 (1981).

[69] 3 Cal.App.2d 624, 40 P.2d 311 (Cal. Ct. App. 1935)

[70] *See, e.g., Hogan v. Midland Nat'l Ins. Co.*, 3 Cal.3d 553, 476 P.2d 825 (Cal. 1970) and *Geddes & Smith, Inc. v. St. Paul Mercury Indem. Co.*, 51 Cal.2d 558, 561-62, 334 P.2d 881 (Cal. 1959). *See also Pruyn v. Agric. Ins. Co.*, 36 Cal.App.4th 500, 527-28, 42 Cal.Rptr.2d 295, 312 (Ct. App. 1995); *Xebec Dev. Partners, Ltd. v. National Union Fire Ins. Co.*, 12 Cal.App.4th 501, 545, 15 Cal.Rptr.2d 726, 749 (Ct. App. 1993), *disapproved on other grounds by Essex Ins. Co. v. Five Star Dye House, Inc.*, 38 Cal.4th 1252, 1265 n. 4, 137 P.2d 192, 199 n. 4, 45 Cal.Rptr.2d 362, 371 n. 4 (Cal. 2006).

[71] *See Pruyn*, 36 Cal.App.4th at 513, 42 Cal.Rptr.2d at 302.

interest. In Texas, the insured would be entitled to defense costs plus statutory penalties of 18 percent per annum for unpaid defense costs, plus interest for a breach of contract.[72]

Jean M. Lawler

Ellen Van Meir

[72] *See* Tex. Ins. Code §542.060.

Bad Faith Is Fairly Debatable

American College of Coverage Counsel
2020 Annual Meeting

September 24, 2020

G. David Godwin
Melanie Cockrum
Squire Patton Boggs (US) LLP
San Francisco, California 94111

I. Introduction to the Genuine Dispute Doctrine and Fairly Debatable Doctrine

Implied in every contract, including insurance contracts, is the covenant of good faith and fair dealing. How that obligation affects an insurer's liability to its policyholder is dependent on the particular state's laws applicable to the coverage dispute at issue. Some states afford the policyholder a separate tort cause of action for breach of the implied covenant, opening up recovery for consequential damages. Other states confine it to breach of contract claims. Moreover, the level of conduct necessary to establish bad faith varies. This article does not attempt to provide a survey of bad faith law generally. Rather, we focus on the issue of whether an insurer may avoid a finding of bad faith when its coverage decision, although ultimately found to be incorrect, was reasonable or fairly debatable in light of the facts or law known at the time. This defense is often referenced as the genuine dispute or fairly debatable doctrine.

In California, courts hold that the genuine dispute doctrine is an affirmative defense offering an insurer protection from bad faith when there is a genuine dispute as to the existence or amount of coverage. *Wilson v. 21st Century Ins. Co.*, 42 Cal.4th 713, 723 (2007). Other states hold that an insurer may not be liable for bad faith if the insured's claim is fairly debatable, that is if there is a reasonable basis for denying the claim. *See e.g. National Sec. Fire & Cas. Co. v. Bowen*, 417 So.2d 179 (Ala. 1982); *Noble v. National Am. Life Ins. Co.*, 624 P.2d 866 (Ariz. 1981); *Sanderson v. Am. Fam. Mut. Ins. Co.*, 251 P.3d 1213 (Colo.App.2010); *Empire Fire & Marine Insurance Company v. Simpsonville Wrecker Service, Inc.*, 880 S.W.2d 886 (Ky.App. 1994); *Windmon v. Marshall*, 926 So.2d 867, 872 (Miss. 2006); *Safeco Ins. Co. v. Ellinghouse*, 223 Mont. 239, 248, 725 P.2d 217 (Mont. 1986); *Niver v. Travelers Indem. Co. of Illinois*, 412 F. Supp. 2d 966, 977 (N.D. Iowa 2006); *Fetch v. Quam*, 623 N.W.2d 357, 366 (N.D. 2001); *Badiali v. New Jersey Mfrs. Ins. Grp.*, 220 N.J. 544 (2015); *Fetch v. Quam*, 623 N.W.2d 357 (N.D. 2001);; *Skaling v. Aetna Ins. Co.*, 799 A.2d 997 (R.I. 2002); State *Farm Fire & Cas. Co. v. Barton*, 897 F.2d 729, 731 (4th Cir. 1990) (South Carolina); *Dakota, Minnesota & Eastern R.R. Corp. v. Acuity*, 771 N.W.2d 623 (S.D. 2009); *Jones v. Farmers Ins. Exch.*, 286 P.3d 301 (Utah 2012); *Cuna Mutual Ins. Society v. Norman*, 375 S.E.2d 724, 726-27 (Va. 1989); *Anderson v. Continental Ins. Co.*, 271 N.W.2d 368 (Wis. 1978); *First Wyoming Bank, N.A., Jackson Hole v. Continental Ins. Co.*, 860 P.2d 1094 (Wyo. 1993).

While Ohio and Oklahoma do not use the term "fairly debatable," the standard is similar: a decision to withhold or delay payment, if based on a legitimate dispute or reasonable justification (legal or factual) cannot form the basis of bad faith tort liability. *Barnes v. Oklahoma Farm Bureau Mut. Ins. Co.*, 11 P.3d 162, 171 (Okla. 2000); *Zoppo v. Homestead Ins. Co.*, 71 Ohio St. 3d 552(1994) ("reasonable justification" standard)

A. Which Party has the Burden?

In some states, the burden is placed on the insured to show that the claim was not fairly debatable. *See e.g., Weinstein v. Prudential Prop. and Cas. Ins. Co.*, 233 P.3d 1221, 1237 (Idaho 2010) ("In order for a first-party insured to recover on a bad faith claim, the insured must show . . . 2) the claim was not fairly debatable . . . ."); *Kmart Corp. v. Footstar, Inc.*, No. 09 CV 3607, 2013 WL 6670746, *2 (N.D. Ill. Dec. 18, 2013) (applying New Jersey law the court held the insured must show that "no debatable reason existed for the denial of benefits.");

In contrast, California law provides the genuine dispute doctrine is an affirmative defense for which the insurer carries the burden. *See Gaylord v. Nationwide Mutual Insurance Co.*, 776 F. Supp. 2d 1101, 1124-1127 (E.D. Cal. 2011) (applying California law, the Eastern District of California found that the genuine dispute doctrine can act as an affirmative defense when an insured contends the insurer breached its duty to indemnify and defend).

Whoever has the burden, the determination of whether the genuine dispute/fairly debatable doctrines applies is typically measured by an objective standard. *See Wilson*, 42 Cal.4th at 724, fn. 7; Iowa: *Dolan v. Aid Ins. Co.*, 431 N.W.2d 790, 794 (Iowa 1988) (finding that the test for bad faith "creates an objective standard and makes clear the intentional nature of the tort"); Wisconsin: *Anderson v. Continental Ins. Co.*, 271 N.W.2d 368, 376 (Wis. 1978) (finding that the tort of bad faith is intentional and relies on an objective standard); South Carolina *State Farm Fire & Cas. Co. v. Barton*, 897 F.2d 729, 731 (4th Cir. 1990) (applying South Carolina law which provides that there must be an objectively reasonable basis for denying an insured's claim); Utah: *Campell v. State Farm Mut. Auto. Ins. Co.*, 840 P.2d 130, 139-40 n.16 (Utah App. 1992) (using an objective standard to determine if the insurer's decisions were "reasonable or unreasonable under all the circumstances"); *but see* Arizona: *Bronick v. State Farm Mut. Auto. Ins. Co.*, No. CV-11-01442-PHX-JAT, 2013 WL 3716600, *4-*5 (D. Ariz. July 15,

2013) (using both an objective standard to determine if the insurer's actions were objectively reasonable and a subjective standard to determine if the insurer's conduct was "consciously unreasonable").

B. Requirement of an Adequate Investigation

The genuine dispute/fairly debatable doctrines do not relieve insurance companies of their obligations to conduct reasonable and thorough investigations. Generally, even if a claim is fairly debatable or if there exists a genuine dispute, the insurer must still exercise reasonable care in its investigation of the claim. *See Skaling v. Aetna Ins. Co.*, 799 A.2d 997, 1010 (R.I. 2002) ("An insurer has a responsibility to assemble all the facts necessary for a fair and comprehensive investigation *before* it refuses to pay a claim . . . ."); *Zilisch v. State Farm*, 196 P.2d 276, 280 (2000) ("The carrier has an obligation to immediately conduct an adequate investigation . . . ."); *Anderson v. Western Nat'l Mut. Ins. Co.*, 857 F. Supp. 2d 896, 904 (D.S.D. 2012) ("if an insurer conducted an inadequate investigation of a claim, and, by doing so, failed to locate information indicating that the plaintiff was entitled to benefits, then the claim may not be fairly debatable . . . ."); *Fetch v. Quam*, 623 N.W.2d 357, 365 (N.D. 2001) ("An insurer does not act in bad faith by a reasonable investigation of a claim which is fairly debatable.").

As a thorough investigation is required in order to establish the applicability of the genuine dispute doctrine. Examples of evidence that could show a biased investigation, which would make the genuine dispute doctrine inapplicable, include: (1) the insurer was guilty of misrepresenting the nature of the investigatory proceedings; (2) the insurer's employees lied during the depositions or to the insured; (3) the insurer dishonestly selected its experts; (4) the insurer's experts were unreasonable; and (5) the insurer failed to conduct a thorough investigation. While a thorough report from an insurer's independent expert to support the genuine dispute doctrine, this is not automatic insulation from bad faith claims. *Keshish v. Allstate Ins. Co.*, 959 F. Supp. 2d 1226 (C.D. Cal. 2013).

II. Application of the Genuine Dispute/Fairly Debatable Doctrines to Issues of Law or Fact

For the states that follow the genuine dispute/fairly debatable doctrine, they appear to uniformly apply the defense to disputed questions of law. Recently, some states have also applied the defense to questions of fact.

A. Question of Law

As applied to questions of law, insurers may refuse to defend in circumstances where there is a sufficient basis in the law for taking such a position. An insurer cannot be held in bad faith on a reasonable but incorrect interpretation of law. *See, e.g., New England Env't Techs. v. American Safety Risk Retention Grp., Inc.*, 738 F. Supp. 2d 249, 259 (D.Mass. 2010) (finding no bad faith where insurer's position was "based on a 'plausible interpretation of the policy's terms); *Brown v. Labor and Industry Review Comm'n*, 671 N.W.2d 279 (Wis. 2003) (concluding there was no bad faith when there was a reasonable conclusion based on a question of law was reached, even if different conclusions were more reasonable); *United States Fire Ins. Co. v. Williams*, 955 S.W.2d 267, 269 (Tex. Sup. Ct. 1997) (finding that the insurer's interpretation of a rule was "at least arguable" as three out of five Commission reviewing officers had the same interpretation); *Aetna Cas. & Sur. Co. v. Superior Court*, 788 P.2d 1333, 1336 (Az. App. Div. 1989) (concluding that the insurer's denial of coverage was reasonable because two courts agreed even though the outcome of the question on appeal was different); *but see Hayes v. Acuity*, No. CV 17-5015-JLV, 2020 WL 1322269, *9 (D.S.D. March 20, 2020) (denying insurer's motion for summary judgment regarding the insured's bad faith claim because the insurer's "legal duty was not fairly debatable" because its "obligation was clear from the statutory language alone").

B. Question of Fact

Wisconsin, Alabama and Iowa allow the fairly debatable doctrine for matters of fact and matters of law. "When a claim is 'fairly debatable,' the insurer is entitled to debate it, whether the debate concerns a matter of fact or law." *Anderson v. Continental Ins. Co.*, 271 N.W.2d 368, 376–77 (Wis. 1978); *see also National Sec. Fire & Cas. Co. v. Bowen*, 417 So.1d 179, 183 (Ala. 1982); *M-Z Enters., Inc. v. Haweye-Security Ins. Co.*, 318 N.W.2d 408, 415 (Iowa 1982).

The Iowa Supreme Court more recently stated, "where an objectively reasonable basis for denial of a claim *actually exists*, the insurer cannot be held liable for bad faith as a matter of law." *Bellville v. Farm Bureau Mut. Ins. Co.*, 702 N.W.2d 468, 473 (Iowa 2005) (citations and quotations omitted) (emphasis in original).

In California, the genuine dispute doctrine was once limited to legal issues. For nearly twenty years, however, California has applied the doctrine to questions of fact, stating, "we see no reason why the genuine dispute doctrine should be limited to legal issues." *Chateau Chamberay Homeowners Ass'n v. Associated Int'l Ins. Co.*, 90 Cal.App.4th 335, 348 (2001).

Oklahoma courts have also applied this to questions of fact, stating, "a claim must be promptly paid unless the insurer has a reasonable belief the claim is either *legally* or *factually* insufficient." *Barnes*, 11 P.3d at 171 (emphasis added).

There appears to be an interplay between the applicability of these doctrines to legal vs. factual issues depending on whether the claim involves first party or liability coverage. Generally, these doctrines are applicable to both legal and factual issues for first party claims. First-party policies often allow for a broader investigation, including reviewing the insured's records and examining the insured under oath. Courts are more likely the permit an insurer to use these doctrines with first party claims for legal and factual issues because an insured is not being held liable and there is no risk of increasing the insured's exposure. For third party claims, the defense is typically limited to disputed questions of law. For example, California courts have stated that "[i]t is doubtful that the so-called 'genuine dispute doctrine' applies in third-party duty to defend cases." *Mt. Hawley Ins. Co. v. Lopez*, 215 Cal.App.4th 1385, 1425 (2013). This is understandable since the duty to defend is dependent on the existence of a potential for coverage. Further, "it has never been held that an insurer in a third party case may rely on a genuine dispute over coverage to refuse settlement." *Howard v. American Nat'l Fire Ins. Co.*, 187 Cal.App.4th 498 (2010). However, the Ninth Circuit has applied the genuine dispute doctrine to an issue of duty to defend. *See Lunsford v. American Guar. Liab. Ins. Co.*, 18 F.3d 653, 654 (9th Cir. 1994); *see also Vaid-Raizada v. Lexington Nat'l Ins. Co.*, 2009 U.S. Dist. LEXIS 76314, *4–*5 (C.D. Cal. Aug. 12, 2009) ("Courts have consistently applied the 'genuine dispute' rule in assessing bad faith tort claims on the duty to defend.").

Utah has also applied the fairly debatable standard to third-party insurance bad faith claims. *See Allegis Inv. Servs., LLC v. Arthur J. Gallagher & Co.*, 371 F. Supp. 3d 983 (D. Utah 2019.)

In contrast, a New Jersey court rejected application of the fairly debatable standard in the context of a third party claim. *See State Nat'l Ins. Co. v. County of Camden*, 10 F.Supp.3d 568, 584 (N.J. 2014) (holding the fairly debatable standard does not apply to claims involving a potential for an excess of limits verdict against the insured).

IV. How Are The Doctrines Utilized?

The genuine dispute/fairly debatable doctrines typically have one of three uses: (a) they can serve as a complete defense to bad faith claims; (b) the existence of a genuine dispute/fairly debatable issue of law or fact is but a factor in the analysis of bad faith; and (c) they may counter a rebuttable presumption of unreasonableness.

A. Complete Defense to Bad Faith Claims

A number of courts hold that the genuine dispute/fairly debatable doctrines may provide a complete defense to a bad faith claim. For example, in *Kmart Corp. v. Footstar, Inc.*, No. 09 CV 3607, 2013 WL 6670746, *4 (N.D. Ill. Dec. 18, 2013) (applying New Jersey law), a customer, injured by a falling infant car seat, sued Kmart and later Footstar because it was believed both companies had employees involved in the accident. *Id.*, at *1. Footstar's insurer, Liberty Mutual Fire Insurance Company, defended Footstar in the action but refused to defend or indemnify Kmart as an additional insured in the action. *Id.*, at *2. Kmart then settled the underlying action and sought reimbursement for the settlement amount from Footstar and Liberty. *Id.* On a motion for summary judgment, the court held that Liberty's duty to defend was triggered on the date Kmart requested coverage, and for the duty to indemnify, it was unclear as to whether Footstar was implicated in the underlying accident, requiring a trial to determine fault. *Id.*, at *2-*3. Kmart now claimed that Liberty acted in bad faith when it refused to indemnify and defend the underlying case. *Id.*, at *3. The court explained that even when summary judgment is granted finding coverage, "if the coverage issue was still 'fairly debatable' at the time, the insurer's decision does not constitute bad faith." *Id.* Due to differing accounts of the underlying incident, the insurer's position "was not so 'obviously

incorrect'" as "there was the potential that the accident did not involve Footstar's work." *Id.* Additionally, Liberty's refusal to indemnify could not be held to be in bad faith as "Kmart could not establish as a matter of law a right to summary judgment," a requirement under New Jersey case law. *Id.*, at *3-*4. As the court was unable to resolve the issue as a matter of law on summary judgment, the court could not extend bad faith to Liberty's refusal to indemnify. *Id.*, at *4; *see also Gaylord v. Nationwide Mutual Insurance Co.*, 776 F. Supp. 2d 1101, 1105, 1127 (E.D. Cal. 2011)(The court found (The court determined that summary judgment in favor of the insurer on the bad faith claim was appropriate because the insurer had conducted an adequate investigation and based on that investigation and a reasonable construction of the policy determined that the cattle was not included in the policy.)

B. One Factor in a Bad Faith Analysis

Oklahoma is among the states that do not allow its version of the fairly debatable doctrine to serve as a complete defense to a bad faith claim. Instead, Oklahoma courts may consider a legitimate dispute or reasonable justification as a factor in determining bad faith. The insurer in *Haberman v. The Hartford Insurance Group*, 443 F.3d 1257, 1269 (10th Cir. 2006), argued that because there was a legitimate dispute regarding coverage, it could not be found to have acted in bad faith. However, the 10th Circuit, applying Oklahoma law, has held that a "legitimate dispute as to coverage will not act as an impenetrable shield against a valid claim or bad faith." *Timberlake Constr. Co. v. U.S. Fidelity & Gaur. Co.*, 71 F.3d 335, 242 (10th Cir. 1995). If the insurer did not actually rely on an existing legitimate defense, a plaintiff may bring a bad faith action. *Haberman*, 443 F.3d at 1270. In *Haberman*, the issue identified by the insurer in its motion for summary judgment was whether Plaintiff was an insured under the policy for purposes of underinsured motorist coverage; however, in its denial letter, the insurer stated that it denied the claim because Plaintiff was not riding in a "covered vehicle" at the time of the accident. The court found that "the 'legitimate' reason for denying [Plaintiff's] claim [was] different from the reason [Plaintiff] was given;" therefore, it was appropriate for the district court to deny the insurer's motion for summary judgment on the bad faith claim. *Id.* at 1270-1271. *See also Wolf v. Prudential Ins. Co.*, 50 F.3d 793, 796 (10th Cir. 1995) (finding that even

though an insurer has a reasonable interpretation of an ambiguity in a policy, this does not mean the insurer acted reasonably if it construed the ambiguous term against the insured).

The court in *Barnes v. Oklahoma Farm Bureau Mutual Insurance Co.*, 11 P.3d 162 (Okla. 2000), stated that in an action for bad faith, "it is the unreasonableness of the insurer's actions that is the essence of the tort." *Id.* at 174. Further, even though reliance on counsel's advice can be a defense to a bad faith claim, "the reliance on counsel's advice must be reasonable." *Id.* Additionally, "advice of counsel is but one factor to be considered in deciding whether the carrier's reason for denying a claim was arguably reasonable." *Id.* (citations removed). In *Barnes*, insurer counsel's advice conflicted with the Oklahoma Supreme Court's prior expression of the meaning of an underinsured motorist statute, and the court found this position was "absolutely insupportable." *Id.*

In *Zilisch v. State Farm Mutual Automobile Insurance Co.*, 995 P.2d 276, 279 (Ariz. 2000), the Arizona Supreme Court, en banc, held that "in defending against a fairly debatable claim, an insurer must exercise reasonable care and good faith." That action involved a first-party bad faith claim regarding underinsured motorist coverage. The insurer argued that the extent of the injuries and thus the value of the claim was fairly debatable. However, the insurer did not evaluate the claim or offer to settle the claim until almost ten months after receiving the demand, the insurer's claim that it was waiting for an expert report was unreasonable because it had reports from several other physicians, and the insurer did not ask for an independent medical examination until after it had offered to settle the claim. *Id.* at 280. The court of appeals essentially stated that as long as the amount offered to the insured is fairly debatable, "nothing else [the insurer] does in investigating the claim, evaluating the claim, and paying the claim really matters." *Id.* at 279. The court of appeals held that the fairly debatable doctrine was a "'threshold question' which is outcome determinative." *Id.* The Arizona Supreme Court, however, reversed, finding that the court of appeals "erred in concluding that fair debatability is both the beginning and the end of the analysis." *Id.* at 280. The court set out the appropriate inquiry for bad faith, looking at the insurer's "investigation, evaluation, and processing of the claim" to determine if "the insured acted unreasonably and either knew or was conscious of the fact that its conduct was unreasonable." *Id.* Further, "while fair debatability is a necessary

condition to avoid a claim of bad faith, it is not always a sufficient condition." *Id.* at 281. The court concluded that the trial court was correct by submitting the case to a jury because there was sufficient evidence for a jury to find that the insurer acted unreasonably and knew it acted unreasonably. *Id.* at 280-81.

The Colorado Court of Appeals, in *Sanderson v. American Family Mutual. Insurance Co.*, 251 P.3d 1213, 1216 (Colo. 2010), chose to follow the standard in *Zilisch* in a similar first-party bad faith action in Colorado. The trial court granted summary judgment for the insurer because the claims were fairly debatable, as there were genuine issues concerning the facts establishing liability and a legal issue as to the amount owed under the policy. The Court of Appeals reversed, following the standard set forth in *Zilisch* the court held that "fair debatability is not a threshold inquiry that is outcome determinative as a matter of law, nor is it both the beginning and the end of the analysis in a bad faith case. *Id.* at 1218 (quoting *Zilisch*, 977 P.2d at 279–80).

Other courts have similarly followed the standard in *Zilisch*. *See, e.g., Skaling v. Aetna Ins. Co.*, 799 A.2d 997, 1011 (R.I. 2002); *Allen v. State Farm Mut. Auto. Ins. Co.*, No. 3:15-cv-0019-HRH, 2018 WL 1474526, *5 (D. Alaska March 26, 2018); *Farmland Mut. Ins. Co. v. Johnson*, 36 S.W.3d 368, 375 (Ky. 2000).

C. Dispute a Rebuttable Presumption of Unreasonableness

Less common is the application of the fairly debatable doctrine as a way to dispute a rebuttable presumption of unreasonableness. In Michigan, attorneys' fees are allowed against the insurer if a court finds the insurer "unreasonably refused to pay the claim or unreasonably delayed in making proper payment." Mich. Comp. Laws § 500.3148(1). If the insurer refuses or delays paying benefits, a rebuttable presumption of unreasonableness is created. *Durmishi v. National Cas. Co.*, 720 F. Supp. 2d 862, 873 (2010). The insurer has the burden of showing that the initial refusal or delay of payment was caused by a legitimate question of law or fact at the time of the initial refusal or delay. *Id.* (quoting *Ross v. Auto Club Grp.*, 748 N.W.2d 552, 558 (2008).) In *Durmishi*, the insured refused to undergo a medical and psychological examination as required under Michigan law and the insurance policy. The insurer claimed the extent of the insured's injuries was fairly debatable. However, the insurer removed the case to federal court prior to seeking the examinations, and the insured insisted compliance with the federal rules

surrounding these types of examinations. The court determined that "[t]he plaintiff's insistence on compliance with Rule 35 does not by itself justify the defendant's delay in payment of benefits that otherwise were 'overdue.'" *Durmishi*, 720 F. Supp. 2d at 877. Further, the court stated that the insurer may be able to rebut the presumption of unreasonableness. *Id.*

V. Conclusion

The genuine dispute and fairly debatable doctrines can be powerful tools for insurance companies when facing potential bad faith claims. Depending on which state's laws apply, these doctrines may be used for matters of law or fact and in defense of first party or third party bad faith claims. Policyholders may hedge against application of these doctrines by focusing on the insurer's investigation of the claim, which generally must be adequate and thorough regardless of whether a genuine dispute or fairly debatable defense to coverage is available.

First-Party Insurance Disputes, Alternative Dispute Resolution Mechanism and Issues with Umpires and Appraisers

American College of Coverage Counsel

2020 Annual Meeting

Virtual Conference
September 10-11 & 24-25, 2020

Wayne D. Taylor
Mozley, Finlayson & Loggins LLP
Atlanta, GA
WTaylor@MFLLaw.com

Melissa Sims
Buke, Merchant and Sims PLC
Miami, FL
MSims@berklawfirm.com

Mark Boyle
Boyle, Leonard & Anderson P.A.
Fort Myers, Florida
mboyle@insurance-counsel.com

Christine Haskett
Covington & Burling, LLP
San Francisco, CA
chaskett@cov.com

IMPARTIALITY IN THE APPRAISAL PROCESS

I. OVERVIEW OF APPRAISAL

Appraisal under a first-party property insurance policy is meant to be an efficient and cost-effective manner in which to resolve disagreements over the amount of a loss. Appraisal provisions are almost uniformly included in property insurance policy forms. A bona fide disagreement over the amount of the loss is required in order for one of the parties to the policy to demand appraisal. Once invoked by one of the parties, appraisal is mandatory in most jurisdictions. Although the language can vary, the typical appraisal clause reads as follows:

> Appraisal
>
> If we and you disagree on the value of the property or the amount of the "loss," either may make written demand for an appraisal of the "loss." In this event, each party will select a competent and impartial appraiser. You and we must notify the other of the appraiser selected within twenty days of the written demand for appraisal. The two appraisers will select an umpire. If the appraisers do not agree on the selection of an umpire within 15 days, they must request selection of an umpire by a judge of a court having jurisdiction. The appraisers will state separately the value of the property and the amount of the "loss." If they fail to agree, they will submit their differences to the umpire. A decision agreed to by any two will be the appraised value of the property or amount of "loss." If you make a written demand for an appraisal of the "loss," each party will:
>
> a. Pay its chosen appraiser; and
> b. Bear the other expenses of the appraisal and umpire equally.

The appraisal process is extrajudicial, so it avoids the procedural nuances associated with most lawsuits.

Appraisal should not be confused with arbitration. Arbitration can encompass an entire controversy between parties. Appraisal is more narrow in scope; it does not resolve issues of coverage or other policy interpretation. Instead, appraisal is limited to determining the amount of the loss sustained, although some states permit the appraisers to determine causation. Appraisal also is much less formal. Indeed, there are no rules about how appraisal is conducted except for what is contained within the policy's appraisal provision itself.

Once appraisal is invoked, each of the parties much appoint an appraiser. The credentials for the appraisers are set forth in the policy's appraisal provision. Most policies restrict the qualification to a "competent and impartial appraiser." Other policies require each party to appoint a "competent and disinterested" or "competent and independent" appraiser.

II. APPRAISER QUALIFICATIONS

A. Competent Appraisers

The appraiser first must be competent. Competent is defined as "having suitable or sufficient skill, knowledge, experience, etc., for some purpose; properly qualified." www.dictionary.com. Merriam-Webster defines competent as "having requisite or adequate ability or qualities." www.merriam-webster.com. It is common that the parties will designate appraisers who are industry experts in the particular area of a dispute, such as a forensic accountant for a disagreement over the amount of a business interruption loss. A forensic accountant may not, however, be a competent appraiser for a dispute over the cost to repair building damages.

B. Disinterested or Impartial Appraisers

The policy also requires that each appraiser be "disinterested" or "impartial." Courts across the country continue to develop the law regarding what it means to be a "disinterested" or "impartial" appraiser in the context of appraisal under an insurance policy. But, in reality and practice, is there an actual distinction between the terms "disinterested" and "impartial?" Black's Law Dictionary defines "disinterested" as "'[f]ree from bias, prejudice, or partiality . . . not having a pecuniary interest in the matter at hand." Black's Law Dictionary (11th ed. 2019). "Impartial" is defined as "not favoring one side more than another; unbiased and disinterested; unswayed by personal interest." Based on the dictionary definitions of these terms, there does not seem to be much difference between a "disinterested" and "impartial" appraiser. Nevertheless, the answer will ultimately depend on the jurisdiction in which your case is pending.

1. Disinterested

Florida courts, in particular, have attempted to define "disinterested" in the context of the insurance appraisal process. Recently, Florida's Third District Court of Appeal, in ***State Farm Fla. Ins. Co. v. Sanders***, No. 3D19-927, 2020 Fla. App. LEXIS 5033, 45 Fla. L. Weekly 870 (Fla. 3d DCA 2020), denied State Farm Florida Insurance Company's request for a writ of certiorari to quash a Miami-Dade Circuit Court order that permitted homeowners Charles and Diana Sanders to appoint their public adjuster as their "disinterested" appraiser. The Sanders filed suit against State Farm alleging breach of contract for failure to pay their Hurricane Irma property damage claim. In response to the complaint, State Farm filed a motion to invoke appraisal under the insurance policy's appraisal provision, claiming that there was a pre-suit dispute regarding the Sanders' designated appraiser. The appraisal provision in the State Farm policy stated that, "Each party will select a qualified, disinterested appraiser . . . ." The parties entered into an agreed order granting the motion to invoke appraisal, which named State Farm's appraiser and required the Sanders to designate their "qualified, disinterested appraiser." The Sanders

chose their public adjuster, with whom they had entered into a contract that assigned 10% of the insurance proceeds recovered, to serve as their appraiser. State Farm moved to stay the appraisal because the Sanders' public adjuster did not qualify as a disinterested appraiser. The Sanders filed a motion to lift the stay and compel compliance with the order of appraisal, which the trial court granted.

In its original July 24, 2019 order, Florida's Third District Court of Appeal granted State Farm's petition for writ of certiorari to quash the trial court's order compelling appraisal and allowing the Sanders' public adjuster to act as their "disinterested" appraiser, holding that a public adjuster who is in a contractual agent-principal relationship with the insureds cannot be "disinterested" as a matter of law. ***State Farm Fla. Ins. Co. v. Sanders***, No. 3D19-927, 2019 Fla. App. LEXIS 11655, at *10-11 (Fla. 3d DCA July 24, 2019). In reaching its original decision, the court relied on the definition of "disinterested" adopted by the Fifth District Court of Appeal in ***Florida Insurance Guaranty Ass'n v. Branco***, 148 So. 3d 488, 490 (Fla. 5th DCA 2014) – "'[d]isinterested' is defined as '[f]ree from bias, prejudice, or partiality; not having a pecuniary interest.'" ***Id.*** at 5-6 (quoting ***Branco***, 148 So. 3d at 496 n.9).

The Sanders moved for a rehearing, which the court granted. The court then withdrew its original opinion and denied State Farm's petition because "the trial court did not depart from the essential requirements of the law because its order followed this Court's existing precedent in ***Rios v. Tri-State Insurance Company***, 714 So. 2d 547 (Fla. 3d DCA 1998) and ***Galvis v. Allstate Insurance Company***, 721 So. 2d 421 (Fla. 3d DCA 1998)." ***Id.*** at *2. ***Rios*** and ***Galvis*** both hold that a "direct or indirect financial or personal interest in the outcome of the [appraisal]" does not require the disqualification of an appraiser so long as the appraiser's financial interest is disclosed. ***Rios***, 714 So. 2d at 550; *see* ***Galvis***., 721 So. 2d at 421. The ***Sanders*** court, however, noted that its scope and standard of review was narrow because the issue was presented by a petition for writ of certiorari. The court stated, "[i]t is possible that our decision might be different had the question before us been presented by way of a plenary appeal." ***Id.*** at *5.

The court also acknowledged the express conflict between the Third District Court of Appeals' decisions of ***Rios*** and ***Galvis*** and the Fifth District Court of Appeal's decisions in ***State Farm Florida Insurance Co. v. Cadet***, 290 So. 3d 1090 (Fla. 5th DCA 2020) (holding that insured's public adjuster, who was under a contingency fee agreement, could not act as "disinterested" appraiser) and ***State Farm Florida Insurance Co. v. Crispin***, 290 So. 3d 150 (Fla. 5th DCA 2020) (holding that insured's appraiser, who was entitled to a ten percent contingency fee of any proceeds received in the same insurance claim, was not "disinterested"), and the decision of the Fourth District Court of Appeal in ***State Farm Florida Insurance Co. v. Valenti***, 285 So. 3d 958 (Fla. 4th DCA 2019) (holding that insured's public adjuster could not later be appointed as a "disinterested" appraiser based on his actions during the investigation of the claim and financial interest). Consequently,

it certified the following question directly to the Florida Supreme Court as one of "great public importance":

> CAN A FIDUCIARY, SUCH AS A PUBLIC ADJUSTER OR APPRAISER WHO IS IN A CONTRACTUAL AGENT-PRINCIPAL RELATIONSHIP WITH THE INSUREDS AND WHO RECEIVES A CONTINGENCY FEE FROM THE APPRAISAL AWARD, BE A **DISINTERESTED** APPRAISER AS A MATTER OF LAW?

Id. at *8 (emphasis added).[1] We now await a ruling from the Florida Supreme Court, which will have significant consequence on future insurance appraisals.

Courts in other jurisdictions have determined that a party's appraiser is not "disinterested" if he or she is frequently employed by the party as an appraiser or has a financial interest, even if indirect, in the outcome of the appraisal. For instance, in ***TAMKO Building Products, Inc. v. Factory Mutual Insurance Co.***, 890 F. Supp. 2d 1129 (E.D. Mo. 2012), the United States District Court for the Eastern District of Missouri found that the appraiser selected by Factory Mutual was "interested as a matter of law." ***Id.*** at 1140. The court based its decision on the fact that the appraiser asked Factory Mutual for advice on the umpire selection, submitted his draft presentation for the appraisal hearing to Factory Mutual for its review and edit, and sought approval from Factory Mutual about whether he should agree to the amount calculated by the umpire. The court also found that Factory Mutual's appraiser had a financial interest in the outcome of the appraisal although he was not receiving a contingency fee, based upon his "ongoing and future business prospects" with Factory Mutual, as demonstrated by the twenty-six (26) matters on which he previously worked for Factory Mutual, that his accounting firm's work for Factory Mutual constituted 4-7% of the accounting firm's annual income, that he had outstanding accounts with Factory Mutual totaling $940,000.00, and that he hosted dinners, lunches, and sporting events with Factory Mutual employees. ***Id.*** at 1141.

Other courts have focused on employment relationships between a party and its appointed appraiser in determining whether the appraiser should be considered "disinterested." *See* ***Tiger Fibers, LLC v. Aspen Specialty Ins. Co.***, 571 F. Supp. 2d 712, 717 (E.D. Va. 2008) (finding that under statute governing parties' appointment of disinterested appraisers to assess insurance losses, "the disinterestedness of a selected appraiser pertains only to the partiality of that appraiser for or against the specific parties in issue . . . only permanent employees of a party to the dispute, as contrasted with persons temporarily retained by the parties, lack the disinterestedness required by the statute."); ***Gebers v. State Farm Gen. Ins. Co.***, 38 Cal. App. 4th 1648, 45 Cal. Rptr. 2d 725 (1995)

[1] That same question was posed to the Florida Supreme Court by the Third District Court of Appeal in ***State Farm Fla. Ins. Co. v. Long***, No. 3D19-1593, 2020 Fla. App. LEXIS 11330 45 Fla. L. Weekly 1923 (Dist. Ct. App. 2020).

(finding that insurer-selected appraiser was not "disinterested" within the meaning of the statute based upon his direct pecuniary interest as an expert witness for insurer in two pending court actions). Therefore, depending on the jurisdiction, a prior or ongoing relationship between an appraiser and a selecting party may support a finding that an appraiser is not "disinterested."

2. Impartial

Some policies require that an appraiser is "impartial." Several recent decisions outline how courts evaluate an appraiser's "impartiality."

In ***Owners Ins. Co. v. Dakota Station II Condo. Ass'n***, the Colorado Supreme court interpreted the term "impartial" as used in an insurance policy's appraisal provision, finding that, based on the term's plain meaning, an appraiser must "be unbiased, disinterested, and unswayed by personal interest." 2019 CO 65, ¶ 1, 443 P.3d 47, 51. The court noted that an "impartial" appraiser cannot favor one side over the other or advocate on behalf of either party. The Colorado Supreme Court drew a distinction between advocating for a party and taking a position, explaining that an appraiser can defend his choice of methodology or use certain data, or explain why he or she disagrees with the other appraiser's methodology or selection of data, but he or she cannot simply seek to maximize the award for the party that retained him. The Colorado Supreme Court stated:

> [W]e acknowledge a distinction between advocating for a party and explaining a position. An appraiser can certainly explain her position without running afoul of the provision's impartiality requirement. An appraiser may, for example, defend her choice of methodology or use of certain data. Conversely, an appraiser may explain why she feels another appraiser's methodology or use of data is wrong. In neither instance would the appraiser necessarily be acting as an advocate *on behalf of* a party to the dispute. An appraiser advocates *for* or *on behalf of* a party when her actions are motivated by a desire to benefit a party. For example, if an appraiser simply seeks top dollar for a client, that is improper. In contrast, explaining a position or defending a choice in methodology can be motivated by a desire to reach an accurate outcome.

Id. 43 P.3d at 53 (emphasis in original). Based on this reasoning, the Colorado Supreme Court reversed the lower court's decision and remanded so the trial court could determine whether the appraiser's conduct conformed to this standard.

The court then addressed the issue of whether contingent-cap fee agreements that tie an appraiser's compensation to the ultimate appraisal award render the appraiser partial as a matter of law. Although "wary of the possible incentives these agreements create," the

Colorado Supreme Court declined to hold that contingent-cap fee agreements render an appraiser partial as a matter of law. On the particular facts of the ***Dakota Station II*** case, the court found that the appraiser's contingent-cap fee agreement (5% of the overall award) did not give her an impermissible financial interest in the outcome of the appraisal award because the final appraisal award was far in excess of the actual fees billed by the appraiser and the cap did not apply.

Other Colorado courts have disqualified appraisers and/or overturned appraisal awards based upon an appraiser's financial interest in the outcome of the insurance dispute and current or prior relationship with the selecting party. In ***Auto-Owners Ins. Co. v. Summit Park Townhome Assn.***, 886 F.3d 852 (10th Cir. 2018), a Colorado federal court entered an order requiring the mandatory disclosure of the parties' appointed appraisers, and holding that the appraisal process should proceed in accordance with the court's order. In that case, the court set aside the appraisal award that was 47% more than the amount claimed, finding that the insured's appointed appraiser was not impartial as required by the policy's appraisal provision based upon the extensive business relationship between the appraiser and the insured's counsel, which was intentionally misrepresented and undisclosed.

Likewise, in ***Axis Surplus Insurance Co. v. City Center West LP***, No. 2015 CV 30453 (Colo. Dist. Ct., Weld County Mar, 14, 2016), a Colorado state court disqualified the insured's appraiser because he had an extensive relationship with the firm representing the insured, was a business partner of the lawyers, advocated in support of positions taken by the firm, and socialized with the firm.

In Florida, an appraiser who has a financial interest in the outcome of the appraisal is often considered not impartial. ***Podolsky v. Federated National Insurance Co.***, 25 Fla. L. Weekly Supp. 530a (15th Cir. Ct. Palm Beach May 15, 2017). In ***Podolsky,*** the insureds hired a public adjuster to assist them with their claim. The public adjuster's contract provided that the insureds agreed to pay the public adjuster's firm "10% of the amount recovered, by adjustment or otherwise, due when paid by the insurance company." The insurer invoked appraisal under the policy's appraisal provision, which required that each party choose a "competent and impartial" appraiser. The insureds' public adjuster named himself as their appraiser. The insurer sent correspondence to the insureds stating that their public adjuster could not act as an impartial appraiser due to his financial interest in the outcome of the appraisal and requesting that the insureds name another appraiser. The insureds refused to name another appraiser. The insurer then denied the claim based on the insureds' failure to comply with the appraisal provision. Litigation ensued. The court in ***Podolsky*** relied on the dictionary definitions of "impartial" and "disinterested." As noted in the court's opinion, Black's Law Dictionary defines "impartial" as "not favoring one side more than another, unbiased and disinterested, unswayed by personal interest," and

"disinterested" as "free from bias, prejudice, or partiality ... not having a pecuniary interest in the matter at hand." Based upon these definitions, the court in ***Podolsky*** held that the selection of an "impartial" appraiser, as required by the policy, "mandate[d] that each party retain its selected appraiser who will be free from an interest in the amount [sic] the loss. An appraiser whose fee is based on the total amount of the loss has an interest in the amount of the loss, and therefore cannot be impartial."

The same reasoning was followed by the United States District Court for the Middle District of Florida in ***Nalcrest Foundation, Inc. v. Landmark American Insurance Company***, No. 8:18-cv-00996, 2018 WL 4293147 (M.D. Fla. July 27, 2018). In that case, the insurer filed a counterclaim for a declaration that the insured's appraiser was not "impartial," as required by the policy, based on the contingency fee agreement he had with the insured. The court denied the insured's motion to dismiss, holding that the insurer had pled sufficient facts to proceed with its claim to disqualify the insured's appraiser "because [the insured's appraiser's] compensation is directly correlated to the amount [the insured] recovers by virtue of the contingency fee agreement." ***Id.*** at *13-14.

Other courts have taken a more expansive view of impartiality. For instance, in ***Brickell Harbour Condo. Ass'n v. Hamilton Specialty Ins. Co.***, 256 So. 3d 245 (Fla. 3d DCA 2018), Florida's Third District Court of Appeal held that "impartiality" means something other than the "dictionary definition" when it concerns appraisers appointed and paid by the parties in the insurance context. According the court, the appraisal provision requires disclosure of an appraiser's "direct or indirect financial interest in the outcome of the [appraisal]" rather than disqualification of an appraiser. ***Id.*** at 249. Notably in that case, the challenged appraiser, who was an employee of a building consulting company often hired by the insurer, was never compensated directly by the insurer for any building consulting services provided by his company and was not compensated for his work on the appraisal on a contingency fee basis. His appointment was upheld by the court.

An Iowa appellate court held that appraisers do not violate their commitment to impartiality by acting as advocates for their selecting party. ***N. Glenn Homeowners Ass'n v. State Farm Fire & Cas. Co.***, 906 N.W.2d 204 (Iowa Ct. App. 2017). In that case, the insurer, in support of its position that the insured's appraiser was not "impartial," presented evidence that the appraiser testified in another proceeding that "he would say anything his client asked of him because that's how he got paid." ***Id.*** According to the court, this was not a sufficient showing of partiality to overturn the appraisal award.

C. CONCLUSION

To preserve the integrity of the appraisal process, the appointed appraisers must satisfy the qualifications required by the policy's appraisal provision: "competent and disinterested" or "competent and impartial." This is especially so since, in most cases, appraisal awards will be upheld. Although there is little dispute over what constitutes a

competent appraiser, there is increasing conflict over what constitutes a disinterested or impartial appraiser. The failure to appoint a disinterested or impartial appraiser could negatively affect the validity of an appraisal award, causing needless delay in the resolution of a claim.

AMERICAN COLLEGE OF COVERAGE COUNSEL
ANNUAL MEETING 2020
SEPTEMBER 25, 2020
CHICAGO, ILLINOIS

RELATED ACTS & INTERRELATED WRONGFUL ACTS – SIX DEGREES OF SEPARATION

Matthew L. Jacobs, Jones Day
Bryan M. Weiss, Murchison & Cumming
Paula E. Litt, Honigman, LLP
Leah Nunn Engelhardt, Chaffe McCall[1]

One of the most heavily-litigated issues between insurers and policyholders involves the issue of whether, in the context of claims-made and reported policies, two claims are "related" or "interrelated." The significance of this issue cannot be understated. It can arise in the context of two separate lawsuits being filed against the insured during a single policy period, thereby raising the issue of whether both lawsuits are limited to a single claim limit or two claim limits, or in the context of two separate claims, or lawsuits, that span two, consecutive claims-made policy periods.

If a lawsuit is filed against the Insured during Policy A's policy period and a second lawsuit is filed during the policy period of the very next policy, Policy B, and the two lawsuits are deemed to be "interrelated" or "related" pursuant to the provisions in the policies, the insured may be left with no coverage for the second lawsuit filed during the term of Policy B because the insurer will assert that (1) Policy A has been exhausted through payments of the first "related" lawsuit filed during the Policy A policy period, and no limits remain to cover the second, "related" lawsuit, (2) because of their "relatedness," the second lawsuit (or claim) is deemed to have been first made against the insured during Policy A's policy period, and any coverage that might apply to the second lawsuit must be determined pursuant to the terms and provisions of Policy A, which may be quite different from those in Policy B, or (3) because of their "relatedness," any notice of the second lawsuit is "late" and ousts the second lawsuit from coverage.

All three of these outcomes are unacceptable to policyholders, who contend that treating two separate lawsuits filed (or "claims made" against the insured) during two

[1] The analysis included herein represents contributions from all four authors, and the content of this paper and the observations expressed herein are not to be attributed to any one of them, individually, or collectively, and are also not to be attributed to their respective law firms or the clients of those law firms.

separate policy periods as “related” and, therefore, a single claim is inconsistent with a policyholder’s reasonable expectations of coverage, and also is incompatible with the very purpose of a claims-made and reported policy to cover claims that are “made” against the insured during the policy period. “Pushing back” a second lawsuit, or claim against the insured, into a prior – possibly now exhausted – policy based on some vague notion of “relatedness” or “interrelatedness”, terms that are typically undefined in the claims-made policies, is not contemplated by a policy form that is described as a policy covering claims “made” against the insured during the policy period.

Insurers contend that treating two separate lawsuits, though filed by different parties and involving different (or the same) causes of action, as a single, “related” or “interrelated” claim is consistent with the intent of claims-made policies to operate more narrowly than occurrence-based policies, and that the insured is only entitled to one policy limit per claim – not more than one. Without the “related” or “interrelated” policy provisions, a policyholder could, conceivably, obtain two claim or policy limits from two consecutive policies for the very same wrongful act or series of wrongful acts just because they were contained in lawsuits filed, or “made,” against the policyholder one year apart.

Most claims-made and reported policies contain provisions “deeming” claims involving the same “wrongful acts” to have been made on the earliest date on which any wrongful act or “related” wrongful act was reported under the policy during which the wrongful or related wrongful act was reported, or “any other policy providing coverage”:

> *"All Claims involving the same Wrongful Act or Related Wrongful Acts of one or more Insureds will be considered a Single Claim, and will be deemed to have been made on . . . the earliest date on which any such Wrongful Act or Related Wrongful Act was reported under this Policy . . . or any other policy providing coverage."*

Another “deemer” clause for “related wrongful acts” states:

> *“Claims alleging, based upon, arising out of or attributable to the same or related wrongful acts shall be treated as a single claim regardless of whether made against one or more than one of you. All such claims, whenever made, shall be considered first made during the policy period or any extended reporting period in which the earliest claim arising out of such wrongful acts was first made, and all such claims shall be subject to the same limits of liability.”*

And yet another:

> *“All Claims arising out of the same Wrongful Act and all Interrelated Wrongful Acts of the Insureds shall be deemed to be one Claim, and such Claim shall be deemed to be first made on the date of the earliest of such Claims is first made, regardless of whether such date is before or during*

the Policy Period. All Loss resulting from a single Claim shall be deemed to be a single Loss."

A common definition of "interrelated wrongful acts" states:

"Wrongful Acts which are based on, arising out of, directly or indirectly resulting from, in consequence of, or in any way involving any of the same or related or series of related facts, circumstances, situations, transactions or events."

This definition of "interrelated wrongful acts" appears in a policy that does not define the term "related," used in the definition, nor the phrase "circumstances, situations, transactions or events," leaving the courts to come up with their own tests and analyses to determine what constitutes a "related" or "interrelated" wrongful act (is a "related" wrongful act different from an "interrelated" wrongful act, for example?).[2]

As demonstrated in the case studies contained herein, many courts have struggled with identifying whether two claims, or two lawsuits, are "related" or "interrelated," and whether the second lawsuit (or an initial lawsuit followed by a regulatory investigation one year later) should be deemed to have been made during an earlier policy period, when the "related" first lawsuit was brought against the insured. Often, the second lawsuit, or claim, was brought by different plaintiffs, alleging different causes of action, seeking different relief, and may even involve a regulatory agency when the first lawsuit was brought by private plaintiffs.[3] Despite these facts, many courts have found two such suits to be sufficiently "related" due to a "common nexus" of facts, or "substantially similar" facts, or after the application of the "sufficient factual nexus" test or the "operative facts" test adopted by the court in *Emmis Communications Corp. v. Illinois National Ins. Co.,* 323 F. Supp. 3d 1012 (S.D. Ind. 2018), *aff'd,* 937 F.3d 836 (7th Cir. Aug. 21, 2019), discussed more fully below.

Case Studies of Various Situations Involving Potentially Interrelated Wrongful Acts, Related Wrongful Acts and Six Degrees of Separation

[2] One court, for example, has held that the terms "same," "essentially the same," and "related" as "so elastic, "so lacking in concrete content, that they import into the contract substantial ambiguities." *See, e.g., Community Health Center of Buffalo, Inc. v. RSUI Indemnity Co.,* 2012 U.S. Dist. LEXIS 28934, at *9-10 (W.D.N.Y. 2012).

[3] *See Am. Cas. Co. of Reading, P.A. v. Gelb*, 18 N.Y.S.3d 30,32 (App. Div. 2015) (rejecting argument that two claims were interrelated where the two proceedings, "while arising from the merger, are wholly different, with different parties, different allegations, and different causes of action.")

CASE STUDY NUMBER 1

Interrelated Wrongful Acts and Fraudulent Business Schemes

I. INTRODUCTION

While the vast majority of business transactions conducted daily worldwide are legitimate and at arms-length, it is also an unfortunate reality that many are not. News reports are filled with stories of Ponzi schemes, pyramid schemes and other fraudulent investing scams. The victims of these schemes are often preyed upon by a network of actors – bankers, lawyers, accountants, brokers, etc. - connected towards a common purpose and enterprise. The scheme often involves a common *modus operandi* but spanning large periods of time, multiple transactions in varied locations and of course, multiple victims each with unique losses in terms of their nature and amount.

State and federal courts nationwide are filled with lawsuits arising out of these fraudulent investment schemes. And of course, many of the defendants in those suits are insured under some sort of D&O or E&O liability policy, policies which no doubt contain some version of an "interrelated wrongful acts" provision, for example:

> *"All Claims involving the same Wrongful Act or Related Wrongful Acts of one or more Insureds will be considered a Single Claim, and will be deemed to have been made on . . . the earliest date on which any such Wrongful Act or Related Wrongful Act was reported under this Policy . . . or any other policy providing coverage."*

A common definition of "interrelated wrongful acts" might include:

> *"Wrongful Acts which are based on, arising out of, directly or indirectly resulting from, in consequence of, or in any way involving any of the same or related or series of related facts, circumstances, situations, transactions or events."*

The usual consequence of deeming a series of seemingly disparate wrongful acts as "interrelated" is that each claim arising out of such acts are treated as a single claim, meaning only policy limit applies to that claim. The policies at issue are typically claims-made policies that typically provide coverage only for claims first made during the given policy period. If disparate wrongful acts are deemed to be "interrelated," these provisions allow insurers to treat all such claims made against an insured as a single claim first made on the earliest date any such claim is made – typically narrowing the claim to a single policy period. This may impact either coverage under the policy at issue (i.e., push the coverage “back” to the policy that was on the risk at the time of the first wrongful act) or the limits of the policy itself (if all claims were made during the policy period.) Thus, a policyholder insured under a policy with a $500,000 per claim

limit could find itself limited to that one claim limit to satisfy hundreds, if not thousands, of claims arising out of the same scheme, claims brought by disparate victims alleging uniquely different damages. It should therefore come as no surprise that this issue has spawned a wide body of litigation over the interpretation of such "interrelated wrongful acts" provisions in the context of these fraudulent schemes. This discussion will provide a brief overview of some of those rulings, with emphasis on a fairly recent California federal court decision focusing on those issues.

II. GENERAL OVERVIEW

As with any discussion of how courts treat a given coverage issue, there are multiple factors that must be taken into account, including the language of the specific policy at issue and the facts of the case as applied to that language. And of course, courts have reached different results on seemingly similar facts and policy language. It is therefore somewhat of a challenge to arrive at a singular "black letter" statement of law that applies across the board to these so-called fraudulent business scheme cases. Nonetheless, there are some common principles courts have employed.

When terms such as “related” or “interrelated” are left undefined in the policy, they are commonly understood and used to broadly encompass both logical and causal connections (see, e.g., *Bay Cities Paving & Grading, Inc. v. Lawyers’ Mut. Ins. Co.* (1993) 5 Cal.4th 854.) In applying this principle to fraudulent business scheme cases, courts have found relatedness where "[e]ach underlying claim was based on a “common business decision.” (*Associated Industries Insurance Company v. Brad Williams, LLC,* 2018 U.S. Dist. LEXIS 84721 (S.D. Miss., No. Div. 2018.) The existence of a common business decision (a *modus operandi*) is often enough to tip the scales in favor of a finding of relatedness, i.e., when an insured is accused of defrauding separate claimants in separate instances using the same basic scheme. Some courts have found a common *modus operandi* to be a strong factor in finding relatedness. For example, in *Am. Commerce Ins. Brokers, Inc. v. Minn. Mut. Fire & Cas. Co.,* 551 N.W.2d 224 (Minn. 1996) an employee of the insured embezzled nearly $200,000 from the company over a one year period using the same method each time. The insured submitted a claim under its Employee Dishonesty coverage, which contained an "interrelated wrongful acts" limitation. The Minnesota Supreme Court applied the provision, noting "[w]e cannot so restrict the plain and ordinary meaning of the word 'related' such that acts of embezzlement which follow each other in time, take place at the same business, and are committed by the same employee are not 'related' as that word is commonly used. Rather, the phrase 'series of related acts' is intended to encompass a continuous embezzlement scheme in which the dishonest employee converts funds from an employer by a common scheme on a constant basis."

Thus, courts have found interrelatedness where the claims were based on the same misleading statement (*Zunenshine v. Exec. Risk Indem., Inc.,* No. 97 Civ. 5525(MBM), 1998 WL 483475, at *5 (S.D.N.Y. Aug. 17, 1998), aff'd, 182 F.3d 902 (2d Cir.1999); the same agreement to sell stocks (*Home Ins. Co. of Ill. (N.H.) v. Spectrum Info. Techs., Inc.,* 930 F.Supp. 825, 850 (E.D.N.Y.1996); the same omissions in the same proxy literature (*Ameriwood Indus. Int'l Corp. v. Am. Cas. Co. of Reading, Pa.,*

840 F.Supp. 1143, 1152 (W.D.Mich.1993); and the same development of an industrial park and one party's attempts to interfere with the development (*Bensalem Twp. v. Int'l Surplus Lines Ins. Co.,* Civ. A. No. 91-5315, 1992 WL 142024, at *2 (E.D.Pa. June 15, 1992), *rev'd on other grounds*, 38 F.3d 1303 (3d Cir.1994.))

The court in *W.C. and A.N. Miller Development Co. v. Continental Casualty Co.,* 814 F. 3d 171 (4th Cir. 2015) distinguished claims related due to a "common scheme" from claims that were unrelated by a mere "common motive." In that case, the insured was sued in 2006 and again in 2010, both suits arising out of the same transaction. The court concluded that the conduct alleged in the lawsuits shared a common nexus of fact and were therefore interrelated wrongful acts. The two lawsuits were held to be linked by a multitude of common facts, a common transaction, and common circumstances. Thus the court held "[t]hese elements logically and causally connect the two lawsuits. . . . "an alleged scheme involving the same claimant, the same fee commission, the same contract, and the same real estate transaction." The court rejected the insured's attempts to avoid this "straightforward conclusion" by characterizing the allegations in the two lawsuits as alleging merely a "common motive" which is insufficient to establish the interrelatedness of the 2006 and 2010 lawsuits.

In *Morden v. XL Specialty Ins.,* 903 F. 3d 1145 (10th Cir. 2018), the insured was the subject of an SEC investigation prior to the policy, followed by a later-filed securities suit. The insured, an investment adviser, was involved in four separate investments alleged to have been gone bad. These four investments were different in nature. They involved investment opportunities in a software company, a real estate lender, a shell company and a literal gold mine. In addition, each of the investors were different. However, the court observed that the investments "share[d] common threads." In all four, "[c]lients were promised too much, not warned of risks, and not informed of conflicts of interest of their advisers, who had undisclosed stakes in the ventures." First, the court noted that the test for relatedness is "quite broad." Next, it noted that the wrongful acts were committed "by the same entity, against the same victims, using the same techniques (understating risk, overstating upside potential, and concealing financial interests of the advisers)." Because the SEC action and subsequent civil complaint alleged a common "scheme," the Tenth Circuit held they were related.

The United States District Court *Nobilis Health Corp. v. Great American Ins. Co*., H-17-2386 (S.D. Tex. 2018) reached a similar result. In Nobilis, the insured was a publicly-traded healthcare corporation. Near the end of the policy period, an anonymous blogger posted an article on a website claiming that the company was overvalued. As a result of that posting, the company's stock dropped. While the policy was still in place, a class of stockholders filed suit against Nobilis alleging, among other things, that it overstated its revenues. The case was voluntarily dismissed. Noblis was sued in another class action following the expiration of the policy, alleging that it overstated its net income and lacked effective internal financial controls. Finally, a third class action was filed against Nobilis alleging Nobilis's financial statements "provided the investing public with a misleading view of Nobilis' revenues, expenses, and general business operations." Great American denied coverage for the second and third class

action suits as being made after the policy period. The court found in the insured's favor, noting that "Related Wrongful Acts" is "broadly defined" and that [a]ll three lawsuits contain allegations that Nobilis' financial statements were misstated, false, misleading, and/or inaccurate." The court noted that the carrier "focus[ed] on minute differences" such as the fact that the later class actions made additional allegations regarding accounting errors. Ultimately the court held the clause applied to "any common fact" and found the common allegations to be sufficient to trigger the clause. Interestingly enough, this was actually a victory for the policyholder in that as a result of the court's ruling, all of the lawsuits, even those filed after the policy period, were deemed related and thus one claim, all which were covered under the policy. This case illustrates the "shifting sands" policyholders and their insurers may find themselves on when confronted with an "interrelated wrongful acts" conundrum.

In *Gregory v Home Insurance Co.,* 876 F. 2d 602 (7th Cir 1989) the insured was sued in a class action arising out of an offering for sale of episodes in a videotape series. Investors brought claims against an attorney alleging that he misrepresented the status of videotapes as securities; and the tax consequences of investment in videotapes.

The court found these acts sufficiently related to constitute a single claim under the policy. With respect to the claims involving the tax advice rendered by the insured, the court held "[it] is easy to decide that all the class claims arising from Mr. Gilbert's mistaken advice on the investment program's tax advantages are treated as a single claim under Paragraph IV of the policy, and therefore are subject to the $500,000 limit." As for the securities violation allegations, the court examined the three documents drafted by the insured in connection with the offering and found there to be "no question that these documents and Gilbert's acts in drafting them are 'related.'" It was clear to the court that the documents were "interdependent components of a single plan." The court further found that the insured's advising the investors of the tax and security law consequences of its offering, specifically his alleged failure to tell them that its offering was a security and should be registered, was also a related act, "by any plain and ordinary meaning of 'related.'"

Finally, the Ninth Circuit found that although two suits "were filed by two different sets of plaintiffs in two different fora under two different legal theories, the common basis for those suits was the WFS business practice of permitting independent dealers to mark up WFS loans." Thus, the relationship between the two claims was not so "attenuated or unusual" to prevent the insurer from treating them as the same claim (*WFS Financial, Inc. v. Progressive Cas. Ins. Co., Inc.,* 232 Fed.Appx. 624 (9th Cir. 2007.)

As can be seen from the above, courts in a wide variety of jurisdictions and as the state and federal level apply a somewhat broad definition of "relatedness" that is often used to connect seemingly disparate claims, suits, facts and damages where there is a common scheme and *modus operandi* to each. This brings us to a California federal court decision that weaved together many of these themes - *Liberty Ins.*

Underwriters, Inc. v. Davies Lemmis Raphaely Law Corp., 162 F. Supp. 3d 1068 (C.D. Cal. 2016) ("Davies.")

III. The Davies Decision

In Davies, the insureds were a transactional real estate firm that represented clients involved in purchasing, selling, transferring, and/or syndicating ownership, leasing, and financing of commercial properties. The firm served as counsel for a licensed California real estate broker that facilitated real estate investment partnerships. They were insured under three successive professional "claims-made-and-reported" liability policies issued by Liberty. Each of the policies defined "wrongful act" as "any actual or alleged act, error, omission or personal injury which arises out of the rendering or failure to render professional legal services." With regard to multiple claims, the policies stated:

> *"Claims alleging, based upon, arising out of or attributable to the same or related wrongful acts shall be treated as a single claim regardless of whether made against one or more than one of you. All such claims, whenever made, shall be considered first made during the policy period or any extended reporting period in which the earliest claim arising out of such wrongful acts was first made, and all such claims shall be subject to the same limits of liability."*

Between 2011 and 2013, seven cases were filed against the insureds and its real estate broker related to 23 transactions which occurred between December 2003 and November 2009. Each of those actions involved a similar alleged scheme - in the course of negotiating a property acquisition transaction, the defendants made a false representation to plaintiff-investors that the sellers would pay all commissions relating to the transaction, when in reality the purchase price of the property was marked up to include a commission payment. The plaintiffs in the underlying actions alleged that they relied upon these misrepresentations in choosing to invest.

All of the underlying actions alleged that the insured participated in the drafting of the offering memoranda and other documents relating to the proposed investment and had knowledge of the alleged misrepresentations and materials omissions but failed to disclose them. With the exception of one action, each of the plaintiffs alleged that they had an attorney-client relationship with the insured and that the insured failed to properly disclose actual or potential conflicts or properly represent the interests of the plaintiff-clients. All of the underlying actions included the same causes of action.

Each property acquisition at issue was completed on a different date, purchased from a separate seller, and on different terms from each other acquisition. The purchase agreements were negotiated at different times with 21 different sellers represented by 21 different law firms. Each of the underlying actions were filed by the same law firm representing these various investor-plaintiffs.

The issue was whether the underlying actions should be considered a single claim for purposes of the 2010-2011 policy's per-claim limit. Ultimately the court found that the seven claims were a single claim, related to the first suit filed in 2011.

The court first noted that California courts have found multiple claims to be sufficiently related where the underlying actions are in service of a "single plan" (*McWethy v. California Ins. Guarantee Ass'n,* No. G035992, 2006 Cal. App. Unpub. LEXIS 5785, 2006 WL 1793640, at *1 (Cal. Ct. App. June 30, 2006 - an attorney hired to prepare a client's will and trusts fraudulently made himself beneficiary and trustee of the trust, and distributed large amounts of stock to himself and his daughter after the client's death; court found that separate allegations relating to (1) exercising undue influence on the client before his death and (2) fraudulent receipt and sale of the stocks should be treated as a single claim as the wrongful acts were considered "both logically and causally related to each other as part of a single plan to obtain . . . a large share of [the estate]." The court noted that that all injuries ultimately arose from defendant's violations of his fiduciary duty to the single deceased client; *Flowers v. Camico Mut. Ins. Co.,* No. A134890, 2013 Cal. App. Unpub. LEXIS 4091, 2013 WL 2571271, at *2 (Cal. Ct. App. June 12, 2013) - an accounting firm failed to protect and guard against an embezzlement scheme perpetrated by its Chief Financial Officer; court found that the firm's acts, errors, and omission were "related", reasoning that "in every instance, the allegations against the Firm remain[ed] the same, that is, the Firm repeatedly failed to detect and guard against Hillyer's embezzlement scheme, which resulted in the same injury to the plaintiffs, namely, the loss of their funds."

Notably, both of these cases cited by the Davies court involved harm to a single victim, albeit through a series disparate acts. Nevertheless, the court noted 9th Circuit decisions finding that claims were sufficiently related even where "the suits were filed by two different sets of plaintiffs in two different fora under two different legal theories" (citing *WFS Fin., Inc. v. Progressive Cas. Ins. Co., supra,* and *XL Specialty Ins. Co. v. Perry,* No. CV 11-02078-RGK JCGx, 2012 U.S. Dist. LEXIS 109341, 2012 WL 3095331, at *8 (C.D. Cal. June 27, 2012) - underlying actions from multiple plaintiffs deemed to be related where the allegations were based on defendant-company's consistent policy of recklessly issuing high-risk mortgages.) The court similarly noted decisions in other jurisdictions holding that "[c]laims may be related even if they allege different types of causes of action and arise from different acts" where there is "a 'single course of conduct' that serves as the basis for the various causes of action." (*In re DBSI, Inc.,* No. 08-12687 PJW, 2011 Bankr. LEXIS 2727, 2011 WL 3022177, at *4 (Bankr. D. Del. July 22, 2011); see also *Kilcher v. Cont'l Cas. Co.,* 747 F.3d 983, 989 (8th Cir. 2014) ("a court may consider several factors in concluding whether dishonest acts are part of a 'series of related acts,' including whether the acts are connected by time, place, opportunity, pattern, and, most importantly, method or modus operandi."); *Cont'l Cas. Co. v. Wendt*, 205 F.3d 1258, 1264 (11th Cir. 2000) - a "single course of conduct" "aimed at a single particular goal" establishes relatedness.)

Following this analysis, the court held:

"In this case, while the Underlying Actions have been brought by different plaintiffs, they all arise from a single course of conduct, a unified policy of making alleged affirmative misrepresentations to investors in order to induce them to invest in commercial real estate acquisitions facilitated by AMC.

. . .

The Underlying Actions all allege the same misrepresentations and omissions by Defendants in the same form relating to similar or identical investments and properties. In deciding to invest in AMC's commercial property transactions, the plaintiffs in the Underlying Actions all uniformly relied on written memoranda and other documents prepared by DLR which contained alleged misleading statements and omissions regarding inflated purchase prices and hidden commissions." (Davies at 1078.)

The court distinguished these facts from those found in *Financial Management Advisors, LLC v. Am. Int'l Specialty Lines Ins. Co.,* 506 F.3d 922, 925 (9th Cir. 2007) where the Ninth Circuit found that fraudulent misrepresentation claims brought by "unrelated investors, with unique investment objectives [who] were advised at separate meetings on separate dates, according to their unique financial positions" were not sufficiently related as to constitute a single claim. In contrast, in Davies, the underlying actions were all ultimately based on the same alleged uniform policies and/or reckless actions of the insured and its client. At the end of the day, the Davies court strictly followed the "causal-or-logical connection" approach adopted by the California Supreme Court in Bay Cities, supra.

The Ninth Circuit affirmed this ruling in an unpublished decision on December 26, 2017, held that "[w]hile the underlying actions are not causally related, they are logically related to each other by the “common purpose or plan”—a scheme to incentivize investments by signifying that sellers would pay commissions, while hiding the fact that the price of the investment included the commissions. . . . The district court did not err in concluding that this common plan satisfied the related conduct language in the policy."

The Davies case thus represents yet another in a series of decisions in which courts have found relatedness based on a common plan, scheme or *modus operandi*, regardless of the number of suits, claims, plaintiffs and disparate damages alleged.

IV. CONCLUSION

Claims-made policies are purposefully intended to provide a more narrow scope of coverage than occurrence-based policies so that insurers can more predictably measure the windows under which their policies may be implicated. Claims-made insurance allows for a close match between premium dollars and claims. Shortly after the expiration of a claims-made policy, an insurer can close its books and determine its

profit or loss. Interrelated wrongful acts provisions preserve the essential workings of claims-made policies, and allow insurers to rightfully deny coverage for claims that are not actually first made during a given policy period.

The court's reasoning in *Davies* may seem logically counterintuitive to the notion that separate wrongful acts that produce separate harms are "related." However, the focus on a common scheme is often all that is required from a legal standpoint. Courts have discussed the difference between a "common motive" (a common purpose amongst disparate acts often different in scope and time) and a "common scheme" (often involving the same claimant, contract, transaction, or outcome) when attempting to determine relatedness. When the only connection between the acts is the furthering of some general business practice or intent, courts are less likely to relate multiple acts based on this common motive. Alternatively, a common scheme is more likely to result in a "common fact, circumstance, situation, transaction, or event" between multiple acts and result in a logical or causal connection that runs throughout the events.

CASE STUDY NUMBER 2

WHAT HAPPENS WHEN A COMPLEX SET OF FACTS, INCLUDING MULTIPLE SECURITIES LAWSUITS AND SIMILAR ACTIONS, RESULTS IN A DISAGREEMENT AMONG INSURANCE COMPANIES OVER THE EXISTENCE OF "INTERRELATED WRONGFUL ACTS"?

WHEN A COURT FINDS POLICY WORDING TO BE "ABSURD" AND "NONSENSICAL"

Emmis Communications Corp. v. Illinois National Ins. Co., 323 F. Supp. 3d 1012 (S.D. Ind. 2018), *aff'd,* 937 F.3d 836 (7th Cir. Aug. 21, 2019).

The *Emmis* decision illustrates the limits of the "interrelated wrongful acts" exclusion and arguments for their application offered by insurers. The decision is noteworthy not only for its recognition of the boundaries of such exclusions, but also for its unusual appellate history.

I. Factual Background

As the district court recognized, the facts of *Emmis* are "voluminous." The significance of this *Emmis* decision regarding relatedness turns on an understanding of those facts, which are summarized below.

A. The 2010 Go-Private Attempt

In 1999, Emmis issued Preferred Stock with certain rights and protections under Emmis's Articles of Incorporation. Ten years later, in 2010, when the value of Emmis's common stock had dropped, its CEO and largest shareholder Jeff Smulyan proposed a go-private transaction (the "2010 Go-Private Attempt"). Smulyan formed a company, JS

Acquisition, LLC ("JSA"), to acquire all of Emmis's common stock. Alden Global Distressed Opportunities Master Fund ("Alden"), a minority holder of Emmis Preferred Stock, agreed to finance the 2010 Go-Private Attempt.

Under the proposed terms of the 2010 Go-Private Attempt, JSA would purchase the Common Stock at a premium and the Preferred Stock would be converted into subordinated debt. Although the Emmis Board of Directors approved these terms, a group of Preferred Stock holders threatened to block the transaction. JSA negotiated an agreement with the Preferred Stock holders to remove their objections. However, Alden withdrew its commitment to finance the transaction. As a result, the 2010 Go-Private Attempt failed.

Litigation followed.

1. Shareholder Suits: Before the transaction collapsed, Emmis shareholders filed seven separate putative class actions alleging that the proposed terms "undervalued the shares of Emmis and the approval of it constituted a breach of fiduciary duty" by Emmis's directors. 323 F. Supp. 3d at 1017.

   The Shareholder Suits were reported under Emmis's D&O policy issued by Chubb for the policy period October 1, 2009 to October 1, 2010 (the "Chubb Policy"). Chubb accepted coverage. All Shareholder Suits were dismissed after the 2010 Go-Private Attempt failed.

2. The JSA Suit and Alden Action: In September 2010, JSA sued Alden for breach of its agreement to finance the Go-Private Attempt (the "JSA Suit").

   Alden (a Preferred Stock holder) responded in February 2011 with a derivate action against Emmis's Board of Directors (the "Alden Action"). Alden claimed that Emmis's Board had breached its fiduciary duties to agreeing to financially support the JSA Suit.

   Emmis reported the Alden Action to its D&O insurers for the period October 1, 2010 to October 1, 2011. Chubb, one of the insurers for this policy period, accepted coverage for the Alden Action. Chubb determined that "the Alden Action and the Shareholder Suits were Related Claims because they both 'emanated from the proposed buyout by JSA – *i.e.*, the 2010 Go-Private Attempt.'" *Id.*at 1018.

B. The Preferred Stock Transactions

In June 2011, Emmis (flush with cash after selling some radio stations) embarked on a successful effort to gain control over its Preferred Stock. This was accomplished through a series of transactions, including Amendments to the Articles of Incorporation,

which affected the rights of the Preferred Stock holders. The shareholders approved the amendments as recommended by the Board.

More litigation ensued.

Several Preferred Shareholders sued Emmis and its officers and directors (the "*COF Suit*"). The *COF Suit* alleged that the transactions resulting in Emmis gaining control over the Preferred Stock violated federal securities laws, Indiana corporate law and were breaches of fiduciary duty. The original and amended complaints in the *COF Suit* alleged that gaining control of the Preferred Stock was the result of Smulyan's frustration with the failed 2010 Go-Private Attempt.

Emmis's broker, Marsh, reported the *COF Suit* under Emmis's D&O policy issued by Illinois National Insurance Co. ("INIC") for the period October 1, 2022 through October 1, 2012. Marsh also reported the *COF Suit* under the 2009-10 and 2010-11 D&O Policies referenced above, including the 2009-10 Chubb Policy that covered the *Shareholder Suits* and *Alden Action*. Chubb and INIC both denied coverage.

II. Coverage for the COF Suit

Emmis successfully defended the *COF Suit* and then sued INIC to recover its defense costs.

A. INIC Policy Provisions

INIC argued that coverage was barred for the *COF Suit* under each of the three subsections of its Policy's "Specific Investigation/Claim/Litigation Event or Act Exclusion." That exclusion barred coverage for

> (i) any of the Claim(s), notices, events, investigations or actions listed under EVENT(S) below (hereinafter "Event(s)"); or (ii) the prosecution, adjudication, settlement, disposition, resolution or defense of: (a) Event(s); or (b) any Claim(s) arising from the Event(s); or (iii) any Claim alleging, arising out of, based upon, attributable to or in any way related directly or indirectly, in part or in whole, to an Interrelated Wrongful Act (as that term is defined below)."

The INIC Policy defined "EVENT" to include "all notice of claim or circumstances as reported under" the Chubb Policy.

The Policy defined "Interrelated Wrongful Act" as "(i) the same or related facts, circumstances, situations, transactions or events alleged in any of the Event(s), and/or (ii) any Wrongful Act(s) that are the same or that are related to those that were alleged in any of the Event(s)." *Id.* "

A "Wrongful Act" was defined as:

(1) any actual or alleged breach of duty, neglect, error, misstatement, misleading statement, omission or act or any actual or alleged Employment Practices Violation or Third–Party EPL Violation ... or
(2) with respect to an Organization, any actual or alleged breach of duty, neglect, error, misstatement, misleading statement, omission or act by such Organization, but solely in regard to a Securities Claim

B. District Court Rejects INIC's Arguments

The court rejected all of INIC's arguments. For purposes of this paper, we focus on the court's rejection of one argument, *i.e*., that the *COF Suit* and the *Shareholder Suits* or the *Alden Action* were "Interrelated Wrongful Acts" and therefore barred under subpart (iii) of the exclusion.

When Emmis notified Chubb, its policy had expired by this time, and Chubb denied coverage for the second lawsuit on the ground that the suit **was not related** to the earlier suits arising from the first, failed "go private" effort. Emmis also notified its current D&O insurer, INIC, which denied coverage for the second suit on the basis that the 2012 suit **was related** to the earlier suits filed in 2010. INIC's primary basis for denying coverage was an exclusion for "Interrelated Wrongful Act[s]," which, as stated above, were defined as "the same or related facts, circumstances, situations, transactions or events alleged in any of the Event(s)." *Id.* at *7. INIC asserted that, in the 2012 complaint, the aggrieved shareholders described Emmis' efforts to take the company private in 2010 and also noted that the 2012 effort was designed to achieve the same goal as the 2010 effort. *Id.* at *6, 11-12. Asserting that the allegations in the 2012 and earlier actions were therefore "logically connected," INIC argued that the 2012 lawsuit arose out of the "facts, circumstances, situations, transactions or events" at issue in the 2010 complaints.

The District Court acknowledged that there were "overlapping factual allegations" between the *COF Suit* and the *Shareholder Suits*. The court reasoned that if the provision "were to be applied literally, it would mean that any shared factual allegation would be sufficient to trigger the exclusion, including the allegation that Emmis is a publicly-traded corporation, or even simply that Emmis does business in Indiana." *Id.* at 1026. The court thus determined that it "would be nonsensical" and "absurd" to read the provision in such a way that would make coverage dependent on the whim of the plaintiff's attorney who drafted the complaint in the lawsuit." *Id.*

Instead, the Court found that subpart (iii) "must be read to exclude only those claims that share operative facts with the *Shareholder Suits* and/or the *Alden Action*; that is, facts that form the basis of the causes of action asserted in the lawsuit. *Id.* The Court found that Emmis's alleged frustration with the failed 2010 Go-Private Attempt and alleged desire to punish the Preferred Stock holders were not relevant to the claims asserted in the *COF Suit*. The Court rejected a "broad application" of subpart (iii). The Court concluded as follows:

> The Shareholder Suits were filed to stop the 2010 Go–Private Attempt, which involved an attempt by JSA to purchase all of Emmis's Common Stock and convert its Preferred Stock into subordinated debt instruments. The Alden Action involved the decision of Emmis to finance a lawsuit related to the 2010 Go–Private Attempt. Section (iii) excludes claims in which someone seeks to hold the insureds liable for the actions or omissions that were at issue in the Shareholder Suits and/or the Alden Action or any actions or omissions that are logically connected to them. The COF Suit simply did not seek to do that. The only connection between the COF Suit and the other suits is that the 2010 Go–Private Attempt is mentioned in the COF Suit as part of the historical context of the relationship between Emmis and its shareholders. That is not enough to bring the COF Suit under Section (iii) and exclude it from coverage.

Id. at 1029.

III. Appellate Proceedings: Seventh Circuit Reverses Then Affirms

On appeal, the Seventh Circuit initially issued a three-page opinion reversing the District Court. The Seventh Circuit found that the subpart of the exclusion barring coverage for claims "as reported" under the Chubb Policy was unambiguous and barred coverage for the *COF Suit.* The Seventh Circuit did not address the District Court's interpretation of the "Interrelated Wrongful Acts" exclusion.

Plaintiffs, joined by *amici curiae*, sought rehearing both by the panel and *en banc*. In what can only be described as a stunning reversal (and that appears to be unprecedented in the Seventh Circuit), the panel granted rehearing, withdrew its original opinion and summarily affirmed the judgment of the district court without opinion.

IV. Take-aways

- No matter how broad the exclusion, exclusions must be narrowly construed.
- Literal application of an "Interrelated Wrongful Acts" exclusion is inconsistent not only with narrow construction of the exclusion, but also with a common-sense application of the policy language.
- Overlapping facts that are not operative facts do not make separate claims or suits "Interrelated Wrongful Acts."
- The parties and court must focus on the claims asserted and the substance of the overlapping allegation, not merely the fact that such overlapping allegations exist.

CASE STUDY NUMBER 3

The Recent *NCAA* Decision

For various colleges, divisions and conferences, decision making is ongoing as to whether football will be played this fall -- or played at all -- as a result of the COVID-19 pandemic. While 2020 collegiate "fall ball" is still in question, whether the National Collegiate Athletic Association ("NCAA") is entitled to $25 million in excess liability coverage for class claims involving alleged violations of the Sherman Act is not – at least for now.

In a July 2020 decision, the Court of Appeals of Indiana in *National Collegiate Athletic Association v. Ace American Insurance, et al.*[4] recently sided with a group of excess insurers holding that they are not required to provide coverage for an underlying lawsuit (the *Jenkins*[5] suit) for claims involving rules used by member colleges and universities to provide financial assistance to student-athletes. The Court of Appeals applied a "Related Wrongful Acts" Exclusion to exclude coverage for the *Jenkins* lawsuit, which covered the same claims as a prior lawsuit (the *White*[6] lawsuit) previously fought by the NCAA.

By way of background, the underlying *Jenkins* lawsuit was filed on March 17, 2014, as a class action by which class plaintiffs (Division I football and basketball players) sought to enjoin the NCAA (and other defendants) from imposing any restrictions on the amount of money or other benefits that may be offered student-athletes by the association schools or anyone else. The *Jenkins* plaintiffs contested, as illegal under the Sherman Act, all NCAA rules that prohibit, cap, or otherwise limit the remuneration that players may receive for their athletic services, including specific NCAA Bylaws 12 (amateurism; prohibiting boosters, etc.), 13 (recruiting), 15 and 16.

In 2012, the NCAA purchased a series of primary and follow form excess liability policies to cover a two-year term. The NCAA made a claim and reported *Jenkins* to the various Insurers pursuant to the terms of the policies in effect at that time. The primary policy provided that the policy would pay on behalf of the NCAA "loss" arising from a "Claim" first made during the policy period and reported to the Insurer for any "actual or alleged 'Wrongful Act'" of the NCAA. "Wrongful Acts" was defined, in relevant part, to include any actual or alleged act, error, omission, misstatement, misleading statement, neglect or breach of duty for "violation of the Sherman Antitrust Act or similar federal, state or local statutes or rule." The primary policy was further subject to a Related Wrongful Acts Exclusion, which stated, in relevant part:

> IV. Exclusions
> The Insurer shall not be liable to make any payment for Loss in connection with a Claim made against the Insured:
>
> * * *

[4] No. 19A-PL-1313, 2020 Ind. App. LEXIS 298 (Ct. App. July 15, 2020).

[5] Cite

[6] *White v. NCAA*, Case No. CV06-0999 (C.D. Cal.).

> C. alleging, arising out of, based upon or attributable to the facts alleged, or to the same or Related Wrongful Act alleged or contained, in any Claim which has been reported, or in any circumstance of which notice has been given before the inception date of this policy, under any other management liability insurance policy, directors and officers liability insurance policy or any similar insurance policy of which this policy is a renewal or replacement or which it may succeed in time.

The primary policy defined "Related Wrongful Act" as:

> Wrongful Acts which are the same, related or continuous, or Wrongful Acts which arise from a common nucleus of facts. Claims can allege Related Wrongful Acts regardless of whether such Claims involve the same or different claimants, Insureds or legal causes of action.[7]

In response to *Jenkins*, the NCAA filed an insurance claim seeking coverage to fund its defense. The primary insurer denied coverage, citing the Related Wrongful Acts Exclusion, and finding that the *Jenkins* lawsuit involved the same Wrongful Acts as those in the earlier *White* action. Specifically, the primary insurer reasoned that both actions challenged the limitation on the amount of financial aid provided to Division I football and basketball players and asserted that the NCAA unlawfully agreed with other entities to cap the financial aid provided to student-athletes. Thus, the actions involved the same, related or continuous Wrongful Acts and/or Wrongful Acts which arise from a common nucleus of facts. Accordingly, *Jenkins* was deemed to have been first made in February 2006 when the *White* lawsuit was filed. The excess insurers relied on the primary insurer's denial to also bar coverage under the 2012-14 excess policies.

In response, the NCAA filed a Complaint for declaratory judgment and damages against the Insurers and the parties subsequently filed cross-motions for partial summary judgment on the NCAA's coverage claim. After a hearing, the trial court ruled in favor of the Insurers, finding (as quoted by the appellate court):

> The NCAA repeatedly draws overly fine distinctions regarding the related actions and deconstructs the language about different class action definitions and causes of actions, etc. The [c]ourt finds these analyses unavailing. The Related Wrongful Acts and prior notice provisions are unambiguous, the underlying claims are clearly all against one wrongful act,

[7] The primary policy also contained a "Notice/Claim Reporting Provision" that, as the appellate court noted, "aligns notice as to an initial and any subsequent 'same or … related" Wrongful Act.

> that is, the enforcement of Bylaws 15 and 16, first made in the White action, and coverage is barred under the policies.

The NCAA appealed that ruling and now faces the Court of Appeals affirmation of that ruling. Following are some of the key facts that the appellate court relied on to reach its ruling below.

White v. NCAA

The plaintiffs in *White* asserted an anti-trust complaint that challenged the NCAA's "Bylaw 15." At the time, Bylaw 15 set the cap on financial aid and provided that every student-athlete's scholarship must be limited to the cost of attending the university. The rule defined "cost of attendance" exclusively to mean tuition, fees, room and board, and required textbooks. The plaintiffs argued that the Bylaw's definition was less than the *actual* cost of attendance because it excluded incidental costs such as transportation or supplies, and it barred schools from providing health or accident insurance to athletes. Thus, the plaintiffs asserted the difference between the Bylaw's "cost of attendance" and the *actual* cost of attendance, collectively, as their damages.

The plaintiffs argued that the scheme of limiting each school's potential to offer aid and incentives was anti-competitive and violated the Sherman Act. They argued that, absent these regulations, "schools competing against one another to attract student-athletes… would increase the amount of financial aid available so that full athletic scholarships would, in fact, cover the full cost of attendance." The NCAA settled *White* in 2008, agreeing to expand "cost of attendance" to include certain incidentals, to enable universities to provide insurance for athletes, and to open a $218 million opportunity fund for student-athletes with financial need. Throughout this litigation, the NCAA's fees and liability were covered by its then-existing liability insurance.

Jenkins v. NCAA

Jenkins commenced several years later as a similar action by student-athletes that essentially broadened *White*'s anti-trust theory. Where *White* focused on Bylaw 15, *Jenkins* attacked "all NCAA rules that prohibit, cap, or otherwise limit the remuneration that players may receive." The complaint described the NCAA's arrangement as a set of "**cartel agreements** with the avowed purpose and effect of placing a ceiling on the compensation that may be paid to those players for their services." Also, rather than money damages, the *Jenkins* plaintiffs sought declaratory and injunctive relief, seeking to enjoin the NCAA from enforcing any restrictions on what money or benefits could be offered to student-athletes.

Arguments on Appeal

On appeal, the NCAA disputed the application of the Related Wrongful Acts Exclusion and argued that such a literal and broad application of the exclusion "would

negate virtually all coverage" and defeat the purpose for which the NCAA obtained the policies. Alternatively, the NCAA also argued that even if the exclusion was not ambiguous, the *Jenkins* and *White* claims were unrelated and not factually connected, but involved separate allegations of wrongdoing. Interestingly, the NCAA sought to support its argument that the exclusion was overbroad and imprecise by likening it to Indiana's precedents on application of pollution exclusions and advocating for the court to apply jurisprudence regarding environmental pollution to the policy language at issue. Relying on precedent in the environmental pollution context, the NCAA claimed that the exclusionary language at issue was overbroad, ambiguous, and failed to give policyholders objective guidance in its application. In defining "related" as "associated; connected," the NCAA argued that every Wrongful Act is "related" to every other Wrongful Act" as every act by the NCAA is associated or connected because the NCAA committed them all.

The court found the NCAA's reliance on the environmental pollution precedent "without merit to the situation" before it, rejecting the arguments and noting that well-established Indiana law is clear that case law interpreting policy language in one policy is inapplicable to different language in different policies and the NCAA's reliance on such case law was "misplaced." The Court found that both suits were attacks on the same framework of the NCAA policy (*i.e*., the cap on student-athlete remuneration). Moreover, it noted that plaintiffs in *Jenkins* specifically cited the *White* settlement in their complaint, arguing that it had failed to curb the anti-competitive restrictions at issue. The court opined that *Jenkins* was simply a broader iteration of the same claim in *White*, against the same alleged anti-competitive agreement, and the Wrongful Acts in both cases stemmed from a common nucleus of facts – the scholarship scheme imposed on student-athletes.

Given that the policy clearly provided for coverage on a claims-made basis, and that the policy provided for a Related Wrongful Acts exclusion, the court upheld the denial of coverage under the 2012-2014 policies. In doing so, the Court further pointed out that relating *Jenkins* back to the earlier 2006 policy did not result in a situation of "no coverage" for the NCAA, it merely placed coverage under the original policy in which the claim was first made.

With respect to the ambiguity argument raised, the appellate court cited to *Gregory v. Home Ins. Co.*[8] noting that a policy is not made ambiguous simply because the parties disagree on how it applies to a given situation, and the court's finding that the term "relate" was not ambiguous. Distinguishing the case of *Am. Home Assurance Co. v. Allen*,[9] which in analyzing the terms "interrelated wrongful acts" found the term "interrelated" to be ambiguous, the Court held the Related Wrongful Act exclusion was not ambiguous or overbroad. The Court's finding of no ambiguity will certainly be relied on by insurers in subsequent coverage claims just as the Court's distinguishing of precedent finding the term "interrelated" as ambiguous will, likewise, be relied on by policyholders in pursuit of covered claims.

[8] 876 F.2d 602 (7th Cir. 1989).

[9] 814 N.E.2d 662 (Ind. Ct. App. 2004).

It remains to be seen whether the NCAA will appeal this ruling further – and whether student-athletes will be showcasing their services in “fall ball” this year.

Looking for IP Coverage: What's In or Out for CGL, Excess & Specialty Policies?

American College of Coverage Counsel
2020 Virtual Meeting

September 25, 2020

Michael Hamilton
Goldberg Segalla LLP
Philadelphia, PA
mhamilton@goldbergsegalla.com

Joann Lytle
McCarter & English LLP
Philadelphia, PA
JLytle@McCarter.com

Marcus Snowden
Snowden Law Professional Corporation
Toronto, ON
marcus@snowdenlaw.ca

Tyler Gerking
Farella Braun + Martel LLP
San Francisco, CA
tgerking@fbm.com

I. Introduction

"An insurance company's duty to defend intellectual property claims under the rubric of 'advertising injury' is the subject of countless lawsuits – indeed a recent litigation explosion – throughout the country." *State Farm Fire and Casualty Co. v. Steinberg*, 393 F.3d 1226 (11th Cir. 2004), *quoting Winklevoss Consultants, Inc. v. Federal Insurance Co*., 991 F. Supp. 1024, 1026 (N.D. Ill. 1998). Insurers and policyholders have continued to litigate coverage under general liability policies for the growing number of intellectual property claims. The numerous court decisions have created an ever-changing area of insurance law that insurance practitioners must frequently monitor.

The proliferation of IP-related risks has prompted some US and foreign market insurers to revise their CGL policies to limit coverage for many IP claims. Some now contain broad IP exclusions. This paper will also address this recent trend, what is standard in the insurance market today and potential for coverage in policies underwritten in Canadian and other foreign markets. Further, IP-specific specialty policies, which vary widely, are now available to address a broader array of IP-related risks than those covered by modern CGL policies, including infringement liability policies and abatement or enforcement coverage.

II. The CGL Policy – Personal and Advertising Injury

A. In General

United States courts generally recognize that in order for there to be a covered advertising injury, a claim must contain these elements: (1) an injury arising out of an enumerated advertising offense; (2) which was committed during the policy period; (3) and which injury occurred "in the course of," i.e., was causally connected to the named insured's advertising activities; and (4) claimed damages. *See e.g. New Hampshire Ins. Co. v. R.L. Chaides Const. Co.*, 847 F. Supp. 1452, 1455 (N.D. Cal. 1994); *National Union Fire Ins. Co. v. Siliconix, Inc.*, 729 F. Supp. 77 (N.D. Cal. 1989).

In Canada*,* In *Reform Party of Canada v. Western Union Insurance Co.*, 2001 BCCA 274 [*Reform Party*]. the BC Court of Appeal, in the context of determining PAI coverage in a CGL insuring agreement, referred to an article summarizing the historical US roots of PAI coverage and the relevance of US case law:

> The Reform Party requested insurance coverage for advertising liability and the insurer responded by providing them with a commercial general liability policy containing the most commonly used advertising injury provision. Steve Winder in an article entitled "Insurance Coverage for Intellectual Property Claims: Understanding "Advertising Injury" Provisions in Liability Policies", [1998] 12 I.P.J. 127 at 129-130 traces the history of this provision… developed in the United States by the Insurance Services Offices ("ISO") and subsequently adopted by the Insurance Bureau of Canada ("IBC"). Before 1986, the provision was normally inserted into U.S. policies as a "broad form endorsement." Since 1986, the ISO has incorporated advertising injury coverage into the main body of the

> policy, as did the [Canadian] insurer in the policy we are considering. Given that the standard form provision under consideration is the same as its American counterpart, American jurisprudence on the scope of coverage afforded to this advertising injury provision is helpful.

Ibid at para 17.

B. Advertisement and Advertising Activities

Most IP-related coverage disputes under CGL policies involve advertising-related offenses or exclusions. The newer CGL forms define an "advertisement," while some manuscripts forms and the older version of the CGL forms do not. The standard definition provides:

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

For those policies that do not define advertisement, courts look to a variety of sources. Black's Law Dictionary defines the verb "advertise" as follows:

> To advise, announce, apprise, command, give notice of, inform, make known, publish. To call a matter to the public attention by any means whatsoever. Any oral, written, or graphic statement made by the seller in any manner in connection with the solicitation of business and includes, without limitation because of enumeration, statements and representations made in a newspaper or other publication or on radio or television or contained in any notice, handbill, sign, catalog or letter or printed on or contained in any tag or label attached or accompanying any merchandise.

Black's Law Dictionary (5th ed. 1979). When applying this definition to material that is not disseminated to the public through print or broadcast media, but rather is merely posted the Internet via a social networking page, courts have, for the most part, applied the same test as that applied to distribution via traditional media (i.e., defining advertising as "the widespread distribution of promotional material to the public at large"). *Amazon.com International, Inc. v. American Dynasty Surplus Lines Ins. Co*., 85 P.3d 974, 977 (Wash. Ct. App. 2004).

In *Teletronics International, Inc. v. CNA Insurance Co.*, 120 Fed. Appx. 440 (4th Cir. 2005). a manufacturer and seller of radio amplifiers posted a user manual on its website that was nearly identical to the copyrighted manual of its competitor. The court held that posting the infringing manual on its website constituted advertising because the defendant admitted that it employed

the user manual to promote the sale of its amplifiers, and because by posting the manual on its website, it distributed the document to a large number of potential customers, i.e. engaging in widespread distribution of promotional material to the public at large. In contrast, in *Rombe Corp. v. Allied Insurance Co.*, 27 Cal. Rptr. 3d 99 (Cal. Ct. App. 2005), the court held that an insured's e-mail newsletter to clients of its direct competitor did not constitute advertising activity because it was more in the form of targeted solicitation rather than widespread distribution to the public at large. *Id* at 104-05. *See also Toffler Assoc. Inc. v. Hartford Fire Ins. Co.*, 651 F. Supp. 2d 332 (E.D. Pa. 2009).

In addition, when looking at the coverage grant/enumerated offenses, set forth below, courts generally require that the injury allegedly caused by the enumerated offense must have occurred "in the course of" the insured's "advertising activities". In other words, coverage exists for advertising injury only if the allegations satisfy the definition of advertising injury and there is a causal connection between the allegations and the insured's advertising activities. *Amazon.com International,* 85 P.3d at 976.

The "caused by an offense" connection is required to limit the coverage to injuries that are the result of the specific enumerated offenses. A careful examination of the facts is required to determine: (1) if there was any advertising, and (2) if the offense occurred in the course of that advertising. In *Hyundai Motor America v. National Union Fire Insurance Co.*, 600 F.3d 1092 (9th Cir. 2010), Hyundai was sued by a third party for patent infringement arising out of an interactive feature of Hyundai's website that allowed the user to build their own vehicle. The plaintiff in the underlying action alleged that it held a patent on the method of generating customizations for potential customers of an automobile dealer. Hyundai sought coverage under the advertising injury provision of its policy with National Fire, who filed a declaratory judgment action. *Id.* at 1096. The court held that the website feature constituted an advertising activity because, even though it created customized proposals for individual users, one at a time, since the feature was on the Internet, it was available to an unlimited amount of potential customers. The court also found that there was a "causal connection" between the advertisement and the injury because Hyundai's use of the website feature, i.e. the advertisement, was itself the patent infringement about which the third party complained.

In *Crum & Forster Specialty Ins. Co. v. Willowood USA, LLC et al.,* 696 Fed. Appx. 276 (9th Cir. August 17, 2017), the insured, Willowood, settled claims against it for trademark infringement and unauthorized use of a trademark. Willowood then sought defense and indemnity under its CGL policies that covered advertising injury "arising out of . . . the use of another's advertising idea in your 'advertisement.'" The Ninth Circuit held that "arising out of" is interpreted broadly, thus, the insured's use of the trademark satisfied the causal element.

In the governing Canadian case on this issue, the BC Court of Appeal analyzed the required nexus between the alleged injury and the policyholder's advertising injury for the purposes of a PAI coverage grant. See *Grayson v. Wellington Insurance Co*., 1997 CanLII 4112 (BC CA), leave to app ref'd [1997] S.C.C.A. No. 487 [*Grayson*]. Based in part on US case law, the Court concluded that the mere fact a product, manufactured in breach of a patent or copyright, was advertised would not

necessarily bring the injury or infringement within the PAI coverage grant. *Ibid* at para 24. Instead, a sufficient causal link must be established by show the underlying plaintiff either alleged the plaintiff has suffered injury "as a result of" the policyholder's advertising activities or sought a remedy which would stop the policyholder's advertising activities from continuing. *Ibid*. Most recently affirmed by *Blue Mountain*, (BCCA) above at paras 40 (Confirming status as leading case on issue) and 53-54 (Applying *Grayson* causal link test). Careful attention must be given to the pleaded facts to determine whether such allegations or remedies are specifically raised or could be inferred. See *PrairieFyre Software Inc. v. St. Paul Fire and Marine Insurance Co.*, [2003] O.J. No. 3116 (SC) aff'd [2004] O.J. No. 2555 (CA) at para 24 (Concluding no duty to defend under "2000 policy" given no allegations supported direct causal link between the advertising and the offence alleged). See also *Halifax Insurance Co. of Canada v. Innopex Ltd*., [2004] O.J. No. 4178 (CA) at para 44 (Inferring trademark infringement occurred "in the course of" advertising for duty to defend purposes given allegations of infringement. Court concluded infringement occurs once policyholder promotes the products to customers, satisfying coverage grant).

C. Enumerated Offenses

The modern CGL form defines person and advertising injury as follows:

> "Personal and advertising injury" means injury, including consequential "bodily injury", arising out of one or more of the following offenses:
>
> **a.** False arrest, detention or imprisonment;
>
> **b.** Malicious prosecution;
>
> **c.** The wrongful eviction from, wrongful entry into, or invasion of the right of private occupancy of a room, dwelling or premises that a person occupies, committed by or on behalf of its owner, landlord or lessor;
>
> **d.** Oral or written publication, in any manner, of material that slanders or libels a person or organization or disparages a person's or organization's goods, products or services;
>
> **e.** Oral or written publication, in any manner, of material that violates a person's right of privacy;
>
> **f.** The use of another's advertising idea in your "advertisement"; or
>
> **g.** Infringing upon another's copyright, trade dress or slogan in your "advertisement".

The initial inquiry in the advertising injury coverage analysis is whether the complained-of act falls within one of the enumerated offenses covered by the applicable policy. If the policyholder's alleged actions do not fall within one of the described types of conduct, there is no coverage. Several of these offenses will be discussed below.

1. Disparagement

One of the offenses that have seen many recent interpretive court decisions is coverage for liability arising from the publication of material that "disparages a person's or organization's goods, products or services." Thus, whether a claimant is asserting a claim of disparagement against an insured is the crux of the coverage issue.

On June 12, 2014, the California Supreme Court issued its decision in the closely watched case of *Hartford Casualty Insurance v. Swift Distribution, Inc.*, 59 Cal. 4th 277, 326 P.3d 253, 172 Cal. Rptr. 3d 653 (Jun. 12, 2014). The Court affirmed the Court of Appeals ruling that an insurer did not have a duty to defend its insured against allegations that it had infringed a competitor's trademark and patents by producing and selling a similar looking music equipment cart with a very similar name ("Multi-Cart" vs. "Ulti-Cart"). *Id*. The insured argued that there was a potential for covered damages, and hence a duty to defend, because the underlying complaint alleged facts supporting a claim of implied disparagement, and its general liability policy covered damages because of the publication of material that "disparages a person's or organization's goods, products or services." The Court found no potential for liability based on disparagement, either express or implied, reasoning that the insured was not alleged to have identified the competitor or its product, or to have "necessarily referred to and derogated" the claimant's product.

In ruling against the insured, the Court clarified the circumstances under which one may be found to have impliedly disparaged a competitor or its goods, products or services. The Court held that allegations that the insured had infringed a competitor's trademark and patents and engaged in unfair competition by producing and selling a similar looking music equipment cart with a very similar name ("Multi-Cart" vs. "Ulti-Cart") did not support a claim of disparagement. The court found no potential for liability based on disparagement, either express or implied, reasoning that the insured was not alleged to have identified the competitor or its product, or to have suggested that the insured's product was superior to that of the competitor. *Id*. In short, this decision was about the facts a plaintiff must allege to support a claim of disparagement. The case is highly relevant to insurance practitioners because many times IP and unfair competition lawsuits involve facts that suggest the possibility of disparagement

The Fifth Circuit in *Uretek USA, Inc. v Continental Casualty Co*., 701 Fed. Appx. 343 (5th Cir. July 28, 2017), overturned the trial court and afforded the insured coverage under its CGL policy. Uretek sued its competitor for patent infringement and the competitor asserted a counterclaim against Uretek claiming misrepresentation to customers regarding the competitors ability to work on various projects without infringing Uretek's patent. The Fifth Circuit focused its analysis on the definition of "disparage" and held that a statement about a competitor's ability or inability to take on work disparages that competitor and the services it offers.

2. Unfair Competition

The 1976 and 1981 advertising injury provisions expressly included coverage for "unfair competition." Coverage for "unfair competition" in these early provisions was intended to be limited to the common law tort of that name, which traditionally involved the "passing off" of one's product as that of another, and a few early opinions established corresponding boundaries on "unfair competition." For example, in, *Ruder & Finn v. Seaboard Surety Co*., 422 N.E.2d 518, 522, 52 N.Y. 2d 663 (1981), cited in *Granite State v. Aamco*, 57 F.3d 316, 320 (3d Cir. 1995), held that, viewed most broadly, "the primary concern in unfair competition is the protection of a business from another's misappropriation of the business' organization or its expenditure of labor, skill and money."

Some courts adopted a more restrictive meaning of the term, holding that unfair competition includes only the common law tort of "passing off." *See, e.g., Smartfood Inc. v. Northbrook Prop. and Cas. Co.,* 35 Mass.App.Ct. 239, 618 N.E.2d 1365 (Mass.App.Ct. 1993) (unfair competition did not cover breach of contract action because at common law it means passing off and policy does not refer to unfair business practice statute); *Sachs v. Industrial Indem. Ins. Co.*, 1993 WL 93562 (C.D. Cal. 1993) (objectively reasonable person would understand "unfair competition" to mean passing off)

Unfair competition is not included in the more modern versions of the CGL policy. Nevertheless, claims of unfair competition are frequently asserted in relation to other IP-specific claims, thus it becomes important to define the context and parameters of such a claim to then determine whether it may fit within an enumerated offense under the policy.

In many states, a claim for unfair competition is now codified. For example, in California, there is a statutory claims for Unfair Competition in Violation of Cal. Bus. & Prof. Code § 17200, which defines unfair competition as "any unlawful, unfair or fraudulent business act or practice and unfair, deceptive, untrue or misleading advertising and any act prohibited by Chapter 1 (commencing with Section 17500) of Part 3 of Division 7 of the Business and Professions Code." Cal Bus & Prof Code § 17200. This claim could allege "personal and advertising injury" under Cal. Bus. & Prof. Code § 17200 by asserting that an insured committed unlawful, unfair, and fraudulent business practices, and engaged in unfair, deceptive, untrue, or misleading advertising. In other words, such a cause of action could fall within the definition of "personal and advertising injury" that includes "written publication, in any manner, of material that slanders or libels a person or organization or disparages a person's or organization's good, products or services."

As with some US jurisdictions, Canadian common law claims alleging unfair business practices were largely limited to the tort of "passing off". *See 599960 Ontario Inc. v. Taylor Steel Inc*., 2000 CanLII 22664 (ONSC) at para 19 ("Passing off is a form of misrepresentation by a trader concerning another trader's business and made to customers of that other trade to lure those customers into falsely believing they are trading with their former trader"). The tort of passing off is one of the oldest remedies in the realm of unfair competition, and stands distinct from a statutory action. *Sharp Electronics of Canada Ltd. v. Continental Electronic Info. Inc*., 1988 CanLII 3340 (BC SC) [*Sharp Electronics*].The Supreme Court of Canada discussed the history of the tort

of "passing off" and its development in Canadian law in the decision of *Kirkbi AG v. Ritvik Holdings Inc*., 2005 SCC 65. stating:

> This tort has a long history. At a very early point in its development, the common law became concerned with the honesty and fairness of competition. For that reason, it sought to ensure that buyers knew what they were purchasing and from whom. It also sought to protect the interest of traders in their names and reputation. As far back as the 17th century, the courts started to intervene. Actions based at first on some form of deceit were allowed. The modern doctrine of passing off was built on these foundations and became a part of Canadian law. Its principles now inform both statute law and common law.

Ibid at para 63. Courts have acknowledged the tort has expanded "to take into account the changing commercial realities in the present-day community". *Atkinson & Yates Boatbuilders Ltd. v. Hanlon*, 2003 NLSCTD 113 (CanLII) at paras 75-76. See also *Sharp Electronics*, (BCSC). This area has now expanded such that it no longer addresses solely one trader deceitfully selling its goods as those of another, but now encompasses protecting the community from the consequential damage of unfair competition or unfair trading. *Sharp Electronics*, (BCSC) above at para 9.

An examination of the development of the common law of "unfair competition" in Canada indicates the sphere of business torts have grown over time, and with this the purpose for the court's involvement has shifted as well. The number of business torts has increased, thereby increasing the number of practices that may constitute "unfair competition". In addition, where the focus of the tort was at one time protecting competitors, it now seems to be protecting the consuming public at large. As stated by one Ontario trial court, "in recent years, Ontario tort law has become a major factor when examining the affairs of the free market place." *Bass Clef Entertainments Ltd. v. Hob Concerts Canada Ltd*., 2007 CanLII 17186 (ON SC) at para 62 [*Bass Clef*].

3. Canadian Business Torts and PAI Coverage

There is a group of torts in Canada, referred to as economic or business torts, dealing with the intentional interference with economic interests. The business torts can be divided into two categories. Firstly, those dealing with deceptive market practices such as deceit, injurious falsehood, passing-off, and misappropriation of personality. *Ibid* at para 118 (Citing chapter 4 of The Law of Torts, Phillip Osborne, 2nd ed., Irwin Law: 2003). Traditionally these practices have been recognized by the Canadian common law as being wrongful and requiring some form of action. However, there has also been the development of an "amorphous group that deals with improper market practices". *Ibid*. This group includes conspiracy, intimidation, inducement to breach a contract, and a general tort of intentional interference with economic interest by unlawful means. These torts focus on the illegitimacy of combined coercion, competition by unlawful means, and the deliberate interference with contractual rights. *Ibid*.

In addition to the common law business tort, an unfair competition claim can be brought in Canada pursuant to the federally enacted *Competition Act*. R.S.C., 1985, c. C-34, as amended [*Act*]. Part VI of the *Act* ("Offences in Relation to Competition") lists and prohibits certain anti-

competitive conduct harming competitors and/or consumers, such as misleading advertising (s. 52). See generally the unfair competitive practices at *ibid*, ss. 45-62. The *Act* provides a statutory cause of cause of action (s. 36), allowing "any person" suffering loss or damage "as a result of" conduct contrary to a Part VI provision to sue for damages.

The recent *Blue Mountain Log Sales Ltd. v. Lloyd's Underwriters,* 2019 BCCA 240 [*Blue Mountain*]. BC Court of Appeal decision involved a CGL "advertising liability" claim for unfair competition. In the underlying US action, the plaintiffs sued for the misappropriation of trade secrets and unfair competition with respect to the policyholders' manufacturing of a fire retardant product. The underlying plaintiffs eventually amended their pleading to only include one cause of action: misappropriation of trade secrets and confidential information in breach of the Washington *Uniform Trade Secrets Act*. Chapter 19.108 RCW. The BC Court of Appeal, agreeing with the trial judge's decision, concluded the pleading alleged a claim for unfair competition within the PAI coverage grant based on the *UTSA* cause of action. See *Blue Mountain*, (BCCA) above at para 59 (Concluding trial judge entitled to rely on Washington law expert witness evidence that while *UTSU* displaced common law unfair competition tort, statutory claim for misappropriation of trade secrets was codified species of unfair competition). The Court of Appeal concluded the trial judge made no error in analysis, noting the CGL definitions of "advertising liability" and "advertising injury" were broad and referred to forms of conduct rather than "technical elements or legal labels that may apply to particular causes of actions in particular jurisdictions." *Ibid*.

D. Damages

Because general liability policies only insure against damages that the insured becomes legally obligated to pay, courts have also carefully examined the complaint to determine whether the requested monetary relief is "damages." Because the intellectual property subject matter tends to give rise to claims for injunctive relief, some cases may not be covered for the lack of a covered damage claim. Although it seems unlikely that there would not be a prayer for damages, in at least one case coverage was denied for this reason. *Feed Store v. Reliance Ins. Co.*, 774 S.W.2d 73 (Tex. App. 1989).

Additionally, claims under state unfair trade practices acts brought by attorney general typically do not request damages. In *Bank of the West v. Superior Court*, 2 Cal.4th 1254 (1992), the statute allowed for restitution, not actual damages. The court, again referring to the common law tort of "passing off," found that actual damages were an element of that tort, therefore the relief requested by the consumers was not within the coverage. Similarly, courts reviewing cases brought by state agencies under such acts have found that there is no coverage for the statutory damage awards. *Seaboard Sur. Co. v. Ralph Williams' Northwest Chrysler Plymouth, Inc.*, 81 Wash.2d 740, 742-3, 504 P.2d 1139 (1973) (Attorney General's action for injunction under RCW 19.86.080 is not one for unfair trade practice because the State is not seeking "damages" and there is no allegation of harm to a competitor).

In *American Employers Insurance Co. v. DeLorme Publishing Co., Inc.*, 39 F.Supp.2d 64 (D. Me. 1999), the underlying complaint sought a permanent injunction, an equitable accounting by

the insured of all its profits, advantages obtained by its sale of the alleged infringing item, costs and attorneys' fees, and contained a general request for "other and further relief as the Court deems just and proper." The court rejected the insurer's argument that it had no duty to defend because the underlying complaint did not seek money damages. Adopting the reasoning of the Eleventh Circuit's decision in *Limelight Productions, Inc. v. Limelite Studios, Inc.,* the court held that the Lanham Act allows recovery of ill-gotten profits as a form of damages because of the unavailability of proof in such cases. The court further reasoned that because the underlying complaint did not seek compensation for lost sales, it was possible that the accounting for lost profits would equal compensation for lost sales.

The court also held that the underlying complaint sought "damages" because of the general request for "other and further relief as the Court deems just and proper." As the Lanham Act permits recovery of compensatory damages, if the claimant proved it was entitled to equitable relief, it also could have received money damages. Therefore, the court held that a request for an accounting of lost profits under the Lanham Act is a request for damages. Ultimately, however, the court held that there was no duty to defend based on an exclusion to coverage.

In the Canadian decision of *Mead Johnson Canada v. Ross Pediatrics*, [1996] O.J. No. 3869 (Gen. Div.), the court states that although the *Competition Act* remedy for unfair competition appears to have been limited to damages, recent decisions by the Supreme Court of Canada call for a broader application of the injunctive power of courts in such cases. *Ibid* at para 30.

E. Exclusions

Some of the typical PAI coverage exclusions include the following:

2. Exclusions

This insurance does not apply to:

a. "Personal and advertising injury":

(1) Knowing Violation Of Rights Of Another

Caused by or at the direction of the insured with the knowledge that the act would violate the rights of another and would inflict "personal and advertising injury".

(2) Material Published With Knowledge Of Falsity

Arising out of oral or written publication, in any manner, of material, if done by or at the direction of the insured with knowledge of its falsity.

(3) Material Published Prior To Policy Period

Arising out of oral or written publication, in any manner, of material whose first publication took place before the beginning of the policy period.

***

(7) Quality Or Performance Of Goods – Failure To Conform To Statements Material Published Prior To Policy Period

Arising out of the failure of goods, products or services to conform with any statement of quality or performance made in your "advertisement".

(8) Wrong Description Of Prices

Arising out of the wrong description of the price of goods, products or services stated in your "advertisement".

***

(10) Insureds In Media And Internet Type Businesses

Committed by an insured whose business is:

(a) Advertising, broadcasting, publishing or telecasting;

(b) Designing or determining content of web sites for others; or

(c) An Internet search, access, content or service provider.

However, this exclusion does not apply to Paragraphs **14.a., b.** and **c.** of "personal and advertising injury" under the Definitions section.

For the purposes of this exclusion, the placing of frames, borders or links, or advertising, for you or others anywhere on the Internet, is not by itself, considered the business of advertising, broadcasting, publishing or telecasting.

(11) Electronic Chatrooms Or Bulletin Boards

Arising out of an electronic chatroom or bulletin board the insured hosts, owns, or over which the insured exercises control.

(12) Unauthorized Use Of Another's Name Or Product

Arising out of the unauthorized use of another's name or product in your e-mail address, domain name or metatag, or any other similar tactics to mislead another's potential customers.

* * *

In advertising injury disputes, courts generally adhere to the maxim that exclusions should be interpreted narrowly so that coverage is not unduly restricted. *See, e.g., Harleysville Mut. Ins. Co. v. Buzz Off Insect Shield, L.L.C.,* 692 S.E.2d 605, 612 (N.C. 2010) ("[W]e strictly construe against an insurance company those provisions excluding coverage under an insurance policy."); *JAR Laboratories LLC v. Great Am. E&S Ins. Co*., No. 12 C 7134, 2013 WL 1966386, at *7 (N.D. Ill. May 10, 2013)("[P]rovisions limiting or excluding coverage 'are . . . construed liberally in favor of the insured and against the insurer.'"); W*estfield Ins. Co. v. Robinson Outdoors, In*c., 700 F.3d 1172, 1175 (8th Cir. 2012) ("Insurance contract exclusions are construed strictly . . . and narrowly against the insurer."); B*ridge Metal Indus., L.L.C. v. Travelers Indem. Co*., 812 F. Supp. 2d 527, 542-43 (S.D.N.Y. 2011) ("An insurer must establish that the exclusion is stated in clear and

unmistakable language, is subject to no other reasonable interpretation, and applies in the particular case.");

1. Knowing Violation of Another's Rights

California law is clear that this exclusion does not apply merely to "unproved and disputed allegations" and therefore even though this exclusion may affect a carrier's liability for indemnification, it does not affect a carrier's duty to defend. *KM Strategic Mgmt., LLC v. Am. Cas. Co. of Reading, PA*, 156 F. Supp. 3d 1154, 1170 (C.D. Cal. 2015). The *KM Strategic* court explained that even though intentional conduct is alleged, there is "usually at least a possibility of coverage because…the insured's conduct may be shown to have been merely reckless or negligent." 156 F. Supp. 3d at 1170; see *Mesa Underwriters Specialty Ins. Co. v. Blackboard Ins. Specialty Co*., 400 F. Supp. 3d 928, 941–42 (N.D. Cal. 2019) (relying in part on KM Strategic to hold that the knowing-violation exclusion did not preclude coverage for allegedly intentional habitability issues that could have arisen from negligent conduct)

2. Failure to Conform

Coverage B's Personal and Advertising Injury Liability coverage for injury arising out of a publication that libels a person or disparages a person's or organization's goods, products or services is intended to address the insured's statements about another person or entity or its goods or services. This intent is reinforced by the "Quality or Performance of Goods – Failure to Conform to Statements" exclusion, commonly referred to as the Failure to Conform exclusion.

At its most basic level, the Failure to Conform exclusion "envisions a scenario in which the plaintiff shows that the insured's product is, in reality, something different from what the insured has advertised. . . . Thus, the exclusion removes from coverage 'personal and advertising injury' proximately caused by a false statement an insured has made about its own product." *See Harleysville Mut. Ins. Co. v. Buzz Off Insect Shield, L.L.C.*, 692 S.E.2d 605, 613 (N.C. 2010).

Some courts analyzing whether the Failure to Conform exclusion applies to a particular claim have addressed whether the exclusion applies only to false advertising claims asserted by consumers of the insured's goods, products or services or whether the exclusion also applies to claims asserted by the insured's competitors. *See, e.g., Harleysville Mut. Ins. Co. v. Buzz Off Insect Shield, Inc., 692 S.E.2d 605, 609 (N.C. 2010); Skylink Techs., Inc. v. Assurance Co. of America*, 400 F.3d 982, 983 (7th Cir. 2005); *Dollar Phone Corp. v. St. Paul Fire and Marine Ins. Co.*, 514 Fed. Appx. 21, 22 (2d Cir. 2013); *Jarrow Formulas, Inc. v. Steadfast Ins. Co.*, No. 2:10-CV-810-JST, 2011 WL 1399805, at *5 (C.D. Cal. April 12, 2011); *Superformance Int'l Inc. v. Hartford Cas. Ins. Co.*, 203 F. Supp. 2d 587, 589-90 (E.D. Va. 2002).

The "Failure to Conform" exclusion usually applies when there is a claim alleging that the insured engaged in false advertising by making false statements about the quality of its own goods or services. *See Westfield Ins. Co. v. Robinson Outdoors, Inc.*, 700 F.3d 1172, 1175 (8th Cir. 2012). However, the insured's statements that expressly disparage another company's goods,

products or services do not fall within the exclusion. *See Dollar Phone*, 2012 WL 1077448, at *10 (finding claim for injury caused by alleged misrepresentations about the insured's products was "precisely the type of harm contemplated by the plain language of the non-conformity exclusion"); *PCB Piezotronics, Inc. v. Kistler Instrument Corp.*, No. 96-CV-0512E(F), 1997 WL 800874, at *3 (W.D.N.Y. Dec. 31, 1997) (excluding coverage for claims that insured misrepresented the nature, characteristics and qualities of its own products). It is less clear when the claim alleges that the insured's statements about its own products or service indirectly disparage the claimant's good or services by implication.

A typical fact pattern in an implied disparagement claim is that the insured's statements about the superior qualities or characteristics of its own product implicitly disparage the claimant's product by making a false comparison. Examples are statements that the insured's product is "the first" or "only" product on the market with a certain characteristic or that the insured's product is "superior to" or "more powerful" or "more advanced" than other products. *See Tria Beauty, Inc. v. Nat'l Fire Ins. Co. of Hartford*, No. C 12-05465 WHA, 2013 WL 2181649, at *3 (N.D. Cal. May 20, 2013); *E. Piphany, Inc. v. St. Paul Fire & Marine Ins. Co.*, 590 F. Supp. 2d 1244, 1253 (N.D. Cal. 2008). Some courts have held that the Failure to Conform exclusion does not apply to implied disparagement claims due to the fact that the claimant's injury does not arise from statements about the insured's own product or that the insured's product does not live up to the advertised qualities. Rather, the injury arises from the negative perception of the claimant's product or service created by implication regardless of the truth or falsity of the statement about the insured's products. *See Tria Beauty, 2013 WL 2181649,* at *4-*6; *JAR Laboratories, LLC v. Great Am. E&S Ins. Co.*, No. 12 C 7134, 2013 WL 1966386, at *5 (N.D. Ill. May 10, 2013) (noting insured's statements that did not refer to claimant by name were clearly directed at the claimant's product and made false comparison between the insured's product and plaintiff's product).

However, in other cases, courts have held that claims of implied disparagement are excluded by the Failure to Conform exclusion. For example, in *Dollar Phone Corp.,* the plaintiff claimed that the insured falsely advertised its phone card product by making false statements about the number of minutes the insured's card provided. The court held that the Failure to Conform exclusion applied because "the failure of [the insured's] products to perform as promised is the entire basis of . . . the plaintiff's alleged injuries [and] the harm to . . . the plaintiff's reputation is premised entirely on the inaccuracy of [the insured's] promises as to the number of minutes their [phone] cards provide." *Dollar Phone Corp. v. St. Paul Fire and Marine Ins. Co.*, No. cv-09-1640, 2012 WL 1077448 at *10 (E.D.N.Y. Mar. 9, 2012), *aff'd* 514 Fed. Appx. 21, 22 (2d Cir. 2013). Although the insured argued that the alleged false statements about the insured's product created a false impression that the plaintiff's products were inferior, the court held that this implied disparagement did not negate the exclusion.

The case of *Harleysville Mutual Ins. Co. v. Buzz Off Insect Shield, L.L.C.*, 692 S.E.2d 605 (N.C. 2010), provides another example of a court rejecting an implied disparagement claim. In this case, the North Carolina Supreme Court rejected the insured's attempt to avoid the Failure to Conform exclusion by characterizing allegations of the underlying claim to include false

statements concerning the plaintiff's products. The insured sold clothing with insect repellant incorporated into the fabric. The insured was sued by S.C. Johnson & Son, Inc. ("SCJ"), which sold topical insect repellants. The court evaluated each of the allegations in the underlying claim that the insured contended rendered the exclusion inapplicable.

First, the court addressed statements that the insured's product was "superior in performance to topical insect repellants, such as those containing DEET." The court stated that "the comparison is alleged to be false not because [the insured] made representations that SCJ's products were ineffective, but because [the insured] made allegedly false claims that their products worked as well, if not better than, SCJ's products . . . [a]s such, the alleged falsity of the advertisements arises from the failure of the [insureds'] products to actually perform as well as [the insureds] claim they perform." Next, the court addressed the insured's advertising statements that topical insect repellents were "messy," "nasty" and "a hassle." The court observed that although these statements implied that SCJ's products were a nuisance, SCJ did not allege that these descriptions of its products were false. The court also stated that these statements were opinions that likely were not actionable as a source of injury in the plaintiff's claim. Finally, the court rejected an implied disparagement claim based on the insured's statements that its products were naturally derived. The court concluded that "while SCJ did allege that [the insured's] advertisements portrayed SCJ's products in a negative light, the alleged falsity of that portrayal lies solely in the alleged failure of [the insured's] products to be of the quality and as effective as [the insured] claimed." *Harleysville Mut. Ins. Co. v. Buzz Off Insect Shield, Inc.*, 692 S.E. 2d 605, 621-22 (N.C. 2010). For these reasons, the Failure to Conform exclusion negated coverage.

3. Insureds in Media and Internet Type Businesses

The Policy's Insureds In Media And Internet Type Businesses exclusion specifically precludes coverage for "'personal and advertising injury' committed by an insured whose business is: (1) Advertising, broadcasting, publishing or telecasting; (2) Designing or determining content of web sites for others; or (3) An Internet search, access, content or service provider." At least one court has held that this exclusion applied to Dish Network ("Dish"), where the carrier sought a declaration from the court that it was not obligated to defend Dish in an underlying case for alleged TCPA violations. *Ace Am. Ins. Co. v. Dish Network, LLC*, 173 F. Supp. 3d 1128, 1130 (D. Colo. 2016). The court explained that the exclusion applied to DISH because "the terms 'broadcasting' and 'telecasting' undoubtedly encompass Dish's transmissions." *Dish Network,* 173 F. Supp. 3d at 1138.

4. Unauthorized Use

The CGL policy's Unauthorized Use Of Another's Name Or Product exclusion specifically precludes coverage for "'personal and advertising injury' arising out of the unauthorized use of another's name or product in your e-mail address, domain name or metatag, or any other similar tactics to mislead another's potential customers."

In a California Court of Appeal case, the court analyzed an insured's appeal from an order sustaining, without leave to amend, the carrier's demurrer for breach of contract and breach of the implied covenant of good faith and fair dealing for the carrier's alleged failure to defend the insured in an underlying complaint for various breaches of a music recording agreement, including the alleged wrongful use of the artist's domain name after expiration of the agreement. *The Oglio Entm't Grp., Inc. v. The Hartford Cas. Ins. Co.*, 200 Cal. App. 4th 573, 575–78 (2011). In holding that the carrier had no duty to defend, the lower court explained that the underlying complaint did not plead facts alleging advertising injury which created a potential for coverage under the policy because, in part, the unauthorized use exclusion applied to preclude coverage for "any advertising injury '[a]rising out of the unauthorized use of another's name or product in your e-mail address, domain name or metatag, or any other similar tactics to mislead another's potential customers.'" *Oglio*, 200 Cal. App. 4th at 580; 583. On appeal, the insured argued the carrier owed a duty to defend based on a number of allegations, but it did not argue that the trial court erred in concluding that the unauthorized use exclusion applied and that there was no duty to defend based on allegations that the insured continued to use the domain name of another to market itself. *Oglio* at 581 n.4. The court of appeal affirmed the lower court's ruling that the carrier owed no duty to defend based on any allegation in the underlying complaint. *Id.* at 586.

In another California case, the court affirmed the lower court's order granting the carrier's motion for summary judgment on the basis that the unauthorized use exclusion unambiguously precluded coverage for allegations that "CollegeSource used AcademyOne's domain name in its own domain name in a way likely to cause confusion in the marketplace." *CollegeSource, Inc. v. Travelers Indem. Co.*, 507 F. App'x 718, 719–20 (9th Cir. 2013). In so holding, the court explained that the allegations fall within the unauthorized use exclusion because the only reasonable reading of the allegations "is that it claims injury from an activity that (1) is 'similar to' the unauthorized use of another's name or product in one's domain name, and (2) would mislead customers." *CollegeSource*, 507 F. App'x at 719–20.

5. Infringement of copyright, patent, trademark or trade secret

Many policies recently issued contain some form of exclusion for certain intellectual property claims. For example, one common exclusion is for injury arising out of infringement of "trademark, trade name, service mark or other designation of origin or authenticity." In *Superperformance International, Inc. v. Hartford Casualty Insurance Co.,* 332 F.3d 215 (4th Cir. 2003), the Fourth Circuit held that this exclusion applied to all trademark infringement claims. In *Native American Arts, Inc. v. Hartford Casualty Insurance Co*., 2004 WL 2065065 (N.D. Ill. Sept. 10, 2004), aff'd, 435 F.3d 729 (7th Cir. 2006), the court held that this exclusion was not restricted to just trademark infringement claims, finding that this exclusion barred coverage for claims of false representation in violation of the Indian Arts and Crafts Act of 1990. However, in *Specific Impulse, Inc. v. Hartford Casualty Insurance Co*., 2002 WL 32052699 (N.D. Cal. Sept. 17, 2002), a California federal court ruled that this exclusion did not apply to copyright infringement claims.

In *Lemko Corp. v. Federal Insurance Co.*, 70 F. Supp. 3d 905 (N.D. Ill. 2014), the policyholder sought coverage under its professional liability policy for alleged theft of

copyrighted and confidential material. The intellectual property exclusion, claims "based upon, arising from, or in consequence of any actual or alleged infringement of copyright, patent, trademark, trade name, trade dress, service mark or misappropriation of ideas or trade secrets," was upheld by the Court and the insured was denied coverage.

In *Hartford Fire Ins. Co. v. Vita Craft Corp.*, 911 F. Supp 2d 1164 (D.Kan. 2012), the insurer sought a declaratory judgment that it owed no duty to defend or indemnify its insured under CGL policies for claims of patent infringement and misappropriation of trade secrets. The insurer argued that the intellectual property rights exclusion barred coverage however, the Court disagreed because the underlying complaint alleged that the insured "spread false rumors" and those allegations fell outside of the exclusion. Similarly, in *MedAssets, Inc. v. Federal Insurance Co.*, 705 F. Supp. 2d 1368 (N.D. GA. 2010), the insurer sought a declaratory judgment under a professional liability policy that the insured was barred from coverage under the intellectual property rights exclusion. However, because the complaint characterized the pricing information as both a "trade secret" and "confidential information," the latter of which did not fall into the exclusion, the insured was provided with coverage.

In *Tela Bio, Inc. v. Federal Insurance Co., No*. 18-1717, 2019 WL 211507 (3d Cir. Jan. 16, 2019), the insured, a hernia mesh manufacturer, for a suit alleging the insured misappropriated confidential trade secrets and poached employees from a competitor. The district court denied the insured coverage and Third Circuit upheld. The Third Circuit reasoned that the insurer had no duty to defend because the underlying complaint had no allegations of libel, slander, or any other defamatory conduct causing reputation harm. Further, even if the underlying complaint did allege libel, slander, or defamatory conduct causing reputational harm, the insured would be denied coverage under the Intellectual Property Exclusion.

6. Prior Publication

The Material Published Prior To Policy Period exclusion specifically precludes coverage for "'personal and advertising injury' arising out of oral or written publication, in any manner, of material whose first publication took place before the beginning of the policy period." This exclusion applies to publications that pre-date the policy period, as well as publications during the policy period that are "substantially similar" to any pre-coverage publications. *St. Surfing, Ltd. Liab. Co. v. Great Am. E&S Ins. Co.*, 776 F.3d 603, 605 (9th Cir. 2014); *MGA Entm't, Inc. v. Crum & Forster Specialty Ins. Co.*, No. CV 07-08276-SGL(RNBx), 2009 U.S. Dist. LEXIS 134871, at *7 (C.D. Cal. June 26, 2009).

In *St. Surfing*, the lower court granted summary judgment to the carrier and found no duty to defend an underlying complaint with allegations of trademark infringement, unfair competition, and unfair trade practices arising from the advertising of a skateboard product under a commercial general liability policy. 776 F.3d at 605–07. In affirming summary judgment, the appellate court held that the prior publication exclusion barred coverage because "an allegedly wrongful advertisement published before the coverage period triggers application of the prior publication exclusion" and because "[i]f this threshold showing is made, the exclusion

bars coverage of injuries arising out of republication of that advertisement, or any substantially similar advertisement, during the policy period, because such later publications are part of a single, continuing wrong that began before the insurance policy went into effect." *St. Surfing* at 610.

The court continued that "[i]f a later advertisement is not substantially similar to the pre-coverage advertisement, however, it constitutes a distinct, or 'fresh,' wrong that does not fall within the prior publication exclusion's scope." *Id.* The court in *St. Surfing* found that the advertisements Street Surfing published during the coverage period were substantially similar to its pre-coverage advertisements because (1) the underlying complaint did not mention any specific advertisements, but rather made general allegations that the insured used the same name and logo on its product and advertisements; (2) the underlying complaint did not allege that the post-coverage advertisements were separate torts occurring during the policy period; (3) the alleged misappropriated advertising terms arose out of each term's similarity to the same individual's advertising idea (*i.e.*, all publications carried out the same alleged wrong); and (4) it was immaterial that the advertisements were for different products because the advertising idea being used was the same regardless of the product. *Id.* at 612–15 (explaining that the advertisements need not be identical and that to assess substantial similarity, courts have not considered all differences between pre-coverage and post-coverage publications, but have focused on the relationship between the alleged wrongful acts manifested by those publications).

Similar to *St. Surfing*, the court in *MGA Entm't* found that the prior publication exclusion precluded coverage for an underlying lawsuit for alleged infringement of intellectual property as to the BRATS versus BRATZ characters. No. CV 07-08276-SGL(RNBx), 2009 U.S. Dist. LEXIS 134871 (C.D. Cal. June 26, 2009). In so holding, the court explained that the only alleged wrong was that "[i]n about June 2001…MGA began advertising and flooding the market with a substantially and confusingly similar genre of characters called 'BRATZ.'" *MGA Entm't* at *9–10. The court continued that "[n]o part of the complaint suggests that the underlying wrongful actions were different in any substantive manner during 2003 [(*i.e.*, during the policy period)]" and that the "underlying complaints reveal that there are no allegations of anything unique or different to the advertising, infringement, or trade libel during the relevant policy period." *Id.* The court also specifically stated that even though the "precise characters, fashions, and accessories may have changed…there is no suggestion in the underlying complaints that any changes occurred in the substance of the advertisements." *Id.* at *10.

The court in *Atl. Mut. Ins. Co. v. J. Lamb, Inc.* sided with the insured and its contributing carrier against the insured's non-contributing carrier regarding a settlement agreement in an underlying action concerning disparaging statements allegedly made by the insured about the third party's business and products. 100 Cal. App. 4th 1017, 1017, 1039 (2002). The insured and the paying carrier sought to appeal a decision by the trial court ruling that the non-paying carrier had no duty to defend on the basis that there was no "advertising or personal injury" during the policy period. *J. Lamb* 100 Cal. App. 4th at 1028. The court of appeal reversed the trial court's decision on the basis that the "first publication" exclusion was inapplicable and the non-paying carrier owed sums for equitable contribution and subrogation. *J. Lamb* at 1045–46.

The court explained that "an insurer may only defeat an existing potential for coverage by *undisputed* facts that *conclusively* negate such coverage." *Id.* at 1038, *relying on Gray v. Zurich Ins. Co.*, 65 Cal. 2d 263 (1966); *Montrose Chem. Corp. v. Superior Court*, 6 Cal. 4th 287 (1993). The court then found that the "first publication" exclusion was inapplicable because "[t]he allegations of the Continental complaint did not specify the date of Lamb's first utterance of any disparagement," such that a possibility of coverage existed. *Id.* at 1038. The court also found that a declaration by the claims adjuster that stated he had spoken with a representative of the insured who stated the dispute originated "with a conversation which occurred in September of 1998", did not *conclusively establish* the date of first publication. *Id.*

III. Other Common Policies Potentially Providing Coverage for IP Risks

The proliferation of IP-related risks has prompted some insurers to revise their CGL policies in recent years to limit coverage for many IP claims that would be covered under traditional "advertising injury" coverages. Some now contain IP exclusions. As a result, a growing number of companies no longer rely solely on CGL policies and are instead purchasing IP-specific policies to address a broader array of IP-related risks than those covered by modern CGL policies.

For example, it is now possible to purchase "infringement liability policies" to cover third-party patent, trademark, copyright, or other infringement claims. Some limit coverage to certain products and cover only those aspects of the products that fall within the insured's own patents. Policies may also obligate the insured to advance defense costs pending the resolution of the underlying case, rather than a true duty to defend. In addition, companies who enforce their own intellectual property rights against potential infringers may purchase "enforcement" coverages. These policies are designed to provide coverage for initiating infringement claims, or in some circumstances cover the costs of defending against counterclaims seeking to invalidate a policyholder's patents and the costs to reissue the patent to strengthen the insured's patent claim.

In addition to IP-specific policies, media liability insurance may also provide coverage for certain types of IP exposures arising from e-commerce activities. These policies address the risks facing entities using non-patentable forms of intellectual property, such as media or entertainment companies. The policies generally cover liabilities stemming from the dissemination of the insured's creative works and/or advertising. The policies are usually written on a named peril basis, typically covering copyright infringement, misappropriation of ideas, trademark infringement, defamation, trade libel and violation of privacy rights.

Cyber policies can also focus on multimedia liability for risks associated with a company's activities when displaying, transmitting, and otherwise using protected content on the Internet. This can include coverage for liability arising out of claims alleging copyright infringement, trademark infringement, defamation, trade libel and violation of privacy rights. These policies, however, generally do not cover claims for patent infringement, false advertising or trade secret misappropriation.

Lastly, Technology Errors and Omissions policies are generally geared toward technology companies and insure against third-party liabilities arising from the provision of technology products and services, which can sometimes include coverage for copyright and patent infringement related to a company's provision of technology. The interplay between CGL and technology E&O coverages can be subject to coverage disputes. For example, in *Educational Impact v. Travelers Property Casualty Company*, No. 15-CV-0510-EMC, 2016 WL 7386139 (N.D. Cal., December 21, 2016), Educational Impact and Teachscape sought insurance coverage for claims arising out of Teachscape's alleged false advertising. In the underlying lawsuits, Educational Impact argued that Teachscape violated the Lanham Act, engaged in unfair competition, and tortiously interfered with Educational Impact's contractual rights when Teachscape publicly claimed that it had exclusive rights to market and sell a product licensed to Educational Impact.

Teachscape tendered the claim to its technology errors and omissions (Tech E&O) insurer and its commercial general liability (CGL) insurer. Educational Impact (now acting as assignee of Teachscape's claims) argued that if coverage for advertising injuries was available under one policy, it must also be available under the other. The District Court for the Northern District of California disagreed. It concluded that coverage was available only under the Tech E&O policy, which provided coverage for "wrongful acts," including for copyright infringement related to false advertising. The CGL policy, in contrast, provided coverage only for "infringement of copyright . . . in your advertisement." Because the complaint did not allege copyright infringement in the advertisement itself, the district court concluded that the CGL policy offered no coverage.

This case highlights a difference between the scope of coverage for advertising and intellectual property claims provided by the "personal and advertising injury" coverage in CGL policies and the coverage in Tech E&O policies for acts, errors or omissions in the performance of technology services or the sale of technology products. Coverage for certain intellectual property claims may be significantly broader under Tech E&O policies than under CGL policies.

In addition, though the court here determined that coverage was only available under the E&O policy, CGL policies often offer coverage for claims alleging product disparagement or other character harms, even if there is not a formal cause of action for disparagement in the complaint. For example, an erroneous assertion of exclusive ownership of a product or intellectual property right can cause reputational harms to competitors marketing the same or similar products, which may be enough to support an implied disparagement claim. The court in *Educational Impact* did not address this argument, and it is unclear whether the policies at issue contained the applicable language. It is possible that the policyholder and the court overlooked the potential for defense coverage under the CGL policy based on allegations that could have supported an implied disparagement theory of liability.

IV. Conclusion

`The "litigation explosion" observed by the Eleventh Circuit in *State Farm Fire and Casualty Co. v. Steinberg*, 393 F.3d 1226 (11th Cir. 2004) is a reality. *See also RGP Dental, Inc. v. Charter*

Oak Fire Ins. Co., 2005 U.S. Dist. LEXIS 28199 (D. R.I. 2005). As the number of intellectual property claims and lawsuits rise, so do the insurance coverage disputes between policyholders and insurers. In order to meet the challenges of this ever-changing area of insurance law, practitioners must be aware of the new decisions and new trends created by courts addressing advertising injury claims.