

Wednesday, May 4, 2016

3:30 – 5:00 pm **Board of Regents Meeting**

5:00 – 6:00pm **Committee Meetings**

6:30 – 7:30 pm **Welcome Reception**

Thursday, May 5, 2016 [Click on Panel title to go to papers from that panel.](#)

8:00 – 9:00 am **Continental Breakfast**

9:00 – 9:50 am **Pushing the Boundaries of D&O Entity Coverage**

Speakers: **Marion Adler** Rachlis Duff Adler & Peel LLC
Dan Bailey Bailey Cavalieri LLC

Although historically aimed at providing coverage for corporate governance claims, the “Entity Coverage” contained within D&O policies has expanded – both as a result of deliberate draftsmanship and of creative reading of policy language – to provide coverage to other types of disputes, such as corporate investigations and consumer claims. This program will address recent developments in such “non-traditional” D&O coverage.

9:50 – 10:40 am **Cyber Liability**

Speakers: **David Anderson** Hoke LLC
Robert Chesler Anderson Kill & Olick, P.C.
Helen Michael Kilpatrick Townsend
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This panel will examine the development of insurance coverage for cyber liability. This will include an analysis of case law under general liability, cyber endorsements and cyber policies. The panel will also examine the coverage provided by the new cyber insurance policies for emerging cyber liabilities.

10:40 – 10:50 am **Break**

10:50 – 11:40 am **London Energy Package Policy, Onshore and Offshore**

Speakers: **Claude Stuart** Hall Mains & Lugin, P.C.

The discussion will include the historical development and scope of the LEPP; the impact of broker drafted wording on policy interpretation and application; its current legal construction with a discussion of representative, key cases and a review of problematic and emerging issues.

11:40 – 12:00 pm **Reps & Warranties Insurance: A Primer and Selected Advanced Issues**

Speaker: **Scott C. Hecht** Stinson Leonard Street LLP

Global M&A deal volume reached a record level in 2015, surpassing the previous record set in 2007. Reps & Warranties insurance is being used more and more in deals. This program will explain basic product features, the process involved in purchasing and integrating the product in a deal, and selected more complex issues.

12:00 – 1:00 pm **Lunch/Recognition of New Members/Annual Business Meeting**

1:00 – 1:50 pm **Global Implications from Climate Change**

Speakers: **David Halbreich** Reed Smith
Neil Rambin Sedgwick LLP

While the number of geophysical disasters has remained fairly stable over the years, the number of climate-related (both hydrological and meteorological) disasters has increased significantly. Experts predict this trend will only continue. As a result, commercial policyholders undoubtedly will have major claims for property damage, loss of business income, extra expenses and contingent liability. These catastrophes present numerous coverage issues. The purpose of this presentation is to explore various coverage issues from the perspective of the policyholder and carrier alike in the context of the law that has evolved around climate change and natural disasters.

1:50 – 2:40 pm **Insurer Guidelines and Third Party Bill Reviews: Ethical and Practical Ramifications**

Speakers: **Douglas McIntosh** McIntosh Sawran & Cartaya, P.A.
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Defense counsel hired by insurers to defend policyholders are met with billing guidelines and file handling requirements, as a means of cost control and effective claims management practices by insurance carriers. Many insurers utilize external billing review vendors or computer programs, for electronic review of defense counsel's bills for determination of the reasonableness of charges for services rendered to their policyholders. The panel will explore the practical effects of these practices, and the dynamics of the impact that such practices have on the insurer-insured contractual relationship, with focus on the tripartite relationship, as well as the potential that such practices might invite extra-contractual exposure in certain instances.

2016 ACCEC Annual Meeting

May 4-6, 2016 Sheraton Grand Chicago· Chicago, Illinois

2:40 – 2:50 pm **Break**

2:50 – 3:30 pm **What Happens after the Duty to Defend has been Breached?**

Speakers: **Janet Davis** Cozen O'Connor
John Vishneski Reed Smith

This program will examine recent developments in case law and identify discrepancies between jurisdictions surrounding the challenges that remain after a breach of the duty to defend has been established. We will examine the following topics: When is a carrier's duty to defend extinguished? Can an insurer raise coverage defenses after a breach? Can an insurer challenge the reasonableness of the fees incurred by the insured in the underlying action?

3:30 – 4:10 pm **Keeping Policyholder Firms Off Panel Counsel Lists—Is This Legal?**

Speakers: **John Mathias, Jr.** Jenner & Block LLP
John Buchanan, Covington & Burling LLP

This program addresses the circumstances experienced by policyholder counsel in large law firms with a diverse litigation practice, including securities litigation defense, when confronted with an insurer's practice of placing restrictions upon law firms as a condition of being listed as "panel counsel" on its D&O insurance policy forms.

4:10 – 4:50 pm **Insurance Company Patterns and Practices—The Discovery and Admissibility of Evidence of "Other Claims"**

Speakers: **Michael Huddleston** Munsch Hardt Kopf & Harr, PC
John Sinnott Irwin Fritchier Urquhart & Moore LLC

A review of potential uses and abuses of discovery of a carrier's handling of other related or similar claims and/or coverage positions taken in such claims, and consideration of recent decisional trends regarding discoverability and admissibility of such evidence.

6:30 – 7:30 pm **Reception**

7:45 – 9:30 pm **Dinner**

Friday, May 06, 2016

8:00 – 9:00 am **Continental Breakfast**

9:00 – 10:00 am **Stipulated Settlements: Under What Circumstances Can the Insured Bind the Insurer for Bad Faith?**

Speakers: **Lewis Collins, Jr.** Butler Weihmuller Katz Craig
Ernest Martin Haynes & Boone, LLP

This topic will analyze and review the circumstances under which an insured can enter into a stipulated settlement agreement without the permission of the insurance carrier. These agreements generally form the basis for a final judgment in excess of the policy limits, and exposure to a bad faith cause of action. The presentation will examine the different requirements across the country for these agreements and how the duty to defend an insured in a tort claim can be determinative of whether the insured can enter into such an arrangement. This topic will examine the critical issues involved from both the carrier and the insured's perspective.

10:00 – 11:00 am **Damages in the Age of Regulation: The Murky Void Between Compensation and Punishment**

Speakers: **Michael Barnes** Dentons
Angela Elbert Neal Gerber & Eisenberg LLP

With the internet society's increased opportunities to cause harm through mass publications and a corresponding increase in legislation to protect consumers, the presenters will address whether statutory remedies constitute "damages" or "loss" under liability policies, as well as the industry's attempt to curb exposure through limiting language.

11:00 – 11:10 am **Break**

11:10 – 12:00 pm **ALI Restatement**

Speakers: **Michael Aylward** Morrison Mahoney
John Buchanan Covington & Burling LLP
Laura Foggan Wiley Rein LLP
Lorelie Masters Perkins Coie

This panel will examine the ALI Restatement of the Law of Liability Insurance project, including controversial provisions in the newly-released draft of Chapter 3, as well the role of ALI Restatements in light of Reporters' mission to "determine the best rule" under the revised ALI Style Manual – A Handbook for ALI Reporters and Those Who Review Their Work (2015).

12:00 – 12:10 pm **Closing Remarks**



2016 Annual Meeting

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Pushing the Boundaries of D&O Entity Coverage

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ENTITY INVESTIGATION COSTS COVERAGE

One of the most frequent coverage disputes under D&O policies in recent years is the existence of coverage for costs incurred by a Company in connection with regulatory and other governmental investigations. Many companies assume there is full coverage for any investigation costs incurred by the company and are surprised when the D&O insurer denies coverage for some or all of those costs.

In reaction to these frequent disputes, D&O policy terms and court rulings have evolved with respect to entity investigation cost coverage. Consistent with insurers' intent, most ABC D&O policies today afford full coverage for investigation costs incurred by insured persons (whether or not the person is a target of the investigation), but afford no coverage for investigation costs incurred by the company.

Subject to a few exceptions, courts have generally based their investigation cost coverage rulings on the clear language of the applicable policy. However, the intended lack of entity coverage has been subverted by some courts under various situations. More recently, some D&O insurers are now offering for an additional premium entity investigation cost coverage.

I. Investigation Costs: A Rising Tide

In recent years, investigation costs have grown exponentially due to an increase in the number of investigations and the rising cost of responding to those inquiries. In 2015, 18% of organizations worldwide identified regulatory and investigatory matters as among the most numerous they face.¹ This percentage has increased within the United States almost every year since 2012, across all company sizes and industry groups, though the increase has been most pronounced within the financial, energy, and life sciences and healthcare industries.² Tellingly, 39% of organizations worldwide now identify regulatory and investigatory matters as the legal disputes of greatest concern to their companies.³

The two most active enforcement authorities are the DOJ and the SEC. Not only are the number of investigations by these authorities at or near record levels, the size and scope of the investigations are often large and broad, thus requiring unprecedented costs to defend.

Due to lack of comprehensive public reporting, it is difficult to precisely measure the number of DOJ investigations commenced annually. Nevertheless, the DOJ has been the primary enforcement body with respect to the Foreign Corrupt Practices Act (FCPA), an area which has exploded since 2005. Approximately 57% of all FCPA enforcement actions since 2005 have been brought by the DOJ. In 2013 and 2014, the DOJ brought twice as many FCPA enforcement actions as the SEC, although this trend ended in 2015, when both agencies brought

10 actions each.⁴ The average settlement value of such matters also increased between 2005 and 2014 from \$7.3 million to \$156.6 million.⁵ In addition to FCPA matters, D&O insurers receive notice of a multitude of DOJ civil investigations relating to other corporate wrongdoing, including antitrust violations, financial fraud, and violations of the False Claims Act.

Investigation statistics reported by the SEC are sobering. The SEC reported that in fiscal year 2014, it filed a record 755 enforcement actions (a 10% increase from 2013) and obtained orders totaling \$4.16 billion in disgorgement and penalties (a 22% increase).⁶ In fiscal year 2015, these figures continued to increase, with 807 enforcement actions filed and \$4.2 billion in penalty and disgorgement orders.⁷ These increases may be due in part to the SEC's renewed focus on investigating and taking enforcement action against individuals responsible for securities law violations, not just the companies they work for, as well as the revived use of Section 20(b) of the Exchange Act. Under Section 20(b), the SEC can pursue persons who, directly or indirectly, do anything "by means of any other person" that would be unlawful for them to do on their own, but who may not be liable under *Janus* because they are not the "makers" of challenged statements.⁸ The increases are also attributable to the SEC's push for greater policing of accounting fraud through the use of innovative computerized tools and the creation of a task force to investigate financial-reporting misconduct, which resulted in the SEC opening more than 100 accounting fraud probes in fiscal year 2014.⁹

In contrast, some regulators appear to be opening fewer investigations, but are still recovering record amounts in the investigations they pursue:

- In recent years, the Commodity Futures Trading Commission (CFTC) has reported a decrease in the number of enforcement actions (from 102 in 2012, to 67 in 2014 and 69 in 2015) and investigations (from 290 in 2013, to 240 in 2014), even while it recovered record sanctions of \$3.7 billion and \$3.2 billion in 2014 and 2015, respectively.¹⁰
- Likewise, the number of disciplinary actions brought by the Financial Industry Regulatory Authority (FINRA) decreased by approximately 9.3% from 1,541 in 2012 to 1,397 in 2014, but the fines and restitution recovered by FINRA over the same period increased from \$102 million to \$166.3 million.¹¹
- The Federal Energy Regulatory Commission (FERC) reports that it opened only 17 investigations in 2014, as compared to 24 in 2013, even while the total penalties and disgorgement damages assessed and/or recovered through settlement increased to \$559.2 million in 2014.¹² However, as these assessments increase, so too does litigation arising out of FERC's assessments, with seven litigation proceedings reported in 2015.¹³ As a likely result, FERC opened 19 new investigations in 2015, but only reached settlements of \$26.26 million and assessed civil penalties and disgorgement of \$111.7 million the same year.¹⁴

The costs associated with defending these investigations continue to soar, largely because of ever-expanding e-discovery. For example, 62% of U.S. companies report that they were required to preserve or collect data from a mobile device in connection with litigation or an investigation in 2014.¹⁵ Because companies and their employees maintain immense amounts of data, discovery costs can total millions (and sometimes tens of millions) of dollars.

Not surprisingly, many companies retain outside counsel to assist in defending investigations, thereby further increasing costs.¹⁶ Directors and officers often request separate counsel to represent them in interviews and to respond to document requests. As such, the cost of responding to regulatory investigations may approach or even exceed the sanctions ultimately imposed. For example, in 2008, Office Depot spent over \$23 million to defend SEC allegations that the company and two of its officers violated the federal securities laws. Office Depot ultimately agreed to pay a \$1 million civil penalty and the officers paid separate \$50,000 penalties to resolve the allegations.¹⁷ That same year, Siemens reportedly spent \$1 billion on its internal investigation into violations of the FCPA, for which it ultimately paid \$1.6 billion in regulatory fines.¹⁸ As shown by these extreme examples, the existence or lack of investigation cost coverage can be critically important for Insureds.

II. Evolving Coverage for Entity Investigation Costs

As with many coverage issues, whether a policy affords entity coverage for an investigation often begins and ends with the definitions of “Claim” and “Securities Claim” in the policy. D&O policies typically contain a definition of “Claim” that includes one or more of the following potentially applicable prongs:

- A written demand for monetary or non-monetary relief against an Insured;
- A civil, criminal, administrative, regulatory or arbitration proceeding against an Insured that is commenced by (i) service of a complaint or similar pleading, (ii) return of an indictment, information, or similar document, or (iii) receipt or filing of a notice of charges; or
- A formal criminal, administrative, or regulatory investigation against an Insured Person.

The definition of “Securities Claim” in turn typically includes certain “Claims” alleging a violation of securities laws, but frequently excludes regulatory or administrative proceedings against the company.

Historically, D&O insurers have not intended to afford entity coverage in connection with regulatory and governmental investigations. Entity investigation costs are viewed by insurers as a highly volatile exposure and an ordinary cost of doing business. The following discussion summarizes how insurers have tried to implement that intent and how insureds have tried to circumvent that intent.

A. “Investigations” Prong of Claim Definition

To avoid entity investigation cost coverage, the “investigation” prong of the definition of “Claim” usually limits coverage for investigations only to Insured Persons. That seemingly clear coverage limitation is not always followed by courts, though. For example, in *Millennium Laboratories Inc. v. Allied World Ins. Co.*, 2015 U.S. Dist. LEXIS 13353 (S.D. Cal. Sept. 30, 2015), the court held that DOJ subpoenas issued to the insured entity satisfied the “investigation” prong of the definition of Claim in the D&O policy even though that prong only referred to investigations of an Insured Person. The court based its holding on a corresponding letter from the DOJ, which stated that the DOJ was conducting a joint criminal and civil investigation of the insured entity and its officers, employees and agents.

B. “Proceeding” Prong of Claim Definition

Because the “investigation” prong of the definition of “Claim” does not expressly grant entity coverage, some Insureds argue that the “proceeding” prong of the definition triggers entity investigation cost coverage. However, investigations often do not rise to the level of a “proceeding.” For example, in *Emplr’s Fire Ins. Co. v. Promedica Health Sys.*,¹⁹ the Sixth Circuit Court of Appeals held that the issuance of an investigative subpoena to the insured entity did not commence a “proceeding,” but merely permitted “the use of compulsory process in connection with [an] ongoing investigation.” The Eleventh Circuit reached a similar conclusion with respect to the SEC’s requests for documents and testimony from the corporate entity in *Office Depot, Inc. v. Nat’l Union Fire Ins. Co.*²⁰ Such a result is particularly appropriate where the definition of “Claim” requires that a proceeding be commenced by the filing or service of a complaint, indictment, or notice of charges, all of which being documents not typically filed until an investigation concludes.²¹

But, in *MBIA Inc. v. Federal Ins. Co.*,²² the Second Circuit held that subpoenas issued by the New York Attorney General pursuant to an investigation commenced a “proceeding or inquiry” as used in the definition of Claim because that definition referred to a proceeding commenced by an “investigative order.” Likewise, in *Biochemics, Inc. v. Axis Reinsurance Co.*, the U.S. District Court for the District of Massachusetts held that subpoenas issued to the insured entity pursuant to an SEC formal order of investigation constituted a “civil, arbitration, administrative or regulatory proceeding against any Insured commenced by...the filing of a notice of charge, investigative order, or like document.”²³

C. “Demand for Relief” Prong of Claim Definition

Even when the “investigation” and “proceeding” prongs of the definition of “Claim” do not apply, some companies seek investigation cost coverage by arguing that the investigation is a “demand for non-monetary relief” under the definition of “Claim.” A majority of the jurisdictions that have considered this argument have rejected it, primarily based on the court’s view that “relief” (a term not defined by D&O policies) does not include compliance with discovery requests or the provision of testimony.

For instance, in *Diamond Glass Cos., Inc. v. Twin City Fire Ins. Co.*,²⁴ the Southern District of New York held that a subpoena and search warrant did not constitute a “demand for non-monetary relief,” based in part on Black’s Law Dictionary definition of “relief,” which includes “redress or benefit...that a party asks of a court.” The First Circuit also articulated this “ordinary meaning” approach in *Ctr. for Blood Research, Inc. v. Coregis Ins. Co.*,²⁵ holding that “an objectively reasonable insured would have...understood that its expenses for attorneys to represent it in response to the subpoena...would not be covered.” The Sixth Circuit, as well as courts in California, Illinois, and Minnesota, has also adopted this view.²⁶

To rebut this majority view, insureds frequently rely on *Syracuse Univ. v. Nat’l Union Fire Ins. Co.*,²⁷ in which the appellate court held that a grand jury subpoena is a “demand for non-monetary relief” because “a subpoena is a grand jury’s means of preventing or redressing a wrong by enforcing the public’s right to ‘every man’s evidence.’” However, several courts have discounted *Syracuse* as relying on distinguishable authority that construed policies which did not contain a definition of “Claim.”²⁸ A few other courts, though, have found a subpoena to be a

“demand for relief” and thus a Claim.²⁹ Thus, whether an investigation is a “demand for relief” may vary from policy to policy and from jurisdiction to jurisdiction.

D. “Reasonably Related” Defense Costs

Even where investigations of the company are expressly excluded from or not included within the definitions of “Claim” and “Securities Claim,” Insureds may argue that the entity’s investigation costs should be covered because they are “reasonably related” to the defense of another covered Claim, such as an investigation of Insured Persons or a securities class action against the Company. A number of courts apply the “reasonably related” test when allocating between covered and non-covered defense costs and conclude that all or virtually all of the jointly incurred defense costs are covered.³⁰ However, those rulings arguably do not apply under most D&O policies today because of the allocation provisions in those policies, which adopt a more even-handed allocation methodology.³¹ Likewise, courts have rejected arguments that a Company’s investigation costs should be covered because such costs benefited the Insureds’ defense of covered lawsuits.³²

E. Express Entity Investigation Cost Coverage

A few insurers today now offer express entity investigation cost coverage in D&O policies. This coverage, which is typically only available for a substantial additional premium, applies to costs incurred by the insured company in connection with regulatory investigations. One can debate whether this expanded entity coverage is wise from both the insurer’s perspective and the insureds’ perspective.

A primary insurer may be benefitted from this coverage because it generates additional revenue and in many instances does not increase the primary insurer’s loss payments because the coverage is likely triggered in situations where the primary policy’s limit of liability will be exhausted by other covered claims even without this coverage. However, excess insurers will more likely be harmed by the coverage because their additional revenue from the coverage will be more modest even though they bear the vast majority of the additional covered loss exposure.

From the insureds’ perspective, this additional entity coverage certainly benefits the insured company. However, this entity coverage dilutes the amount of coverage available for the insured persons. As a result, prudent risk management may result in companies purchasing this entity investigation cost coverage in the first few layers of the ABC D&O program but not adding this coverage to a large portion of the ABC layers, thereby protecting those higher ABC layers (and any Side A layers) from erosion by reason of this expanded entity coverage.

¹ Norton Rose Fulbright, *2015 Litigation Trends Annual Survey* (the “2015 Litigation Trends Survey”), p. 8 (2015), http://www.nortonrosefulbright.com/files/20150514-2015-litigation-trends-survey_v24-128746.pdf.

² *Id.* at p. 9; *see also* Norton Rose Fulbright, *2014 Litigation Trends Survey Report*, p. 8 (2014), <http://www.nortonrosefulbright.com/files/20140415-norton-rose-fulbrights-10th-annual-litigation-trends-115113.pdf>.

³ 2015 Litigation Trends Survey at p. 10.

⁴ Gibson, Dunn & Crutcher LLP, *2014 Year-End FCPA Update* (the “2014 FCPA Update”), p. 2 (Jan. 5, 2015), <http://www.gibsondunn.com/publications/documents/2014-Year-End-FCPA-Update.pdf>; Gibson, Dunn & Crutcher LLP, *2015 Year-End FCPA Update*, p. 2 (Jan. 4, 2016), <http://www.gibsondunn.com/publications/documents/2015-Year-End-FCPA-Update.pdf>.

⁵ See 2014 FCPA Update at p. 2. However, in 2015, the average FCPA settlement dropped to \$12.5 million. See Jones Day, *FCPA 2015 Year in Review*, p. 3 (Jan. 2016), http://www.jonesday.com/files/Publication/9a38cc48-0c4b-404d-8e0f-891f0a93d321/Presentation/PublicationAttachment/43ffd904-bef5-41ef-ab88-a6c26ed86da2/FCPA_2015_Year_in_Review.pdf.

⁶ Press Release, U.S. Securities & Exchange Commission, *SEC's FY 2014 Enforcement Actions Span Securities Industry and Include First-Ever Cases* ("2014 SEC Enforcement Report") (Oct. 15, 2014), <https://www.sec.gov/News/PressRelease/Detail/PressRelease/1370543184660>.

⁷ Press Release, U.S. Securities & Exchange Commission, *SEC Announces Enforcement Results for FY 2015* (Oct. 22, 2015), <http://www.sec.gov/news/pressrelease/2015-245.html>; see 2014 SEC Enforcement Report.

⁸ Mary Jo White, Speech at the NYC Bar Association's Third Annual White Collar Crime Institute: *Three Key Pressure Points in the Current Enforcement Environment* (May 19, 2014), www.sec.gov/news/speech/2014-spch051914mjw.html.

⁹ Jean Eaglesham & Michael Rapoport, *SEC Gets Busy With Accounting Investigations*, WALL STREET JOURNAL, Jan. 20, 2015, <http://www.wsj.com/articles/sec-gets-busy-with-accounting-investigations-1421797895>. (Data for fiscal year 2015 is not yet available.)

¹⁰ Press Release, U.S. Commodity Futures Trading Commission, *CFTC Releases Annual Enforcement Results for Fiscal Year 2014* (Nov. 6, 2014); Press Release, U.S. Commodity Futures Trading Commission, *CFTC Releases Annual Enforcement Results for Fiscal Year 2015* (Nov. 6, 2015), <http://www.cftc.gov/PressRoom/PressReleases/pr7274-15>.

¹¹ Financial Industry Regulatory Authority, *Oversight – Enforcement*, <http://www.finra.org/industry/enforcement>.

¹² Federal Energy Regulatory Commission, *2014 Report on Enforcement*, p. 21 (Nov. 20, 2014), <http://www.ferc.gov/legal/staff-reports/2014/11-20-14-enforcement.pdf> (noting that a majority of these amounts are the subject of pending appeals).

¹³ Federal Energy Regulatory Commission, *2015 Report on Enforcement*, p. 6 (Nov. 19, 2015), <https://www.ferc.gov/legal/staff-reports/2015/11-19-15-enforcement.pdf>.

¹⁴ *Id.* at pp. 3, 9.

¹⁵ 2015 Litigation Trends Survey at p. 40.

¹⁶ *Id.* at p. 34 (approximately 64% of larger companies report that they retain outside counsel to assist with investigations, as compared to 44% of mid-sized companies and 17% of small companies).

¹⁷ Edward Wyatt, *Office Depot to Pay \$1 Million to Settle SEC's Fair Disclosure Charge*, NEW YORK TIMES, Oct. 21, 2010, <http://www.nytimes.com/2010/10/22/business/22sec.html>.

¹⁸ Eric Lichtblau & Carter Dougherty, *Siemens to Pay \$1.34 Billion in Fines*, NEW YORK TIMES, Dec. 15, 2008, http://www.nytimes.com/2008/12/16/business/worldbusiness/16siemens.html?_r=1&.

¹⁹ 524 Fed. Appx. 241, 251 (6th Cir. 2013).

²⁰ 453 Fed. Appx. 871, 876 (11th Cir. Fla. 2011).

²¹ *Diamond Glass Cos. v. Twin City Fire Ins. Co.*, 2008 U.S. Dist. LEXIS 86752, *10 (S.D.N.Y. Aug. 18, 2008).

²² 652 F.3d 152 (2d Cir. 2011).

²³ *Biochemics, Inc. v. Axis Reinsurance Co.*, 2015 U.S. Dist. LEXIS 896, *6-*7 (D. Mass. Jan. 6, 2015).

²⁴ 2008 U.S. Dist. LEXIS 86752 at *11.

²⁵ 305 F.3d 38, 43 (1st Cir. 2002).

²⁶ *Emplr's Fire Ins. Co. v. Promedica Health Sys.*, 524 Fed. Appx. 241, 250-52 (6th Cir. 2013) ("The subpoenas [and civil investigative demands] sought information related to the FTC's investigation, not a remedy provided by a court.... Therefore, they did not demand 'relief' as required by the second element of a 'claim.'"); *St. Paul Mercury Ins. Co. v. RMG Capital Corp.*, 2012 U.S. Dist. LEXIS 80034, *9 (C.D. Cal. June 7, 2012) (relying on the analysis from *Diamond Glass* and *Ctr. for Blood Research* to hold that a demand for "return correspondence" did not constitute a demand for "non-monetary relief"); *Federal Ins. Co. v. Illinois Funeral Director's Ass'n*, 2010 U.S. Dist. LEXIS 129747, *13-*14 (N.D. Ill. Dec. 8, 2010) (a subpoena did not constitute a "written demand for monetary damages or non-monetary relief"); *St. Paul Mercury Ins. Co. v. Foster*, 268 F. Supp. 2d 1035, 1048 (C.D. Ill. 2003) (a letter requesting information or documents regarding an ERISA plan did not seek "other relief" as used in the policy's definition of a Claim); *Foster v. Summit Med. Systems, Inc.*, 610 N.W.2d 350, 355 (Minn. App. 2000) ("The SEC's ability to compel production of documents does not fit any reasonable reading of the term 'relief.'").

²⁷ *Syracuse University v. Nat'l Union Fire Ins. Co.*, 40 Misc. 3d 1205(A) (N.Y. Sup. Ct. Mar. 7, 2013), *aff'd* 112 A.D.3d 1379 (N.Y. App. Div. Dec. 27, 2013).

²⁸ *McCalla Corp. v. Certain Underwriters at Lloyd's*, 2014 U.S. Dist. LEXIS 60309 (D. Kan. May 1, 2014); *RSUI Indem. Co. v. Desai*, 2014 U.S. Dist. LEXIS 122068 (M.D. Fla. Sept. 2, 2014).

²⁹ *Minuteman Int'l, Inc. v. Great Am. Ins. Co.*, 2004 U.S. Dist. LEXIS 4660 (N.D. Ill. Mar. 18, 2004); *Agilis Benefit Services LLC v. Travelers Cas. And Sur. Co. of Am.*, 2010 U.S. Dist. LEXIS 144491 (E.D. Tex. Apr. 30, 2010).

³⁰ See, e.g., *Continental Cas. Co. v. Board of Education*, 302 Md. 516, 489 A.2d 536 (1985).

³¹ See, e.g., *Dobson v. Twin City Fire Ins. Co.*, 2012 U.S. Dist. LEXIS 93823, *53 (C.D. Cal. July 5, 2012), *reversed on other grounds* 590 Fed. Appx. 687 (9th Cir. 2015) (“[T]his Court rejects Plaintiffs’ argument that the default [‘reasonably related’] rule applies because the allocation provision clearly requires allocation and some of the Claims are not covered.”).

³² *Office Depot, Inc. v. Nat’l Union Fire Ins. Co. of Pittsburgh, Pa.*, 734 F. Supp. 2d 1304, 1322 (S.D. Fla. 2010) (“However, it does not follow that any pre-suit investigation costs which may have related to and benefitted the defense of those suits [now operating as ‘subsequent Claims’] are transformed into a covered ‘loss’ which ‘arises from’ that securities litigation under operation of the Policy’s ‘relation back’ provision or otherwise.”); *Telxon Corp. v. Federal Ins. Co.*, 309 F.3d 386, 391-92 (6th Cir. 2002) (costs incurred by individual insureds for coordinated defense of non-covered entity did not constitute loss which the officers were “legally obligated to pay”).

COVERAGE FOR CONSUMER AND SIMILAR NON-FIDUCIARY CLAIMS UNDER D&O POLICIES

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Most policyholders and their coverage attorneys think of their Directors and Officers policies in terms of providing protection from claims brought by shareholders and others to whom the fiduciary duties are owed for the malfeasance or misfeasance of corporate managers, officers, and/or directors.² Especially for privately-held insureds, however, their D&O policies may be sufficiently expansive to provide coverage for claims brought by customers and others outside the fiduciary relationship, unrelated to issues of corporate governance.

For example, courts have upheld corporations' rights to coverage under their D&O policies for claims arising under state consumer protection statutes,³ real estate and construction transactions,⁴ franchisor-franchisee disputes,⁵ and investment

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² We use the term "corporation" in this article interchangeably with "entity" to refer to the business that is the Named Insured on the D&O policy. Such named insureds include other organizational structures, such as limited liability companies and limited liability partnerships but, for simplicity's sake, they are referred to as "corporations" in this article.

³ See *24 Hour Fitness USA, Inc. v. National Union Fire Ins. Co.*, CV 11-8088-GHK (RZx) Mem. Op. at 10-11 (C.D. Cal. March 21, 2013) (class action under consumer protection statutes for allegedly misleading statements that allegedly induced plaintiff class to enter into gym memberships) (copy included in Tab D of Addendum); *Integra Telecom, Inc. v. Twin City Fire Ins. Co.*, Civ. No. 08-906-AA, 2010 WL 1753210 (D. Or. Apr. 29, 2010) (claims brought under state consumer protection statute for overbilling of customers).

⁴ See *Corky McMillin Constr. Svc., Inc. v. U.S. Specialty Ins. Co.*, 597 Fed. Appx. 925 (9th Cir. 2015) (class action claims by home buyers against real estate broker for misrepresentations and omissions in marketing material); *S.J. Amoroso Constr. Co. v. Exec. Risk Indem., Inc.*, 325 Fed. Appx. 548, 2009 WL 1154202 (9th Cir. Apr. 30, 2009), *rev'g*, No. C 06-2572 SBA, 2007 WL 3231741 (N.D. Cal. Oct. 7, 2007) (misrepresentations by construction company that induced developer to consent to assignment of construction contract).

⁵ See *Cousins Submarines, Inc. v. Federal Ins. Co.*, No. 12-CV-387-JPS, 2013 WL 494163 (E.D. Wis. Feb. 28, 2013) (insofar as franchisor's settlement with franchisees compensated for damages incurred before parties entered into the franchise agreements, settlement was covered by D&O policy).

relationships.⁶ This article addresses the coverage opportunities and obstacles that arise in these situations.

First some clarifying points:

- Oftentimes insurers sell package policies that may be generically referred to as “D&O” policies but may also include additional coverage parts for Employment Practices Liability Insurance, Fiduciary Liability Coverage (for claims arising out of the management and administration of employment benefits plans), and other assorted coverages. This article is limited to discussing coverage available under the D&O portion only of such package policies – what is sometimes labeled the “Management Liability” coverage.
- The Insuring Agreement of the standard D&O policy provides three distinctive types of coverage: (a) coverage available directly to individual persons for claims brought against them arising from their acts and omissions in executing their duties as officers, directors, or employees of the corporation; (b) coverage payable to the corporation for sums incurred by the corporation to indemnify such officers, directors, or employees for such claims; and (c) coverage for the corporate entity, itself, for claims brought directly against it. This last category of coverage is referred to as “Entity” coverage and is the focus of this article.
- The scope of this paper is limited to claims involving economic harm, not “bodily injury” or “property damage.” Not only do D&O policies invariably exclude coverage for the latter types of claims, but insureds facing such claims should be seeking coverage under their CGL policies.

A. Claims by Consumers and Similar Persons Typically Fall within the Insuring Agreement of D&O Entity Coverage.

As with any coverage analysis, the starting point for seeking coverage under a D&O policy is the coverage grant – i.e., “Insuring Agreement” – of the policy. The Insuring Agreement for Entity Coverage under the typical D&O policy issued to a privately held company is very broadly worded and will generally encompass virtually any type of claim brought by a consumer or customer. For example:

⁶ See *Great American Ins. Co. v. Geostar Corp.*, No. 09-123888-BC, 2010 WL 845953 at *12 (E.D. Mich. Mar. 5, 2010) (investors in tax-advantaged mare lease program); *Westchester Fire Ins. Co. v. Rosenthal Collins Group, LLC*, No. 2013 CH 01508 (Ill. Cir. Ct. Cook Cty. July 3, 2014) (copy included in Tab E of Addendum) (claims by investors against futures commission merchant that cleared trades by self-dealing financial advisor who squandered underlying plaintiffs’ funds), *vacated pursuant to settlement*.

- Chubb’s form (no. 14-02-13781 (02/2008)) provides in relevant part:

The Company shall pay, on behalf of an **Organization**, **Loss** which such **Organization** becomes legally obligated to pay on account of any **Claim** ... for a **Wrongful Act** by the **Organization**⁷

- AIG’s form (no. 95727 (9/07)) states in relevant part:

This **D&O Coverage Section** shall pay the **Loss** of the **Company** arising from a:

(i) **Claim** made against the **Company** ...,
for any **Wrongful Act**

- ACE’s form (no. PF15193 (12-08)) states in relevant part:

The **Insurer** shall pay the **Loss** of the **Company** which the **Company** becomes legally obligated to pay by reason of a **Claim** ...
for any **Wrongful Act**

Thus, there are four key defined terms within each of these Insuring Agreements: **Company/ Organization**, **Loss**, **Claim**, and **Wrongful Act**. The term “**Company**” or “**Organization**” is typically defined to encompass the Named Insured, as well as subsidiaries and affiliated companies in which the Named Insured has a direct or indirect majority stake.

The term “**Loss**” encompasses monetary sums incurred in responding to the claim, *including defense costs*, but often with specified exceptions such as fines or penalties. The AIG definition is illustrative:

“**Loss**” means damages, judgments, settlements, pre-judgment and post-judgment interest, **Crisis Management Loss** and **Defense Costs**; provided, however, **Loss** shall not include: (i) civil or criminal fines or penalties imposed by law; (ii) taxes; (iii) any amounts for which an **Insured** is not financially liable or which are without legal recourse to an **Insured**; or (iv) matters which may be deemed uninsurable under the law pursuant to which this policy shall be construed. **Defense Costs** shall be provided for items specifically excluded from **Loss** pursuant to

⁷ Specimen forms from AIG, Chubb, and Ace, as obtained from their websites, are included in the Addendum to this article.

subparagraphs (u)(i) through (u)(iv) above of this Definition, subject to the other terms, conditions and exclusions of this policy.

Loss shall specifically include, subject to the other terms, conditions and exclusions of this **D&O Coverage Section**, including, but not limited to, exclusions 4(a), 4(b) and 4(c) of this **D&O Coverage Section**, punitive, exemplary and multiple damages The enforceability of the first sentence of this paragraph shall be governed by such applicable law which most favors coverage for punitive, exemplary and multiple damages.

The term “**Claim**” encompasses, not just lawsuits and similar formal proceedings, but typically, also includes pre-suit written demands. Here is the most relevant portion of the AIG definition:

- (i) a written demand for monetary or non-monetary relief (including any request to toll or waive any statute of limitations);
- (ii) a civil, criminal, administrative, regulatory or arbitration proceeding for monetary or non-monetary relief which is commenced by:
 - (1) service of a complaint or similar pleading;
 - (2) return of an indictment, information or similar document (in the case of a criminal proceeding); or
 - (3) receipt or filing of a notice of charges

This broadened definition of a “claim” is necessitated by the “claims-made” nature of D&O coverage, as discussed in Section C, below. As a consequence of this broadened definition, however, an insured has stronger bases for obtaining coverage for pre-suit attorneys’ fees and even pre-suit settlements compared to the language of CGL policies, for example.

Most critically, these policies employ a wide-open definition of the term “Wrongful Act” that is broad enough to reach virtually any type of misconduct, act, or omission, including acts of intentional wrongdoing, as illustrated by the AIG definition, which defines the term, with respect to Entity coverage as:

any breach of duty, neglect, error, misstatement, misleading statement, omission or act by a **Company**

Cases arising in the context of coverage for consumer claims have specifically interpreted this definition of a “Wrongful Act” to encompass claims alleging that the insured corporation engaged in intentionally misleading or deceptive practices.⁸

⁸ See, e.g., *24 Hour Fitness USA*, Mem. Op. at 10-11 (because the definition encompasses “any breach of duty, neglect, error, misstatement, *misleading statement*, omission or act by the Company.” an objectively reasonable insured would not expect a limitation on the Policy’s coverage that is commonly

Indeed, this broad interpretation of the term “Wrongful Act” is well-recognized in other D&O coverage disputes too, where the courts have read the term as reaching allegations of intentional and even criminal misconduct by officers and directors.⁹

In short, the language defining “claim,” “loss,” and “wrongful act” in the typical D&O policy is broad enough to reach almost any consumer claim asserted against an insured entity.

B. The Typical D&O Policy Exclusions Significantly Reduce the Availability of Coverage for Consumer Claims.

While the Insuring Agreement is thus extraordinarily broad in the typical D&O policy, these policies are rife with exclusions that significantly cut back on the actual scope of coverage. The exclusions that present the most significant obstacles when coverage is sought for claims brought by consumers and similar claimants include the “contractual liability,” “anti-trust” or “unfair trade practices,” and “professional services” exclusion.

1. The contractual liability exclusion.

D&O policies typically include an exclusion – which applies only to the Entity prong of coverage – that bars claims arising out of “contractual liability.” The AIG exclusion, for example, excludes Entity coverage for claims:

alleging, arising out of, based upon or attributable to any actual or alleged contractual liability of the **Company** or any other **Insured** under any express contract or agreement; provided, however, this exclusion shall not apply to liability which would have attached in the absence of such express contract or agreement.

included in express terms, such as a term limiting coverage to ‘accidental occurrences,’ but was left out here.”) (emphasis in original).

The author was lead counsel for the insured in *24 Hour Fitness*.

⁹ See, e.g., *Wintermute v. Kansas Bankers Sur. Co.*, 630 F.3d 1063, 1065, 1069 (8th Cir. 2011) (criminal indictment charging director with bank fraud and filing false statements involved “Wrongful Acts” under definition identical to AIG policy form); *Nat’l Union Fire Ins. Co. v. Brown*, 787 F. Supp. 1424, 1428-29 (S.D. Fla. 1991) (director’s scheme to defraud homeowners within definition of “Wrongful Act” similar to definition quoted above).

Similar definitions of “Wrongful Acts” within Errors & Omissions policies have likewise been held to encompass intentional misconduct. See, e.g., *PMI Mortg. Ins. Co. v. American Internat’l Specialty Ins. Co.*, 394 F.3d 761, 764 (9th Cir. 2005) (kickback scheme fell within similar definition of “wrongful act” in E&O policy).

The breadth of this may impede D&O coverage for many consumer type claims.¹⁰

Not all claims that arise out of contractual relationships, however, are necessarily excluded from D&O coverage as a result of the contractual liability exclusion. Even where a contractual relationship undergirds the transaction, the exclusion has been held inapplicable to underlying claims arising from pre-contractual misrepresentations.¹¹ So too, if the contract did not run between the underlying plaintiffs and the insured, some courts will not allow the exclusion to bar coverage even where the dispute does arise from a contractual relationship between one of those parties and some other person or entity.¹²

2. The “anti-trust” or “unfair trade practices” exclusion.

Some D&O policies contain an exclusion – generally called the “anti-trust” or “unfair trade practices” – that bars coverage for claims:

¹⁰ See, e.g., *Fed. Ins. Co. v. KDW Restr. & Liq. Svc., LLC*, 889 F. Supp. 2d 694, 708 (M.D. Pa. 2012) (exclusion barred coverage for tort claims that purchasers of convenience marts were induced by sellers’ misrepresentations to purchase stores regardless that claims did not sound in breach of contract; the claims fit within the exclusion’s bar for claims “based upon, arising from, or in consequence of any actual or alleged liability’ under the contracts”); *Medill v. Westport Ins. Corp.*, 143 Cal. App. 4th 819, 49 Cal. Rptr. 3d 570 (2006), (claims by bondholders against issuer that defaulted on municipal bonds barred by contractual liability exclusion because the parties’ relationship was contractual in nature, even though underlying suit asserted claims sounding in tort, not breach of contract).

¹¹ See *24 Hour Fitness*, Mem. Op. at 6-8, 11 (claims arising under RICO and federal Electronics Fund Transfer Act were barred by contractual liability exclusion because they were based on allegations that insured’s electronic transfer of funds exceeded insured’s contractual rights; however, consumer protection claims for alleged pre-contractual misrepresentations that induced plaintiffs to purchase gym memberships were not barred by exclusion); *Cousins*, 2013 WL 494163 at *8 (contractual liability exclusion barred all post-contractual damages incurred by franchisees but did not bar coverage of components of settlement representing damages incurred before the franchisees entered in franchise agreements such as “fees to financial analysts, seeking advice on opening Cousins franchises[, ... or] travel expenses to meet with Cousins representatives”).

¹² See *S.J. Amoroso*, 325 Fed. Appx. at 549:

... Mauna Kea Properties alleged that Amoroso made negligent or intentional misrepresentations that induced Mauna Kea Properties to contract *with DAP*. This theory of liability in the Mauna Kea litigation depends on the fact that Amoroso was not a party to the construction contract and, therefore, did not have liability under the contract (when Mauna Kea allegedly thought that Amoroso would). To that extent, Amoroso’s liability is not liability under a contract or agreement, and Executive Risk may not rely on Exclusion III(C)(2) to deny coverage.

(Italics in original; underlining added.) See also *Lifespan Corp. v. Nat’l Union Fire Ins. Co.*, 59 F. Supp. 3d 427, 448 (D.R.I. 2014) (claims brought by state Attorney General against hospital for breaching fiduciary duties in negotiating insurance contracts for its subsidiaries were not barred by contractual liability exclusion because hospital and Attorney General had no contractual relationship).

for any actual or alleged violation of any law, whether statutory, regulatory or common law, respecting any of the following activities: anti-trust, business competition, *unfair trade practices* or tortious interference in another's business or contractual relationships.

(Quoting AIG form; emphasis added.) Unlike other policy language, for which various D&O insurers all have similarly worded provisions, the presence of an anti-trust and unfair trade practices exclusion is not as uniform, however. Neither the Chubb nor Ace D&O jackets that are included in the Addendum contain such an exclusion – which does not rule out the possibility that those insurers might, at least under certain circumstances, endorse such exclusions onto their D&O policies.

At first blush, the bar for coverage for claims involving “unfair trade practices” may be perceived as an almost insurmountable hurdle to obtaining coverage for claims brought under state or federal consumer protection statutes. Indeed, this may seem self-evident given that the words “unfair trade practices” or similar terminology are often contained within the very name of the statute and the statutes impose liability against businesses that engage in “unfair practices.”¹³

Courts construing such exclusions, however, generally do *not* interpret the phrase “any law ... respecting ... unfair trade practices” to include the entirety of the law of consumer protection. Rather, because the term “unfair trade practices” is among a larger listing of a claims relating to the law of competitive injury, courts often rely upon the doctrine of *noscitur a sociis* – i.e., that “a word is given more precise content by the neighboring words with which it is associated”¹⁴ – as well as the maxim that all ambiguities in policy exclusions are construed against the insurer, to hold that only *anti-competitive* “unfair trade practices” are within the scope of this exclusion.¹⁵ The same rationale has been applied to similarly-worded “unfair trade practices” exclusions found in errors and omissions policies to limit their scope to claims involving competitive injury.¹⁶ Where “unfair trade practices” exclusions have

¹³ See, e.g., Illinois Consumer Fraud and Deceptive Business Practices Act, 815 ILCS 5/1 *et seq.*, which creates liability for engaging in “unfair or deceptive acts or practices.” *Id.* § 505/2. See also Oregon Unlawful Trade Practices Act, ORS § 646.605 *et seq.*, which identifies a variety of prohibited activities as “an unlawful practice” when committed “in the course of the persons’ business, vocation or occupation.” *Id.* § 646.07, § 646.08.

¹⁴ *Freeman v. Quicken Loans, Inc.*, 132 S. Ct. 2034, 2042 (2012) (providing the quoted English translation for the Latin doctrine).

¹⁵ See, e.g., *Integra*, 2010 WL 1753210 at *4-6; *Cousins*, 2013 WL 494163 at *11-*12; *24 Hour Fitness*, Mem. Op. at 12-13.

¹⁶ See *Beyer v. Heritage Realty Inc.*, 251 F.3d 1155, 1557-58 (7th Cir. 2001).

been held to bar coverage for consumer claims, the underlying suits have typically involved allegations of anti-competitive behavior.¹⁷

3. The “professional services” exclusion.

Not infrequently, D&O policies also contain an exclusion for claims involving “professional services,” which is sometimes referred to as an “E&O exclusion.” For example the attached Chubb form excludes claims:

based upon, arising from, or in consequence of performing or the failure to perform any professional service; provided this Exclusion ... shall not apply to any **Claim** brought by or on behalf of a securityholder of the **Organization** in his or her capacity as such.

Neither the attached AIG nor Ace jackets include a professional service exclusion. The absence of such an exclusion from the policy jacket does not preclude the possibility that the insurer may endorse such an exclusion onto the policy, especially where the insured is primarily in the business of furnishing services entailing specialized training or experience. Thus, the Ace policy issued to the insured in *Rosenthal Collins* – which was a regulated “futures commission merchant” in the business of clearing the trades of options (see footnote 6) – was endorsed with a professional services exclusion banning coverage for claims:

alleging, based upon, arising out of, attributable to, directly or indirectly resulting from, in consequence of, or in any way involving the rendering or failing to render professional services. Provided, however, this exclusion shall not apply to any **Claim(s)** brought by a security holder of the **Company** in the form of a securities holder class, individual or derivative action alleging failure to supervise those who performed or failed to perform such professional services, provided that such securities holder action is instigated and continued totally independent of, and totally without the solicitation of, or assistance of, or active

¹⁷ See *Welch Foods, Inc. v. Nat’l Union Fire Ins. Co.*, 659 F.3d 191, 193 (1st Cir. 2011), *aff’g*, Civ. No. 09–12087–RWZ, 2010 WL 3928704 (D. Mass. Oct. 1, 2010) (unfair trade practice exclusion barred coverage for consumer class claims that fruit juice manufacturer had used deceptive marketing to increase its market share vis-à-vis its competition). See also National Union’s appellate brief, which describes the underlying claims as arising from “competition” between the insured and its competitor “for market share in the consumer market for pomegranate products.” (Case No. 10-2261, Doc. 00116208936, Page 26, Filed: 05/16/2011 Entry ID: 5550698).

participation of, or intervention of the **Company** and/or any **Insureds**.¹⁸

Where the policy does not specifically define the term “professional services,” the general rule is that:

The term is not limited to services performed by persons who must be licensed by a governmental authority in order to practice their professions. Rather, it refers to *any business activity conducted by the insured which involves specialized knowledge, labor, or skill, and is predominantly mental or intellectual as opposed to physical or manual in nature*.¹⁹

(Emphasis added.) Although this formulation originally developed to interpret professional services exclusions contained in general liability policies, the same formulation is typically used where the term is used, but not defined, in an exclusion to a D&O policy.²⁰

As the court in *Geostar* recognized, the entire nature of the coverage afforded under a D&O policy is “designed specifically to protect directors and officers from liability arising from negligence or misconduct in managing a business,”²¹ – i.e., activity that, by its nature is “predominantly mental or intellectual as opposed to physical or manual.” Therefore a professional services exclusion in a D&O policy “must be interpreted more narrowly to avoid negating the entire coverage scheme through the operation of an overly broad exclusion.”²²

¹⁸ The author was lead counsel for the policyholder in *Rosenthal Collins*. The court’s quote of the exclusion at page 3 of its opinion omits the entirety of the exception to the exclusion for claims brought by a “security holder.”

¹⁹ See, e.g., *State St. Bk & Tr. Co. v. INA Ins. Co.*, 207 Ill. App. 3d 961, 967, 567 N.E.2d 42, 47 (1991), citing *American Fellowship Mut. Ins. Co. v. Ins. Co. of N.A.*, 90 Mich. App. 633, 282 N.W.2d 425 (1979), and *Multnomah Cty. v. Oregon Auto. Ins. Co.*, 256 Or. 24, 470 P.2d 147 (1970).

²⁰ See, e.g., *Geostar*, 2010 WL 845953 at *10; *Rosenthal Collins*, Mem. Op. at 3.

²¹ *Geostar*, 2010 WL 84593 at *12.

²² *Id.* Accord *Federal Ins. Co. v. Hawaiian Elec. Indus., Inc.*, No. 94-125 HG, 1997 U.S. Dist. LEXIS 24129 at *33-*34 (D. Haw. Dec. 23, 1997):

The definition of professional service ... as “one calling for specialized skill and knowledge in an occupation or vocation[.]” *Ministers Life*, 483 N.W.2d at 91, is *not readily transferrable from the general liability policy context to the D&O policy context without modification*. Otherwise, claims arising from any services or acts performed by officers or directors calling for specialized skill or knowledge in the performance of their duties as officers or directors, would be excluded from coverage. Such an expansive interpretation is *not reasonable because it would have the effect of vitiating virtually all of the coverage provided by a D&O policy*, the purpose of which is to cover

Accordingly, the better-reasoned cases interpreting professional services exclusions in D&O policies issued to policyholders in the business of providing professional services recognize that the exclusion should only be applied to claims directly involving the insured’s furnishing of a professional service. Thus, in *Geostar*, the court held that the exclusion barred coverage for claims asserting that the defendant investment advisor provided “negligent tax or investment advice” but did not extend to the entirety of the fraudulent “mare lease” scheme by which certain of the defendant’s rogue employees had leased the same thoroughbred mare to multiple clients.²³ In the same vein, *Rosenthal Collins* held that, regardless that some of the complaint allegations asserted failings by the insured in the performance of its duties as a future commissions merchant, other allegations – to wit, that the insured had allegedly “aided and abetted” the miscreant investment advisor in “his scheme to defraud the plaintiff investors and itself participated in such fraudulent activities” – were outside the scope of the professional services exclusion.²⁴

Similarly, the Illinois Appellate Court declined to interpret a professional services exclusion – albeit in a CGL, not D&O – policy issued to a real estate brokerage firm so broadly so as to negate the coverage available to the policyholder under the “advertising injury” coverage for TCPA claims stemming from unsolicited fax advertising.²⁵ The insurer argued that the exclusion applied because the faxes advertised a commercial property listing and therefore were sent in furtherance of insured’s professional services; the Appellate Court disagreed, observing that the insured “was a real estate agency, not an advertising company.”²⁶ Because the gravamen of the underlying claims was *not* “incorrectly performed real estate services” but rather improper fax advertising, “the claim was based on [the insured]’s tortious conduct ancillary to the performance of real estate services,” and therefore not barred by the professional services exclusion.²⁷ Otherwise, the exclusion “would read

any wrongful act committed by an officer or director in their capacity as an officer or director.

(Emphasis added.) See also *Prosper Marketplace, Inc. v. Greenwich Ins. Co.*, A132967, 2012 WL 2878121 at *7-*8 (Cal. App. 1st Dist. July 16, 2012) (“close connection between the provision of professional services and the underlying claim” is necessary because a broad interpretation of the exclusion “would effectively vitiate the coverage provided by the D&O policy”).

²³ 2010 WL 845953 at *9.

²⁴ As noted in footnote 6, the opinion in *Rosenthal Collins* was vacated as part of the settlement of the case, following the court’s grant of the policyholder’s motion for summary judgment. It thus has no precedential value but is included in this discussion merely to illustrate the types of arguments and situations that may arise in this area of the law.

²⁵ See *Standard Mutual Ins. Co. v. Lay*, 2014 IL App (4th) 110527-B, 2 N.E.3d 1253.

²⁶ *Id.* ¶¶ 27-28.

²⁷ *Id.* ¶ 28 (emphasis added).

the coverage of the policy for advertising injuries entirely out of the policies despite the fact that such coverage is specifically available under the policies.”²⁸

When insurers have prevailed in barring D&O coverage pursuant to a professional services exclusion often either (a) the policy contains a definition of “professional services” that provides more guidance as to the types of activities within the term’s scope,²⁹ or (b) the acts or omissions of the insured upon which the claim is based involve performance of core professional services.³⁰

C. Miscellaneous Caveats and Pointers, especially for Readers Primarily Familiar with Liability Policies Written on an Occurrence Basis.

Although edited out of the quoted language from the Insuring Agreements in Section A of this paper, D&O policies are invariably written on a “claims-made” basis. Several consequences flow from this form of policy:

- Most D&O policies are written on a “claims made and reported” basis. This means, not only must the “claim” – i.e., written demand, suit, or other event encompassed by the “claim” definition – take place during the policy period under which coverage is sought, notice of the claim must be “reported” to the insurer during that policy period (or, as to claims “made” during the last portion of the policy period, within the short grace period after the policy expires). Moreover, even as to jurisdictions that generally follow the “notice-prejudice” rule as to belatedly reported claims under “occurrence”-based coverage, failure to strictly comply with the notice provisions of a claims-made-and-reported policy often results in the voiding of coverage, even if the insurer sustained no prejudice. Therefore, it is important that a policyholder and its coverage counsel quickly analyze whether coverage is available under a D&O policy as soon as the policyholder learns of the claim and promptly give notice of the claim to the D&O insurer.
- The defense coverage under a D&O policy often differs from the defense coverage of an occurrence-based liability policy in two respects: Typically,

²⁸ *Id.*

²⁹ See *MDL Capital Mgmt., Inc. v. Federal Ins. Co.*, No. 06–4815, 274 Fed. Appx. 169 2008 WL 876406 at *4-*5 (U.S. Ct. App. 3d Cir. 2008) (per curiam) (where policy explicitly defined term “professional services,” to include services as “investment advisor” and “investment manager,” exclusion barred coverage for (1) suit by firm client, accusing firm and its officers and directors of “derelictions as investment adviser and investment manager” and (2) investigation by SEC, arising out of firm’s “providing of, or failure to provide, investment adviser or investment manager services”).

³⁰ See, e.g., *Piper Jaffray Cos. v. National Union Fire Ins. Co.*, 967 F. Supp. 1148, 1151, 1156 (D. Minn. 1997) (professional services exclusion barred coverage for claims arising investment advisor’s “alleged failure *prudently to manage the assets* of its investors”) (emphasis added).

defense fees are treated as within the definition of “Loss,” and erode policy limits. Also, many – but not all – D&O policies do not impose a “duty to defend” upon the insurer but only a duty to pay expenditures incurred in defense. In this latter regard, D&O policies sometimes have language specifically permitting the insurer to allocate defense costs between insured and uninsured claims, and only pay those fees incurred in defense of the insured claims. This differs from the standard interpretation of the duty-to-defend, which imposes a duty on the insurer to defend the entirety of any suit, including portions that are outside the scope of coverage. On the other hand, unless the D&O policy contains express language excusing the insurer from paying defense allocated to uninsured claims, the courts typically treat the insurer’s duty to pay defense costs analogously to the duty to defend, imposing a duty to pay all defense costs even if only a subset are for defense of insured claims.³¹

- As noted in Section A above, because the Insuring Agreement of most D&O policies is based upon the alleged commission of “wrongful acts,” rather than “occurrences,” even allegations of intentional misconduct are within the scope of the covered claims. Indeed, the typical exclusion of coverage for “fraudulent” or “criminal” misconduct contains an explicit obligation for the insurer to fund the defense of such claims and *only* excuses the insurer from indemnifying settlements or judgments of such misconduct when there has been a “final adjudication” in the underlying action directly finding that the insured acted with the requisite level of intentional misconduct.
- Similarly, although most D&O policies have an exclusion that bars coverage for claims of unearned “profits” or “gains” – which insurers may argue bars coverage for claims where the relief sought is a refund of sums paid for the insured’s goods or services – that exclusion likewise typically includes explicit language requiring the insurer to fund the defense of such claims, and bars indemnity only upon “final adjudication” in the underlying action establishing that the relief obtained by the underlying plaintiffs is within the scope of that exclusion.

M.B.A.

³¹ See, e.g., *Amer. Chem. Soc. v. Leadscope, Inc.*, 2005-Ohio-2557 ¶¶ 17-22, 2005 WL 1220746 (Oh. App. 10th Dist. May 24, 2005).

ADDENDUM

Tab A	AIG Form 95727(9/07)
Tab B	ACE Form PF15193 (12-08)
Tab C	Chubb Form 14-02-13781 (02/2008)
Tab D	Memorandum Opinion in <i>24 Hour Fitness USA, Inc. v. National Union Fire Ins. Co.</i> , CV 11-8088-GHK (RZx) (U.S. Dist. Ct. C.D. Cal. March 21, 2013)
Tab E	Memorandum Opinion and Order, <i>Westchester Fire Ins. Co. v. Rosenthal Collins Group, LLC</i> , No. 2013 CH 01508 (Ill. Cir. Ct. Cook Cty. July 3, 2014)

Directors, Officers and Private Company Liability Insurance ("D&O COVERAGE SECTION")

Notice: Pursuant to Clause 1 of the General Terms and Conditions, the General Terms and Conditions are incorporated by reference into, made a part of, and are expressly applicable to this D&O Coverage Section, unless otherwise explicitly stated to the contrary in either the General Terms and Conditions or in this D&O Coverage Section.

In consideration of the payment of the premium, and in reliance upon the statements made to the Insurer by Application, which forms a part of this policy, the Insurer agrees as follows:

1. INSURING AGREEMENTS

With respect to Coverage A, B and D and the Defense Provisions, solely with respect to Claims first made during the Policy Period or the Discovery Period (if applicable) and reported to the Insurer pursuant to the terms of this policy, and subject to the other terms, conditions and limitations of this policy, this D&O Coverage Section affords the following coverage:

COVERAGE A: INDIVIDUAL INSURED INSURANCE

This D&O Coverage Section shall pay the Loss of an Individual Insured of the Company arising from a Claim made against such Individual Insured for any Wrongful Act of such Individual Insured, except when and to the extent that the Company has indemnified such Individual Insured. The Insurer shall, in accordance with and subject to Clause 7 of this D&O Coverage Section, advance Defense Costs of such Claim prior to its final disposition.

COVERAGE B: PRIVATE COMPANY INSURANCE

This D&O Coverage Section shall pay the Loss of the Company arising from a:

- (i) Claim made against the Company, or
- (ii) Claim made against an Individual Insured,

for any Wrongful Act, but, in the case of Coverage B(ii) above, only when and to the extent that the Company has indemnified the Individual Insured for such Loss. The Insurer shall, in accordance with and subject to Clause 7 of this D&O Coverage Section, advance Defense Costs of such Claim prior to its final disposition.

COVERAGE C: CRISISFUND® INSURANCE

This D&O Coverage Section shall pay the Crisis Management Loss of a Company solely with respect to a Crisis Management Event occurring during the Policy Period or the Discovery Period (if applicable) and reported to the Insurer pursuant to the terms of this policy, up to the amount of the Crisis Management Fund; provided that payment of any Crisis Management Loss under this D&O Coverage Section shall not waive any of the Insurer's rights under this D&O Coverage Section or at law. This Coverage C shall

apply regardless of whether a **Claim** is ever made against an **Insured** arising from such **Crisis Management Event** and, in the case where a **Claim** is made, regardless of whether the amount is incurred prior to or subsequent to the **Claim** being first made.

COVERAGE D: COSTS OF INVESTIGATION FOR DERIVATIVE DEMAND

This **D&O Coverage Section** shall pay the **Costs of Investigation** of the **Company** arising from a **Company Shareholder Derivative Investigation** in response to a **Derivative Demand**, up to the amount set forth in Item 7(d) of the Declarations. Payment of **Costs of Investigation** to a **Company** shall be made in accordance with and subject to Clause 8 of this **D&O Coverage Section**.

DEFENSE PROVISIONS

The **Insurer** does not assume any duty to defend; provided, however, the **Named Entity** may at its sole option tender to the **Insurer** the defense of a **Claim** for which coverage is provided by this **D&O Coverage Section** in accordance with and subject to Clause 7 of this **D&O Coverage Section**. Regardless of whether the defense is so tendered, the **Insurer** shall advance **Defense Costs** of such **Claim**, excess of the applicable Retention amount, prior to its final disposition. Selection of counsel to defend a **Securities Claim** shall be made in accordance with Clause 9 of this **D&O Coverage Section**.

With respect to Coverage D above, it shall be the duty of the **Company** and not the duty of the **Insurer** to conduct, investigate and evaluate any **Company Shareholder Derivative Investigation** against its own **Executives**; provided, however, that the **Insurer** shall be entitled to effectively associate in the investigation and evaluation of, and the negotiation of any settlement of, any such **Company Shareholder Derivative Investigation**.

2. DEFINITIONS

(a) "**Affiliate**" means: (i) any person or entity that directly, or indirectly through one or more intermediaries, controls or is controlled by, or is in common control with, another person or entity; or (ii) any person or entity that directly, or indirectly through one or more intermediaries, is a successor in interest to another person or entity.

(b) "**Claim**" means:

(i) a written demand for monetary or non-monetary relief (including any request to toll or waive any statute of limitations);

(ii) a civil, criminal, administrative, regulatory or arbitration proceeding for monetary or non-monetary relief which is commenced by:

(1) service of a complaint or similar pleading;

(2) return of an indictment, information or similar document (in the case of a criminal proceeding); or

(3) receipt or filing of a notice of charges; or

(iii) a civil, criminal, administrative or regulatory investigation of an **Individual Insured**:

(1) once such **Individual Insured** is identified in writing by such investigating authority as a

person against whom a proceeding described in Definition 2(b)(ii) may be commenced; or

(2) in the case of an investigation by the Securities Exchange Commission ("SEC") or a similar state or foreign government authority, after:

(a) the service of a subpoena upon such **Individual Insured**; or

(b) the **Individual Insured** is identified in a written "Wells" or other notice from the SEC or a similar state or foreign government authority that describes actual or alleged violations of laws by such **Individual Insured**.

The term "Claim" shall also include any **Securities Claim** and any **Derivative Demand**.

(c) "**Cleanup Costs**" means expenses (including but not limited to legal and professional fees) incurred in testing for, monitoring, cleaning up, removing, containing, treating, neutralizing, detoxifying or assessing the effects of **Pollutants**.

(d) "**Company Shareholder Derivative Investigation**" means the investigation by the **Company** or, on behalf of the **Company** by its board of directors (or the equivalent management body) or any committee of the board of directors (or the equivalent management body), as to whether or not the **Company** should bring the civil proceeding demanded in a **Derivative Demand**.

(e) "**Costs of Investigation**" means the reasonable and necessary costs, charges, fees and expenses consented to by the **Insurer** (including but not limited to attorney's fees and expert's fees but not including any settlement, judgment or damages and not including any compensation or fees of any **Individual Insured**) incurred by the **Company** or its board of directors (or any equivalent management body), or any committee of the board of directors (or any equivalent management body), solely in connection with a **Company Shareholder Derivative Investigation**.

(f) "**Crisis Management Event**" means **Crisis Management Event**, as that term is defined in Appendix D attached to this policy.

(g) "**Crisis Management Fund**" means the dollar amount set forth in Item 7(b) of the Declarations.

(h) "**Crisis Management Loss**" means **Crisis Management Loss**, as that term is defined in Appendix D attached to this policy.

(i) "**Crisis Management Services**" means **Crisis Management Services**, as that term is defined in Appendix D attached to this policy.

(j) "**D&O Punitive Damages Sublimit of Liability**" means the **D&O Punitive Damages Sublimit of Liability**, if any, stated in Item 7(c) of the Declarations.

(k) "**Defense Costs**" means the reasonable and necessary fees, costs and expenses consented to by the **Insurer** (including premiums for any appeal bond, attachment bond or similar bond arising out of a covered judgment, but without any obligation to apply for or furnish any such bond), resulting solely from the investigation, adjustment, defense and appeal of a **Claim** against an **Insured**, but excluding compensation of any **Individual Insured**. **Defense Costs** shall not include any fees, costs or expenses incurred prior to the time that a **Claim** is first made against an **Insured**.

(l) "**Derivative Demand**" means a written demand by shareholders upon the board of directors (or

equivalent management body) of a **Company** requesting that it file, on behalf of the **Company**, a civil proceeding in a court of law against any **Executive** of the **Company** for a **Wrongful Act** of such **Executive** in order to obtain relief from damages arising out of such **Wrongful Acts**.

- (m) "**Employee**" means any past, present or future employee, other than an **Executive** of a **Company**, whether such employee is in a supervisory, co-worker or subordinate position or otherwise, including any part-time, volunteer, seasonal and temporary employee. An individual who is leased to the **Company** shall also be an **Employee**, but only if the **Company** provides indemnification to such leased individual in the same manner as is provided to the **Company's** employees. Any other individual who is contracted to perform work for the **Company**, or who is an independent contractor for the **Company** shall also be an **Employee**, but only if the **Company** provides indemnification to such individual in the same manner as that provided to the **Company's** employees, pursuant to a written contract.
- (n) "**Executive**" means:
- (i) any past, present or future duly elected or appointed director, officer, management committee member or member of the Board of Managers;
 - (ii) any past, present or future person in a duly elected or appointed position in an entity which is organized and operated in a **Foreign Jurisdiction** that is equivalent to an executive position listed in Definition (n)(i); or
 - (iii) any past, present or future General Counsel and Risk Manager (or equivalent position) of the **Named Entity**.
- (o) "**Financial Insolvency**" means the: (i) appointment by any government official, agency, commission, court or other governmental authority of a receiver, conservator, liquidator, trustee, rehabilitator or similar official to take control of, supervise, manage or liquidate an insolvent **Company**; (ii) the filing of a petition under the bankruptcy laws of the United States of America; or (iii), as to both (i) or (ii), any equivalent events outside the United States of America.
- (p) "**Foreign Jurisdiction**" means any jurisdiction, other than the United States or any of its territories or possessions.
- (q) "**Foreign Policy**" means the **Insurer's** or any other company of Chartis Inc.'s ("**Chartis**") standard executive managerial liability policy (including all mandatory endorsements, if any) approved by **Chartis** to be sold within a **Foreign Jurisdiction** that provides coverage substantially similar to the coverage afforded under this **D&O Coverage Section**. If more than one such policy exists, then "**Foreign Policy**" means the standard basic policy form typically offered for sale in that **Foreign Jurisdiction** for comparable risks by the **Insurer** or any other company of **Chartis**. The term "**Foreign Policy**" shall not include any partnership managerial, pension trust or professional liability coverage.
- (r) "**Indemnifiable Loss**" means **Loss** for which a **Company** has indemnified or is permitted or required to indemnify an **Individual Insured** pursuant to law, contract or the charter, bylaws, operating agreement or similar documents of a **Company**.
- (s) "**Individual Insured**" means any:
- (i) **Executive** of a **Company**;

(ii) Employee of a Company; or

(iii) Outside Entity Executive.

(t) "Insured" means:

(i) an Individual Insured; or

(ii) a Company.

(u) "Loss" means damages, judgments, settlements, pre-judgment and post-judgment interest, Crisis Management Loss and Defense Costs; provided, however, Loss shall not include: (i) civil or criminal fines or penalties imposed by law; (ii) taxes; (iii) any amounts for which an Insured is not financially liable or which are without legal recourse to an Insured; or (iv) matters which may be deemed uninsurable under the law pursuant to which this policy shall be construed. Defense Costs shall be provided for items specifically excluded from Loss pursuant to subparagraphs (u)(i) through (u)(iv) above of this Definition, subject to the other terms, conditions and exclusions of this policy.

Loss shall specifically include, subject to the other terms, conditions and exclusions of this D&O Coverage Section, including, but not limited to, exclusions 4(a), 4(b) and 4(c) of this D&O Coverage Section, punitive, exemplary and multiple damages. As more fully set forth in Clause 5. "LIMIT OF LIABILITY" of this D&O Coverage Section, coverage under this D&O Coverage Section for punitive, exemplary and multiple damages is subject to any applicable D&O Punitive Damages Sublimit of Liability or Shared Punitive Damages Sublimit of Liability. The enforceability of the first sentence of this paragraph shall be governed by such applicable law which most favors coverage for punitive, exemplary and multiple damages.

(v) "Non-Indemnifiable Loss" means Loss for which a Company has neither indemnified nor is permitted or required to indemnify an Individual Insured pursuant to law or contract or the charter, bylaws, operating agreement or similar document of a Company.

(w) "Outside Entity" means:

(i) any not-for-profit organization; or

(ii) any other corporation, partnership, joint venture or other organization listed as an "Outside Entity" in an endorsement to this D&O Coverage Section.

(x) "Outside Entity Executive" means any: (i) Executive of the Company serving in the capacity as director, officer, trustee or governor of an Outside Entity, but only if such service is at the specific request or direction of the Company; or (ii) any other person listed as an Outside Entity Executive in an endorsement to this D&O Coverage Section. It is understood and agreed that, in the event of a disagreement between the Company and an individual as to whether such individual was acting "at the specific request or direction of the Company," this D&O Coverage Section shall abide by the determination of the Company on this issue and such determination shall be made by written notice to the Insurer within ninety (90) days after the Claim is first reported to the Insurer pursuant to the terms of the policy. In the event no determination is made within such period, this D&O Coverage Section shall apply as if the Company determined that such Individual Insured was not acting at the Company's specific request or direction.

(y) "Pollutants" means, but is not limited to, any solid, liquid, gaseous, biological, radiological or

thermal irritant or contaminant, including smoke, vapor, dust, fibers, mold, spores, fungi, germs, soot, fumes, acids, alkalis, chemicals and **Waste**. "**Waste**" includes, but is not limited to, materials to be recycled, reconditioned or reclaimed and nuclear materials.

(z) "**Securities Claim**" means a **Claim** made against any **Insured**:

(i) 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 which is:

(1) brought by any person or entity alleging, arising out of, based upon or attributable to the purchase or sale, or offer or solicitation of an offer to purchase or sell, any securities of a **Company**; or

(2) brought by a security holder of a **Company** with respect to such security holder's interest in securities of such **Company**; or

(ii) brought derivatively on the behalf of a **Company** by a security holder of such **Company**.

(aa) "**Shared Punitive Damages Sublimit of Liability**" means the **Shared Punitive Damages Sublimit of Liability**, if any, stated in Item 7(c) of the Declarations.

(bb) "**Third Party Violation**" means any actual or alleged harassment (including sexual harassment, whether "quid pro quo", hostile work environment or otherwise) or unlawful discrimination (including, but not limited to, discrimination based upon age, gender, race, color, national origin, religion, sexual orientation or preference, pregnancy, or disability), or the violation of the civil rights of a person relating to such harassment or discrimination, when such acts are alleged to be committed against anyone other than an **Individual Insured** or applicant for employment with the **Company** or an **Outside Entity**.

(cc) "**Wrongful Act**" means:

(i) with respect to any **Executive** or **Employee** of a **Company**, any breach of duty, neglect, error, misstatement, misleading statement, omission or act by such **Executive** or **Employee** in their respective capacities as such, or any matter claimed against such **Executive** or **Employee** of a **Company** solely by reason of his or her status as an **Executive** or **Employee** of a **Company**;

(ii) with respect to a **Company**, any breach of duty, neglect, error, misstatement, misleading statement, omission or act by a **Company**; or

(iii) with respect to service on an **Outside Entity**, any breach of duty, neglect, error, misstatement, misleading statement, omission or act by an **Outside Entity Executive** in his or her capacity as such.

3. WORLDWIDE EXTENSION

For **Claims** made and maintained in a **Foreign Jurisdiction** for **Wrongful Acts** committed in such **Foreign Jurisdiction**, the **Insurer** shall apply to such **Claims** the provisions of the **Foreign Policy** in the **Foreign Jurisdiction** that are more favorable to such **Insured** in the **Foreign Jurisdiction**; provided however,

that this paragraph shall apply only to provisions more favorable by virtue of insuring clauses, extensions, definitions, exclusions, pre-authorized securities or other defense counsel, discovery or extended reporting period, notice and authority, dispute resolution process or order of payments provisions, if any, of the **Foreign Policy** when compared to the same or similar clauses of this **D&O Coverage Section**. This paragraph shall not apply to excess provisions or policy provisions that address non-renewal, duty to defend, defense within or without limits, taxes, claims made and reported provisions or any other provision of this policy intended to govern coverage worldwide.

All premiums, limits, retentions, **Loss** and other amounts under this **D&O Coverage Section** are expressed and payable in the currency of the United States of America. If judgment is rendered, settlement is denominated or other elements of **Loss** are stated or incurred in a currency other than United States of America dollars, payment of covered **Loss** due under this **D&O Coverage Section** (subject to the terms, conditions and limitations of this **D&O Coverage Section**) will be made either in such other currency (at the option of the **Insurer** and if agreeable to the **Named Entity**) or, in United States of America dollars, at the rate of exchange published in The Wall Street Journal on the date the **Insurer's** obligation to pay such **Loss** is established (or if not published on such date the next publication date of The Wall Street Journal).

4. EXCLUSIONS

The **Insurer** shall not be liable to make any payment for **Loss** in connection with any **Claim** made against an **Insured**:

- (a) arising out of, based upon or attributable to the gaining of any profit or advantage to which any final adjudication establishes the **Insured** was not legally entitled;
- (b) arising out of, based upon or attributable to: (i) the purchase or sale by an **Insured** of securities of the **Company** within the meaning of Section 16(b) of the Securities Exchange Act of 1934 and amendments thereto or similar provisions of any state statutory law if any final adjudication establishes that such Section 16(b) violation occurred; or (ii) the payment to any **Insured** of any remuneration without the previous approval of the stockholders of the **Company**, if any final adjudication establishes such payment was illegal;
- (c) arising out of, based upon or attributable to the committing of any deliberate criminal or deliberate fraudulent or dishonest act, or any willful violation of any statute, rule or law, if any final adjudication establishes that such deliberate criminal, deliberate fraudulent or dishonest act or willful violation of statute, rule or law was committed;
- (d) alleging, arising out of, based upon or attributable to the facts alleged, or to the same or **Related Wrongful Act(s)** alleged or contained in any claim which has been reported, or in any circumstances of which notice has been given, under any policy of which this **D&O Coverage Section** is a renewal or replacement of in whole or in part or which it may succeed in time;
- (e) alleging, arising out of, based upon or attributable to, as of the **Continuity Date**, any pending or prior: (i) litigation; or (ii) administrative or regulatory proceeding or investigation of which an **Insured** had notice, or alleging any **Wrongful Act** which is the same or **Related Wrongful Act(s)** to that alleged in such pending or prior litigation or administrative or regulatory proceeding or investigation;

- (f) with respect to an **Outside Entity Executive**, for any **Wrongful Act** occurring prior to the **Continuity Date** if any **Insured**, as of such **Continuity Date**, knew or could have reasonably foreseen that such **Wrongful Act** could lead to a **Claim** under this **D&O Coverage Section**.
- (g) alleging, arising out of, based upon or attributable to any actual or alleged act or omission of an **Individual Insured** serving in any capacity, other than as an **Executive** or **Employee** of a **Company**, or as an **Outside Entity Executive** of an **Outside Entity**;
- (h) for any **Wrongful Act** arising out of an **Individual Insured** serving in a capacity as an **Outside Entity Executive** of an **Outside Entity** if such **Claim** is brought by the **Outside Entity** or any **Executive** thereof; or which is brought by any security holder of the **Outside Entity**, whether directly or derivatively, unless such security holder's **Claim** is instigated and continued totally independent of, and totally without the solicitation of, or assistance of, or active participation of, or intervention of the **Outside Entity**, the **Company**, or any **Executive** of the **Outside Entity** or the **Company**; provided, however, this exclusion shall not apply to:
 - (i) any **Claim** brought by an **Executive** of an **Outside Entity** in the form of a cross-claim or third-party claim for contribution or indemnity which is part of and results directly from a **Claim** that is covered by this **D&O Coverage Section**;
 - (ii) in any bankruptcy proceeding by or against an **Outside Entity**, any **Claim** brought by the examiner, trustee, receiver, liquidator or rehabilitator (or any assignee thereof) of such **Outside Entity**;
 - (iii) any **Claim** brought by any past **Executive** of an **Outside Entity** who has not served as a duly elected or appointed director, officer, trustee, governor, management committee member, member of the management board, General Counsel or Risk Manager (or equivalent position) of or consultant for an **Outside Entity** for at least four (4) years prior to such **Claim** being first made against any person; or
 - (iv) any **Claim** brought by an **Executive** of an **Outside Entity** formed and operating in a **Foreign Jurisdiction** against any **Outside Entity Executive** of such **Outside Entity**, provided that such **Claim** is brought and maintained outside the United States, Canada or any other common law country (including any territories thereof);
- (i) which is brought by or on behalf of a **Company** or any **Individual Insured**, other than an **Employee** of a **Company**; or which is brought by any security holder of the **Company**, whether directly or derivatively, unless such security holder's **Claim** is instigated and continued totally independent of, and totally without the solicitation of, or assistance of, or active participation of, or intervention of, any **Company** or any **Executive** of a **Company**; provided, however, this exclusion shall not apply to:
 - (i) any **Claim** brought by an **Individual Insured** in the form of a cross-claim or third-party claim for contribution or indemnity which is part of and results directly from a **Claim** which is covered by this policy;
 - (ii) in any bankruptcy proceeding by or against a **Company**, any **Claim** brought by the examiner, trustee, receiver, liquidator or rehabilitator (or any assignee thereof) of such **Company**;
 - (iii) any **Claim** brought by any past **Executive** of a **Company** who has not served as a duly elected or appointed director, officer, trustee, governor, management committee member, member of the

management board, General Counsel or Risk Manager (or equivalent position) of or consultant for a **Company** for at least four (4) years prior to such **Claim** being first made against any person; or

- (iv) any **Claim** brought by an **Executive** of a **Company** formed and operating in a **Foreign Jurisdiction** against such **Company** or any **Executive** thereof, provided that such **Claim** is brought and maintained outside the United States, Canada or any other common law country (including any territories thereof);
- (j) alleging, arising out of, based upon or attributable to any public offering of securities by a **Company**, an **Outside Entity** or an **Affiliate** or alleging a purchase or sale of such securities subsequent to such public offering; provided, however, this exclusion will not apply to:
 - (i) any purchase or sale of securities exempted pursuant to Section 3(b) of the Securities Act of 1933. Coverage for such purchase or sale transaction shall not be conditioned upon payment of any additional premium; provided, however, the **Named Entity** shall give the **Insurer** written notice of any public offering exempted pursuant to Section 3(b), together with full particulars and as soon as practicable, but not later than thirty (30) days after the effective date of the public offering;
 - (ii) any public offering of securities (other than a public offering described in subparagraph 4(j)(i) above), as well as any purchase or sale of such securities subsequent to such public offering, in the event that within thirty (30) days prior to the effective time of such public offering: (1) the **Named Entity** shall give the **Insurer** written notice of such public offering together with full particulars and underwriting information required thereto; and (2) the **Named Entity** accepts such terms, conditions and additional premium required by the **Insurer** for such coverage. Such coverage is also subject to the **Named Entity** paying when due any such additional premium. In the event the **Company** gives written notice with full particulars and underwriting information pursuant to subpart 4(j)(ii)(1) above, then the **Insurer** must offer a quote for coverage under this paragraph; or
 - (iii) any **Claim** for **Loss** alleging a **Wrongful Act** which occurred during the **Insured's** preparations to commence an initial public offering ("**IPO**") and which occurred at any time prior to 12:01 a.m. on the date the initial public offering commences ("**IPO Effective Time**"), including any **Claim** for **Loss** alleging a **Wrongful Act** which occurred during the road show; provided, however that the coverage otherwise afforded under this subparagraph (iii) shall be deemed to be void *ab initio* effective the **IPO Effective Time**; provided further, however, that coverage shall not be deemed void *ab initio* if (1) the **Claim** is first made and reported pursuant to Clause 7(a) of the **General Terms and Conditions** prior to the **IPO Effective Time**, and (2) a public company D&O policy is not applicable to such **Claim**;
- (k) alleging, arising out of, based upon or attributable to the purchase by a **Company** of securities of a "**Publicly Traded Entity**" in a transaction which resulted, or would result, in such entity becoming an **Affiliate** or a **Subsidiary** of a **Company**; provided, however, this exclusion shall not apply in the event that within thirty (30) days prior to it becoming an **Affiliate** or **Subsidiary**, the **Named Entity** gives written notice of the transaction to the **Insurer** together with full particulars and underwriting information required and agrees to any additional premium or amendment of the provisions of this **D&O Coverage Section** required by the **Insurer** relating to the transaction. Further, coverage as shall be afforded to the transaction is conditioned upon the **Named Entity** paying when due any additional premium required by the **Insurer** relating to the transaction. An entity is a **Publicly Traded Entity** if any securities of such entity have previously been subject to a public offering;

- (l) for bodily injury, sickness, disease or death of any person, or damage to, loss of use of or destruction of any tangible property; provided, however, this exclusion shall not apply to **Securities Claims**;
- (m) for emotional distress or mental anguish, or for injury from libel or slander, or defamation or disparagement, or for injury from a violation of a person's right of privacy; provided, however, this exclusion shall not apply to any **Securities Claim**;
- (n) for: (i) any actual, alleged or threatened discharge, dispersal, release or escape of **Pollutants**; or (ii) any direction or request to test for, monitor, clean up, remove, contain, treat, detoxify or neutralize **Pollutants**; provided, however, this exclusion shall not apply to:

- (1) **Non-Indemnifiable Loss**, other than **Non-Indemnifiable Loss** constituting **Cleanup Costs**; or

- (2) **Loss** in connection with a **Securities Claim**, other than **Loss** constituting **Clean-up Costs**;

- (o) for violation(s) of any of the responsibilities, obligations or duties imposed by the Employee Retirement Income Security Act of 1974, the Fair Labor Standards Act (except the Equal Pay Act), the National Labor Relations Act, the Worker Adjustment and Retraining Notification Act, the Consolidated Omnibus Budget Reconciliation Act, the Occupational Safety and Health Act, any rules or regulations of the foregoing promulgated thereunder, and amendments thereto or any similar federal, state, local or foreign statutory law or common law;
- (p) alleging, arising out of, based upon or attributable to the ownership, management, maintenance or control by the **Company** of any captive insurance company or entity, including, but not limited, to any **Claim** alleging the insolvency or bankruptcy of the **Named Entity** as a result of such ownership, operation, management or control;
- (q) alleging, arising out of, based upon, or attributable to the employment of any individual or any employment practice, including, but not limited to, wrongful dismissal, discharge or termination, discrimination, harassment, retaliation or other employment-related claim;
- (r) alleging, arising out of, based upon, or attributable to a **Third Party Violation**; provided, however, this exclusion shall not apply to a **Securities Claim**;
- (s) alleging, arising out of, based upon, or attributable to:
 - (i) payments, commissions, gratuities, benefits or any other favors to or for the benefit of any full or part-time domestic or foreign governmental or armed services officials, agents, representatives, employees or any members of their family or any entity with which they are affiliated;
 - (ii) payments, commissions, gratuities, benefits or any other favors to or for the benefit of any full or part-time officials, directors, agents, partners, representatives, members, principal shareholders, owners or employees, or affiliates (as that term is defined in the Securities Exchange Act of 1934, including any of their officers, directors, agents, owners, partners, representatives, principal shareholders or employees) of any customers of the **Company** or any members of their family or any entity with which they are affiliated; or
 - (iii) political contributions, whether domestic or foreign; or
- (t) with respect to Coverage B(i) only:

- (i) for any actual or alleged plagiarism, misappropriation, infringement or violation of copyright, patent, trademark, trade secret or any other intellectual property rights;
- (ii) for any actual or alleged violation of any law, whether statutory, regulatory or common law, respecting any of the following activities: anti-trust, business competition, unfair trade practices or tortious interference in another's business or contractual relationships;
- (iii) alleging, arising out of, based upon or attributable to any actual or alleged contractual liability of the **Company** or any other **Insured** under any express contract or agreement; provided, however, this exclusion shall not apply to liability which would have attached in the absence of such express contract or agreement; or
- (iv) seeking fines or penalties or non-monetary relief against the **Company**; provided, however, that this exclusion shall not apply to any **Securities Claim**.

For the purpose of determining the applicability of the foregoing Exclusions, other than exclusions 4(d), 4(e), 4(h), 4(i) and 4(t): (1) the facts pertaining to and knowledge possessed by any **Insured** shall not be imputed to any other **Individual Insured**; and (2) only facts pertaining to and knowledge possessed by any past, present or future chief executive officer, chief operating officer or chief financial officer (or equivalent positions) of the **Company** shall be imputed to the **Company**.

5. LIMIT OF LIABILITY

The following provisions shall apply in addition to the provisions of Clause 4. of the **General Terms and Conditions**:

CRISISFUND® INSURANCE

The maximum limit of the **Insurer's** liability for all **Crisis Management Loss** arising from all **Crisis Management Events** occurring during the **Policy Period** or the **Discovery Period** (if applicable), in the aggregate, shall be the amount set forth in Item 7(b) of the Declarations as the **Crisis Management Fund**. This **Crisis Management Fund** shall be the maximum limit of the **Insurer** under this **D&O Coverage Section** for **Crisis Management Loss**, regardless of the number of **Crisis Management Events** occurring during the **Policy Period**; provided, however, the **Crisis Management Fund** shall be part of and not in addition to the **Policy Aggregate Limit of Liability** stated in the Item 7(a) of the Declarations and any **Separate Limit of Liability** or **Shared Limit of Liability** applicable to this **D&O Coverage Section** as set forth in Item 3 of the Declarations.

COSTS OF INVESTIGATION FOR DERIVATIVE DEMAND

The maximum limit of the **Insurer's** liability for **Costs of Investigation** arising from all **Company Shareholder Derivative Investigations** occurring during the **Policy Period** or the **Discovery Period** (if applicable), in the aggregate, shall be the amount set forth in Item 7(d) of the Declarations (the "**Costs of Investigation Sublimit of Liability**"). The **Costs of Investigation Sublimit of Liability** is the maximum limit of the **Insurer** under this **D&O Coverage Section** for **Costs of Investigation** regardless of the number of such **Company Shareholder Derivative Investigations** occurring during the **Policy Period** or the **Discovery Period** (if applicable), or the number of **Executives** subject to such **Company Shareholder Derivative Investigations**; provided, however, that the **Costs of Investigation Sublimit of Liability** shall be part of and not in addition to the **Policy Aggregate Limit of Liability** set forth in Item 7(a) of the Declarations and any **Separate Limit of Liability** or **Shared Limit of Liability** applicable to this **D&O Coverage Section** as set forth in Item 3 of the Declarations.

PUNITIVE DAMAGES SUBLIMIT OF LIABILITY

If Item 7(c) of the Declarations indicates that the **D&O Punitive Damages Sublimit of Liability** was elected, then the **D&O Punitive Damages Sublimit of Liability** is the limit of the Insurer's liability for punitive, exemplary and multiple damages under this **D&O Coverage Section**. If Item 7(c) of the Declarations indicates that a **Shared Punitive Damages Sublimit of Liability** was elected, then the **Shared Punitive Damages Sublimit of Liability** is the limit of the Insurer's liability under both this **D&O Coverage Section** and the **EPL Coverage Section** combined for punitive, exemplary and multiple damages. If Item 7(c) of the Declarations indicates that no sublimit of liability is applicable to punitive damages, then neither the **D&O Punitive Damages Sublimit of Liability** nor the **Shared Punitive Damages Sublimit of Liability** is applicable to punitive, exemplary and multiple damages under this **D&O Coverage Section**. The **D&O Punitive Damages Sublimit of Liability** and the **Shared Punitive Damages Sublimit of Liability**, if applicable, shall be a part of and not in addition to **Policy Aggregate Limit of Liability** stated in the Item 7(a) of the Declarations and any **Separate Limit of Liability** or **Shared Limit of Liability** applicable to this **D&O Coverage Section** as set forth in Item 3 of the Declarations.

6. RETENTION CLAUSE

The following provision shall apply in addition to the provisions of Clause 5. **RETENTION** of the **General Terms and Conditions**:

The **Insurer** shall only be liable for the amount of **Loss** arising from a **Claim** which is in excess of the applicable Retention amount stated in Item 3 of the Declarations for this **D&O Coverage Section**, such Retention amount to be borne by the **Company** and/or the **Insureds** and shall remain uninsured, with regard to: (i) all **Indemnifiable Loss**; and (ii) **Loss of the Company**. A single Retention amount shall apply to **Loss** arising from all **Claims** alleging the same **Wrongful Act** or **Related Wrongful Act(s)**.

It is further understood and agreed that in the event the **Company** is unable to pay an applicable Retention amount due to **Financial Insolvency**, then the **Insurer** shall commence advancing **Loss** within the Retention; provided, however, that the **Insurer** shall be entitled to recover the amount of **Loss** advanced within the Retention from the **Company** pursuant to Clause 10. **SUBROGATION** of the **General Terms and Conditions**.

No Retention amount is applicable to **Crisis Management Loss** or **Non-Indemnifiable Loss**.

7. DEFENSE COSTS, SETTLEMENTS, JUDGMENTS (INCLUDING THE ADVANCEMENT OF DEFENSE COSTS)

The **Insurer** does not assume any duty to defend. The **Insureds** shall defend and contest any **Claim** made against them.

Notwithstanding the foregoing, the **Insureds** shall have the right to tender the defense of the **Claim** to the **Insurer**, which right shall be exercised in writing by the **Named Entity** on behalf of all **Insureds** to the **Insurer** pursuant to the notice provisions of Clause 12 of the **General Terms and Conditions**. This right shall terminate if not exercised within thirty (30) days of the date the **Claim** is first made against an **Insured**. Further, from the date the **Claim** is first made against an **Insured** to the date when the **Insurer** accepts the tender of the defense of such **Claim**, the **Insureds** shall take no action, or fail to take any required action, that prejudices the rights of any **Insured** or the **Insurer** with respect to such **Claim**. Provided that the **Insureds** have complied with the foregoing, the **Insurer** shall be obligated to assume the defense of the **Claim**, even if such **Claim** is groundless, false or fraudulent. The assumption of the defense of the **Claim** shall be effective upon written confirmation sent thereof by the **Insurer** to

the **Named Entity**. Once the defense has been so tendered, the **Insured** shall have the right to effectively associate with the **Insurer** in the defense and the negotiation of any settlement of any **Claim**, subject to the provisions of this Clause 7; provided, however, the **Insurer** shall not be obligated to defend such **Claim** after the **Policy Aggregate Limit of Liability** or any applicable **Separate Limit of Liability** or **Shared Limit of Liability** have been exhausted.

When the **Insurer** has not assumed the defense of a **Claim** pursuant to this Clause 7, the **Insurer** nevertheless shall advance, at the written request of the **Insured**, **Defense Costs** prior to the final disposition of a **Claim**. Such advanced payments by the **Insurer** shall be repaid to the **Insurer** by each and every **Insured** or the **Company**, severally according to their respective interests, in the event and to the extent that any such **Insured** or the **Company** shall not be entitled under the terms and conditions of this **D&O Coverage Section** to payment of such **Loss**.

The **Insurer** shall have the right to fully and effectively associate with each and every **Insured** in the defense of any **Claim** that appears reasonably likely to involve the **Insurer**, including, but not limited to, negotiating a settlement. Each and every **Insured** agrees to provide such information as the **Insurer** may reasonably require and to give the **Insurer** full cooperation, including:

(a) cooperating with and helping the **Insurer**:

(i) in making settlements, subject to subparagraph 7(b) below;

(ii) in enforcing any legal rights the **Insured** may have against anyone who may be liable to the **Insured**;

(iii) by attending depositions, hearings and trials; and

(iv) by securing and giving evidence, and obtaining the attendance of witnesses; and

(b) taking such actions which, in such **Insured's** judgment, are deemed necessary and practicable to prevent or limit **Loss** arising from any **Wrongful Act**.

Additionally, the **Insured** shall not admit or assume any liability, enter into any settlement agreement, stipulate to any judgment, or incur any **Defense Costs** without the prior written consent of the **Insurer**. If the **Insured** admits or assumes any liability in connection with any **Claim** without the consent of the **Insurer**, then the **Insurer** shall not have any obligation to pay **Loss** with respect to such **Claim**. Only those settlements, stipulated judgments and **Defense Costs** which have been consented to by the **Insurer** shall be recoverable as **Loss** under the terms of this **D&O Coverage Section**. The **Insurer** shall not unreasonably withhold any consent required under this **D&O Coverage Section**, provided that the **Insurer**, when it has not assumed the defense of a **Claim** pursuant to this Clause 7, shall be entitled to effectively associate in the defense and the negotiation of any settlement of any **Claim**, and provided further that in all events the **Insurer** may withhold consent to any settlement, stipulated judgment or **Defense Costs**, or any portion thereof, to the extent such **Loss** is not covered under the terms of this **D&O Coverage Section**. In addition, the **Insured** shall not take any action, without the **Insurer's** written consent, which prejudices the **Insurer's** rights under this **D&O Coverage Section**.

This Clause 7 shall not be applicable to Crisis Management Loss.

8. COSTS OF INVESTIGATION FOR DERIVATIVE DEMAND COVERAGE PROVISION

It is understood and agreed that the **Company** shall be entitled to payment under Coverage D of this **D&O Coverage Section** for reimbursement of its covered **Costs of Investigation** ninety (90) days after: (i) the **Company** has made its final decision not to bring a civil proceeding in a court of law against any of its **Executives**, and (ii) such decision has been communicated to the shareholders who made the **Derivative Demand** upon the **Company**. However, such payment shall be subject to an undertaking by the **Company**, in a form acceptable to the **Insurer**, that the **Company** shall return to the **Insurer** such payment in the event any **Company** or any shareholder of the **Company** brings a **Claim** alleging, arising out of, based upon or attributable to any **Wrongful Acts** which were the subject of the **Derivative Demand**.

Nothing in this **D&O Coverage Section**, including Coverage D, shall be construed to afford coverage under this **D&O Coverage Section** for any **Claim** brought by the **Company** against one or more of its own **Executives**, other than **Costs of Investigation** incurred in a covered **Company Shareholder Derivative Investigation**. Payment of any **Costs of Investigation** under this **D&O Coverage Section** shall not waive any of the **Insurer's** rights under this policy or at law.

9. PRE-AUTHORIZED DEFENSE ATTORNEYS FOR SECURITIES CLAIMS

This Clause 9 applies only to **Securities Claims**.

Affixed as Appendix A hereto and made a part of this **D&O Coverage Section** is a list of Panel Counsel law firms ("**Panel Counsel Firms**") from which a selection of legal counsel shall be made to conduct the defense of any **Securities Claim** against an **Insured** pursuant to the terms set forth in this Clause.

In the event the **Insurer** has assumed the defense pursuant to Clause 7. of this **D&O Coverage Section**, then the **Insurer** shall select a **Panel Counsel Firm** to defend the **Insureds**. In the event the **Insureds** are already defending a **Securities Claim**, then the **Insureds** shall select a **Panel Counsel Firm** to defend the **Insureds**.

The selection of the **Panel Counsel Firm**, whether done by the **Insurer** or the **Insureds**, shall be from the list of **Panel Counsel Firms** designated for the type of **Claim** and be from the jurisdiction in which the **Securities Claim** is brought. In the event a **Securities Claim** is brought in a jurisdiction not included on the appropriate list, the selection shall be made from a listed jurisdiction which is the nearest geographic jurisdiction to either where the **Securities Claim** is maintained or where the corporate headquarters or state of formation of the **Named Entity** is located. In such instance, however, the **Insurer** shall, at the written request of the **Named Entity**, assign a non-**Panel Counsel Firm** of the **Insurer's** choice in the jurisdiction in which the **Securities Claim** is brought to function as "local counsel" on the **Securities Claim** to assist the **Panel Counsel Firm** which will function as "lead counsel" in conducting the defense of the **Securities Claim**.

With the express prior written consent of the **Insurer**, an **Insured** may select (in the case of the **Insured** defending the **Claim**), or cause the **Insurer** to select (in the case of the **Insurer** defending the **Claim**), a **Panel Counsel Firm** different from that selected by other **Insured** defendants if such selection is required due to an actual conflict of interest or is otherwise reasonably justifiable.

The list of **Panel Counsel Firms** may be amended from time to time by the **Insurer**. However, no change shall be made during the **Policy Period** to the **Panel Counsel Firms** listed in Appendix A without the consent of the **Named Entity**.

10. REPRESENTATIONS AND SEVERABILITY

In granting coverage under this **D&O Coverage Section**, it is agreed that the **Insurer** has relied upon the statements and representations contained in the **Application** for this **D&O Coverage Section** as being accurate and complete. All such statements and representations are the basis of this **D&O Coverage Section** and are to be considered as incorporated into this **D&O Coverage Section**.

The **Insureds** agree that in the event that the particulars and statements contained in the **Application** are not accurate and complete and materially affect either the acceptance of the risk or the hazard assumed by the **Insurer** under the policy, then this **D&O Coverage Section** shall be void *ab initio* as to any **Insured** who knew as of the inception date of the **Policy Period** of the facts that were not accurately and completely disclosed in the **Application** (whether or not such **Insured** knew that such facts were not accurately and completely disclosed in the **Application**). Solely for purposes of determining whether this **D&O Coverage Section** shall be void *ab initio* as to an **Insured**, such aforesaid knowledge possessed by any **Insured** shall not be imputed to any other **Insured**.

11. ORDER OF PAYMENTS

In the event of **Loss** arising from any **Claim** for which payment is due under the provisions of this **D&O Coverage Section** but which **Loss**, in the aggregate, exceeds the remaining available **Separate Limit of Liability** or **Shared Limit of Liability** applicable to this **D&O Coverage Section**, then the **Insurer** shall:

- (a) first pay such **Loss** for which coverage is provided under Coverage A of this **D&O Coverage Section**, then with respect to whatever remaining amount of the applicable **Separate Limit of Liability** or **Shared Limit of Liability** is available after payment of such **Loss**,
- (b) then pay such **Loss** for which coverage is provided under Coverage B(ii) of this **D&O Coverage Section**, and
- (c) then pay such **Loss** for which coverage is provided under Coverage B(i), C or D of this **D&O Coverage Section**.

In the event of **Loss** arising from a **Claim** for which payment is due under the provisions of this **D&O Coverage Section** (including those circumstances described in the first paragraph of this Clause 11), the **Insurer** shall at the written request of the **Named Entity**:

- (a) first pay such **Loss** for which coverage is provided under Coverage A of this **D&O Coverage Section**, then
- (b) either pay or hold payment for such **Loss** for which coverage is provided under Coverage B, C or D of this **D&O Coverage Section**.

In the event that the **Insurer** withholds payment under Coverage B, C or D of this **D&O Coverage Section** pursuant to the above request, then the **Insurer** shall at any time in the future, at the request of the **Named Entity**, release such **Loss** payment to the **Company**, or make such **Loss** payment directly to the **Individual Insured** in the event of covered **Loss** under any **Claim** covered under this **D&O Coverage Section** pursuant to Coverage A of this **D&O Coverage Section**.

The **Financial Insolvency** of any **Company** or any **Individual Insured** shall not relieve the **Insurer** of any of its obligations to prioritize payment of covered **Loss** under this **D&O Coverage Section** pursuant to this Clause 11.



ACE EXPRESS Private Company Management Indemnity Package

Directors & Officers and Company
Coverage Section

In consideration of the payment of premium, in reliance on the **Application** and subject to the Declarations, and terms and conditions of this **Policy**, the **Insurer** and the **Insureds** agree as follows.

A. INSURING CLAUSES

1. The **Insurer** shall pay the **Loss** of the **Directors and Officers** for which the **Directors and Officers** are not indemnified by the **Company** and which the **Directors and Officers** have become legally obligated to pay by reason of a **Claim** first made against the **Directors and Officers** during the **Policy Period** or, if elected, the **Extended Period**, and reported to the **Insurer** pursuant to subsection E1 herein, for any **Wrongful Act** taking place prior to the end of the **Policy Period**.
2. The **Insurer** shall pay the **Loss** of the **Company** for which the **Company** has indemnified the **Directors and Officers** and which the **Directors and Officers** have become legally obligated to pay by reason of a **Claim** first made against the **Directors and Officers** during the **Policy Period** or, if elected, the **Extended Period**, and reported to the **Insurer** pursuant to subsection E1 herein, for any **Wrongful Act** taking place prior to the end of the **Policy Period**.
3. The **Insurer** shall pay the **Loss** of the **Company** which the **Company** becomes legally obligated to pay by reason of a **Claim** first made against the **Company** during the **Policy Period** or, if applicable, the **Extended Period**, and reported to the **Insurer** pursuant to subsection E1 herein, for any **Wrongful Act** taking place prior to the end of the **Policy Period**.

B. DEFINITIONS

1. **Claim** means:
 - a) a written demand against any **Insured** for monetary damages or non-monetary or injunctive relief;
 - b) a written demand by one or more of the securities holders of the **Company** upon the board of directors or the management board of the **Company** to bring a civil proceeding against any of the **Directors and Officers** on behalf of the **Company**;
 - c) a civil proceeding against any **Insured** seeking monetary damages or non-monetary or injunctive relief, commenced by the service of a complaint or similar pleading;
 - d) a criminal proceeding against any **Insured**, commenced by a return of an indictment or similar document, or receipt or filing of a notice of charges;
 - e) an arbitration proceeding against any **Insured** seeking monetary damages or non-monetary or injunctive relief;
 - f) a civil, administrative or regulatory proceeding against any **Insured** commenced by the filing of a notice of charges or similar document;

- g) a civil, criminal, administrative or regulatory investigation commenced by:
- (i) the service upon or other receipt by any natural person **Insured** of a written notice, investigative order, or subpoena; or
 - (ii) the service upon or other receipt by any **Company** of a written notice or investigative order;
- from the investigating authority identifying such natural person **Insured** as an individual, or such **Company** as an entity, respectively, against whom a proceeding described in paragraphs c, d or f immediately above may be commenced; or
- h) a written request of the **Insured** to toll or waive a statute of limitations relating to a **Claim** described in paragraphs a through g immediately above.
2. **Continuity Date** means the date set forth in Item C of the Declarations relating to this Coverage Section.
3. **Costs, Charges and Expenses** means:
- a) reasonable and necessary legal costs, charges, fees and expenses incurred by the **Insurer**, or by any **Insured** with the **Insurer's** consent, in defending **Claims** and the premium for appeal, attachment or similar bonds arising out of covered judgments, but with no obligation to furnish such bonds and only for the amount of such judgment that is up to the applicable Limit of Liability; and
 - b) reasonable and necessary legal costs, charges, fees and expenses incurred by any of the **Insureds** in investigating a written demand, by one or more of the securities holders of the **Company** upon the board of directors or the management board of the **Company**, to bring a civil proceeding against any of the **Directors and Officers** on behalf of the **Company**.
- Costs, Charges and Expenses** do not include salaries, wages, fees, overhead or benefit expenses of or associated with officers or employees of the **Company**.
4. **Directors and Officers** means any person who was, now is, or shall become:
- a) a duly elected or appointed director, officer, or similar executive of the **Company**, or any member of the management board of the **Company**;
 - b) a person who was, is or shall become a full-time or part-time employee of the **Company**; and
 - c) the functional equivalent of directors or officers of a **Company** incorporated or domiciled outside the United States of America.
5. **Insureds** mean the **Company** and the **Directors and Officers**.
6. **Interrelated Wrongful Acts** means all **Wrongful Acts** that have as a common nexus any fact, circumstance, situation, event, transaction, cause or series of facts, circumstances, situations, events, transactions or causes.
7. **Loss** means damages, judgments, settlements, pre-judgment or post-judgment interest awarded by a court, and **Costs, Charges and Expenses** incurred by **Directors and Officers**

under Insuring Clauses 1 or 2, or the **Company** under Insuring Clause 3. **Loss** does not include:

- a) taxes, fines or penalties;
- b) matters uninsurable under the laws pursuant to which this **Policy** is construed;
- c) punitive or exemplary damages, or the multiple portion of any multiplied damage award, except to the extent that such punitive or exemplary damages, or multiplied portion of any multiplied damage award are insurable under the internal laws of any jurisdiction which most favors coverage for such damages and which has a substantial relationship to the **Insureds**, **Insurer**, this **Policy** or the **Claim** giving rise to such damages;
- d) the cost of any remedial, preventative or other non-monetary relief, including without limitation any costs associated with compliance with any such relief of any kind or nature imposed by any judgment, settlement or governmental authority;
- e) any amount for which the **Insured** is not financially liable or legally obligated to pay; or
- f) the costs to modify or adapt any building or property to be accessible or accommodating, or more accessible or accommodating, to any person.

8. **Outside Entity** means:

- a) any non-profit company in which any of the **Directors and Officers** is a director, officer, trustee, governor, executive director or similar position of such non-profit company; and
- b) any other company specifically identified by endorsement to this **Policy**.

9. **Wrongful Act** means any actual or alleged error, omission, misleading statement, misstatement, neglect, breach of duty or act allegedly committed or attempted by:

- a) any of the **Directors and Officers**, while acting in their capacity as such, or any matter claimed against any **Director and Officer** solely by reason of his or her serving in such capacity;
- b) any of the **Directors and Officers**, while acting in their capacity as a director, officer, trustee, governor, executive director or similar position of any **Outside Entity** where such service is with the knowledge and consent of the **Company**; and
- c) the **Company**, but only with respect to Insuring Clause 3 of this Coverage Section.

C. EXCLUSIONS

1. Exclusions Applicable to All Insuring Clauses

Insurer shall not be liable for **Loss** under this Coverage Section on account of any **Claim**:

- a) for actual or alleged bodily injury, sickness, disease, death, false imprisonment, mental anguish, emotional distress, invasion of privacy of any person, or damage to or destruction of any tangible or intangible property including loss of use thereof, whether or not such property is physically injured;
- b) alleging, based upon, arising out of, attributable to, directly or indirectly resulting from, in consequence of, or in any way involving:

- (i) any **Wrongful Act**, fact, circumstance or situation which has been the subject of any written notice given under any other policy of which this **Policy** is a renewal or replacement or which it succeeds in time; or
 - (ii) any other **Wrongful Act**, whenever occurring, which together with a **Wrongful Act** which has been the subject of such prior notice, would constitute **Interrelated Wrongful Acts**;
- c) alleging, based upon, arising out of, attributable to, directly or indirectly resulting from, in consequence of, or in any way involving:
- (i) the actual, alleged or threatened discharge, dispersal, release, escape, seepage, migration or disposal of **Pollutants**; or
 - (ii) any direction or request that any **Insured** test for, monitor, clean up, remove, contain, treat, detoxify or neutralize **Pollutants**, or any voluntary decision to do so;

provided, however, this exclusion shall not apply to any **Claim** brought directly, derivatively or otherwise by one or more securities holders of the **Company** in their capacity as such, or, except as to **Clean Up Costs**, to any **Non-Indemnifiable Loss** of a **Director and Officer**, or **Loss** of a **Director and Officer** for which the **Company** does not indemnify such **Director and Officer** because of either the appointment by any state or federal official, agency or court of any receiver, conservator, liquidator, trustee, rehabilitator or similar official to take control of, supervise, manage or liquidate the **Company**, or because of the **Company** becoming a debtor-in-possession.

For purposes of this exclusion:

Clean Up Costs means expenses, including but not limited to legal and professional fees, incurred in testing for, monitoring, cleaning up, removing, containing, treating, neutralizing, detoxifying or assessing the effects of **Pollutants**;

Non-Indemnifiable Loss means **Loss** for which a **Company** has not indemnified, and is not permitted or required to indemnify, a **Director and Officer** pursuant to law or contract or the charter, bylaws, operating agreement or similar documents of a **Company**;

Pollutants means any substance exhibiting any hazardous characteristics as defined by, or identified on, a list of hazardous substances issued by the United States Environmental Protection Agency or any federal, state, county, municipal or local counterpart thereof or any foreign equivalent. Such substances shall include, without limitation, solids, liquids, gaseous, biological, bacterial or thermal irritants, contaminants or smoke, vapor, soot, fumes, acids, alkalis, chemicals or waste materials (including materials to be reconditioned, recycled or reclaimed). **Pollutants** shall also mean any other air emission or particulate, odor, waste water, oil or oil products, infectious or medical waste, asbestos or asbestos products, noise, fungus (including mold or mildew and any mycotoxins, spores, scents or byproducts produced or released by fungi, but does not include any fungi intended by the **Insured** for consumption) and electric or magnetic or electromagnetic field;

- d) for any actual or alleged violation of the responsibilities, obligations or duties imposed by Employee Retirement Income Security Act of 1974, as amended, or any rules or regulations promulgated thereunder, or similar provisions of any federal, state or local statutory or common law;
- e) brought or maintained by, on behalf of, in the right of, or at the direction of any **Insured** in any capacity, or any **Outside Entity**, in any respect and whether or not collusive, or

which is brought by any securities holder or member of the **Company**, whether directly or derivatively, unless the **Claim** of such securities holder or member is instigated and continued totally independent of, and totally without the solicitation, assistance, active participation, or intervention of, any **Director and Officer** or the **Company**; provided, however, that **Whistleblower Conduct** by a **Director and Officer**, other than a **Director and Officer** as that term is defined in subparagraphs a or c of definition 4, shall not be considered solicitation, assistance, active participation, or intervention of a **Director and Officer**;

and provided further that this exclusion shall not apply to any **Claim** that:

- (i) is brought or maintained by any **Insured** in the form of a cross claim, third party claim or other proceeding for contribution or indemnity which is part of, and directly results from a **Claim** that is covered by this Coverage Section;
- (ii) is brought or maintained by an employee of the **Company** who is not or was not a director or officer of the **Company**, including any **Claim** brought by such employee for any actual or alleged violation of the provisions of 31 U.S.C. 3729 of the Federal False Claims Act, or any similar provision of any federal, state, local or foreign statutory law;
- (iii) is brought or maintained by any former director or officer of the **Company** and where such **Claim** is solely based upon and arising out of **Wrongful Acts** committed subsequent to the date such director or officer ceased to be a director or officer of the **Company** and where such **Claim** is first made two (2) years subsequent to the date such director or officer ceased to be a director or officer of the **Company**;
- (iv) is brought or maintained by any bankruptcy or insolvency trustee or bankruptcy appointed representative of the **Company**, or receiver, examiner, liquidator or similar official for the **Company**; or
- (v) any **Claim** brought and maintained by a **Director and Officer**, as that term is defined in subparagraphs a or c of definition 4, of a **Company** formed and operating solely in a country other than the United States of America, Canada, or any other common law country.

For purposes of this exclusion, **Whistleblower Conduct** means any of the activity set forth in 18 U.S.C. Sec. 1514A(a), engaged in by a whistleblower with a federal regulatory or law enforcement agency, Member of Congress or any committee of Congress, or person with supervisory authority over the whistleblower, or an enforcement action by the whistleblower set forth in 18 U.S.C. Sec. 1514A (b);

- f) alleging, based upon, arising out of, attributable to, directly or indirectly resulting from, in consequence of, or in any way involving:
 - (i) any deliberately fraudulent or criminal act of an **Insured**; provided, however this exclusion f)(i) shall not apply unless and until there is a final judgment against such **Insured** as to such conduct; or
 - (ii) the gaining of any profit, remuneration or financial advantage to which any **Directors and Officers** were not legally entitled; provided, however this exclusion f)(ii) shall not apply unless and until there is a final judgment against such **Directors and Officers** as to such conduct.

When f) (i) or (ii) apply, the **Insured** shall reimburse the **Insurer** for any **Costs, Charges**

or Expenses;

- g) for the return by any of the **Directors and Officers** of any remuneration paid to them without the previous approval of the appropriate governing body of the **Company** or **Outside Entity**, which payment without such previous approval shall be held to be in violation of law;
- h) against any of the **Directors and Officers** of any **Subsidiary** or against any **Subsidiary** alleging, based upon, arising out of, attributable to, directly or indirectly resulting from, in consequence of, or in any way involving any **Wrongful Act** actually or allegedly committed or attempted by a **Subsidiary** or **Directors and Officers** thereof before the date such entity became a **Subsidiary** or after the date such entity ceased to be a **Subsidiary**;
- i) alleging, based upon, arising out of, attributable to, directly or indirectly resulting from, in consequence of, or in any way involving any **Wrongful Act** actually or allegedly committed subsequent to a **Takeover**;
- j) for a **Wrongful Act** actually or allegedly committed or attempted by any of the **Directors and Officers** in his or her capacity as a director, officer, trustee, manager, member of the board of managers or equivalent executive of a limited liability company or employee of, or independent contractor for or in any other capacity or position with any entity other than the **Company**; provided, however, that this exclusion shall not apply to **Loss** resulting from any such **Claim** to the extent that:
 - (i) such **Claim** is based on the service of any of the **Directors and Officers** as a director, officer, trustee, governor, executive director or similar position of any **Outside Entity** where such service is with the knowledge and consent of the **Company**; and
 - (ii) such **Outside Entity** is not permitted or required by law to provide indemnification to such **Directors and Officers**; and
 - (iii) such **Loss** is not covered by insurance provided by any of the **Outside Entity's** insurer(s);
- k) alleging, based upon, arising out of, attributable to, directly or indirectly resulting from, in consequence of, or in any way involving:
 - (i) any prior or pending litigation or administrative or regulatory proceeding, demand letter or formal or informal governmental investigation or inquiry filed or pending on or before the **Continuity Date**; or
 - (ii) any fact, circumstance, situation, transaction or event underlying or alleged in such litigation or administrative or regulatory proceeding, demand letter or formal or informal governmental investigation or inquiry;
- l) alleging, based upon, arising out of, attributable to, directly or indirectly resulting from, in consequence of, or in any way involving, any **Wrongful Act**, fact, circumstance or situation which any of the **Insureds** had knowledge of prior to the **Continuity Date** where such **Insureds** had reason to believe at the time that such known **Wrongful Act** could reasonably be expected to give rise to such **Claim**;
- m) alleging, based upon, arising out of, attributable to, directly or indirectly resulting from, in consequence of, or in any way involving:

- (i) improper payroll deductions, unpaid wages or other compensation, misclassification of employee status, or any violation of any law, rule or regulation, or amendments thereto, that governs the same topic or subject; or
 - (ii) any other employment or employment-related matters brought by or on behalf of or in the right of an applicant for employment with the **Company**, or any of the **Directors and Officers**, including any voluntary, seasonal, temporary, leased or independently-contracted employee of the **Company**;
- n) alleging, based upon, arising out of, attributable to, directly or indirectly resulting from, in consequence of, or in any way involving:
- (i) any public offering of **Securities** undertaken or consummated by or on behalf of the **Company** ("Public Offering"), or the solicitation, sale, purchase, distribution, or issuance of any such **Securities**, whether any such activity occurs or allegedly occurs prior to, during, or after such Public Offering; or
 - (ii) any **Wrongful Act**, including without limitation any actual or alleged violation of any **Securities Law**, relating in any way to a Public Offering or to any **Securities** issued, sold or distributed pursuant to a Public Offering, whether any such **Wrongful Act** occurs or allegedly occurs prior to, during, or after such Public Offering,

provided that this exclusion shall not apply to **Claims** arising from an offer, sale or purchase of **Securities** in a transaction that is exempt from registration under the Securities Act of 1933, or any amendments thereto or any rules and regulations promulgated thereunder.

For purposes of this exclusion:

Securities means common or preferred stock or rights, warrants or options in such stock representing an ownership interest in the **Company** or a right to acquire or dispose of such interest; or notes, bonds or debentures representing a debt owed by the **Company** to the extent such instruments would be deemed securities under the federal or state laws of the United States;

Securities Law means the Securities Act of 1933, the Securities Exchange Act of 1934, or any rules or regulations of the Securities Exchange Commission adopted pursuant thereto, or any federal, state, provincial or foreign statute or common law regulating securities similar to the foregoing; or any amendments to the foregoing or any rules or regulations adopted pursuant to the foregoing; or any other federal, state, provincial or foreign law or common law relating to liability in connection with an offering of **Securities** of a **Company**, including without limitation the solicitation, sale, purchase, distribution or issuance of such **Securities**;

- o) for that portion of **Loss** which is covered under any other Coverage Section of this **Policy**.
2. Exclusions Applicable Only to Insuring Clause A3

Insurer shall not be liable for **Loss** on account of any **Claim**:

- a) alleging, based upon, arising out of, attributable to, directly or indirectly resulting from, in consequence of, or in any way involving the actual or alleged breach of any contract or agreement; except and to the extent the **Company** would have been liable in the absence of such contract or agreement; or

- b) alleging, based upon, arising out of, attributable to, directly or indirectly resulting from, in consequence of, or in any way involving:
 - (i) any actual or alleged infringement, misappropriation, or violation of copyright, patent, service marks, trademarks, trade secrets, title or other proprietary or licensing rights or intellectual property of any products, technologies or services; or
 - (ii) any goods or products manufactured, produced, processed, packaged, sold, marketed, distributed, advertised or developed by the **Company**.

Provided, however, the exclusions in 2a) and 2b) above shall not apply to any such **Claim** brought or maintained, directly or indirectly, by one or more securities holders of the **Company** in their capacity as such.

No **Wrongful Act** of one or more **Insureds** shall be imputed to any other **Insureds** for the purpose of determining the applicability of any of the above exclusions.

D. LIMIT OF LIABILITY AND RETENTIONS

1. The liability of the **Insurer** shall apply only to that part of **Loss** which is excess of the Retention amounts applicable to this Coverage Section, as shown in Item C of the Declarations. Such Retentions shall be borne uninsured by the **Insureds** and at their own risk. If different parts of a single **Claim** are subject to different applicable Retentions under this Coverage Section, the applicable Retentions will be applied separately to each part of such **Loss**, but the sum of such Retentions shall not exceed the largest applicable Retention.
2. As shown in Item C1 of the Declarations relating to this Coverage Section, the following Limits of Liability of the **Insurer** shall apply:
 - a) The amount set forth in Item C1a relating to this Coverage Section shall be the aggregate limit of liability for the payment of **Loss** under all Insuring Clauses for this Coverage Section, subject to additional payments for **Loss** under Insuring Clause A1 as further described in subsection b) immediately below.
 - b) The amount set forth in Item C1b relating to this Coverage Section shall be an aggregate limit of liability for the payment of **Loss** under Insuring Clause A1 in addition to the limit described in subsection a) immediately above; provided, all payments for **Loss** under the additional limits described in this subsection b) shall be excess of the limit described in subsection a) above, and excess of any other available insurance that is specifically excess to this **Policy**. Such excess insurance must be completely and fully exhausted through the payment of loss, including but not limited to defense costs thereunder, before the **Insurer** shall have any obligations to make any payments under the additional limits described in this subsection b).
 - c) The amount set forth in Item C1c of the Declarations relating to this Coverage Section shall be the maximum aggregate limit of liability for the payment of **Loss** under all Insuring Clauses for this Coverage Section. The limit of liability set forth in C1a and C1b relating to this Coverage Section shall be a part of and not in addition to the maximum aggregate limit of liability set forth in Item C1c for this Coverage Section.
3. All **Claims** arising out of the same **Wrongful Act** and all **Interrelated Wrongful Acts** shall be deemed to constitute a single **Claim** and shall be deemed to have been made at the earliest of the following times, regardless of whether such date is before or during the **Policy Period**:

- a) the time at which the earliest **Claim** involving the same **Wrongful Act** or **Interrelated Wrongful Act** is first made; or
 - b) the time at which the **Claim** involving the same **Wrongful Act** or **Interrelated Wrongful Acts** shall be deemed to have been made pursuant to subsection E2, below.
4. The Retention applicable to Insuring Clause 2 shall apply to **Loss** resulting from any **Claim** if indemnification for the **Claim** by the **Company** is required or permitted by applicable law, to the fullest extent so required or permitted, regardless of whether or not such actual indemnification by the **Company** is made, except and to the extent such indemnification is not made by the **Company** solely by reason of the **Company's** financial insolvency.
5. Payments of **Loss** by **Insurer** shall reduce the Limit(s) of Liability under this Coverage Section. **Costs, Charges and Expenses** are part of, and not in addition to, the Limits of Liability and payment of **Costs, Charges and Expenses** reduce the Limits of Liability. If such Limit(s) of Liability are exhausted by payment of **Loss**, the obligations of the **Insurer** under this Coverage Section are completely fulfilled and extinguished.

E. NOTIFICATION

1. The **Insureds** shall, as a condition precedent to their rights to payment under this Coverage Section only, give **Insurer** written notice of any **Claim** as soon as practicable after the **Company's** general counsel, risk manager, chief executive officer or chief financial officer (or equivalent positions) first becomes aware of such **Claim**, but in no event later than sixty (60) days after the end of the **Policy Period**, or respecting any **Claim** first made against the **Insureds** during the **Extended Period**, if purchased, sixty (60) days after the end of the **Extended Period**.
2. If, during the **Policy Period** or the **Discovery Period**, if purchased, any of the **Insureds** first becomes aware of facts or circumstances which may reasonably give rise to a future **Claim** covered under this **Policy**, and if the **Insureds**, during the **Policy Period** or the **Discovery Period**, if purchased, give written notice to **Insurer** as soon as practicable of:
- a) a description of the **Wrongful Act** allegations anticipated;
 - b) the identity of the potential claimants;
 - c) the circumstances by which the **Insureds** first became aware of the **Wrongful Act**;
 - d) the identity of the **Insureds** allegedly involved;
 - e) the consequences which have resulted or may result; and
 - f) the nature of the potential monetary damages and non-monetary relief;

then any **Claim** made subsequently arising out of such **Wrongful Act** shall be deemed for the purposes of this Coverage Section to have been made at the time such notice was received by the **Insurer**. No coverage is provided for fees, expenses and other costs incurred prior to the time such **Wrongful Act** results in a **Claim**.

3. Notice to **Insurer** shall be given to the address shown under Item G of the Declarations for this **Policy**.

F. SETTLEMENT AND DEFENSE

1. It shall be the duty of the **Insurer** and not the duty of the **Insureds** to defend any **Claim**. Such duty shall exist even if any of the allegations are groundless, false or fraudulent. The **Insurer's** duty to defend any **Claim** shall cease when the Limits of Liability have been exhausted by the payment of **Loss** including **Costs, Charges and Expenses**.
2. The **Insurer** may make any investigation it deems necessary, and shall have the right to settle any **Claim**; provided, however, no settlement shall be made without the consent of the **Parent Company**, such consent not to be unreasonably withheld.
3. The **Insureds** agree not to settle or offer to settle any **Claim**, incur any **Costs, Charges and Expenses** or otherwise assume any contractual obligation or admit any liability with respect to any **Claim** without the prior written consent of the **Insurer**, such consent not to be unreasonably withheld. The **Insurer** shall not be liable for any settlement, **Costs, Charges and Expenses**, assumed obligation or admission to which it has not consented. The **Insureds** shall promptly send to the **Insurer** all settlement demands or offers received by any **Insured** from the claimant(s).
4. The **Insureds** agree to provide the **Insurer** with all information, assistance and cooperation which the **Insurer** reasonably requests and agree that, in the event of a **Claim**, the **Insureds** will do nothing that shall prejudice the position of the **Insurer** or its potential or actual rights of recovery.
5. If the **Insurer** recommends a settlement within the **Policy** Limit of Liability which is agreed to by the claimant ("Settlement Opportunity") and:
 - a) the **Insureds** consent to such settlement within thirty (30) days of the date the **Insureds** are first made aware of the Settlement Opportunity; and
 - b) such consent occurs within the first ninety (90) days after the **Claim** is first reported; and
 - c) such **Claim** is reported within the first thirty (30) days after it is made,then, in the event the **Claim** settles as a result of such Settlement Opportunity, the Retention applicable to such **Claim** shall be waived, and any amounts paid by the **Insureds** towards the Retention shall be reimbursed by the **Insurer**.

G. OTHER INSURANCE

If any **Loss** covered under this Coverage Section is covered under any other valid and collectible insurance, then this **Policy** shall cover the **Loss**, subject to its terms and conditions, only to the extent that the amount of the **Loss** is in excess of the amount of such other insurance whether such other insurance is stated to be primary, contributory, excess, contingent or otherwise, unless such other insurance is written only as specific excess insurance over the Limit of Liability for this Coverage Section.

H. PAYMENT PRIORITY

1. If the amount of any **Loss** which is otherwise due and owing by the **Insurer** exceeds the then-remaining Limit of Liability applicable to the **Loss**, the **Insurer** shall pay the **Loss**, subject to such Limit of Liability, in the following priority:
 - a) first, the **Insurer** shall pay any **Loss** covered under Insuring Clause A1, in excess of any applicable Retention shown in Item C of the Declarations; and
 - b) second, only if and to the extent the payment under subsection 1.a above does not exhaust the applicable Limit of Liability, the **Insurer** shall pay any **Loss** in excess of the Retention shown in Item C of the Declarations covered under any other applicable Insuring Clause.

- c) Subject to the foregoing subsection, the **Insurer** shall, upon receipt of a written request from the Chief Executive Officer of the **Parent Company**, delay any payment of **Loss** otherwise due and owing to or on behalf of the **Company** until such time as the Chief Executive Officer of the **Parent Company** designates, provided the liability of the **Insurer** with respect to any such delayed **Loss** payment shall not be increased, and shall not include any interest, on account of such delay.

I. ALLOCATION

If a **Claim** includes both **Loss** that is covered under this **Policy** and loss that is not covered under this **Policy**, either because the **Claim** is made against both **Insureds** and others, or the **Claim** includes both covered allegations and allegations that are not covered, the **Insureds** and the **Insurer** shall allocate such amount between covered **Loss** (except for **Costs, Charges and Expenses**) and loss that is not covered based upon the relative legal and financial exposures and the relative benefits obtained by the parties. The **Insurer** shall not be liable under this **Policy** for the portion of such amount allocated to non-covered **Loss**.



In consideration of payment of the premium and subject to the Declarations, General Terms and Conditions, limitations, conditions, provisions and other terms of this Policy, the Company and the **Insureds** agree as follows:

I. INSURING CLAUSES

Insuring Clause (A): Insured Person Liability Coverage

- (A) The Company shall pay, on behalf of each of the **Insured Persons**, **Loss** for which the **Insured Person** is not indemnified by the **Organization** and which the **Insured Person** becomes legally obligated to pay on account of any **Claim** first made against the **Insured Person**, during the **Policy Period** or, if exercised, during the Extended Reporting Period, for a **Wrongful Act** by such **Insured Person** before or during the **Policy Period**.

Insuring Clause (B): Insured Person Indemnification Coverage

- (B) The Company shall pay, on behalf of an **Organization**, **Loss** for which such **Organization** grants indemnification to an **Insured Person**, and which the **Insured Person** becomes legally obligated to pay on account of any **Claim** first made against the **Insured Person**, during the **Policy Period** or, if exercised, during the Extended Reporting Period, for a **Wrongful Act** by such **Insured Person** before or during the **Policy Period**.

Insuring Clause (C): Entity Liability Coverage

- (C) The Company shall pay, on behalf of an **Organization**, **Loss** which such **Organization** becomes legally obligated to pay on account of any **Claim** first made against the **Organization** during the **Policy Period** or, if exercised, during the Extended Reporting Period, for a **Wrongful Act** by the **Organization** before or during the **Policy Period**.

Insuring Clause (D): Outside Directorship Liability Coverage

- (D) The Company shall pay, on behalf of each of the **Insured Persons**, **Loss** for which the **Insured Person** becomes legally obligated to pay on account of any **Claim** first made against the **Insured**, during the **Policy Period** or, if exercised, during the Extended Reporting Period, for a **Wrongful Act** by such **Insured Person** while acting in an **Outside Capacity**, before or during the **Policy Period**; provided that coverage under this Insuring Clause (D) shall be specifically excess of any indemnity (other than the indemnity provided by the **Organization**) and insurance available to such **Insured Person** by reason of serving in an **Outside Capacity**, including any indemnity or insurance available from or provided by the **Outside Entity**.

II. DEFINITIONS

When used in this Coverage Part:

- (A) **Claim** means:
- (1) a written demand for monetary damages or non-monetary relief;
 - (2) a civil proceeding commenced by the service of a complaint or similar pleading;
 - (3) an arbitration proceeding commenced by receipt of a written demand for arbitration or similar document;
 - (4) a criminal proceeding commenced by the return of an indictment, information or similar document; or



- (5) a formal administrative or formal regulatory proceeding commenced by the filing of a notice of charges, entry of a formal order of investigation, or similar document,

against an **Insured** for a **Wrongful Act**, including any appeal therefrom.

Except as may otherwise be provided in Section IV. EXTENDED REPORTING PERIOD, paragraph (H) of Section V. LIMITS OF LIABILITY, RETENTION AND COINSURANCE, or paragraph (B) of Section VI. REPORTING, of the General Terms and Conditions, a **Claim** shall be deemed to have first been made when such **Claim** is commenced as set forth in this definition or, in the case of a written demand, when such demand is first received by an **Insured**.

- (B) **Defense Costs** means that part of **Loss** consisting of reasonable costs, charges, fees (including but not limited to attorneys' fees and experts' fees) and expenses (other than regular or overtime wages, salaries, fees or benefits of any **Insured Person**) incurred in defending any **Claim** and the premium for appeal, attachment or similar bonds.
- (C) **Insured** means any **Organization** and any **Insured Person**.
- (D) **Insured Person** means any **Executive** of an **Organization** or any **Employee** of an **Organization**. Solely for purposes of Insuring Clause (D), **Insured Person** means any **Executive** of an **Organization** while acting in an **Outside Capacity**.
- (E) **Loss** means the amount that an **Insured** becomes legally obligated to pay on account of any **Claim**, including but not limited to damages (including punitive, exemplary, or multiplied damages, if and to the extent that such punitive, exemplary or multiplied damages are insurable under the law of the jurisdiction most favorable to the insurability of such damages; provided such jurisdiction has a substantial relationship to the relevant **Insured**, to the Company, or to the **Claim** giving rise to the damages), judgments, settlements, pre-judgment and post-judgment interest, and **Defense Costs**.

Loss shall not include:

- (1) any costs incurred by an **Insured** to comply with any order for injunctive or other non-monetary relief, any agreement to provide such relief, or any regulatory or administrative directive;
- (2) taxes, fines or penalties, except as provided above with respect to punitive, exemplary or multiplied damages;
- (3) any amount not insurable under the law pursuant to which this Policy is construed, except as provided above with respect to punitive, exemplary or multiplied damages;
- (4) regular or overtime wages, salaries, commissions, or fees of **Insured Persons**; or
- (5) any amount that represents or is substantially equivalent to an increase in any consideration paid (or proposed to be paid) by an **Organization** in connection with its purchase of any securities or assets.
- (F) **Outside Capacity** means service by an **Executive** of an **Organization** as a director, trustee, or equivalent executive position with an **Outside Entity** at or prior to the Inception Date of this Policy or during the Policy Period, if service by such **Executive** is, or was, at the specific request or direction of an **Organization**.
- (G) **Outside Entity** means any non-profit corporation, community chest, fund organization or foundation exempt from federal income tax as any organization described in Section 501(c)(3), Internal Revenue Code of 1986, as amended.



(H) **Wrongful Act** means:

- (1) any error, misstatement, misleading statement, act, omission, neglect, or breach of duty committed, attempted, or allegedly committed or attempted by an **Insured Person** in his or her capacity as such, or for purposes of Insuring Clause (C), by the **Organization**;
- (2) any other matter claimed against an **Insured Person** solely by reason of serving in his or her capacity as such; and
- (3) for purposes of Insuring Clause (D): any error, misstatement, misleading statement, act omission, neglect, or breach of duty committed, attempted, or allegedly committed or attempted by an **Insured Person** in his or her **Outside Capacity**.

III. EXCLUSIONS APPLICABLE TO ALL INSURING CLAUSES

The Company shall not be liable for **Loss** on account of any **Claim** under this Coverage Part:

- (A) based upon, arising from, or in consequence of **Prior Notice**;
- (B) based upon, arising from, or in consequence of **Pending or Prior Litigation**;
- (C) brought or maintained by or on behalf of any **Insured** in any capacity, or by any entity that owns more than 50% of the outstanding securities of the **Named Organization**; provided this Exclusion III.(C) shall not apply to **Loss** on account of:
 - (1) any **Claim** brought or maintained derivatively on behalf of an **Organization** by one or more securityholders of such **Organization**; provided such **Claim** is brought and maintained without any assistance or participation of, or solicitation by any **Insured Person**, other than assistance, participation or solicitation for which 18 U.S.C. 1514A(a) (the Sarbanes-Oxley Act of 2002), or any similar "whistleblower" protection provision of any applicable federal, state, local or foreign securities law, affords protection to such **Insured Person**;
 - (2) any wrongful termination **Claim** brought or maintained by or on behalf of an **Executive** of an **Organization**;
 - (3) any **Claim** brought or maintained by an **Insured Person** for contribution or indemnity, if such **Claim** directly results from another **Claim** covered under this Coverage Part;
 - (4) any **Claim** brought or maintained against an **Insured Person** by a bankruptcy or insolvency trustee, examiner, receiver, any assignee of such trustee, examiner or receiver, or any creditors' committee, that has been appointed to take control of, supervise, manage or liquidate the **Named Organization**; or
 - (5) any **Claim** brought or maintained by an **Insured Person** if such **Insured Person** has not served in the capacity of an **Insured Person** within any of the three (3) years immediately preceding the date the **Claim** was made, and such **Claim** is brought and maintained without any assistance, participation, or intervention of or solicitation by any other **Insured**;
- (D) based upon, arising from, or in consequence of **Pollution** or a **Biological Event**;
- (E) for bodily injury, emotional distress, mental anguish, sickness, disease or death of any person; provided this Exclusion III.(E) shall not apply to **Loss** on account of any **Claim**:
 - (1) for emotional distress or mental anguish for which a claimant seeks compensation in an employment **Claim**; or



- (2) brought by an employee of an **Outside Entity** against an **Insured Person** serving in an **Outside Capacity**;
- (F) for damage to or destruction of any data or tangible property, including loss of use thereof;
- (G) for an actual or alleged violation of the responsibilities, obligations or duties imposed on fiduciaries by **ERISA**;
- (H) for any **Wrongful Act** committed, attempted, or allegedly committed or attempted by a **Subsidiary** or any **Insured Person** of a **Subsidiary** during any time when such entity was not a **Subsidiary**;
- (I) for any **Wrongful Act** of an **Insured Person** in his or her capacity as a director, officer, trustee, governor, general partner, managing general partner, venture partner, administrative general partner, manager, managing partner, regent, partner, or employee of any entity other than an **Organization**; provided this Exclusion III.(I) shall not apply to a **Wrongful Act** by an **Insured Person** serving in his or her **Outside Capacity** under Insuring Clause (D) Outside Directorship Liability Coverage;
- (J) based upon, arising from, or in consequence of performing or the failure to perform any professional service; provided this Exclusion III.(J) shall not apply to any **Claim** brought by or on behalf of a securityholder of the **Organization** in his or her capacity as such;
- (K) based upon, arising from, or in consequence of any public offering of securities issued by any **Organization**, or the purchase or sale of any such securities in or subsequent to any such public offering;
- (L) brought by or on behalf of any (1) entity in which any pooled investment vehicle that is managed by an **Organization** previously owned or controlled, currently owns or controls, or proposes to own or control, outstanding debt, equity securities, or debentures of such entity ("Portfolio Company"); or (2) creditors or shareholders of such Portfolio Company; or
- (M) based upon, arising from, or in consequence of:
- (1) any criminal or deliberately fraudulent act or omission or any willful violation of any statute or regulation by an **Insured**, if a judgment or final adjudication in any proceeding establishes such criminal or deliberately fraudulent act or omission or willful violation; or
- (2) an **Insured** having gained any profit, remuneration or advantage to which such **Insured** was not legally entitled, if a judgment or final adjudication in any proceeding establishes the gaining of such profit, remuneration or advantage.

For purposes of these Exclusions III.(M)(1) and III.(M)(2) above:

- (a) If:
- (i) an **Insured** pleads guilty in a criminal proceeding, the elements of each of the offenses to which such plea relates shall, as of the date of such plea, be deemed to have been established by a final adjudication; or
- (ii) by written agreement or consent order with any federal or state prosecutorial authority or regulatory agency, an **Insured** admits or otherwise agrees to facts, charges or allegations of conduct set forth in Exclusions III.(M)(1) and III.(M)(2) above, then the facts, charges or allegations to which such **Insured** has admitted or otherwise agreed in such written agreement or consent order shall, as of the date of the agreement or order, be deemed to have been established by a final adjudication.
- (b) No criminal or deliberately fraudulent act or omission or any willful violation of any statute or regulation by an **Insured** shall be imputed to any **Insured Person**, and only criminal or deliberately fraudulent acts or



omissions or willful violations of any statute or regulation by an **Executive** of an **Organization** shall be imputed to such **Organization**.

IV. EXCLUSIONS APPLICABLE ONLY TO INSURING CLAUSE (C) ENTITY LIABILITY COVERAGE

In addition to the Exclusions in Section III. above, the Company shall not be liable under Insuring Clause (C), Entity Liability Coverage, for **Loss** on account of any **Claim** made against any **Organization**:

- (A) based upon, arising from, or in consequence of any actual or alleged infringement, piracy, misappropriation, disclosure, or slander of title of any actual, alleged or prospective copyright, patent, service mark, trade name, trade mark, licensing right, idea or trade secrets;
- (B) based upon, arising from, or in consequence of any **Insured's** liability under any contract or agreement regardless of whether such liability is direct or assumed; provided this Exclusion IV.(B) shall not apply to liability that would attach to an **Insured** even in the absence of a contract or agreement; or
- (C) based upon, arising from, or in consequence of any employment-related **Wrongful Act** or any actual or alleged third party discrimination or sexual harassment of any third party.

V. EXCLUSIONS APPLICABLE ONLY TO INSURING CLAUSE (D) OUTSIDE DIRECTORSHIP LIABILITY COVERAGE

In addition to the Exclusions in Section III. above, the Company shall not be liable under Insuring Clause (D), Outside Directorship Liability Coverage, for **Loss** on account of any **Claim** against any **Insured Person**:

- (A) for any **Wrongful Act** by an **Insured Person** while serving in an **Outside Capacity**, if such **Wrongful Act** is committed, attempted, or allegedly committed or attempted, after the date:
 - (1) such **Insured Person** ceases to be an **Executive** of an **Organization**, or
 - (2) service by such **Insured Person** in an **Outside Capacity** ceases to be at the specific request of the **Organization**;
- (B) brought or maintained by or on behalf of any **Outside Entity**, or by or on behalf of any affiliate of an **Outside Entity** or one or more of such **Outside Entity's** directors, officers, or equivalent positions; or
- (C) based upon, arising from, or in consequence of any demand, suit, administrative, regulatory or other proceeding against an **Outside Entity** occurring prior to, or pending as of the date the **Insured Person** first commenced serving in his or her **Outside Capacity**, of which such **Outside Entity** or any director, officer, or equivalent position with the **Outside Entity** received notice or otherwise had knowledge as of such date.

VI. NON-ACCUMULATION OF LIMITS

If any **Loss** arising from any **Claim** made against any **Insured Person** in his or her **Outside Capacity**, is insured under any other valid policy(ies) issued by the Company or any parent, subsidiary or affiliate of the Company, then any payment under such policy(ies) on account of a **Claim** also covered under this Coverage Part shall reduce, by the amount of any such payment, the Company's Limit of Liability under this Coverage Part.

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UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

CIVIL MINUTES - GENERAL

Case No. CV 11-8088-GHK (RZx) Date March 21, 2013

Title *24 Hour Fitness USA, Inc. v. National Union Fire Insurance Co. Of Pittsburgh, PA*

Presiding: The Honorable

GEORGE H. KING, CHIEF U. S. DISTRICT JUDGE

Beatrice Herrera

N/A

N/A

Deputy Clerk

Court Reporter / Recorder

Tape No.

Attorneys Present for Plaintiff:

Attorneys Present for Defendant:

None

None

Proceedings: (In Chambers) AMENDED¹ ORDER re: Joint Cross-Motions for Summary Judgment [Dkt. No. 62]

This matter is before us on the Parties' Joint Cross-Motions for Summary Judgment on the issue of liability only. We have considered the papers filed in support of and in opposition to these Motions, and deem this matter appropriate for resolution without oral argument. L.R. 7-15. As the Parties are familiar with the facts, we will repeat them only as necessary. Accordingly, we rule as follows.

I. Background

On July 6, 2011, Plaintiff 24 Hour Fitness USA, Inc. ("24 Hour Fitness" or "Plaintiff"), filed this action against Defendant National Union First Insurance Co. of Pittsburgh, PA ("National Union" or "Defendant"). This action involves an insurance coverage dispute arising out of a liability policy ("Policy") National Union issued to 24 Hour Fitness. (See Uncontroverted Fact D19 [Dkt. No. 62-1]). In the original Complaint, Plaintiff sought to recover the cost of defending a since-settled class action – *Friedman v. 24 Hour Fitness USA, Inc.*, No. CV 06-06282-AHM (CTx) (C.D. Cal.) ("*Friedman*"). On January 5, 2012, we granted Plaintiff leave to file a supplemental complaint to add a claim for defense costs in another since-settled class action, *Alatorre v. 24 Hour Fitness USA, Inc.*, No. CV 11-4318-JCS (N.D. Cal.) ("*Alatorre*," and collectively with *Friedman*, "Underlying Actions"), under the same insurance policy.

The allegations in both Underlying Actions were similar. (Uncontroverted Fact D13). According to the Complaints, 24 Hour Fitness, a national fitness club company, surreptitiously charged its members fees, contrary to their membership agreements, after they had cancelled their memberships. In particular, all members were required to sign a monthly membership contract requiring them to pre-pay the first and last month's membership dues, and to automatically pay ongoing monthly dues by electronic fund transfers ("EFTs"). (Uncontroverted Fact D2). The Underlying Actions alleged, among

¹ The amendment(s) to this Order correct only typographical errors; there are no substantive changes.

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other things, that 24 Fitness surreptitiously charged its members fees via EFTs after members cancelled memberships (and that 24 Hour Fitness was not entitled to such charges under the membership contracts). (Uncontroverted Facts D1, D3). The Fifth Amended Complaint in *Friedman* asserted the following claims based on these allegations: (1) RICO Act violations; (2) Electronic Funds Transfer Act (“EFTA”)² violations; (3) California Consumer Legal Remedies Act violations; (4) California Unfair Competition Act violations; and (5) breach of contract. (Uncontroverted Facts D7-D10; *see* Joint Evidentiary Appendix Ex. A.). The Complaint in *Alatorre* asserted similar claims. (Uncontroverted Fact D13; *see* Joint Evidentiary Appendix Ex. B).

II. Motions For Summary Judgment**A. Legal Standard**

We may grant summary judgment only “if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law.” Fed. R. Civ. P. 56(c); *see also Celotex Corp. v. Catrett*, 477 U.S. 317, 322–23 (1986). “Only disputes over facts that might affect the outcome of the suit under the governing law will properly preclude the entry of summary judgment.” *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986). On a motion for summary judgment, the district court’s “function is not . . . to weigh the evidence and determine the truth of the matter but to determine whether there is a genuine issue for trial.” *Id.* at 249.

B. Discussion

As this case involves an insurance coverage dispute, we first review principles of insurance contract interpretation and then address whether, based on the undisputed facts, National Union owed 24 Hour Fitness a duty to defend the Underlying Actions.

Under California law, the insured bears the initial burden to prove that the underlying action raises claims that the insurance policy covers or potentially covers. *See Collin v. American Empire Ins. Co.*, 26 Cal. Rptr. 2d 391, 398-99 (Ct. App. 1994). In general, the interpretation of an insurance policy is a question of law, not fact. *Waller v. Truck Ins. Exch., Inc.*, 11 Cal.4th 1, 18 (1995). It is error to leave policy interpretation to the jury. *Parsons v. Bristol Develop. Co.*, 62 Cal. 2d 861, 865 (1965); *California Shoppers, Inc. v. Royal Globe Ins. Co.*, 175 Cal. App. 3d 1, 35 (Ct. App. 1985).

The general rules of contract interpretation govern the judicial interpretation of an insurance policy. *Waller*, 11 Cal.4th at 18. As the California Supreme Court set forth:

² The EFTA “establishes the rights, liabilities, and responsibilities of participants (consumers, financial institutions, and intermediaries) in electronic fund transfer systems.” *Ferrington v. McAfee, Inc.*, 2012 WL 1156399, at *9 (N.D. Cal. 2012).

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The fundamental rules of contract interpretation are based on the premise that the interpretation of a contract must give effect to the ‘mutual intention’ of the parties. Under statutory rules of contract interpretation, the mutual intention of the parties at the time the contract is formed governs interpretation. Such intent is to be inferred, if possible, solely from the written provisions of the contract. . . . [L]anguage in a contract must be interpreted as a whole.

Id. (citations omitted).

If only one construction of the policy language is reasonable, the analysis ends there, but “[a] policy provision will be considered ambiguous when it is capable of two or more constructions, both of which are reasonable.” *Id.* However, “[c]ourts will not strain to create an ambiguity where none exists.” *Id.* at 18-19. A court faced with ambiguous policy language must first attempt to determine whether coverage is consistent with the insured’s “objectively reasonable expectations.” *AIU Ins. Co. v. Sup.Ct.*, 51 Cal.3d 807, 822 (Cal. 1990). In resolving the ambiguity, courts must “interpret the language in context, with regard to its intended function in the policy.” *Bank of the West v. Sup.Ct.*, 2 Cal.4th 1254, 1265 (Cal. 1992). Only if the ambiguity is not capable of resolution in light of the insured’s “objectively reasonable expectations” and the “context of [the] instrument as a whole” do we construe the policy provision against the party who drafted the policy, i.e., the insurer. *Id.* at 1265.

“[I]nsurance coverage is interpreted broadly so as to afford the greatest possible protection to the insured, [whereas] exclusionary clauses are interpreted narrowly against the insurer.” *Manzarek v. St. Paul Fire & Marine Ins. Co.*, 519 F.3d 1025, 1032 (9th Cir. 2008) (alterations original) (citations and quotation marks omitted). In interpreting exclusions, “[t]he burden is on . . . the insurer to establish that the claim is specifically excluded.” *Id.* (citation omitted). “An insurer cannot escape its basic duty to insure by means of an exclusionary clause that is unclear [A]ny exception to the performance of the basic underlying obligation must be so stated as clearly to apprise the insured of its effect.” *MacKinnon v. Truck Ins. Exch.*, 31 Cal.4th 635, 648 (Cal. 2003).

1. Duty to Defend

24 Hour Fitness seeks to recover only the cost of defending the Underlying Actions. (*See* Compl., Prayer for Relief; Supp. Compl. at 8). Accordingly, this case turns on whether National Union owed 24 Hour Fitness a duty to defend the Underlying Actions. “In California, the insurer’s duty to defend is [broader] than the insurer’s obligation to indemnify covered claims, such that an insurer may have a duty to defend where it would not have a duty to pay damages.” *St. Paul Mercury Ins. Co. v. Tessera, Inc.*, __ F.Supp.2d ___, 2012 WL 6002466, *3 (N.D. Cal. 2012) (citing *Horace Mann Ins. Co. v. Barbara B.*, 4 Cal.4th 1076, 1081 (Cal. 1993)). “[A]n insurer has a duty to defend an insured if it becomes aware of, or if the third party lawsuit pleads, facts giving rise to the potential for coverage under the insuring agreement.” *Waller*, 11 Cal.4th at 19; *see also St. Paul Mercury Ins. Co.*, 2012 WL 6002466, *3 (“The operative inquiry is not whether the underlying complaint specifically names the claims covered by the policy, but rather whether there is a *potential* for liability for a covered cause of

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action under the policy based on the allegations in the complaint and any extrinsic facts known to the insurer at the time the duty to defend arises.”) (emphasis original) (citation omitted). An insurer owes no duty to defend “only when the third party complaint can by no conceivable theory raise a single issue which could bring it within the policy coverage.” *Fire Ins. Exchange v. Superior Court*, 181 Cal. App. 4th 388, 391 (Ct. App. 2010) (citation and internal quotation marks omitted). Thus, Plaintiff need only prove that the Policy covers a single claim that is not excluded to establish Defendant’s duty to defend. *See Gray v. Zurich Insurance Co.*, 65 Cal.2d 263, 276 (Cal. 1966) (finding potential for coverage when policy had exclusion for intentional acts and insured was accused of assault and battery but could have alternatively been liable for negligent use of force). “[T]he determination whether the insurer owes a duty to defend usually is made in the first instance by comparing the allegations of the complaint with the terms of the policy.” *Waller*, 11 Cal. 4th at 19. The duty to defend is determined by “the facts alleged in the complaint” and “facts known to the insurance company at the time of the coverage decision.” *Griffin Dewatering Corp. v. N. Ins. Co. of N.Y.*, 176 Cal.App.4th 172, 197–98 (Ct. App. 2009). “Any doubt as to whether the facts give rise to a duty to defend is resolved in the insured’s favor.” *Horace Mann Ins. Co. v. Barbara B.*, 4 Cal.4th 1076, 1081 (Cal. 1993).

a. Claims Based on Alleged Contractual Liability Are Excluded and Cannot Support a Duty to Defend

We conclude that the following claims are excluded because they are based on alleged contractual liability and therefore cannot support a duty to defend: (1) RICO violations; (2) EFTA violations;³ (3) CLRA violations based on allegedly unconscionable contracts; and (4) breach of contract. *See generally Feldman v. Illinois Union Ins. Co.*, 198 Cal. App. 4th 1495, 1504 (Ct. App. 2011) (explaining that “[b]ecause the policy clearly excluded this claim for invasion of privacy, it could not have triggered any duty to defend”).

The Policy’s Exclusion (h) provides as follows:

The Insurer shall not be liable to make any payment for Loss in connection with a Claim made against an Insured: . . . (h) alleging, arising out of, based upon or attributable to any actual or alleged contractual liability of the Company . . . under any express contract or agreement

(Joint Evidentiary Appendix, Ex. C at 119).

National Union argues that because all of the claims in the Underlying Actions arise from contracts, Exclusion (h) bars coverage and potential coverage. 24 Hour Fitness contends, however, that because Exclusion (h) applies only to claims “alleging, arising out of, based upon, or attributable to any . . . contractual liability,” a contract must “serve as the ‘legal basis,’ not merely the ‘factual basis,’” for a claim to fall within the exclusion. (Joint Memo at 27 (citing *Foodtown, Inc. v. National Union Fire*

³ Only *Friedman* asserted an EFTA claim. *Alatorre* did not.

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(h).⁴ Accordingly, we analyze the Underlying Actions to determine whether the claims are based on actual or alleged contractual liability and therefore fall within Exclusion (h).⁵

First, we conclude the RICO claims are based on alleged contractual liability and fall within Exclusion (h). The RICO claims therefore cannot support a duty to defend. These claims alleged that 24 Hour Fitness “engaged in [a] . . . pattern of racketeering . . . by . . . effecting, without authorization, one or more [EFTs] from the bank accounts and credit card accounts of members who have cancelled their memberships.” (*Friedman* 5AC ¶ 81, Joint Evidentiary Appendix Ex. A; *see also Alatorre* Compl. ¶ 58, Joint Evidentiary Appendix Ex. B (similar allegation)). Further, the Underlying Actions alleged that the membership contracts “expressly provide[] that the member’s EFT authorization terminates when the membership is cancelled.” (*Friedman* 5AC ¶¶ 80; *see also Alatorre* Compl. ¶¶ 14-15 (similar allegations)). Accordingly, the RICO claims turn on whether 24 Hour Fitness’s withdrawals were unauthorized, which is equivalent to whether the withdrawals breached the membership contracts. The RICO claims refer to the terms of the membership contracts and require a determination of whether the withdrawals were unauthorized under those contracts. Without alleged contractual liability, i.e., the unauthorized withdrawals, there could be no recovery against 24 Hour Fitness for an alleged racketeering scheme to withdraw funds from members’ accounts. The RICO claims are thus based on

⁴ This conclusion is also consistent with *Medill v. Westport Ins. Corp.*, 143 Cal. App. 4th 819 (Ct. App. 2006). *Medill* addressed the scope of an insurance exclusion for claims “arising out of breach of any contract.” 143 Cal. App. 4th at 829-30. Preliminarily, we do not see a difference, and the Parties suggest none, between an exclusion phrased in terms of “contractual liability” and an exclusion phrased in terms of “breach of contract.” Further, 24 Hour Fitness acknowledges that the contract exclusion in this case has similar wording to the exclusion in *Medill*. (*See* Joint Memo at 27 n.5). In any case, the underlying actions in *Medill* alleged that the insured, directors and officers of Heritage Housing Development, Inc. (“Heritage”), fraudulently misappropriated funds from a municipal bond offering, on which Heritage defaulted, as part of a Ponzi scheme. *Id.* at 824. The underlying actions asserted claims for negligence, breach of fiduciary duty, and violations of federal and state securities laws; they did not assert claims for breach of contract. *See id.* at 822, 824, 829. Nonetheless, *Medill* held that all claims arose from breach of contract and thus fell within the exclusion. “Without the *breaches of the contractual obligations* to make repayments on the bonds,” the court reasoned, “there would have been no loss to the bondholders and no recovery against the [insureds] for mismanagement, negligence or breach of fiduciary duty.” *Id.* at 831 (emphasis added). Thus, *Medill* did not hold, as National Union appears to contend, that a causal connection to a contract is sufficient to bring a claim within the breach of contract exclusion.

⁵ We also note that “California law makes no distinction as to the insurability of damages based on whether the causes of action alleged in the underlying action are specifically pleaded in tort or contract.” *Health Net, Inc. v. RLI Ins. Co.*, 206 Cal.App.4th 232, 254 (Ct. App. 2012). Thus, in *Medill*, “when an insured was sued for negligence and breach of fiduciary duty arising out of its default on a bond obligation, the claim was held to arise out of a breach of contract, regardless of the fact that no breach of contract cause of action was actually pleaded.” *Id.*

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alleged contractual liability, in the form of unauthorized withdrawals, and these claims fall within Exclusion (h).

Similarly, the EFTA claim in *Friedman* is based on alleged contractual liability. This claim alleges that by making unauthorized withdrawals from members' accounts, 24 Hour Fitness violated 15 U.S.C. § 1693e(a). (*Friedman* 5AC ¶ 113). In particular, the claim alleges that "the EFT authorization language in [members'] Monthly Contracts is clear: [24 Hour Fitness] did not have the authority to tap the bank and credit card accounts of [members] after termination and/or cancellation of their monthly membership." (*Id.*) As with the RICO claim, the EFTA claim is based on alleged contractual liability because it is premised on the same alleged unauthorized withdrawals.

24 Hour Fitness's arguments that RICO and EFTA claims are not based on alleged contractual liability are not persuasive. First, 24 Hour Fitness's reliance on purportedly analogous cases for the proposition that the membership contracts only have a slight causal relationship to RICO and EFTA claims, (Joint Memo 27-28), is misplaced. *Foodtown, Inc. v. National Union Fire Ins. Co.*, for instance, dealt with a similarly worded insurance exclusion for claims arising out of "contractual liability." 2008 WL 3887617, at *2 (D.N.J. 2008). The underlying action alleged that the insured breached its fiduciary duties by failing to exercise a purported contractual right of first refusal to obtain certain assets from another grocer. *Id.* *5-6. The insured's failure to exercise this right resulted in a lost economic opportunity and thus breached fiduciary duties. *Id.* *Foodtown* held that the breach of fiduciary duty claim did not fall within the "contractual liability exclusion." *Id.*

[T]he mere mention of a contract does create a claim alleging, arising out of, based upon or attributable to any actual or alleged contractual liability. The allegations concerning the contract for the purchase of the . . . assets serve as part of the factual basis for the claim, not the legal basis. Put specifically, the allegations concerning the Manyfoods/Food King contract are in the complaint as evidence of the concreteness, and the particularity, of Food King's claim against the Board for its alleged breach of fiduciary duties with respect to the lost opportunity to purchase the assets, not as the actual basis of the claim.

Id. In other words, the claims in *Foodtown* were not based on breaches of contract because the insured's failure to exercise its right of first refusal did not give rise to any such breach. Here, by contrast, the RICO and EFTA claims are based on breaches of contract – i.e., contractually unauthorized withdrawals from members' accounts. *Foodtown* therefore does not support 24 Hour Fitness's view that these claims fall outside Exclusion (h). Similarly, in *Westpoint Intern., Inc.*, another contractual liability exclusion case, the court held that "the thrust of the underlying action is not plaintiffs' breaches of the various contracts at issue, but their marginalizing of the underlying plaintiff lenders' shareholder rights and devaluing of their collateral, which actions give rise primarily to the tort and statutory claims asserted in the action and which would provide a basis for the action even in the absence of the agreements." *Westpoint Intern., Inc. v. American Intern. South Ins. Co.*, 71 A.D.3d 561, 562 (N.Y. App. Div. 2010). Here, however, the RICO and EFTA claims would not exist "even in the absence" of the membership

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contracts because these claims are premised on withdrawals that were unauthorized under those contracts.

Next, 24 Hour Fitness argues that “Judge Matz in the underlying *Friedman* suit directly held that the claims sounding in RICO and EFTA . . . were ‘different in character from the . . . breach of contract claims that were at the core of three previous iterations of the complaint.’” (Joint Memo at 30 (emphasis original) (citing *Friedman v. 24 Hour Fitness USA, Inc.*, 580 F. Supp. 2d 985, 997 (C.D. Cal. 2008) (holding that RICO and EFTA claims did not relate back to breach of contract claim in original complaint for statute of limitations purposes)). “As such,” 24 Hour Fitness contends, “the RICO and EFTA claims are independent of any liability arising in contract.” (Id.) Reading *Friedman*’s full discussion of the relation back issue demonstrates, however, that the court did not purport to decide the relevant issue here: whether the RICO and EFTA claims are based on alleged contractual liability. Instead, *Friedman* concluded that RICO and EFTA claims are “different in character” from the breach of contract claims because they “escalate Defendant’s potential liability: Treble damages and civil forfeiture are available under RICO, and the EFTA authorizes potentially significant damages for class actions.” 580 F. Supp. 2d at 997. But the difference in available damages for RICO and EFTA claims, on the one hand, and breach of contract claims, on the other, does not inform whether these claims are based on alleged contractual liability within the meaning of Exclusion (h) – the relevant inquiry here. Indeed, Judge Matz had no occasion to address the scope of Exclusion (h) in the statute of limitations relation back analysis. *Friedman* does not support 24 Hour Fitness’s position that the RICO and EFTA claims fall outside of Exclusion (h).

We now turn to the CLRA claim based on the theory that 24 Hour Fitness’s membership contracts were unconscionable. This claim relies on the allegation that the membership contracts are “enforced in a manner differing from the language” and therefore are “illegal and against public policy to the extent [they] effectuate[] [24 Hour Fitness’s] scheme to wrongly take and transfer funds from member[s]’ checking accounts after the member cancelled his/her monthly membership.” (*Friedman* 5AC ¶ 121; see also *Alatorre* Compl. ¶ 88 (materially identical allegation)). In other words, this purported theory of unconscionability is based on the same alleged breaches of contract (the unauthorized withdrawals) on which the RICO and EFTA claims are based. Like those claims, this CLRA claim falls within Exclusion (h).

Finally, both actions assert a breach of contract claim, which obviously falls within Exclusion (h).⁶ Thus, in light of the foregoing, we conclude that the RICO claims, EFTA claims, CLRA claims based on allegedly unconscionable contracts, and breach of contract claims fall within Exclusion (h) and cannot support a duty to defend.

b. Claims Based on Allegedly Misleading Statements Trigger a Duty to Defend

⁶ We also note that both Underlying Actions include UCL claims, but these do not warrant independent analysis because they assert other claims as their predicates.

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We conclude that the following claims are potentially covered under the Policy, are not excluded, and are not precluded under public policy: (1) CLRA violation based on contractual misrepresentations (“Misrepresentation Claim”), (*see Friedman* 5AC ¶ 130; *see also Alatorre* Compl. ¶ 97); and (2) CLRA violation based on “making false statements” (“Special Deal Claim”).⁷ (*See Friedman* 5AC ¶ 139-40). Accordingly, these claims trigger a duty to defend.

i. The Misrepresentation and Special Deal Claims Are Potentially Covered and Are Not Excluded Under Exclusion (h).

First, we must decide whether 24 Hour Fitness has met its burden to show the Policy covers or potentially covers the Misrepresentation and Special Deal Claims. 24 Hour Fitness argues that under the plain meaning of the Policy, these claims are covered. National Union responds that under the language of the Policy, the Underlying Actions do not involve a “Loss” resulting from a “Wrongful Act.”

Coverage B of the Policy provides in relevant part that National Union “shall pay the Loss . . . arising” from a “Claim first made against the Company . . . for any actual or alleged Wrongful Act The Insurer shall . . . advance Defense Costs of such Claim prior to its final disposition.” (Joint Evidentiary Appendix, Ex. C at 113). The Policy defines “Wrongful Act” as “any breach of duty, neglect, error, misstatement, misleading statement, omission or act by the Company,” (*Id.* at 118), and “Loss” as “damages . . . , judgments, settlements, pre- and post-judgment interest, and Defense Costs.”⁸ (*Id.* at 116).

The Parties dispute whether the Underlying Actions involve claims for any “Wrongful Act.” We conclude that although the Policy is arguably ambiguous, a reasonable insured would expect coverage of the Misrepresentation and Special Deal Claims. Accordingly, consistent with our duty to interpret insurance coverage broadly, we conclude that the Misrepresentation and Special Deal Claims are potentially covered. We further conclude that because these claims are based on misleading statements rather than alleged unauthorized withdrawals, these claims are not based on contractual liability and do not fall within Exclusion (h).

First, the Misrepresentation Claim alleges that 24 Hour Fitness had a deceptive practice of misrepresenting that the membership contracts had “characteristics or benefits which they did not have.”

⁷ Both Underlying Actions assert a Misrepresentation Claim. Only *Friedman* asserts a Special Deal Claim.

⁸ “Defense Costs” is defined as “reasonable and necessary fees, costs and expenses consented to by the insurer . . . resulting solely from the investigation, adjustment, defense and appeal of a Claim against the insureds, but excluding salaries of officers or Employees of the Company.” (Joint Evidentiary Appendix, Ex. C at 114).

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(*Friedman* 5AC ¶ 130; *see also Alatorre* Compl. ¶ 97 (similar allegation)). In particular, this claim alleges that 24 Hour Fitness represented that members could cancel at any time even though the membership contracts had “a term . . . [that] requires the consumer to remain a member for at least two months after cancellation of the membership.” (*Friedman* 5AC ¶ 130; *see also Alatorre* Compl. ¶ 97 (similar allegation)). Second, the Special Deal Claim in *Friedman* alleges CLRA liability for “making false statements.” In particular, the Special Deal Claim alleges that “to pressure a potential consumer into immediately signing up for membership, [24 Hour Fitness] engages in a pattern and practice of deceptively advising all potential consumers that [24 Hour Fitness] is currently offering a ‘special’ which will expire that day or soon thereafter,” even though 24 Hour Fitness in fact offers some sort of “special” every day. (*Friedman* 5AC ¶ 139-40).

The Misrepresentation and Special Deal Claims appear to entail a “breach of duty, neglect, error, misstatement, *misleading statement*, omission, or act” and thus appear to fall within the definition of “Wrongful Act” under the plain meaning of the Policy. (Joint Evidentiary Appendix, Ex. C at 113, 118 (emphasis added)). Both claims allege, in substance, that 24 Hour Fitness made misleading statements – which expressly fall within the Policy’s definition of “Wrongful Act” – to induce consumers into signing membership contracts. The Misrepresentation Claim alleges that 24 Hour Fitness misled consumers by telling them that they could cancel at any time even though they could not. And the Special Deal Claim alleges that 24 Hour Fitness misled consumers by telling them about a bogus “special deal.” These claims therefore appear to be based on allegedly “misleading statements.”

Nonetheless, we conclude that the term “misleading statement” is at least somewhat ambiguous as to whether it includes intentional conduct, as alleged here. The Policy does not provide any express guidance on whether “Wrongful Act” includes intentional conduct. In general, a word or phrase “is given more precise content by the neighboring words with which it is associated.” *Freeman v. Quicken Loans, Inc.*, 132 S.Ct. 2034, 2042 (2012); *see also Shell Oil Company v. United States*, __ Fed. Cl. ___, 2013 WL 163804, *9 n.4 (Fed. Cl. 2013) (explaining that “[a]lthough this canon is more frequently used by courts in interpreting statutes, it applies with equal force to contracts”). Hence, we look to the surrounding terms to inform whether “misleading statement” includes intentional conduct. First, a “breach of duty” may be intentional or unintentional; this term therefore does not help resolve the ambiguity. “Neglect” and “error” generally refer to unintentional conduct, but “misstatement” and “misleading statement” can refer to either intentional or unintentional conduct. *Cf. Michael J. v. Los Angeles County Dept. of Adoptions*, 201 Cal.App.3d 859, 867 (Ct. App. 1988) (“California law recognizes several categories of fraud and deceit, including negligent and intentional misrepresentation.”). Accordingly, some of the terms in the Policy’s definition of “Wrongful Act” appear to refer to unintentional conduct, and other terms appear to refer to conduct that can be either unintentional or intentional, and the Policy is therefore arguably ambiguous on this question.

Thus, to the extent the Policy is arguably ambiguous, we resolve any ambiguity by looking to the objectively reasonable expectations of the insured. In general, many types of insurance limit coverage to unintentional conduct. *See, e.g., State Farm Fire & Casualty Co. v. Panko*, 1996 WL 162977, *5 (N.D. Cal. 1996) (explaining that “[b]ecause both the homeowner’s policy and the umbrella policy limit

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coverage to “accidental” occurrences or losses, there is no duty to defend against claims arising from . . . deliberate conduct”). Here, however, the Policy does not expressly limit coverage to accidental, unintentional, or negligent occurrences. Rather, it covers “Wrongful Acts,” which it defines as “any breach of duty, neglect, error, misstatement, *misleading statement*, omission or act by the Company.” (Joint Evidentiary Appendix, Ex. C at 118 (emphasis added)). Accordingly, an objectively reasonable insured would not expect a limitation on the Policy’s coverage that is commonly included in express terms, such as a term limiting coverage to “accidental occurrences,” but was left out here. *Cf. Group Voyagers, Inc. v. Employers Ins. of Wausau*, 2002 WL 356653, *3 (N.D. Cal. 2002) (noting that policy could have been phrased to cover any error or omission, even non-negligent ones, had the parties so intended). The objectively reasonable expectations of the insured therefore support coverage.

Furthermore, courts have found coverage for intentional conduct in cases dealing with similar policy language. *See Hardin v. Greenwich Ins. Co.*, 2012 WL 3217704 (C.D. Cal. 2012) (holding that liability policy with similar definition of “Wrongful Acts” covered RICO and breach of fiduciary duty claims based on allegations that the insured fraudulently billed California for unlicensed dental services); *PMI Mortg. Ins. Co. v. American Intern. Specialty Lines Ins. Co.*, 394 F.3d 761, 762-65 (9th Cir. 2005) (reversing district court and holding that plain meaning of liability policy for “Wrongful Act[s],” defined as “any act, error or omission in the rendering of or failure to render Professional Services,” covered underlying action alleging that insured undercharged lenders for mortgage insurance in exchange for kickbacks in violation of RESPA). Thus, consistent with our duty to interpret insurance coverage broadly, we conclude that the term “Wrongful Act” includes the intentionally misleading statements alleged in the Misrepresentation and Special Deal Claims and that the Policy therefore covers these claims.

Next, because the Misrepresentation and Special Deal Claims are based on misleading statements rather than contractual liability, we also conclude that these claims do not fall within Exclusion (h), discussed at length in Section II.B.1.a., above. These claims are not based on withdrawals from consumer accounts that were allegedly unauthorized under membership contracts. Rather, the theory of the Misrepresentation and Special Deal Claims appears to be that 24 Hour Fitness misled consumers into signing membership contracts by telling them they could cancel at any time even though they couldn’t or by telling them about a bogus special deal. This theory is based on misleading statements, not contractual liability. Even without the alleged breaches of contract (i.e., the unauthorized withdrawals), these purported legal theories based on misleading statements would still apply. Accordingly, the Misrepresentation and Special Deal Claims are not based on any actual or alleged contractual liability and do not fall within Exclusion (h).

Finally, National Union contends there is no coverage because the claims in the Underlying Actions are based on alleged breaches of contract and thus there is no loss resulting from a wrongful act. But as we explained above, the Misrepresentation and Special Deal Claims are based on misleading statements, not contractual liability.

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In light of the foregoing, we conclude that the Misrepresentation and Special Deal Claims are potentially covered under the Policy and are not excluded under Exclusion (h).

ii. The Misrepresentation and Special Deal Claims Are Not Excluded Under the Policy's Antitrust Exclusion

National Union argues that Exclusion (q)(2) bars coverage for the Underlying Actions. Exclusion (q)(2) provides as follows:

The Insurer shall not be liable to make any payment for Loss in connection with a Claim made against an Insured: . . . (q)(2) for any actual or alleged violation of any law, whether statutory, regulatory or common law, respecting any of the following activities: anti-trust, business competition, unfair trade practices or tortious interference in another's business or contractual relationships.

(Joint Evidentiary Appendix, Ex. C at 120).

National Union contends that the claims in the Underlying Action concern allegedly unfair trade practices. In particular, National Union contends that Exclusion (q)(2) covers the CLRA claims, including the Misrepresentation Claim and Special Deal Claim, because the purpose of the CLRA is to protect consumers from unfair and deceptive business practices. 24 Hour Fitness responds that in light of the surrounding terms, the exclusion for "unfair trade practices" should be limited to claims involving competitive injury.

We conclude that the exclusion for unfair business practices is ambiguous, and 24 Hour Fitness's interpretation is reasonable. Therefore, this exclusion should be construed narrowly against the insurer. As discussed above, a word or phrase "is given more precise content by the neighboring words with which it is associated." *Freeman v. Quicken Loans, Inc.*, 132 S.Ct. 2034, 2042 (2012); *see also Integra Telecom, Inc. v. Twin City Fire Ins. Co.*, 2010 WL 1753210 (D. Or. 2010) (concluding that a similarly worded exclusion was ambiguous and therefore interpreting it narrowly against the insurer to exclude only anti-competitive unfair trade practices).

We find *Integra Telecom*'s reasoning persuasive here.⁹ Both of the Parties' interpretations of "unfair trade practices" are reasonable. On the one hand, "unfair trade practices" could refer generally to any unfair trade practice that harms competition, the public, or consumers. On the other hand, in light of the surrounding terms, all of which refer to competitive harms, "unfair trade practices" could refer specifically to only such practices that harm competition. Exclusion (q)(2) is therefore ambiguous. Further, as discussed above, the coverage portion of the Policy would lead an insured to reasonably expect coverage of the Misrepresentation and Special Deal Claims, which clearly allege wrongful acts.

⁹ Although *Integra Telecom* was decided under Oregon law, California law is identical in all material respects.

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Accordingly, we construe Exclusion (q)(2) narrowly against the insurer. *See Manzarek v. St. Paul Fire & Marine Ins. Co.*, 519 F.3d 1025, 1032 (9th Cir. 2008) (“[E]xclusionary clauses are interpreted narrowly against the insurer. An ‘exclusionary clause must be conspicuous, plain and clear.’ . . . ‘This rule applies with particular force when the coverage portion of the insurance policy would lead an insured to reasonably expect coverage for the claim purportedly excluded.’”) (citations omitted). Accordingly, we conclude that the Misrepresentation and Special Deal Claims do not fall within Exclusion (q)(2).

National Union’s argues that *Integra Telecom* is distinguishable because the exclusion in that case listed many more terms implicating anti-competitive behavior. In particular, the exclusion in *Integra Telecom* applied to claims “based upon . . . price fixing, restraint to trade, monopolization, unfair trade practices or any violation of the Federal Trade Commission Act, Sherman Anti-Trust Act, Clayton Act, or any similar law regulating anti-trust, monopoly, price fixing, price discrimination, predatory pricing or restraint of trade activities.” *Integra Telecom*, 2010 WL 1753210 at *1. Here, Exclusion (q)(2) applies to claims for “anti-trust, business competition, unfair trade practices or tortious interference in another’s business or contractual relationships.” (Joint Evidentiary Appendix, Ex. C at 120). National Union’s attempt to distinguish *Integra Telecom* is unavailing. Although it is correct that there were more terms indicating anti-competitive behavior in *Integra Telecom*’s exclusion, we do not think that the number of such terms alone determines whether an exclusion is ambiguous. Rather, we must also look at what the terms are, and here, all the surrounding terms in Exclusion (q)(2), while fewer in number, implicate anti-competitive conduct or conduct implicating competitors, not consumers. Thus, as discussed above, it is ambiguous whether “unfair trade practices” refers broadly to any such practices or more narrowly to only such practices that involve competitive harm. This ambiguity is particularly stark in California, where the term “unfair business practice” is a term of art that refers to a practice “that threatens an incipient violation of an antitrust law, or violates the policy or spirit of one of those laws because its effects are comparable to or the same as a violation of the law, or otherwise significantly threatens or harms competition.” *Cel-Tech Commc’ns, Inc. v. Los Angeles Cellular Tel. Co.*, 20 Cal. 4th 163, 187 (1999); *see also Durell v. Sharp Healthcare*, 183 Cal. App. 4th 1350, 1365-66 (Cal. 2010) (reasoning that *Cel-Tech*’s definition of “unfair” applies in consumer UCL actions). Accordingly, 24 Hour Fitness’s reading of “unfair trade practices” is reasonable, and a reasonable insured in its position could expect that the Misrepresentation and Special Deal Claims in the Underlying Actions would not fall within Exclusion (q)(2).

In light of the foregoing, we conclude that the Misrepresentation Claim and Special Deal Claim do not fall within Exclusion (q)(2) because these claims do not allege any competitive harm.

c. Uninsurability of Claims in Underlying Actions

National Union next argues that it does not owe a duty to defend because public policy bars the indemnification of all the claims in the Underlying Action. *See Bank of the West v. Superior Court*, 2 Cal.4th 1254, 1266 (Cal. 1992) (“It is well established that one may not insure against the risk of being ordered to return money or property that has been wrongfully acquired.”). We disagree. First, as 24

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Hour Fitness points out, this case involves defense costs, not indemnity. The purpose of the public policy bar on indemnification is to prevent an insured from transferring the cost of wrongdoing to an insurer because such transfer would “eliminate the incentive for obeying the law.” *Bank of the West*, 2 Cal.4th at 1269. Here, this public policy does not apply because only defense costs are at issue.¹⁰ As California courts have explained, “[o]bviously, the public policy concerns applicable to an insurer’s indemnification do not extend to the provision of a defense. An agreement to defend an insured upon mere accusation of a wilful tort,” for example, “does not encourage such wilful conduct.” *Downey Venture v. LMI Ins. Co.*, 66 Cal.App.4th 478, 508 (Ct. App. 1998) (citations and internal quotation marks omitted). This principle applies with particular force here, where the Policy expressly states that National Union’s obligation to defend applies even to “groundless, false or fraudulent” claims. (Joint Evidentiary Appendix, Ex. C at 123). Hence, the duty to defend applies regardless of whether 24 Hour Fitness actually committed any “Wrongful Acts” because mere *allegations* of such acts trigger the duty to defend.

Second, the Policy expressly covers “the Loss . . . arising” from a “Claim . . . for any actual or alleged Wrongful Act.” (Joint Evidentiary Appendix, Ex. C at 113). “Loss” includes “Defense Costs” and “Claim” includes actions for “monetary or non-monetary relief.” (Id. at 114, 116 (emphasis added)). Here, both Underlying Actions sought non-monetary relief, such as an injunction. (*Friedman* 5AC ¶ 143; *Alatorre* Compl. ¶ 101). Accordingly, the Policy potentially covers the Underlying Actions to the extent they assert non-monetary relief, even if all the claims for monetary relief cannot be indemnified as against public policy. See *Bodell*, 119 F.3d at 118 (similarly distinguishing California law barring indemnity as against public policy and concluding that insurer had duty to defend where policies “specifically provide a duty to defend not only when there is a claim for damages but also when a governmental regulatory agency institutes a proceeding seeking non-pecuniary relief”). Thus, we conclude that *Bank of the West* does not bar 24 Hour Fitness’s claim for defense costs.

III. Conclusion

In light of the foregoing, we conclude the Policy potentially covers the Misrepresentation Claim and the Special Deal Claim in the Underlying Actions and that no exclusion applies to these claims. Further, we conclude that public policy does not preclude coverage for defense costs. Accordingly, because the Policy potentially covers defense costs for at least two claims in *Friedman* and one claim in *Alatorre*, National Union owed a duty to defend these actions. See *Fire Ins. Exchange v. Superior Court*, 181 Cal. App. 4th 388, 391 (Ct. App. 2010) (explaining that an insurer owes no duty to defend “only when the third party complaint can by no conceivable theory raise a single issue which could bring it within the policy coverage” (citation and internal quotation marks omitted)); see also *Health Net, Inc. v. RLI Ins. Co.*, 206 Cal.App.4th 232, 259 (Ct. App. 2012) (explaining that “[b]y law, an

¹⁰ We note that the cost of defending a lawsuit may be at most an incidental, practical incentive to obey the law and thus clearly does not fall within the doctrine barring indemnification for wrongfully acquired money. See *Bodell v. Walbrook Ins. Co.*, 119 F.3d 1411, 1418 (9th Cir. 1997) (holding that “a contract to defend an insured in a criminal proceeding ‘does not encourage’ criminal conduct”).

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insurer who has a duty to defend potentially-covered claims is required, as a prophylactic measure, to defend the entire action”).¹¹ 24 Hour Fitness’s Motion for Summary Judgment is **GRANTED**. National Union’s Motion for Summary Judgment is **DENIED**.

IT IS SO ORDERED.

Initials of Deputy Clerk

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¹¹ Because these Motions are directed at liability only, we do not decide here the amount of defense costs National Union is liable to pay. *See generally Health Net, Inc.*, 206 Cal.App.4th at 259 (citing *Buss v. Superior Court*, 16 Cal.4th 35, 48-50 (Cal. 1997)).

**IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
COUNTY DEPARTMENT, CHANCERY DIVISION**

WESTCHESTER FIRE INSURANCE
COMPANY,

Plaintiff,

v.

ROSENTHAL COLLINS GROUP, LLC,
et. al.,

Defendant.

ROSENTHAL COLLINS GROUP, LLC,

Counter-Plaintiff,

v.

WESTCHESTER FIRE INSURANCE
COMPANY,

Counter-Defendant,

No. 13 CH 15108

Calendar 16

Judge David B. Atkins

JUDGE DAVID B. ATKINS

JUL 03 2014

Circuit Court-1879

MEMORANDUM OPINION AND ORDER

THIS CAUSE COMING ON TO BE HEARD on plaintiff Westchester Fire Insurance Company's Motion for Summary Judgment and defendant Rosenthal Collins Group, LLC's Motion for Partial Summary Judgment, and the court having considered the briefs submitted and the arguments of counsel, and the court being fully advised in the premises,

IT IS HEREBY ORDERED that plaintiff's motion for summary judgment is denied and defendant's motion for summary judgment is granted.

Background

This case arises out of an insurance coverage dispute between the insured, defendant Rosenthal Collins Group, LLC ("RCG") and its insurer, Westchester Fire Insurance Company ("Westchester"). Westchester insured RCG under a Directors & Officers and Company policy ("D&O Policy") for the policy period of December 31, 2009 to March 15, 2011.

RCG is a Futures Commission Merchant registered with the Commodity and Futures Trading Commission ("CFTC") and the National Futures Association. As such, RCG is

regulated by the Commodity Exchange Act (“CEA”). The CFTC is the agency responsible for enforcing the CEA.

In 2011, three underlying lawsuits were filed that form the basis of this declaratory judgment action: *Pieretti v. Rosenthal Collins Group, LLC, et al.*, *Vasa Order of America v. Rosenthal Collins Group, LLC et al.*, and *Burdick v. Rosenthal Collins Group, LLC, et al.* As of the filing of RCG’s counterclaim, the *Pieretti* suit had been dismissed with prejudice pursuant to settlement. A fourth complaint was also filed in September 2012 but RCG withdrew its tender for that suit.

The underlying lawsuits center on the conduct of Enrique Villalba, a customer of RCG who used their services to process his trades. The underlying plaintiffs were customers of Villalba, not RCG. They allege that Villalba and his wholly-owned business, Money Market Alternative LP, orchestrated a Ponzi scheme whereby they represented to investors that their funds would be placed into segregated accounts for conservative investment when the money was actually commingled into a single account and used by Villalba to engage in high risk day-trading on his own behalf. The underlying complaints allege that Villalba eventually squandered all the investors’ money. Neither Villalba nor his business are named in the present declaratory judgment action.

Legal Standard

Summary judgment is appropriate when the pleadings, depositions, admissions, and affidavits illustrate no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. 735 ILCS 5/2-1005; *Miller v. William Chevrolet*, 326 Ill. App. 3d 642, 648 (2001). When evaluating a motion for summary judgment, the court must consider “all the evidence before it strictly against the movant and liberally in favor of the nonmovant.” *Id.* (citing *Largosa v. Ford Motor Co.*, 303 Ill. App. 3d 751, 753 (1999)). Because summary judgment is a drastic means of disposition of litigation it should be allowed only when the resolution of the case depends on a question of law, and the moving party’s right to judgment is free and clear from doubt. *Country Mut. Ins. Co. v. Hagan*, 298 Ill. App. 3d 495, 500 (1998).

The purpose of summary judgment is not to try a question of fact, but rather to determine whether a genuine issue of material fact exists. *Williams v. Manchester*, 228 Ill. 2d 404, 417 (2008). When parties file cross-motions for summary judgment, they agree that no material issues of fact exist and that only legal questions are involved. *State Farm Ins. Co. v. Am. Serv. Ins. Co.*, 332 Ill. App. 3d 31, 36 (1st Dist. 2006).

Discussion

RCG argues that Westchester has a duty to defend it against the underlying suits under the insurance policy it purchased from Westchester. The policy provides “Directors & Officers” (“D&O”) coverage, which protects directors and officers of corporations against legal judgment and related expenses resulting from allegations of wrongful acts committed in their individual capacity as company directors and officers. As RCG notes in its response, most D&O policies now include “entity coverage,” which provides coverage for claims asserted directly against the corporation itself. Both forms of coverage are contained in the Westchester policy, as set forth in

Insuring Clauses 1-3. Errors and Omissions (“E&O”) coverage, on the other hand, protects professionals from wrongful acts which occur in the course of their performance of professional services. There is no E&O policy in this case.

The Westchester policy also contains a Professional Services Exclusion, central to both motions, which bars coverage for any claim:

“[A]lleging, based upon, arising out of, attributable to, directly or indirectly resulting from, in consequence of, or in any way involving the rendering of or failing to render professional services.”

(Compl. Ex. D)

Although the term “professional services” is not defined in the policy, Illinois courts have defined it as, “any business activity conducted by the insured [1] that involves specialized knowledge, labor, or skill, and [2] is predominantly mental or intellectual as opposed to physical or manual.” *Pekin Ins. Co. v. L.J. Shaw & Co.*, 291 Ill. App. 3d 888, 892 (1st Dist. 1997).

Westchester’s Motion for Summary Judgment

Westchester contends that it owes no duty to defend RCG in the underlying suits because the conduct alleged is excluded under the Professional Services Exclusion, emphasizing that RCG is in fact a company in the business of providing professional services.

In support of its motion, Westchester urges a broad approach to interpreting the policy language that seeks to draw a general distinction between D&O coverage and E&O coverage. No Illinois case law interpreting a professional services exclusion in a D&O policy exists, but certain decisions are nevertheless instructive. For instance, Westchester relies heavily on *L.J. Shaw*, which held that a professional services exclusion “should not be read so narrowly as to transform a general business liability policy into a professional errors and omissions policy.” 291 Ill. App. 3d at 895. However, the court in *Shaw* also stated that such an exclusion “cannot be read so broadly as to exclude liability for any act at all taken in the course of providing professional services.” *Id.*

Further, unlike the policy in *Shaw*, the insurance policy at issue here is not a general business liability policy but rather a D&O policy. Unlike general liability policies, D&O policies specifically protect directors and officers from liability arising from negligence or misconduct in managing a business. Westchester argues that this distinction further supports its position, citing cases wherein similar factual scenarios were found to fall within the coverage of E&O policies. However, this approach fails to consider the legal standards for insurance interpretation, which require that policy language be construed broadly and that exclusionary language be construed narrowly. See *Int’l Ins. Co. v. Rollprint Packaging Product, Inc.*, 312 Ill. App. 3d 998, 1009 (1st Dist. 2000). Accordingly, many cases may exist which would fall within an E&O policy but still fall outside of a professional services exclusion. Because the issue here pertains to interpretation of an exclusion, rather than to whether coverage lies under an E&O policy, these cases are distinguishable.

Accordingly, the court finds that the underlying suits are not covered by the Professional Services Exclusion. In arguing that the Professional Services Exclusion should apply to the allegations in the underlying suits, Westchester attempts to paint the entirety of RCG's activities as professional services, suggesting that because RCG renders professional services, all of the allegations in the underlying claims fall within that exception. While RCG is indeed a company in the business of providing professional services and some of the allegations do arise out of their rendering, others do not and, as the court in *Shaw* indicated, not every act done while providing professional services is itself a professional service. Therefore, because the court finds, as further discussed below, that some of the underlying allegations are not based on RCG's rendering of professional services, plaintiff's motion for summary judgment is denied.

RCG's Motion for Partial Summary Judgment

In its motion, RCG contends that it is entitled to partial summary judgment with respect to count I of its counterclaim, which seeks a declaration that Westchester owes a duty to defend because the underlying complaints contain allegations that potentially implicate coverage and because the Professional Services Exclusion does not apply. To prevail on its motion, RCG must demonstrate not only that the allegations in the underlying complaints fall within coverage, but also that the Professional Services Exclusion does not apply.¹

In *Rollprint*, the Illinois appellate court held that an insurer must defend an entire underlying suit if any allegation potentially implicates coverage. 312 Ill. App. 3d 998 at 1009. There, the insured sought coverage for an underlying claim it argued arose out of an employee's "wrongful eviction" from its place of business. The court found that coverage applied even though the underlying plaintiff had not pled the specific cause of action for wrongful eviction, noting that "[t]he question of coverage should not depend on the draftsmanship skills or the whims of the plaintiff in the underlying action." *Id.* at 1007-08. The same reasoning applies with equal force here, and the substance of the underlying claims rather than their form will determine whether coverage applies.

Neither side disputes that the allegations in the underlying claims fall within coverage; rather, as discussed above, Westchester argues that coverage is nonetheless excluded under the Professional Services Exclusion. However, as RCG correctly notes, if any allegations are not subsumed by the Professional Services Exclusion, even under the expansive definition promoted by Westchester, then the duty to defend is triggered. As the court in *Rollprint* indicated, the existence of allegations that do not implicate coverage will not defeat this duty so long as even one allegation exists that does implicate coverage. *Id.* at 1009.

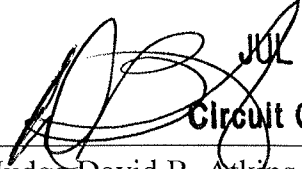
To that end, RCG points to several allegations in the underlying complaints that it "aided and abetted" Villalba in his scheme to defraud investors and that RCG itself participated in such fraudulent activities. In arguing that the exclusion nevertheless applies, Westchester essentially contends that criminal fraud constitutes the rendering of a professional service (or failure to render such a service), an assertion that is tenuous at best. As discussed above, the duty to defend is triggered where even one allegation exists that potentially implicates coverage, and here there are several. The court finds that the allegations of criminal conduct do not fall within

¹ At oral argument, both parties agreed that any other exclusions pertain only to indemnity and are thus not relevant to these motions.

the Professional Services Exclusion, and thus that they trigger Westchester's duty to defend under the policy. Accordingly, RCG's motion for partial summary judgment as to count I of its counterclaim is granted.

WHEREFORE, plaintiff Westchester Fire Insurance Company's Motion for Summary Judgment is denied and defendant Rosenthal-Collins Group, LLC's Motion for Partial Summary Judgment is granted in that the court finds that plaintiff Westchester Fire Insurance Company has a duty to defend defendant Rosenthal-Collins Group, LLC in the underlying lawsuits.

ENTERED: **JUDGE DAVID B. ATKINS**

 **JUL 03 2014**
Circuit Court-1879

Judge David B. Atkins

The Court.

Cyber Liability

Speakers:

David Anderson, Hoke LLC

Robert Chesler, Anderson Kill & Olick,
P.C.

Helen Michael, Kilpatrick Townsend

Alan Rutkin, RivkinRadler

CYBER-CRIMES: How Have Courts Dealt with the Insurance Implications of this Emerging Risk?

By Alan Rutkin

Insurance coverage law has one firm rule: *when a new risk emerges, new coverage issues follow*. There are roughly forty cases addressing insurance coverage for cyber-crime liability. We have seen three interesting questions recurring:

- (1) Does the policy apply to acts by this person?
- (2) Does the policy apply to this type of conduct?
- (3) Was the problem *caused* by computer activity?

1) Does the policy apply to acts by this person?

A common coverage question in cyber-crime claims is whether the policy applies to the acts of the *person* who used the computer to cause the injury.

The issue is authorization. Computer-specific policies often limit coverage to the bad acts of persons who are *not* authorized. Acts by employees are often excluded.

In *Apps Communication, Inc. v. Hartford Casualty Insurance Co.*,¹ a Computers and Media Endorsement excluded dishonest or criminal acts by employees. A virus damaged the policyholder's computers. The policyholder alleged that a "virus was introduced" into its computer system, but the policyholder did not allege who introduced the virus. The court held that the policyholder needed to allege who introduced the virus to make it clear that the employee exclusion did not apply.²

¹ No. 11C3994, 2011 U.S. Dist. LEXIS 118906 (N.D. Ill. Oct. 14, 2011); *see also Palm Hills Properties v. Continental Ins. Co.*, No. 07-668-RET-SCR, 2008 WL 4303817 (M.D. La. July 23, 2008)(court applied employee exclusion to bar coverage).

² This decision is very favorable to insurers. Generally, insurers have the burden to establish exclusions. But here, the court found that the policyholder's complaint effectively needed to allege that the exclusion did not apply. *But see NMS Services, Inc. v. Hartford*, 62 F. App'x 511, 2003 U.S. App. LEXIS 7442 (4th

Like the employee exclusion, several courts have considered and enforced exclusions for acts of authorized representatives. In *Stop & Shop v. Federal Insurance Co.*,³ the First Circuit applied an “authorized representatives” exclusion when a tax payment service stole \$13 million from a supermarket. In *Milwaukee Area Technical College v. Frontier Adjusters*,⁴ the court applied an “authorized representatives” exclusion when a college’s claim adjuster stole \$1.6 million.

Other courts faced more nuanced versions of the authorized person issue.

In *Universal American Corp. v. Union Fire Insurance Co.*,⁵ a “Computer Systems Fraud” policy covered “[l]oss resulting directly from a fraudulent ... entry of Electronic Data.” The policyholder, a health insurer, suffered \$18 million in losses from fraudulent claims. Most of these claims were submitted by providers. The providers entered fraudulent information. The case hinged on the meaning of “fraudulent entry.” Did it extend to the entry of information that was fraudulent? Or, was it limited to instances where it was fraudulent to enter any information at all. The court found that “entry” focused on the act of entering data; the data was fraudulent, but the act of entering it was legitimate. The court found for the insurer.

In *Morgan Stanley Dean Witter & Co. v. Chubb*,⁶ an authorized person made unauthorized transfers causing about \$100 million in losses. The policy, an “Electronic Computer Crime Policy,” focused on how the transfers were made. If the transfer was

Cir. Sept. 24, 2003) (applying “acts of destruction” exception to exclusion where bad actor was an employee).

³ 136 F.3d 71 (1st Cir. 1998).

⁴ 312 Wis. 2d 360 (Wis. App. 2008).

⁵ 38 Misc. 3d 859, 959 N.Y.S.2d 849 (N.Y. Sup. Ct. 2013), *aff’d*, 25 N.Y. 3d 675 (2015).

⁶ No. A-4124-03T2, 2005 N.J. Super. Unpub. LEXIS 798 (App. Div. Dec. 2, 2005).

made by fax, coverage only applied if the person giving the fax instructions was not authorized to do so. The voice coverage, however, extended to unauthorized instructions by authorized persons. Consequently, the court found that the fax coverage did not apply, but the voice coverage did apply.

In *Pestmaster Services v. Travelers Casualty and Surety Co.*,⁷ a payroll company was authorized to electronically transfer funds from the insured's account into its own as part of its payroll services. The payroll company failed to pay the insured's payroll taxes as required by the contract, and instead used the money to pay its own obligations. The insured made a claim under its Computer Crime policy, which covered losses directly caused by "Computer Fraud." The court held that the payroll company's acts did not constitute "Computer Fraud" because the funds transfer was authorized and did not involve hacking or any unauthorized entry into a computer system.⁸ The fraud took place only after the authorized transfer.

1. Does the policy cover this act?

In claims arising from cyber-crimes, many cases focus on whether the policy applies to the *act* that caused the injury.

Generally, computer fraud policies cover hacking. Nearly *all* criminals *use* computers. Only *some* criminals *hack* computers. Consequently, a common issue in the "act" cases is distinguishing *hacking* a computer from *using* a computer.

⁷ No. CV-13-5039-JFW(MRWx), 2014 U.S. Dist. LEXIS 108416 (C.D. Cal. July 17, 2014).

⁸ The court observed that "Computer Fraud" occurs "when someone 'hacks' or obtains unauthorized access or entry to a computer in order to make an unauthorized transfer or otherwise uses a computer to fraudulently cause a transfer of funds." *Id.* at *19.

Hacking is “to gain access to a computer illegally.”⁹ Policyholders have tried to extend hacking coverage to instances in which criminals give bad information that is then legally entered into the policyholder’s computer. At least two courts have distinguished giving bad information from actually breaking into a computer. Both courts found that the hacking coverage did not apply.¹⁰

Similarly, another court recently distinguished a data *refusal* from a data *error*. The policy covered errors, not intentional refusals. The court upheld the insurer’s disclaimer.¹¹

Just a few weeks ago, the Supreme Court of New Hampshire found that “hacking” is not an occurrence because it is “inherently injurious.”¹²

Finally, we’re seeing talk about whether coverage can be subject to policyholders following “best practices.” In 2013, an insurer sought a declaratory judgment of no coverage based upon an exclusion for “Failure to Follow Minimum Required Practices.” The case was dismissed on procedural grounds. But, we will surely see more of the “best practices” issue.¹³

⁹ Merriam-Webster.com definition of “hack,” *available at* <http://www.merriam-webster.com/dictionary/hack>.

¹⁰ *Hudson United Bank v. Progressive Cas. Ins. Co.*, 112 F. App’x 170, 2004 U.S. App. LEXIS 21335 (3d Cir. Oct. 14, 2004) (fraudulent data entry was not recoverable because data was not entered into the covered computer (*i.e.*, the policyholder’s computer); *Northside Bank v. American Cas. Co.*, 60 Pa. D. & C. 4th 95 (Ct. Common Pleas Jan. 10, 2001), *aff’d*, 792 A.2d 625 (Pa. Super. Ct. 2001) (coverage protecting a bank against hackers did not apply to the introduction of information that was fraudulent when received). *See also Metro Brokers v. Transportation Ins. Co.*, No. 1:12-cv-3010, 2013 U.S. Dist. LEXIS 184638 (N.D. Ga. Nov. 21, 2013), *aff’d*, 603 Fed. App’x. 833 (11th Cir. 2015) (policyholder conceded that malicious code and system penetration exclusion applied to virus).

¹¹ *Travelers Property Cas. Co. v. Federal Recovery Services, Inc.*, 103 F. Supp. 3d 1297 D. Utah 2015).

¹² *Todd v. Vermont Mutual Insurance Co.*, No. 2015-0233 (N.H. Apr. 7, 2016).

¹³ *Columbia Casualty Co. v. Cottage Health System*, No. 2:15-cv-03432 (C.D. Cal. 2015).

2. Does the policy limit coverage to losses that computer activity caused “directly”?

Claims under computer policies frequently involve a causation issue. Coverage is typically limited to losses “directly related” to some type of bad act on a computer.

Insurers often maintain that direct means immediate, without an intervening cause.¹⁴ Policyholders, on the other hand, argue for a “proximate cause” approach.

In *Retail Ventures*,¹⁵ criminals used computers to gain access to their victims. The criminals used computers to steal credit card information, and then stole from the accounts. The computers set up the crimes, but the computers were not used to carry out the crimes. The court found the losses resulted directly from computers.

Similarly, in *Apache Corp. v. Great American Insurance Co.*,¹⁶ a federal district court held that a computer fraud policy covered wire transfers to a phony account because a fraudulent email was a substantial factor in bringing about the injury. There, the insured’s employee received a phone call from an imposter posing as one of the insured’s vendors. The imposter claimed to be providing new account information for future wire payments. The employee asked for a written request on the vendor’s official letterhead. The imposter sent the letter by email. Another employee of the insured called the number on the letter to verify the request and obtained supervisor clearance before wiring the funds.

After learning that the account was fraudulent, the insured sought recovery under the computer fraud section of its crime protection policy. The policy covered loss

¹⁴ See, e.g., *Retail Ventures, Inc.*, 691 F.3d at 824.

¹⁵ 691 F.3d 821.

¹⁶ No. 4:14-CV-237, 2015 U.S. Dist. LEXIS 161683 (S.D. Tex. Aug. 7, 2015).

“resulting directly from the use of any computer to fraudulently cause a transfer of” property to another. The insurer declined coverage on the basis that the scheme’s success hinged on the telephone calls and related acts. It did not result directly from the use of a computer. The court disagreed and held “despite the human involvement that followed the fraud, the loss still resulted directly from computer fraud, i.e. the email directing [the insured] to disburse payments to a fraudulent account.”¹⁷

In contrast to these decisions, several courts have found that the use of a computer was merely incidental to the loss. In *Pinnacle Processing Group v. Hartford Casualty Insurance Co.*,¹⁸ the court held that “direct” means “without any intervening cause.” In *Brightpoint, Inc. v. Zurich American Insurance Co.*,¹⁹ the court cited Black’s Law Dictionary to state that direct means “in a straight line or course” and “immediately.”²⁰ In *Pestmaster*, the court stated that “direct means direct,” and held that losses must “flow immediately and directly” from computer use.²¹

¹⁷ *Id.* at *6-7. The case is currently on appeal before the Fifth Circuit.

¹⁸ No. C10-1126-RSM, 2011 U.S. Dist. LEXIS 128203 (W.D. Wash. Nov. 4, 2011).

¹⁹ 2006 U.S. Dist. LEXIS 26018.

²⁰ *Id.* at *20.

²¹ *Pestmaster*, 2014 U.S. Dist. LEXIS 108416 at *23-24 (computer was merely incidental to misuse of funds where fraud occurred after an authorized electronic transfer).

London Energy Package Policy, Onshore & Offshore

Speaker:

Claude Stuart, Hall Mains & Lugrin, P.C.

A Primer on Property Insurance for Offshore and Onshore Energy Risks

2016 ACCEC Annual Meeting

May 4-6, 2016

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I. INTRODUCTION TO THE ENERGY INDUSTRY

A. THE THREE SECTORS

The oil industry is a massive, multi-faceted environment that spans a number of different processes and occupations. Because it is so complex and encompasses so much, it is divided into three distinct sections based on the steps from drilling to refinement to ultimate use. These three distinct subdivisions of the energy industry are: Upstream, Midstream, and Downstream.¹

Upstream can be broken into many components, but the main ones are: searching out and selecting potential oil sites, evaluation of these sites, drilling exploratory wells, and operating these wells to extract crude oil.² The offshore energy package policy provides coverage for Upstream energy risks.

The Midstream industry involves the transportation and storage of oil and gas. Midstream takes the oil and gas retrieved in the Upstream sector and gets it to the Downstream processing facilities so that it can be turned into the various finished products in consumers' daily lives. There are quite a few logistical pathways that the Midstream sector may follow, including gathering and processing, logistics, pipelines, compressor stations, trucking, barges, rail, and terminals.³

The Downstream sector provides the closest connection to everyday consumers. In the Downstream sector, crude oil or natural gas arrives at processing plants where it is refined and eventually turned into various products which will then be sold and distributed, including: Gasoline, Diesel Fuel, Jet Fuel, Asphalt, Fertilizers, and Liquefied Natural Gas (LNG), among others.⁴

Some in the energy industry classify only the Upstream and Downstream sectors. When that classification is used, the Midstream sector is traditionally classified with the Downstream sector.⁵ The onshore energy package policy typically provides coverage for Downstream energy risks and some Midstream risks, such as pipelines and processing terminals.

B. INSURING THE ENERGY INDUSTRY

Energy insurance coverage is generally "arranged on a 'package' basis by specialist insurance brokers for upstream, midstream, and downstream exposures, with the latter sector

¹ See, e.g., STI Group, *The Three Oil and Gas Energy Markets: What is Upstream?* (Jan. 28, 2013), available at <http://setxind.com/upstream/what-is-upstream/> (last retrieved on April 5, 2016) (hereinafter "*What is Upstream?*"); Sumit Dutta, *Oil & Gas 101: Explaining Upstream, Midstream, Downstream & Services*, OIL & GAS IQ (Oct. 13, 2013), available at <http://www.oilandgasiq.com/strategy-management-and-information/articles/video-oil-gas-101-explaining-upstream-midstream-d/> (last retrieved on February 11, 2014) (hereinafter "*Explaining Upstream?*").

² *Explaining Upstream*, *supra* note 1.

³ See e.g., *What is Upstream?*, *supra* note 1.

⁴ See, e.g., STI Group, *The Three Oil and Gas Energy Markets: What is Downstream?* (Feb. 5, 2013), available at <http://setxind.com/downstream/oil-and-gas-energy-what-is-downstream/> (last retrieved on April 5, 2016).

⁵ See e.g., STI Group, *The Three Oil and Gas Energy Markets: What is Midstream?* (Feb. 1, 2013), available at <http://setxind.com/midstream/energy-markets-what-is-midstream/> (last retrieved on April 5, 2016).

dominating business interruption.”⁶ Energy insurance packages typically include covers for onshore property, offshore property, business interruption, well control/redrill, and some include third-party liabilities, including pollution clean-up. *Cost of Oil & Gas Claims*, *supra* note 6.

According to one experienced commentator, “[a] mini cottage industry has evolved to handle complex business interruption losses involving loss adjusters, accountants, engineers, schedulers, and attorneys to provide specialist legal advice on the correct interpretation of the complicated contractual and policy language.” *Id.* When there are insurance claims in the oil and gas industry, they can be very large. The average claim in the energy sector is in excess of \$25 million, according to the Global Claims Review 2014 issued by Allianz Corporate Global & Specialty.

II. THE OFFSHORE ENERGY PACKAGE POLICY

A. OPERATORS EXTRA EXPENSE / CONTROL OF WELL INSURANCE

1. Overview

The somewhat tortured history of the development of today’s predominant Control of Well (“COW”) wording over the past 70 years is a classic study in the London Market’s creative adaptation of policy language to match practical and judicial interpretation realities so that the risks in drilling could be realistically and actuarially insured. Today’s COW language expresses in writing the blend of risks which can be feasibly insured. While nothing is perfect and language is fluid, the resulting Energy Exploration and Development Policy (“EED (8/86)”) form is, by any fair measure, a splendid work of underwriting art.

The focus of this section of the paper is the Market dominant EED (8/86) form. The best way to truly understand the development and application of the EED Policy is to first absorb its history, rather than simply reading the policy language itself or dry summaries of its various provisions.

From a macroscopic view, there are two distinct tranches to the history of the Offshore Energy Package Policy. The first was development of the COW policy beginning in the 1940s and how that grew significantly to the Operators Extra Expense (“OEE”) Policy, and then to the EED/86 Policy today with its own multiple endorsements. The second roughly parallel tranche was the London Market’s beginning to provide insurance for offshore property in the 1960s which then allowed the rapid and concomitant development of the full Offshore Energy Package Policy by combining all of the requisite operational and property covers into the Offshore Energy Package Policy—the heart of which remains the COW policy.

1940s-1970s

⁶ See Chris Dye, *Cost of Oil and Gas Insurance Claims Continue to Rise*, ENERGY INSURANCE TRENDS, December 16, 2014, available at <http://www.ogfi.com/articles/print/volume-11/issue-12/features/energy-insurance-trends.html> (hereinafter “*Cost of Oil & Gas Claims*”).

Beginning in the 1940s, as an add-on to Onshore Property Damage policies, the London Market began offering Control Of Well policies (“COW”) covering expenses to control a blowout, crater or fire stemming from a blowout. The basic thinking was that the oil industry presented a unique risk exposure that had to be treated separately from property damage.⁷

The early COW policies, a bit naively, provided above-ground blowouts were covered and “kicks”⁸ were not, but neither was defined, or if so, poorly.⁹ These terms, even when defined, basically foundered in ambiguity construed in favor of the insured. The result was that Insurers were covering risks well beyond those that they had intended to cover and upon which they had based their insufficient premiums. Employing “clarifying” terms such as “total blowout,” “continuous flow,” and “wild wells” often fared no better and were likewise deemed on occasion by the courts as ambiguous. The policies had to yield to some degree to the practical realities of operating in the oil patch with risks which should be deemed insured as viewed by the courts.

In the 1950s, situated at the geographical heart of offshore (and land based) drilling in the United States, the United States Court of Appeals for the Fifth Circuit became a predominant voice in articulating the judicial concerns with construing Control of Well policies, and inferentially signaled potential solutions for less than ideal wording.¹⁰ See generally *Fidelity-Phoenix Fire Insurance Company of New York v. Dyer*, 220 F.2d, 697 (5th Cir. 1955); *Feeney and Myers v. Empire State Insurance Company of Watertown, New York*, (130 F. Supp. 729 E.D. Okla. 1955), rev’d on other grounds, 228 F.2d 770 (10th Cir. 1955); *Equity Oil Company v. National Fire Insurance Company of Hartford*, 144 F. Supp. 830 (D. Utah 1956); *Creole Explorations, Inc. v. Underwriters at Lloyd’s, London*, 161 So. 2d 768 (La. 1964); *Sutton Drilling Company, Inc. v. Universal Insurance Company*, 335 F.2d 820 (5th Cir. 1964); *Aladdin Oil Co., Inc., v. Rayburn Well Service, Inc.*, 202 So. 2d 477 (La. App. 1967).

Insurers understandably imposed operational warranties and due diligence provisions on the Insured. The warranty centered on the use of the Blowout Preventer (“BOP”) and, unfortunately at first, engendered further confusion. So much that, led by Chief Judge John R. Brown in the Fifth Circuit, the Courts began to fuse construction of the literal wording of the COW

⁷ See DAVID SHARP, UPSTREAM AND OFFSHORE ENERGY INSURANCE at 339 (Witherbys Insurance 2009) (Sharp) at 123.

⁸ A kick is generally defined as the entry of water, gas, oil, or other formation fluid into the wellbore during drilling operations. Kicks occur when the pressure exerted by the column of drilling fluid is not great enough to overcome the pressure exerted by the fluids in the formation being drilled. Absent prompt action, a kick may become a blowout. See, e.g., *In re DEEPWATER HORIZON*, 2014 WL 4375933 (E.D. La. 2014) (describing drilling and well control process in great detail).

⁹ See *Blackstock Drilling Co. v. Olsen Oil Co.*, 72 F.Supp. 358 (W.D. Okla. 1947) for an excellent discussion of general drilling operations including an explanation of lost circulation. There are numerous treatises on the subject, e.g., Robert D. Grace, ADVANCED BLOWOUT AND WELL CONTROL, HANDBOOK (2003); Douglas B. Owen, BLOWOUTS: WELL CONTROL INSURANCE AND RISK MANAGEMENT (1982); David Watson, Terry Brittenham & Preston L. Moore, ADVANCED WELL CONTROL (2003); and Michael Summerskill, OIL RIGS: LAW AND INSURANCE (1979). See also *In Re Equinox Oil Company, Inc.*, 300 F.3d 614, 619 (5th Cir. 2002) (describing COW policy somewhat incongruously in a pollution context as “particularly analogous to a standard fire policy which is designed to reimburse the insured for repairs to his structure after a fire.”)

¹⁰ For an extensive history of energy exploration including that of blowouts, see NATIONAL COMMISSION ON THE BP DEEPWATER HORIZON OIL SPILL AND OFFSHORE DRILLING, THE HISTORY OF OFFSHORE OIL AND GAS IN THE UNITED STATES (CreateSpace Independent Publishing Platform 2012).

Policy with an underlying public policy principle that realistic risks should or would be covered, irrespective of the precise policy language – not a good situation.

1970s-1985

Something had to be done to clarify the language, or the COW policy was in danger of fading away as being actuarially unsustainable in the Market place. The solution lay in a new linguistic structure where the risks covered would be described in language reflecting the practical realities of drilling, with a fair balance between risks which could be insured in ordinary prudent operation, on the one hand, and attendant difficulties inherent in drilling which cannot be economically insured but the cost of which should be borne instead by the insured as a normal cost of doing business in the oil patch, on the other.

By the 1970s, the predominant form of this conglomerate COW package was the Operators Extra Expense (“OEE”) policy.¹¹ See *Phillip Rosamond Drilling Company, Inc. v. St. Paul Fire and Marine Insurance Company*, 305 So. 2d 630 (La. App. 1974); *Atlantic Richfield Company v. Underwriters at Lloyd’s London*, 398 F. Supp. 708 (S.D. Tex. 1975). The development generally followed the gradual evolution of drilling from onshore to offshore. By the early 1960s, the London Market developed a policy that covered redrilling expenses as a separate but complimentary coverage to the Control of Well policy. In other words, in addition to providing the Control of Well to reimburse expenses to bring the well under control, the ancillary coverage for redrill included the cost of redrilling the damaged well. Eventually, these forms were converted to a single package policy. Also, by the late 1960s, one could purchase property damage for fixed platform equipment and supplies to add to the package as well.¹²

Following some catastrophic events in the late 1960s which illustrated the serious risks arising from seepage and pollution from wells following a blowout, the London Market created a separate section for pollution liability, including certain cleanup and containment costs to the Control of Well package. This combined policy became known as the OEE Policy and emerged as the standard policy form for exploration and production companies at that time.¹³

The development of the OEE Policy was in two phases. First, the original OEE Policy, and then in 1978, the OEE Composite Policy, a more definitive version of an OEE form which became known as the London Composite “all risk” of physical damage and/or operator’s extra expense (“the OEE Composite Policy”). It contained a Control of Well section covering expenses to regain control of a well out of control, a redrilling section covering the cost of redrilling, a well lost or damaged as a result of blowout, crater, or fire, as well as a seepage and pollution coverage.¹⁴

¹¹ C. Stuart, *Downhole, Offshore and Blowouts - A Primer on Oil and Gas Coverage: The Offshore Energy Package Policy*, University of Texas, 18th Annual Insurance Law Institute (2013), and authorities cited therein.

¹² See Sharp at 12.3.

¹³ See Sharp at 124.

¹⁴ See Sharp at 12.4-12.5.

1985-86

As with earlier forms, the final phase of the development of the EED policy came about from problems encountered in the American legal system with the construction of the OEE form. Against a somewhat arguably ambiguous policy form, the American courts struggled with drawing a line between an uncovered kick and a covered blowout, and interpreted the policy to cover events that were probably not within the intent of the Insurers.¹⁵ Thus, as the final development of the OEE Policy, it was virtually superseded by the EED (9/85) and then the definitive EED (8/86) Policy forms put together by the Joint Rig Committee.¹⁶

The broad judicial hints from the Fifth Circuit, and the hard won experience of Insurers from the adverse case law, led the Joint Rig Committee to craft its solution beginning in 1985. The idea would be to view and define with clarity the continuum of the risk of an incipient blowout when drilling as having a beginning and an ending point: a well out of control and a well under control. Each would be defined in such a way as to have a clear beginning and ending point in time as to impose operational warranties and due diligence practices on the operator and thereby encompass the practical realities of the task at hand. The idea was to separate the insurable from the uninsurable risks in a practical, workable, understandable and actuarially possible manner by use of temporal clarity.

In the late 1980s, the Operator's Extra Expense policy form was eclipsed by the Energy Exploration and Development Policy ("EED (8/86)") (which itself had quickly eclipsed the short lived EED (9/85) form). However, one must be aware that many EED form policies are generically referred to in the same way that all copiers are "Xerox machines" as an "OEE Policy" or sometimes even just "Control of Well" as an all-inclusive term. Technically, the Control of Well policy now is simply Section A of either the EED or OEE Policy. While a bit confusing, this linguistic looseness must be kept in mind when reading the policies, cases and secondary authorities.

Until 1985 the definitions related predominantly to "continuous flows" which were either uncontrollable or could not be properly controlled by the equipment on site.¹⁷ The EED definitions represent an understandable attempt by insurers to avoid claims where flow exists within the wellbore which can be brought under control very quickly by regaining circulation through standard industry procedures.

Under the EED (8/86), a "well out of control" will be defined as an unintended flow from the well above the surface of the ground or water bottom which flow cannot be promptly:

(a) stopped by use of the equipment on site and/or the blowout preventer, storm chokes or other equipment required by the Due Diligence and Warranties clauses or

¹⁵ See Sharp at 126.

¹⁶ The Joint Rig Committee "represents the interest of insurers writing offshore energy risks in London. Membership of the Committee comprises energy underwriters drawn from the membership of both the Lloyd's Market Association and the International Underwriting Association." See Lloyd's Market Association www.lmalloyds.com.

¹⁷ See Sharp at 129.

(b) stopped by increasing the weight by volume of drilling fluid or by the use of other conditioning materials in the well or

(c) safely diverted in the production or which flow is declared to be out of control by the appropriate regulatory authority.

Nonetheless a well shall not be deemed out of control solely because of the existence or occurrence of a flow of oil, gas or water into the wellbore which can within a reasonable period to time be circulated out or bled off through the surface controls. Normal operational risks and procedures are not covered events.

On the other hand, a well is “under control” when:

(1) a flow giving rise to a claim is stopped or can be safely stopped or

(2) the operation taking place in the well immediately before the occurrence giving rise to a claim is resumed or can be resumed or

(3) the well can be returned to the same or similar status that existed immediately prior to the occurrence giving rise to the claim or

(4) the flow giving rise to a claim is or can be safely diverted into production, whichever occurs first, unless the well continues to be declared out of control by the appropriate regulatory authority but will be deemed to be brought under control when such authority ceases to designate the well as being out of control.

Note that “uncontrolled flow” is rephrased as “unintended flow” with the emphasis on control being on factors which can or cannot control a flow, e.g., blowout preventer, storm chokes, etc.

The EED (8/86) wording is designed in the form of a stand-alone package policy rather than a part of a multi-interest package policy. Nevertheless, the OEE or EED Policy is almost always included within a larger Offshore Energy Package Policy. It consists of three basic sections: (1) Section A, Control of Well, (2) Section B, Redrilling/Extra-Expense, and (3) Section C - Seepage and Pollution, Cleanup and Contamination. A “Control of Well” occurrence giving rise to a claim under Section A is an essential prerequisite for coverage under Sections B and C of the OEE or EED Policy.

The entire EED Policy must be read in conjunction with its general conditions. The general conditions contain among other things, definitions, attachment of coverage, termination of coverage, rating provisions, rating areas, warranties, due diligence, exclusions, subrogation, partial interest clause, cancellation, co-venturers, and other general conditions.

With some tweaks here and there as time has gone by, the EED (8/86) Policy is the dominant form in the Market today but, much like mitochondrial DNA, the OEE Policy, or at least portions of it, have not left (and may never completely leave) the genome. The two forms are not

entirely equivalent. There are some differences.¹⁸ The EED Policy continues to evolve today to meet changing Market conditions driven by evolving technology.

This paper attempts to explain in broad strokes how the Control of Well mini-package policy, if you will, then fits into the development and broader evolution of the full scale Offshore Energy Package Policy that is seen in the Market today covering a wide variety of property and operational risks. These include, but are not limited to, given the Market's creativity and pragmatic response to insureds' needs, the following:

1. OEE/EED policies¹⁹ which themselves aggregate a number of related covers into a harmonious whole:
 - Control of Well which itself includes:
 - Section A: Control of Well
 - Section B: Redrilling/Extra Expense
 - Section C: Seepage and Pollution, Cleanup and Contamination
 - Underground Control of Well
 - Extended Redrill and Restoration
 - Making Well Safe
 - Care Custody and Control
 - OPA Endorsement
 - OPOL Endorsement
 - Resultant Plugging and Abandonment Endorsement
 - Evacuation Expenses
 - Deliberate Well Firing
 - Contingent Joint Ventures
 - Turnkey Wells Endorsement
 - Farmout Wells Endorsement
 - Developmental Drilling Wells Endorsement
 - Wild Well Contractor Endorsement
 - No Claims Return of Premium Endorsement
 - Priority of Payments Endorsement
 - Various Excess Cover Endorsements
 - Windstorm Endorsement

¹⁸ For example, only the EED Policy in Section B 1.(A) contains the proviso expressly stated (implied inferentially in the OEE Policy) that reimbursable costs and expenses must be via the employment of "the most prudent and economical methods".

¹⁹ The present and predominant EED form is the EED (8/86) Policy which supplanted and replaced the EED (9/85) Policy. **All references to "EED," unless otherwise stated, will be to the EED (8/86) form.** The OEE Policy in its original pure form is rarely, if ever, seen in the Market today. Variations of it survive and, to be sure, the name lives on.

2. Physical Damage (“PD”)

- Physical Damage
- Removal of Debris (Removal of Wreck) (“ROD,” “ROW”)
- Sue and Labor
- Oil in Line
- Property in Transit
- Oil & Gas Well Drilling Tools Floater/All Risks

3. Pollution²⁰

4. Business Interruption (“BI”) including:

- Contingent Business Interruption (“CBI”)
- Loss of Production Income (“LOPI”)
- Contingent LOPI
- Loss of Hire
- Delay of Start Up

5. Third Party Liability

6. Construction Risk

7. Charterer’s Liability

8. Windstorm

9. Crude Oil Storage

10. Political Risk²¹

11. War and Related Risks

12. Contingent OEE/EED (“COEE”)

It helps to keep in mind a mental image of a Matryoshka doll (Russian nesting doll) to grasp the policy within a policy within a policy framework of the Offshore Energy Package Policy – keeping in mind always that the OEE or EED Policy is its fundamental core and, in turn, the core of the EED Policy is the Control of Well section. Time does not permit a full explication of each of the above-listed components of the Offshore Energy Package; instead, the focus will be on the core control-of-well coverage around which the application of the others’ revolve.

²⁰ The OEE and EED Policies contain a seepage and pollution cover but it is restricted to a control of well event as the operative trigger so a broader third party liability pollution cover must be included in the Offshore Energy Package Policy.

²¹ There may be different markets for confiscation and expropriation.

B. THE EED (8/86) POLICY FORM

The EED (8/86) Policy in its basic form, before the addition of available endorsements, contains three sections: Section A- Control of Well; Section B- Redrilling/Extra-Expense; and Section C- Seepage and Pollution, Clean-up and Contamination.

1. Section A- Control of Well

The requisite trigger for either Section B or C, is a control of well event covered under Section A. Hence, we begin our analysis with Section A.

A typical policy provides in Section A:

1) Coverage

Underwriters agree, subject to the Combined Single Limit of Liability, terms and conditions of this policy, to reimburse the Assured for actual costs and/or expenses incurred by the Assured a) in regaining or attempting to regain **control of any and all well(s) insured hereunder which get(s) out of control**, including any other well that gets out of control as a direct result of a well insured hereunder getting out of control, **but only such costs and/or expenses incurred until the well(s) is (are) brought under control** as defined in Paragraph 2b of this Section A; and b) in extinguishing or attempting to extinguish i) fire above the surface of the ground or water bottom from well(s) insured hereunder or from any other well(s) which are burning as a direct result of well(s) insured hereunder getting out of control or ii) fire above the surface of the ground or water bottom which may endanger the well(s) insured hereunder.

Relief Wells are automatically held covered under this section subject to notice to Underwriters as soon as possible and rates to be established by Underwriters.

The form actually covers three different scenarios:

1. Wells out of control as defined in the policy;
2. Extinguishing or attempting to extinguish fire above the surface of the ground or water bottom from wells which are burning as a result of a well getting out of control; and,
3. Extinguishing or attempting to extinguish fire above the surface of the ground or water bottom which may endanger the wells insured.²²

²² Note that the third scenario appears not to be restricted by or related precisely to a well being out of control. Sharp observes “[t]he second insuring agreement (b) allows for a sue and labour type expense when fire above the wellhead, **which may presumably originate from any cause**, endangers the insured well(s).” Sharp II at 128. (emphasis

In dealing with the principles developed by and troubling the courts, the control of well has a beginning point—the well being out of control—and a terminus point—the well being brought under control. Both have highly elaborate practically and technically based definitions as follows:

Definitions

(a) Well Out of Control

For the purposes of this insurance, a well(s) shall be deemed to be out of control only when there is an unintended flow from the well(s) of drilling fluid, oil, gas or water above the surface of the ground or water bottom,

1. which flow cannot promptly be:
 - (a) stopped by use of the equipment on site and/or the blowout preventer, storm chokes or other equipment required by the Due Diligence and Warranties clauses herein; or
 - (b) stopped by increasing the weight by volume of drilling fluid or by the use of other conditioning materials in the well(s); or
 - (c) safely diverted into production; or
2. which flow is declared to be out of control by the appropriate regulatory authority.

Nevertheless and for the purpose of this insurance, a well shall not be deemed out of control solely because of the existence or occurrence of a flow of oil, gas or water into the well bore which can, within a reasonable period of time, be circulated out or bled off through the surface controls.²³

(b) Well Brought under Control

A well(s) deemed out of control in accordance with Paragraph 2a) of this Section A shall, for the purposes of this insurance, be deemed to be brought under control at the time that:

1. the flow giving rise to a claim hereunder stops, is stopped or can be safely stopped²⁴; or
2. the drilling, deepening, servicing, working over, completing, reconditioning or other similar operation(s) taking place in the well(s) immediately prior to

added); *see also*, W.E. Rice, *et al.*, WELL CONTROL INSURANCE: AN OVERVIEW AND OUTLOOK, SPE/IADC 16095, Drilling Conference at 5 (New Orleans, La. March 15-18, 1987) (noting “EED (8/86) policy wording provides limited liability coverage for firefighting undertaken to extinguish above-ground fires from any wells, whether or not insured under the policy wording, which are burning as a direct result of wells insured thereunder getting out of control **or fires which may endanger the wells** insured under the policy wording.”) (emphasis added).

²³ Notice the definition is negative in nature and deals only with above surface, unintended flows. This “Nevertheless” provision has sometimes been colloquially referred to as the “kick exclusion”. Obviously, it is not an exclusion but a policy coverage requirement, the burden of which is squarely on the insured.

²⁴ Note that part of the definition depends on a hypothetical circumstance, e.g., when the flow can be safely stopped which may become the subject of expert testimony both as to if it can be and, if so, when.

- the occurrence giving rise to a claim hereunder is (are) resumed or can be resumed; or
3. the well(s) is (are) or can be returned to the same producing, shut-in or other similar status that existed immediately prior to the occurrence giving rise to a claim hereunder; or
 4. the flow giving rise to a claim hereunder is or can be safely diverted into production;

whichever shall first occur, unless the well(s) continues at that time to be declared out of control by the appropriate regulatory authority, in which case, for the purpose of this insurance, the well(s) shall be deemed to be brought under control when such authority ceases to designate the well(s) as being out of control.²⁵

For a general discussion of where plugging and abandoning a well intersects an exclusion for “bringing under control” following a blowout, in a liability policy exclusion, *see Pioneer Exploration, LLC v. Steadfast Insurance Company*, 2013 WL 3557541 (W.D.La. 2013), *aff’d* 767 F.2d 503 (5th Cir. 2014).

(c) Expenses

Expenses recoverable hereunder shall include costs of materials and supplies required, the services of individuals or firms specialising in controlling wells, and directional drilling and similar operations necessary to bring the well(s) under control, including costs and expenses incurred at the direction of regulatory authorities to bring the well(s) under control, and other expenses included within Clause 1 of this Section A.

1. Termination of Expenses

In any circumstances and subject always to the Combined Single Limit of Liability of this policy, Underwriters' liability for costs and/or expenses incurred in regaining or attempting to regain control of a well(s) shall cease when the well(s) is (are) brought under control as defined in Paragraph 2b) of this Section A.

Note that a “well out of control” requires an “unintended” flow from above the surface of the ground or water bottom.²⁶ That unintended flow must be one which cannot “promptly” be stopped by the use of onsite equipment including a blowout preventer or other equipment required by the Due Diligence Warranties, stopped by increasing the weight of the volume of drilling fluid or other conditioning materials, safely diverted into production, by which flow is deemed out of control by appropriate regulatory authority.

²⁵ This administrative declaration is somewhat of a “joker is wild card”. During the Hurricane Katrina/Rita cases it was not uncommon to find that the oil companies attempted to solicit “friendly” letters from the now extinct MMS to support the well being declared or remaining out of control. Sharp points out that this proviso can be problematic when the assured is state owned and is at once a well operator and appoints the regulatory authorities. Prominent examples include Saudi Aramco, Gazprom, China National Petroleum Corp., National Iranian Oil Co., Petróleos de Venezuela, Petrobras, and Petronas.

²⁶ An extension for Underground Control of Well is available.

The question of when a flow can be “safely diverted into production” came up in *Goodrich Operating Company, Inc. v. Burnett & Company, Inc.*, 2006 WL 1118137 (S.D. Tex April 24, 2006). The trial court found the resolution of the issue was a “swearing match” and that summary judgment was inappropriate. *Id.* at 7.

There appears to only one reported decision (and a recent one) touching on the interpretation of the Due Diligence and Warranties in the OEE/EED Policy. In *Eagle Oil & Gas Co. v. Travelers Property Cas. Co. of Am.*, 2014 WL 3406686 (N.D.Tex. 2014), the court addressed whether the policy’s due-diligence clause was an exclusion/covenant or a condition precedent. The clause was located in the policy’s Common Conditions section and required the insured to exercise due care and diligence in conducting well operations by using generally prudent safety practices and equipment. But this section also contained a subsection entitled “Exclusions” that read, “There shall be no indemnity under this Section I for: [a]ny claim arising out of any “occurrence caused, in whole or in part, by any breach of any condition or warranty set forth in Paragraph 6. DUE DILIGENCE AND WARRANTIES below[.]”

Eagle argued that the due-diligence provision was its covenant – its agreement to act diligently – enforceable through an exclusionary clause. Travelers argued that the provision was a condition precedent to coverage and Eagle had to comply before Travelers had any coverage obligation. Unable to harmonize the provisions, the court reasoned that a parallel-worded condition and exclusion could not co-exist in an insurance policy; that the provisions created an ambiguity; that the due-diligence clause was a covenant/exclusion; and that Travelers had the burden to prove at trial that the insured failed to exercise “due care and diligence.” 2014 WL 3406686 at *10.

The *Eagle* court’s treatment of the due diligence clause as an exclusion is subject to criticism for muddying the waters, as it was clearly intended, given *inter alia* its historical development and context, as a condition on which the insured should have the burden of proof. Since the insured’s employment of due diligence is essential to both the practical production of oil and gas and to the logical basis for any underwriting of those activities, an insured’s failure to carry its burden to establish due diligence, if challenged, should void the policy.²⁷ It would appear the court has swung and missed.

²⁷ Whether the English rule of avoiding breach of warranty without causation will control has not yet been decided in Texas but any dispute over causation in a blowout is probably theoretical at best given the nature of the phenomenon. The imposition of well understood warranties in the oil patch are part and parcel of Texas law. See generally the concept of reasonable and prudent operations by an oil and gas operator. *Amoco Prod. Co. v. Alexander*, 622 S.W.2d 563, 567-68 (Tex. 1981); *Shell Oil Co. v. Stansbury*, 410 S.W.2d 187, 188 (Tex. 1966); *Willingham v. Bryson*, 294 S.W.2d 421, 423 (Tex. App. 1956); see also *Lane v. Travelers Indem. Co.*, 391 S.W.2d 399, 400-402 (Tex. 1965) (discusses indicia of a valid warranty); *U.S. Fire Ins. Co. v. Marr's Short Stop of Texas, Inc.*, 680 S.W.2d 3 (Tex. 1984) (unambiguous pilot warranty required valid pilot certificate in compliance with FAA ratings); *Duzich v. Marine Office of Am. Corp.*, 980 S.W.2d 857 (Tex. App 1998) (insured failed to satisfy warranty to promptly notify insurer of claim); *Fidelity & Cas. Co. of New York v. Bun's Bros., Inc.*, 744 S.W.2d 219 (Tex. App. 1987) (unambiguous pilot warranty required pilot-in-command to have certain qualifications and ratings); *Old Reliable Fire Ins. Co. v. Alduro-Raynes Arabians, Inc.*, 717 S.W.2d 124 (Tex. App. 1986) (warranty of sole ownership of horse was unambiguous and susceptible to only one reasonable construction); *Cartusciello v Allied Life Ins. Co. of Texas*, 661 S.W.2d 285 (Tex. App. 1983) (insured's warranty of good health is a condition to coverage); *Eureka Security Fire & Marine Ins. Co. v. DeRoss*, 40 S.W.2d 924 (Tex. App. 1931) (warranty of sole ownership is a condition precedent to coverage); *Jefferson Ins. Co. of New York v. Huggins*, 2000 WL 1881201 (N.D. Tex. July 10, 2000) (marine insurance "lay-up" warranty

The terminus point of a “well brought under control” occasionally raises a few issues such as when could a flow have been safely stopped or when it could have been resumed. In other words the use of the future possible “can” or “could” raises hypothetical questions which may involve expert opinion. Note again the proviso that the policy language can, in effect, be overridden by the regulatory authority.

It has been observed:

One coverage issue that frequently arises involves the meaning of a phrase “can be stopped.” Most blowouts occur as a result of human error, and is not uncommon for the crew on-site to fail to detect timely the warning signs of a kick. There is kick-detection equipment on the drill floor, and when a sudden increase in flow (or penetration rate) occurs, one can surmise that a kick is in progress. At this point, the BOP should be shut in, and recognized procedures to handle the kick should be implemented. If, however, the kick goes undetected for a significant amount of time (probably in the fifteen minute range or longer) before the well is shut in, the pressures encountered increase significantly. **So what, then, does the phrase “can be stopped” mean?** Underwriters can take the position that if the well could have been shut in had the kick been timely detected, coverage is not triggered. On the other hand, if the kick is so severe that it causes equipment failures leading to an uncontrolled flow, underwriters are inclined to treat that situation as a covered well-control event.

Another similar issue involves what is meant by the terms “promptly” and “within a reasonable period of time” in terms of stopping a flow. One way to conceptualize the issue is to distinguish the situation where routine control-of-well procedures can be used to handle the kick as opposed to the services of a well-control expert, like Boots & Coots or Wild Well Control, who might be called to the well in more complex situations. In any event, whether a flow may be stopped promptly or within a reasonable period of time, is fact-intensive and often involves expert opinion.

Hall I at 1312-13 (emphasis added).

was unambiguous and its breach voided policy); *Affiance Gen. Ins. Co. v. Club Hospitality, Inc.*, 1999 W L 118798 (N. D. Tex. Mar. 2, 1999) (warranties contained in firearms endorsement were unambiguous and failure to comply with them voided coverage) and warranties are susceptible of no construction other than mutual intent that policy is not binding unless the statement is literally true. A warranty is clearly not an exclusion. See David D. Hallock, Jr., *Recent Development In Marine Hull Insurance: Charting a Course Through The Coastal States of The Fourth, Fifth, Ninth, and Eleventh Circuits*, 10 U.S.F. Mar. L. J. 277, 301 (1998). “Due Diligence” essentially equates with the conduct of a “reasonable prudent operator,” *Atlantic Richfield Co. v. Gruy*, 720 S.W. 2d 121, 123 (Tex. App. 1986). See also *Green v. Farmers Ins. Exch.*, Case No. 12-0867 (Tex. 2012) (the Court accepted certiorari to consider whether a vacancy warranty in a homeowner context required causation between the breach of the warranty and the loss). The case may or may not have a significant effect on the issue as it might arise under an EED Policy, but is worth following.

As would be expected in Section A2(c), the expenses and their termination go hand-in-hand. The expenses are normally audited on a mutually agreeable basis by Insurer-appointed adjusting firms.

There are three (3) significant exclusions under Coverage A, Control of Well:

- (1) Any loss of or damage to any drilling or production equipment,
- (2) Any loss of or damage to any well or wells or hole or holes; and,
- (3) Any loss damage or expense caused by or arising out of delay (including delayed and/or deferred production) and/or loss of use, and/or loss of or damage to production (including that due to loss of reservoir pressure) and/or loss of or damage to any reservoir or reservoir pressure. Well control deals with expenses to control the well not any aftermath resulting from its damage.

2. Section B: Redrilling/Extra-Expense

Since the likely major result from a well being out of control is the necessary expense to redrill it, it was not long in the evolution of Control of Well insurance that Section B evolved. A currently used form provides as follows:

1. Coverage

Underwriters agree, subject to the Combined Single Limit of Liability, terms and conditions of this policy, to reimburse the Assured for actual costs and/or expenses reasonably incurred to restore or redrill a well insured hereunder, or any part thereof, which has been lost or otherwise damaged as a result of an occurrence giving rise to a claim which would be recoverable under Section A of this policy if the Assured's Retention applicable to Section A were nil, subject to the following conditions:

- (a) Underwriters shall reimburse the Assured only for such costs and expenses as would have been incurred to restore or redrill a well had the **most prudent and economical methods been employed**.
- (b) There shall be no coverage under this Section B for restoration or redrilling of any well whose flow can be safely diverted into production, including by completing through drill stem left in the well insured hereunder, or which can be completed through a relief well(s) drilled for the purpose of controlling a well.
- (c) In no event shall Underwriters be liable for costs and/or expenses incurred (a) with respect to drilling wells, to drill below the depth reached when the well became out of control as defined in Clause 2 of Section A of this policy and (b) with respect to producing or shut-in wells, to drill below the geologic zone or zones from which said well(s) was (were) producing or capable of producing.
- (d) In respect of drilling wells, Underwriters' liability hereunder shall in no event exceed 130% of the cost incurred to drill the original well to the depth reached at the time when the well became out of control or fire occurred.

- (e) In respect of producing, shut-in or workover wells, Underwriters' liability hereunder shall in no event exceed 130% of the cost incurred to drill the original well, plus 10% per annum compound thereof from the date of spudding of the original drilling of the well until the date of the occurrence giving rise to the aforesaid claim which would have been recoverable under Section A of this policy if the Assured's Retention applicable to Section A were nil, subject to a maximum of 250% of the original cost.
- (f) In any circumstances, Underwriters' liability under this Section B for costs and expenses shall cease 1) if actual restoration or redrilling has not commenced within 540 days after a) the date of the accident or occurrence giving rise to coverage under this Section B or b) the date of cancellation or expiry of this policy, whichever shall later occur; and 2) in any event when the depths set forth in Paragraph 1c of this Section B have been reached and the well restored to a condition comparable to that existing prior to the occurrence giving rise to the claim, or so far as possible utilising generally available equipment and technology.

(1) Exclusions

There shall be no indemnity or liability under this section for:

- (a) any loss of or damage to any **drilling or production equipment**;
- (b) any loss, damage or expense caused by or arising out of **delay** (including delayed and/or deferred production) and/or loss of use and/or loss of or damage to production (including that due to loss of reservoir pressure) and/or loss of or damage to any reservoir or reservoir pressure;
- (c) costs and/or expenses incurred to **restore or redrill any relief well**, or any part thereof;
- (d) any claim recoverable under this policy solely by reason of the addition or attachment to Section A of this policy of the Making Wells Safe Endorsement;
- (e) redrilling and/or recompletion or for in-hole equipment in respect of any well that was plugged and abandoned prior to loss or damage covered under Section A hereof and that remained plugged and abandoned at the time of such loss or damage.

Recalling that a combined single limit of liability for all sections of the OEE or EED (A, B and C) is in play, Section B will reimburse expenses to restore or redrill a well that is damaged as a result of an occurrence giving rise to a Section A claim.

Under Section B, in addition to enforcing the due diligence warranties, Insurers will only pay for cost and expenses that would have been incurred to restore or redrill a well “had the most prudent and economical methods been employed.”²⁸ The redrilling/extra-expense is further conditioned on:

²⁸ See W.E. Rice, *et al.*, WELL CONTROL INSURANCE: AN OVERVIEW AND OUTLOOK, SPE/IADC 16095, Drilling Conference at 6 (coverage is “only for such efforts conducted by the most prudent and economical means which the

- (1) Only if the flow cannot be safely diverted into production including completing through a drill stem left in the well or which can be completed through relief wells drilled for the purpose of controlling the well.
- (2) Wells drilled below the depth reached when the well became out of control or with respect to producing a shut in wells below the geologic zone which they had been producing or were capable of producing.
- (3) Liability shall not exceed 130% of the cost incurred to drill the original well to the depth reached at the time when the well became out of control.
- (4) For producing shut-in or workover wells, Underwriters liability shall not exceed 130% of the cost incurred to drill the original well plus 10% per annum compounded from the date of spudding of the original drilling until the date of the occurrence giving rise to the Section A claim subject to a maximum of 250% of the original cost.
- (5) Underwriters' liability shall cease if the actual restoration or redrilling has not commenced within 540 days of the date of the accident or occurrence giving rise to coverage under this section or the date of cancellation of the policy, whichever occurs later, and, in any event, when the depths set out in paragraph 1c of Section B have been reached and the well restored to conditions comparable to that existing prior to the occurrence giving rise to the claim or so far as possible, utilizing generally available equipment and technology.

David Sharp has observed:

“It is to be noted that the expression “*reasonably incurred*” has crept into the insuring agreement, reinforced by a provision further on in the coverage that “*the most prudent and economical methods*” are employed. Thus, insurers are expecting the Assured to have some control over the methods chosen to redrill the well and to keep the total AFE (approved for expenditure cost) within reasonable bounds. In any event, in respect of drilling wells, insurers' maximum liability is limited to 130% of the cost incurred to drill the original well to the depth reached at the time when the well became out of control or the fire occurred. This formula is varied in respect of production wells to allow the 130% limitation to be increased by 10% per annum compound from the date of spudding of the original well until the date of the occurrence giving rise to the claim, limited overall to 250% of the original cost. These limitations can be deleted by purchasing ‘unlimited’ redrilling coverage as an option on payment of an additional premium. However, in all eventualities, insurers will not be liable for redrilling costs where the redrilling

technology available at the time and place of the occurrence, meaning that Underwriter shall not be forced to bear the expense of either creation or utilization of technology not currently available at the time an occurrence takes place.”).

operation is not commenced within 540 days after the date of the accident, or the date of expiry of a policy, whichever shall occur later.

The indemnity payable is further restricted to expenditures incurred, with respect to drilling wells, to redrill only to the depth at which the well became out of control, and in respect of production or shut-in wells, to the geographical zone or zones from which the well(s) were producing or capable of producing.”

Sharp at 132; *see also Goodrich Operating Co., Inc. v. Burnett & Co., Inc.*, 2006 WL 1118137 (S.D. Tex. Apr. 24, 2006). There the Court upheld the 540 day limitation:

The blowout occurred on May 4, 2001 and the Policy expired on either March 1, 2003 or March 1 2002. Accordingly, the latest possible date the Plaintiffs could have commenced restoration operations was August 23, 2004. The estimated cost for the sidetrack well included in Plaintiffs’ Second Supplemental Claim have not been incurred to date, so there is no question that they are outside the 540 day limit. Again, Plaintiffs’ argued that this type of time limit is often waived in the industry. However, as analyzed above, the language of the contract is clear and it is the Underwriters’ prerogative to enforce the terms of the Policy as written. Accordingly, the Court agrees with Underwriters that the above-quoted provision of the Policy precludes Plaintiffs’ Second Supplemental Claim for drilling the sidetrack well.

Goodrich Operating Co., 2006 WL 1118137 at *3; *see, generally, Mobil Exploration & Prods. US, Inc. v. Certain Underwriters*, 837 So. 2d 11 (La. App. 2003) (discussing a redrill arising from a blowout because pipe had been pulled too quickly.)

It is has also been observed:

One feature of redrill coverage that is often overlooked is the triggering event for coverage. In order for redrill coverage to be triggered, the well must have been damaged by a well-control event that would have been covered under Section A of the Policy (i.e., a well out of control). **The extended redrill endorsement broadens this coverage** by providing that when certain well equipment is damaged by an enumerated peril listed in the endorsement, redrill coverage also will be triggered. Where a well is damaged as a result of something other than a well-control event or an enumerated peril, coverage does not attached. For example, when problems are encountered as a result of loss circulation – such as a drill string becoming stuck in the hole necessitating fishing or sidetracking operations – coverage will not typically be afforded.

Hall I at 1316-17 (emphasis added).

3. Section C: Seepage and Pollution, Cleanup and Contamination

As earlier noted, the risk of seepage and pollution is inherent when a well gets out of control. Insurers provide coverage for this exposure *only* when caused by a Section A event, under

the Control of Well.²⁹ There are also circumstances where a general pollution carrier and EED Underwriter³⁰ may have a difference of opinion as to which policy covers a specific event.

Section C provides:

1. Insuring Agreements

Underwriters, subject to the Combined Single Limit of Liability, terms and conditions of this policy, agree to indemnify the Assured against;

- (a) all sums which the Assured shall by law or under the terms of any oil and/or gas and/or thermal energy lease and/or license be liable to pay for the cost of remedial measures and/or as damages for bodily injury (fatal or nonfatal) and/ or loss of, damage to or loss of use of property caused directly by seepage, pollution or contamination arising from wells insured herein;
- (b) the cost of, or of any attempt at, removing, nullifying or cleaning up seeping, polluting or contaminating substances emanating from wells insured herein, including the cost of containing and/or diverting the substances and/or preventing the substances reaching the shore;
- (c) costs and expenses incurred in the defense of any claim or claims resulting from actual or alleged seepage, pollution or contamination arising from wells insured herein, including Defense Costs and costs and expenses of litigation awarded to any claimant against the Assured, provided, however, that the inclusion of the above costs and expenses shall in no way extend the Combined Single Limit of Liability of Underwriters over all sections of this policy;

provided always that such seepage, pollution or contamination results from both 1) an accident or occurrence taking place during the period of this insurance (including any continuation thereof provided for by Clause 16 of the General Conditions) and of which notice has been given in accordance with Clause 10 of the General Conditions hereto and 2) an occurrence giving rise to a claim which would be recoverable under Section A of this policy if the Assured's Retention applicable to Section A were nil.

²⁹ The operator must obtain additional coverage for any pollution events caused by something other than a Section A claim.

³⁰ A commentator has observed that OEE Policies provide a Seepage, Pollution and Contamination section, but it covers only pollution caused by occurrences under Section I of the Policy, that is wells out of control and fire above the surface. Coverage is also typically limited to above ground pollution. It is important to ensure that the liability program and the OEE program work together when there is a duplication of coverage, such as pollution caused by wells out of control. If the insurance carrier is agreeable, it is a good idea to have the OEE Policy respond as primary coverage for pollution caused by a blowout, but subject to a Priority of Payments Clause, and for the Liability program to be excess. ... This structure allows the OEE program to respond to what could be a significant pollution loss, thus preserving the Liability program for other types of claims such as bodily injury claims. Again, it is important that the operator identify any liability policy requirements for maintaining pollution under an OEE Policy for wells that get out of control. Theresa M. Fadul, *Maximizing Insurance Protection as Part of Contractual Risk Allocation*, 2004 No. 2 Rocky Mountain Mineral Law Forum. Paper No. 12 (May 20-21, 2004).

2. Assured

As respects this Section C only, but subject always to the Combined Single Limit of Liability over all sections of this policy, the unqualified word “Assured” includes the named Assured, and any principal, officer, director or stockholder or employee thereof while acting within the scope of his duties as such.

Note that Section C cover provides for Cost and Appeals Clause as follows:

In the event of any claim and/or series of claims arising out of one occurrence where the Assured's final gross claim is likely to exceed the retention of the Assured, no costs shall be incurred on behalf of Underwriters without the consent³¹ of Underwriters, and if such consent is given, Underwriters shall consider such costs as part of the final claim hereunder. No settlement of losses by agreement shall be effected by the Assured without the consent of Underwriters where the Assured's final gross claim will exceed the retention of the Assured.

In the event that the Assured elects not to appeal against a judgment in excess of the retention of the Assured, Underwriters may elect to conduct such appeal at their own cost and expense, and shall be liable for the taxable cost and interest incidental thereto, but in no event shall the liability of Underwriters exceed the Combined Single Limit of Liability over all sections of this policy.

Section C does provide for certain **Exclusions** as follows:

There shall be no indemnity or liability under this section for:

- (a) any loss of or damage to any **drilling or production equipment** at the site of any well insured herein;
- (b) any claim recoverable under this policy solely by reason of the addition or attachment to Section A of this policy of the Underground Control of Well Endorsement;
- (c) any claim arising directly or indirectly from seepage, pollution or contamination if such seepage, pollution or contamination:

- 1. is **deliberate** from the standpoint of the Assured or any other person or organisation acting for or on behalf of the Assured;³² or

³¹ Cf. *Lennar Corp. v. Markel Am. Ins. Co.*, 2013 WL 4492800 (Tex. Aug. 23, 2013).

³² Contrast the exclusion in *Meridian Oil Production, Inc. v. Hartford Accident Indemnity Co.*, 27 F.3d 150, 152 (5th Cir. 1994) (“an operator knows when the drill stem goes through a fresh water aquifer and knows that if no surface casing or string of pipe is set and placed to protect the water from drilling mud, fluids and subsequent contaminants, the fresh water will be polluted. The operator knows that the pollution will continue if no plug or cemented pipe

2. results directly from any condition which is in **violation of or noncompliance with any governmental rule, regulation or law applicable** thereto; notwithstanding the foregoing, this exclusion does not apply with respect to any such condition which at the time of loss is in the process of being corrected by a schedule or program sanctioned and approved by the appropriate governmental authority with jurisdiction over such rule, regulation or law, to the extent that the Assured is in compliance with such schedule or program;³³

(d) any claim for mental injury, anguish or shock unless same results from physical injury to the claimant.

David Sharp aptly observed:

There are **three main insuring agreements covering pollution**, clean-up and costs of defense. Coverage is triggered under these insuring agreements by virtue of an accident or occurrence (*occurrence is defined in the General Conditions*) taking place during the policy period, or any continuation provided for the policy, that would give rise to a claim under *Section A*, deductible application notwithstanding. While the word “sudden” is not used, the *Occurrence* definition (refer 4.8.1) would infer that the event is instantaneous in time.

...

There are several comments to be made with respect to the above. First, that the seepage and pollution must arise from wells insured (there is an appropriate definition of wells insured in the *General Conditions*). The EED wording is **not covering seepage**, pollution or contamination arising from leaks or ruptures **from any of the installed facilities** owned by the Assured or its partners, although some wording may be tweaked to cover “pollution from facilities,” but even so, the pollution must arise as a consequence of a covered event, namely a well becoming out of control.

A second observation is there is no definition provided for *property damage* and *bodily injury*, which is somewhat surprising given that a primary aim of the EED is clarification and that pollution losses are likely to embrace claims for environmental impairment. However, some of the exclusions in the *General Conditions* are of relevance here since there are exclusions relating to fines and penalties and punitive or exemplary damages. A specific exclusion in *Section C* is also pertinent as there will be no liability

prevent migration of fluids up and down the wellbore. ... The *Marshall* record establishes a matter of law that the damages to the Marshall’s land were not unexpected from the standpoint of the insured.”).

³³ On the surface this exclusion is extremely broad and may grow more so particularly in light of the heightened regulatory oversight post-Macondo.

for claims in respect of “... *mental injury, anguish or shock unless same results from physical injury of claimant.*” There is, nevertheless, no restriction in terms of the identity of the claimant. Clearly claims from public and statutory authorities are contemplated by the reference to liabilities incurred under the terms of the license or lease, but claims for individuals or other entities would also be contemplated by reference to liability at law.

With respect to the second insuring agreement, a **major benefit** of this wording when compared to a typical umbrella liability policy is that clean-up expenditure is indemnified **irrespective of legal liability**. It is assumed that, in the majority of cases, the Assured would incur legal or statutory liability, but there is no necessity to demonstrate this or to wait for action to be commenced against the Assured. The triggering incident is the pollution itself, provided it arises from an insured well becoming out of control. This is a sensible position; it encourages immediate action, as would inevitably be needed, the Assured knowing that he will have a right of claim even absent legal or statutory liability.

Sharp at 133-34 (emphasis added); *see Jones v. Southern Marine & Aviation Underwriters, Inc.*, 888 F.2d 358, 361 (5th Cir. 1989) (finding Underwriters had no liability under Section C since the insured was not personally liable); *Jones v. Southern Marine & Aviation Underwriters, Inc.*, 739 F. Supp. 315, 321 (S.D. Miss. 1988) (discussing whether payment to the insured is based on liability or indemnity); *Taylor Energy Co. v. Underwriters at Lloyd’s*, 2010 WL 4553482 (E.D. La. 2010) (discussion of Section C). For a more recent case, *see Pioneer Exploration, L.L.C. v. Steadfast Ins. Co.*, 2013 WL 3557541 (W.D.La. 2013), *aff’d* 767 F.2d 503 (5th Cir. 2014) (when insured chooses to use an umbrella policy as an excess well-control policy, beware of the umbrella’s numerous exclusions relating to well-control losses).

III. THE ONSHORE ENERGY PACKAGE POLICY

A. TYPES OF ENERGY RISKS

1. Insurance for Construction of Energy-Related Risks

New facilities are continuously being constructed in the energy sector, especially as many companies consider converting older coal-fired plants to more modern plants running on biofuels. All or part of a current facility might be involved in construction, or the facility may be built from the ground up. For damage to property during construction, owners and/or contractors typically purchase Construction All-Risk (CAR) policies. These are also known in the energy industry as Builder’s Risk (BR) or Erection All-Risk (EAR) policies.

These policies start with coverage for “direct physical damage,” which does not include coverage for time-related expenses that can be incurred by either the contractor or owner when the property is damaged and the Project Schedule is delayed. Insurance related to expenses incurred

during the time it takes to repair or replace the damaged property must be added by endorsement or coverage extension to the typical CAR Policy. These coverages often include:

- Delay in Completion
- Delay in Start-Up (DSU)
- Advanced Loss of Profits (ALOP)
- Soft Costs
- Contractor's Extra Expense

There are few reported cases construing BR or CAR policies, especially those insuring energy risks. For a thorough and well-reasoned overview of what is usually covered by the typical construction policy, see the Illinois federal court's opinion in *One Place Condominium, LLC v. Travelers Property Casualty Co. of America*, No. 11 C 2520, 2015 WL 2226202 (N.D. Ill. Apr. 22, 2015).

2. Operational Property Insurance

The "operational" onshore energy property policy is designed to cover the onshore energy risk after construction has been completed, the facility has been fully tested, and it is up and running as designed and producing the intended product (i.e. petroleum, LNG, gasoline, jet fuel). Onshore energy property policies typically provide cover for Property Damage (PD), Business Interruption (BI) and Extra Expense (EE) for facilities in operation. Sometimes coverage for Contingent Business Interruption (CBI), Extended Period of Indemnity (EPOI), or Machinery Breakdown (known as Boiler & Machinery insurance) is also included.

Issues often arise when a facility is transitioned from a CAR policy to an operational policy. Many terms used in the construction industry which mark the hand-off from contractor to owner, such as "Mechanical Completion," "Substantial Completion" or "Hot Testing" indicate that construction activities are complete and are assumed by the insured or broker to mark the end of the construction policy and beginning of the operational policy. However, the facility may not have worked out all the bugs that can be found during performance testing and before full production begins. If this issue is not addressed during underwriting, an insured may be left without coverage under either the construction policy or operational policy.

Many London policies include a Testing and Commissioning clause, often by endorsement. An endorsement added to a London policy involved in a recent claim provides the following language:

TESTING AND COMMISSIONING CLAUSE

It is hereby noted and agreed that this Insurance does not, except as provided for within the Sub-limit for Incidental Course of Construction, Erection and

Assembly, extend to cover destruction or damage to property in course of construction or erection, dismantling, revamp or undergoing testing or commissioning including mechanical performance testing or any consequential loss resulting therefrom.

Acceptance of the [risk] hereon is subject to satisfactory completion of the following procedures and otherwise to the terms and conditions of this Policy.

1. The plant is mechanically complete. This requires all key items to be complete and that no temporary structures (such as pipe supports) remain awaiting permanent fixture.
2. Plant testing and commissioning has been completed with the design /construction/erection contract performance levels having been satisfactorily achieved.
3. Design performance criteria maintained by the entire plant in a stable and controlled manner for a continuous ongoing period of one hundred and sixty eight (168) hours.
4. The Insured has accepted the plant without reservation or waiver of guarantee conditions.

It is further noted and agreed that these provisions do not apply to normal routine maintenance activities and scheduled turnarounds.

In January 2014, the Lloyd's Market Association's (LMA)³⁴ Non-Marine Committee Engineering Business Panel issued a new wording for its Property & Plant Testing & Commissioning Clause and a questionnaire template to insureds and brokers.³⁵ The purpose of the questionnaire "is to facilitate the transfer of a newly constructed Onshore Oil, Gas & Petrochemical asset from a construction policy to an operational policy."³⁶ The new wording provides:

PROPERTY & PLANT TESTING AND COMMISSIONING CLAUSE

1. It is hereby noted and agreed that this (Re)insurance does not cover destruction of or damage to property in course of construction or erection,

³⁴ The LMA is "the representative body for underwriting businesses at Lloyd's." *See* Lloyd's Market Association, *Non-Marine Committee Terms of Reference* at § 2.1 (June 2013), available at <http://www.lmalloyds.com/CMDownload.aspx?ContentKey=c8aa8eff-9b40-4dbe-b799-970367226922&ContentItemKey=c584132a-c68c-467a-a3d1-b6a1538fa175>. Its mission is "to provide professional, technical support to the Lloyd's underwriting community." *Id.* at § 2.2. The various committees of the LMA draft wordings for various types of risks and submit the draft wordings to the Lloyd's Wordings Repository.

³⁵ *See* Testing and Commissioning Clause LMA5197A and questionnaire template, attached as Exhibit A.

³⁶ *Id.*

dismantling, revamp or undergoing testing or commissioning including mechanical performance testing any business interruption resulting therefrom.

2. Acceptance of property hereon is subject to satisfactory completion of the following:

2.1. Mechanical Completion.

2.2. Testing and Commissioning.

2.3. Performance Testing conforming to 100% Contract Design Criteria having been maintained by the entire plant in a stable state and controlled manner for a continuous period of 72 hours duration.

2.4. Official acceptance by the Insured following formal hand over without reservation or waiver of guarantee conditions.

2.5. Any deficiencies identified during the testing, commissioning and start-up that may affect the mechanical integrity, process safety or reliability of the plant, having been declared to (Re)Insurers prior to attachment.

3. NOTWITHSTANDING THE ABOVE, ATTACHMENT OF PROPERTY AND PLANT HEREON TO BE AGREED BY (Re)Insurers. It is further noted and agreed that the terms and conditions to be reviewed, if required by (Re)Insurers.

4. It is further noted and agreed that the above provisions do not apply to normal routine maintenance activities, scheduled turnarounds and / or minor works (as defined in the policy).

Additionally, (Re)Insurers request completion of the attached information request template "INFORMATION TO SUPPORT THE TRANSFER OF ONSHORE OIL, GAS & PETROCHEMICAL ASSETS FROM CONSTRUCTION TO OPERATIONAL INSURANCE."

LMA5197A
27 January 2014

B. KEY RISKS TO COVER IN THE ONSHORE ENERGY INDUSTRY

The LMA's Joint Power Generation Committee recently issued wording for Onshore Energy policies for Power and Utilities.³⁷ As this Wording demonstrates, Onshore Energy Property Insurance usually contains coverage for Property Damage and Business Interruption,³⁸ with certain common extensions of coverage. More often than not, the first-party insurance coverages discussed herein make up the onshore energy package policy. Occasionally, these types of first-party insurance are combined with third-party liability insurance within the package.

C. PROPERTY DAMAGE INSURANCE

The goal of the Property Damage section of the onshore energy package policy is the insuring agreement to repair or replace physical damage to covered property, such as pipelines, compressors, processing equipment, refinery equipment, storage tanks and equipment, piping, boilers, gas or steam turbines, stock/inventory, and structures. In other words, tangible property owned or in the care and custody of the insured.

The Property Damage policy will describe what property is covered and what property is excluded. The covered property is usually described within the body of the policy or in an attached Schedule of Insured Values which lists the different property or locations and the value of each.

After stating what property is covered and not covered, the Property Damage policy for onshore energy will usually include a coverage grant for all risks of direct physical damage to covered property, except as excluded in the policy.

The insuring clause in the LMA Wording provides:

In consideration of the payment of premium specified in the Risk Details and subject to the terms, conditions and exclusions of this Contract, the Insurers agree to cover against risk of direct physical loss or physical damage to the Property Insured by a Peril not excluded by this Contract occurring during the Period of Insurance.³⁹

Other common coverage grants for physical damage insurance policies include:

Example 1:

³⁷ A copy of the Power & Utilities Property Damage and business Interruption Wording (USA), LMA3110, is attached as Exhibit B.

³⁸ Onshore Energy policies often contain a section titled "Time Element" which combines coverage for Business Interruption and Extra Expense. Any other time-related coverages are usually included together in a Time Element section.

³⁹ See Power & Utilities Property Damage and Business Interruption Wording (USA), LMA3110, at 13.

This Section insures against all risks of direct physical loss or damage in respect of property insured from perils not otherwise excluded, subject to the terms and conditions of this Section.

Example 2:

We will pay for direct physical loss or damage to Covered Property at the premises described in the Declarations caused by or resulting from any Covered Cause of Loss.

1. What is “direct physical loss or damage”?

In the typical uncomplicated case, the physical loss or damage is obvious and the issues are simply the scope and cost of the contemplated repair or replacement. However, ascertaining physical loss or damage in certain circumstances can become problematic. The terms “direct” and “physical” have been held to limit coverage. While there is scant direct authority in the energy insurance context on what constitutes “direct physical loss or physical damage,” there are cases that examine the issue in other contexts that may be relevant to and helpful in determining the restrictive scope of those phrases.

“The requirement that loss be physical is widely held to exclude alleged losses that are intangible or corporeal such as a detrimental economic impact unaccompanied by a distinct, demonstrable, physical alteration of the property.” *One Place Condo., LLC*, 2015 WL 2226202, at *3 (builder’s risk policy’s insuring clause covered only direct physical loss or damage).

One interesting case in the energy context is *Hartford Insurance Co. of the Midwest v. Mississippi Valley Gas Co.*, 181 F. App’x 465 (5th Cir. 2006). In that case, the insured gas company claimed a loss because it paid more than once for the same gas recirculated through a meter. The court upheld the insurer’s denial of coverage, reasoning that the insured suffered a loss of money, not covered property. The gas from the wells was not physically lost or damaged in any way before it was eventually returned to the gas company after multiple passes through the meter, and was not returned to the insured in a damaged state.

In *Trinity Industries, Inc. v. Insurance Co. of North America*, 916 F.2d 267 (5th Cir.1990), the Fifth Circuit explained that “physical loss or damage” strongly implies that there was an initial satisfactory state that was changed by some external event into an unsatisfactory state—for example, the car was undamaged before the collision that dented the bumper. It would not ordinarily be thought to encompass faulty initial construction. *Id.* at 270–71.

A Texas court of appeals and the Texas Supreme Court held that weather stand-by charges incurred in connection with covered repairs on an offshore platform which were delayed by tropical storms were not “physical loss” or “physical damage.” *Wellington Underwriting Agencies, Ltd. v. Houston Exploration Co.*, 267 S.W. 3d 277, 284 (Tex. App.—Houston [14th Dist.] 2008),

aff'd, 352 S.W.3d 462 (Tex. 2011). The insured argued that stand-by charges are covered under an all risks policy because they “naturally flowed” from the covered damage to the platform. The court disagreed, stating that “[t]he weather stand-by charges themselves did not constitute ‘physical loss’ of or ‘physical damage’ to covered property; rather, as a cost associated with repairing the original damage, they are a cost caused only by a delay in the repairs.” *Id.*

Contamination of product is certainly possible in the energy industry, and the existence of physical loss or physical damage has been raised in contamination cases in other industries. *Compare Pirie v. Fed. Ins. Co.*, 696 N.E.2d 553, 554-55 (Mass. App. 1998) (need for remediation is not physical damage; mere presence of lead paint not physical loss or damage) and *Leafland Grp.-II, Montgomery Towers Ltd. P’ship v. Ins. Co. of N. Am.*, 881 P.2d 26, 28 (N.M. 1994) (presence of asbestos does not constitute “direct loss or damage”) with *W. Fire Ins. v. First Presbyterian Church*, 437 P.2d 52, 55 (Colo. 1968) (presence of gas vapors constitutes physical injury to property) and *Farmers Ins. Co. v. Trutanich*, 858 P.2d 1332, 1335 (Or. App. 1993) (fumes from methamphetamine cooking sufficient to constitute physical injury to property).

2. Property Covered and Excluded

Many onshore energy policies cover a broad range of property. The LMA Wording provides:

PROPERTY INSURED

This Contract insures the following property, unless otherwise excluded elsewhere in this Contract, located at an Insured Location or within one thousand (1,000) feet thereof:

A Real Property, including new buildings and additions under Construction at an Insured Location, in which the Insured has an insurable interest;

B Personal Property:

- 1 owned by the Insured, including the Insured’s interest as a tenant in improvements and betterments. In the event of direct physical loss of or physical damage to the Property Insured by a Peril not excluded by this Contract, the Insurers agree to accept and consider the Insured as sole and unconditional owner of improvements and betterments, notwithstanding any contract or lease to the contrary;
- 2 of officers and employees of the Insured;

- 3 of others in the Insured's custody to the extent the Insured is under obligation to keep insured for direct physical loss or physical damage insured by this Contract;
- 4 of others in the Insured's custody to the extent of the Insured's legal liability for direct physical loss or physical damage insured by this Contract. The Insurers will defend that portion of any suit against the Insured that alleges such liability and seeks damages for such direct physical loss or physical damage. The Insurers may, without prejudice, investigate, negotiate and settle any claim or suit as the Insurers deem expedient.

This Contract also insures the interest of contractors and subcontractors in Property Insured during Construction at an Insured Location or within one thousand (1,000) feet thereof, to the extent of the Insured's legal liability for direct physical loss or physical damage to such property. Such interest of contractors and subcontractors is limited to the property for which they have been hired to perform work and such interest will not extend to any Business Interruption coverage provided under this Contract.

Another example is:

A.1.B. PROPERTY INSURED

This Section covers all **Onshore** real and personal property of every kind and description owned, operated, controlled, leased, rented, used or intended for use by the **Assured**, provided that such property is scheduled and declared at inception and includes but is not limited to improvements and betterments, property of others in the care, custody and control of the **Assured** or in the care, custody and control of others on behalf of the **Assured**, property for which the **Assured** is responsible, personal property of the **Assured's** employees or officials while on premises owned or controlled by the **Assured** at the option of the **Assured**, electronic data equipment and media, valuable papers and records, property in the course of construction and/or alteration and/or extension and/or addition and/or repair and/or installation and/or erection and/or assembly in progress at inception or any time during the policy period or acquired subsequent thereto, and property in transit. This Section includes but is not limited to pipelines, compression and pump stations, terminals, and gas or other product in lines and/or storage, including but not limited to petroleum products, natural gas and its by-products, liquids derived from natural gas, liquefied natural gas, ethanol and ethanol production by-products.

Onshore energy property damage insurance typically excludes certain types of property, such as:

- Land or improvements to land
- Water (except that normally contained in a piping system, tank or processing equipment)
- Money, currency, notes, securities
- Mines or underground property
- Crops, timber
- Livestock
- Railroads, railroad rolling stock
- Offshore property except docks, wharves, piers, or jetties, extending from shore
- Electrical power distribution lines
- Motor vehicles, aircraft

3. Perils Excluded from Coverage

Onshore energy property damage insurance typically exclude damage caused by certain perils. While policy language varies, these policies almost universally exclude perils, such as:

- a. Faulty Workmanship, Faulty Materials, Defective Design or Specifications

Most onshore energy property insurance contains an exclusion for faulty workmanship or design, and many of these exclusions contain an exception for “ensuing loss.” A typical exclusion is:

This Policy does not insure loss, damage or expense caused directly or indirectly by any of the following. Such loss, damage or expense is excluded regardless of any other cause or event that contributes concurrently or in any sequence to the loss.

14. Cost of making good;

- A. Error, omission or deficiency in design, plans, specification engineering or surveying; or
- B. Faulty or defective workmanship, materials and supplies;

unless direct physical loss or damage by an insured peril ensues, and then, only to the extent otherwise covered by this policy, any direct physical loss or damage directly resulting from such insured peril is covered.

Courts have generally enforced faulty workmanship and defective design exclusions. *See Am. Concept Ins. Co. v. Jones*, 935 F. Supp. 1220, 1229 (D. Utah 1996) (holding “damage to the pipe itself is not covered, but the ensuing [collapse] loss to the Joneses’ home is covered unless it is otherwise excluded or excepted in the policy.”); *City of Burlington v. Hartford Steam Boiler Inspection and Ins. Co.*, 190 F. Supp. 2d 663, 672 (D. Vt. 2002) (finding “a large majority of courts which examined the issue held that ‘faulty workmanship’ is unambiguous when used in an exclusionary clause of an insurance contract.”).

In *RK Mechanical, Inc. v. Travelers Property Casualty Co. of America*, 944 F. Supp. 2d 1013, 1016-17 (D. Colo. 2011), the court explained:

An ensuing loss clause, however, does not reinsert coverage for excluded losses, but rather reaffirms coverage for secondary losses ultimately caused by the excluded perils. The cost of making good faulty work or defective products is not contemplated nor covered by the policy at issue since this kind of loss is specifically excluded. . . . if this Court were to ignore the nature of the policy and its exclusions in order to allow coverage, the result would be to turn these policies into something they are not: performance bonds or guarantees of contractual work.

Id. at 1021 (citations and internal quotations omitted).

The court further held that an “ensuing loss provision does not cover loss caused by the excluded peril; it covers loss caused to the property wholly separate from the defective property itself, in this case the escaping water, not the cracked flange.” *Id.* (internal citations omitted).

The same reasoning is generally applied in defective design cases. *See Vt. Elec. Power Co., Inc. v. Hartford Steam Boiler Inspection & Ins. Co.*, 72 F. Supp. 2d 441 (D. Vt. 1999) (“The loss . . . was not the design defect, but the damage to the transformers; the defective design was the cause.”); *Swire Pac. Holdings, Inc. v. Zurich Ins. Co.*, 845 So. 2d 161, 168 (Fla. 2003) (the contractor was not entitled to recover expenses associated with repairing the design defect); *Allianz Ins. Co. v. Impero*, 654 F. Supp. 16, 18 (E.D. Wash. 1996) (holding ensuing loss provision was not applicable because claim was solely for cost of correcting deficiencies in construction not covered under exclusionary clause); *Narob Dev. Corp. v. Ins. Co. of N. Am.* 219 A.D.2d 454, (N.Y. App. Div. 1995) (ensuing loss exception is not applicable if the ensuing loss was directly related to the original excluded risk); *Schloss v. Cincinnati Ins. Co.*, 54 F. Supp. 2d 1090 (M.D. Ala. 1999) (when a non-covered loss occurs, only a separate loss that occurs as a result of the non-covered loss would be protected by ensuing loss provision); *Montefiore Med. Ctr. v. Am. Protection Ins. Co.*, 226 F. Supp. 2d 470, 479 (S.D.N.Y. 2002) (“An ensuing loss provision does not cover loss caused by the excluded peril, but rather covers loss caused to other property wholly separate from the defective property itself.”).

b. Corrosion

Most energy-generating plants and oil refineries require large metal processing equipment which, when exposed to the elements, naturally deteriorates and corrodes over time. Thus, onshore energy property insurance policies typically include an exclusion for gradual deterioration and corrosion. A typical corrosion exclusion is:

This Policy does not insure against:

e) Gradual deterioration, depletion, rust or corrosion, wear and tear, inherent vice or latent defect; but not excluding ensuing physical loss caused by a peril not otherwise excluded hereunder;

For cases addressing the corrosion exclusion, see *Pioneer Chlor Alkali Co., Inc. v. Royal Indemn. Co.*, 879 S.W.2d 920 (Tex. App.—Houston [14th Dist.]1994, no pet.); *Certain Underwriters at Lloyd's Subscribing to Policy No. WDO-10000 v. KKM, Inc.* 215 S.W.3d 486 (Tex. App.—Corpus Christi-Edinburg 2006, pet. denied); *Bishop v. Alfa Mut. Ins. Co.*, 796 F. Supp. 2d 814 (S.D. Miss. 2011); *Nat'l Union Fire Ins. Co. of Pittsburgh, Pa. v. Valero Energy Corp.*, 777 S.W.2d 501 (Tex. App.—Corpus Christi 1989, writ denied).

4. Extensions of Coverage to Property Damage Insurance

The PD section of a typical onshore energy policy often includes one or more of the following extensions of coverage which broaden coverage to include certain costs in addition to repair or replacement of physical damage, usually subject to sublimits of liability:

- Debris Removal
- Demolition and Increased Costs of Construction
- Expediting Costs
- Professional Fees (Claims Preparation Costs)
- Service Interruption

D. BUSINESS INTERRUPTION INSURANCE

The onshore energy policy typically includes coverage for Business Interruption and Extra Expense.⁴⁰ Business Interruption coverage developed as an outgrowth of, and supplement to, Property Damage coverage for the insured's own premises. Consider the landlord whose building is destroyed by fire. Business Interruption (known in the early days as "loss of use and occupancy") protects his lost income stream during repairs while the Property Damage coverage permitted rebuilding his building.

⁴⁰ See Power & Utilities Property Damage and Business Interruption Wording (USA), LMA3110, at 29-41.

While the basic concept is clear, “business interruption” is a somewhat misleading term. The Business Interruption policy is not designed to cover all risk of loss of an insured’s profits. Rather, because of its historical development, the coverage is tied to a requirement of actual physical damage to covered property by a peril not excluded in the Property Damage section of the policy.

Courts and commentators have described the purpose of BI coverage as follows:

- (1) To indemnify the insured for loss caused by the interruption of a going business due to the destruction of the building, plant or parts thereof.⁴¹
- (2) To reimburse the insured for lost income and extra expenses that are sustained during the interruption and that result from a covered cause of loss that caused the insured to temporarily cease its business operations, i.e., to place the insured in the position it would have occupied had no interruption occurred.⁴²
- (3) To cover the insured against “actual loss sustained,” which is to say that it is designed to keep the insured’s business in essentially the same position that it would have maintained for itself absent an interruption – to do for the insured during a period of suspended operations what the business itself would have done had no loss occurred.⁴³

1. Typical Business Interruption Policy Language

1. Coverage

a) Business Interruption

This Policy covers loss sustained by the Insured resulting from the necessary interruption of business caused by destruction or damage, by a peril insured against, to property insured herein, occurring during the term of this Policy.

* * *

e) Expenses to Reduce Loss:

⁴¹ *Quality Oil Field Prods., Inc. v. Mich. Mut. Ins. Co.*, 971 S.W.2d 635, 638 (Tex. App.—Houston [14th Dist.] 1998, no pet.) (citation omitted) (emphasis added).

⁴² Jon C. Rice, *Business Interruption Coverage in the Wake of Katrina: Measuring the Insured’s Loss in a Volatile Economy*, 41 TORT TRIAL & INS. PRAC. L.J. 857, 858 (2006) (emphasis added).

⁴³ See also *Paramount Fire Ins. Co. v. Aetna Cas. & Sur. Co.*, 353 S.W.2d 841, 844 (Tex. 1962) (purpose is to put insured in same position had the event causing loss not occurred, but not to provide the insured a windfall where no loss has occurred); *Royal Indem. Ins. Co. v. Mikob Props. Inc.*, 940 F. Supp. 155, 157-60 (S.D. Tex. 1996) (business interruption insures against loss of insured’s earnings when covered causes of loss prevents use of insured’s premises and continuing normal operations); and *Cora Pub, Inc. v. Cont’l Cas. Co.*, 619 F.2d 482, 488 (5th Cir. 1980) (purpose of business interruption is to preserve continuity of insured’s earnings and place it in same financial posture as if there had been no casualty).

This Policy also covers such expenses as are necessarily incurred for the purpose of reducing loss under this Policy and such expenses, in excess of Normal, as would necessarily be incurred in replacing any finished stock used by the Insured to reduce loss under this Policy; but in no event shall the aggregate of such expenses exceed the amount by which the loss under this Policy is thereby reduced.

2. Measure of Recovery

The measure of recovery in the event of loss hereunder shall be the reduction in "Gross Earnings" directly resulting from such interruption of business but not exceeding such length of time as would be required, with the exercise of due diligence and dispatch, to rebuild, repair, or replace the destroyed or damaged property, commencing with the date of such destruction or damage and not limited by the date of expiration of this Policy but not exceeding the ACTUAL LOSS SUSTAINED by the Insured resulting from such interruption of business.

3. Resumption of Operations

It is the condition of this Insurance that if the Insured could reduce the loss resulting from the interruption of business:

- a). By complete or partial resumption of operations of the property herein described whether damaged or not, or
- b). By making use of Stock (Raw, In Process or Finished) at the location of the loss or elsewhere, or
- c). By making use of other property at the location(s) described herein and elsewhere.

Then such reduction shall be taken into account in arriving at the amount of loss hereunder.

2. The Elements Necessary for a Covered BI Claim

While policy language of the BI section varies, in order for the business loss to be covered, generally it must result directly from (1) a covered peril that causes (2) physical loss or damage to

covered property that causes (3) an interruption of the Insured's business operations (4) during the period of restoration.⁴⁴

3. What is "Interruption" of the Insured's Business?

A common issue addressed by courts "is whether the level of interruption to the business has been sufficient under the policy language. Business interruption insurance commonly uses the phrase 'necessary suspension of operations.' The issue is whether a significant *slowdown* in operations is sufficient, or whether the policy requires a total *shutdown* in operations."⁴⁵ The majority of courts have held that in order for business interruption insurance to be triggered, the loss must result from a "complete cessation" of business activity. *Lantheus Med. Imaging, Inc. v. Zurich Am. Ins.*, No. 10 Civ. 9371, 2015 WL 1914319, at *9-*10 (S.D.N.Y. April 28, 2015), *app. filed* (2d Cir. May 26, 2015).⁴⁶

Some policy language requires only a "necessary interruption of business, whether total or partial." *See Aztar Corp. v. U.S. Fire Ins. Co.*, 224 P.3d 960, 966-67 (Ariz. Ct. App. 2010) That language has been interpreted to specifically allow less than a complete shutdown of operations, in order to trigger business interruption coverage. *Id.*

4. What is the "Period of Restoration"?

The Period of Restoration (also referred to as Period of Indemnity) is typically limited to the amount of time that *would be required* with the exercise of due diligence and dispatch to rebuild, repair or replace such property which has been lost or damaged.

A period of "suspension" or "restoration" is a common feature of business interruption policies. The purpose of the period of restoration is to restrict coverage to earnings lost during the period of time "necessary to restore the business to its pre-accident condition." Courts have observed that, without a temporal limitation, "[t]here would be no available method to determine with any degree of accuracy the amount of [business interruption] losses."

⁴⁴ See Randy Paar, The Elements of a Business Interruption Claim, 2 NO. 7 E-COMMERCE & TECH. 13 (April 30, 2002).

⁴⁵ *Id.* at 4 (emphasis in original).

⁴⁶ See generally 11 COUCH ON INS. § 167:11 ("[A] business ... 'suspension' triggering coverage typically involves a total cessation of business, not merely a slowdown or reduction of operations."); see also, e.g., *GBP Partners, Ltd. v. Md. Cas. Co.*, 505 F. App'x 389, 392 (5th Cir. 2013) (unpublished opinion) ("Under Texas law, a suspension of operations clause requires business to have completely ceased for some interval."); *H & H Hosp. LLC v. Discover Specialty Ins. Co.*, No. H-10-1886, 2011 WL 6372825, at *3 (S.D. Tex. Dec. 20, 2011) ("While the Policy does not define 'necessary suspension of your operations,' courts have interpreted language identical or similar to the clause in this policy to cover the risk of a complete cessation of business activities at the covered premises[.]; *Quality Oilfield*, 971 S.W.2d at 639 ("[W]e find that 'interruption of business' is an unambiguous term meaning 'cessation or suspension of business.' Therefore, [plaintiff] was not entitled to business interruption coverage for the work slowdown it experienced, and we find the trial court did not err in granting [defendant's] motion for summary judgment.")).

Am. Guar. & Liab. Ins. Co. v. So. Minn. Beet Sugar Co-op., 320 F. Supp. 2d 879, 882 (D. Minn. 2004) (quoting *Rogers v. Am. Ins. Co.*, 338 F.2d 240, 243 (8th Cir.1964); *Great N. Oil Co. v. St. Paul Fire & Marine Ins. Co.*, 227 N.W.2d 789, 792-93 (Minn. 1975)).

Typical policy language provides that the period of restoration begins on the date of physical loss or damage that caused the business interruption, and ends when the repairs are completed, or if the repairs have been delayed, the date that the insured reasonably could have completed such repairs with due diligence. In the latter case, the period of indemnity is a hypothetical reasonable amount of time that the repairs could have been made. Generally, the period of restoration “runs concurrently with an interruption due to an insured peril and lasts until the damaged property is restored.” *Pennbarr Corp. v. Ins. Co. of N. Am.*, 976 F.2d 145, 154 (3d Cir. 1992) (business interruption insurance does not cover lost sales sustained beyond the period of restoration).

Consider the refinery that suffers an explosion in a 30-year-old boiler. The explosion damages the boiler, related electrical equipment and piping, and causes a small fire. The period of restoration, for the purpose of the refinery’s lost income and extra expense coverage, would be the time it *should* take to repair or replace all of the damage and restart the boiler equipment. The refinery’s and insurers’ experts agree that the repairs could be completed in three months. However, if the refinery takes an additional six months to decide whether it prefers to repair the old boiler or purchase a new one (or some other reason not related to the actual repairs), that delay in completing the repairs is not included in the period of restoration—the period is still three months.

5. Idle Periods Exclusion

A common exclusion found in the Business Interruption section of onshore energy policies is for “Idle Periods.”

The LMA Wording provides:

In addition to the Exclusions elsewhere in this Contract, this Section does not insure:

A. any loss during any idle period, (including but not limited to when production, operation, service or delivery or receipt of goods would cease, or would not have taken place or would have been prevented):

1. due to planned or scheduled shutdown or outage;
2. due to strikes or other work stoppage;

3. when it is not possible to attain or maintain Profitable Output for reasons other than direct physical loss or physical damage; or

4. for any other reason other than direct physical loss or physical damage insured by this Contract.⁴⁷

Onshore energy facilities usually plan a shutdown or outage to perform maintenance on equipment, such as turbines and boilers, from time to time.

For example, industrial plants schedule plant “turnarounds” during which times the facility will be down for annual or periodic scheduled maintenance and repairs. If a catastrophe strikes during or just before or after a scheduled plant outage, such “normal” downtimes may need to be factored into the business interruption loss calculation such that only downtime caused by the insured peril is reflected in the calculated loss.

John K. DiMugno et al., *Estimating Loss Amounts under the Actual Loss Sustained Form*, CAT CLAIMS: INSURANCE COVERAGE FOR NATURAL AND MAN-MADE DISASTERS § 10:8.

Courts have generally enforced idle periods exclusions. *See Mech. Equip. Co. v Affiliated FM Ins. Co.*, No. 08-4705, 2010 WL 1293822 (E.D. La. March 30, 2010); *Tex. Indus., Inc. v. Factory Mut. Ins. Co.*, No. 3:07-CV-1355-P, 2006 WL 5486783 (N.D. Tex. Feb. 6, 2006); *Air Liquide Am. Corp., v. Prot. Mut. Ins. Co.*, 132 F.3d 38 (9th Cir. 1997) (unpublished); *Cargill, Inc. v. Appalachian Ins. Co. of Providence*, No. 4:77 CV 238, 1983 WL 496522 (D. Minn. Jan. 24, 1983); *Mrs. Mut. Fire Ins. Co. v. Royal Indemn. Co.*, 501 F.2d 299 (9th Cir. 1974); *but see Del Monte Fresh Produce, N.A., Inc. v. ACE Ins. Co.*, No. 00-4792-CIV-Martinez, 2002 WL 34702174 (S.D. Fla. Oct. 3, 2002).

E. CONTINGENT BUSINESS INTERRUPTION COVERAGE

Given the interconnected nature of modern commerce, physical damage to the insured’s sources of supply, output, distribution, and customers can obviously cause serious interruption of the insured’s income stream, even in the absence of physical damage to the insured’s own property. Historically, insurers broadened Business Interruption coverage to cover the insured’s business interruption caused by physical damage to certain third party premises upon which the insured’s business was dependent, by developing the Contingent Business Interruption (CBI) policy. “Contingent” is used in the sense that the insured’s business is dependent upon others.

⁴⁷ See Power & Utilities Property Damage and Business Interruption Wording (USA), LMA3110, at 41.

Given the historical development of the Business Interruption policy, Contingent Business Interruption insurance also requires physical damage at the third party premises due to the type of risk that would be covered under the insured's own Property Damage policy.⁴⁸

An example of a CBI coverage grant is as follows:

Subject to all its provisions, this policy insures against loss resulting directly from necessary interruption of business conducted on the Insured's premises occupied by the Insured, caused by physical loss or damage of the type insured against to:

1. Real or personal property of the type covered at locations situated within the territorial limitations for up to USD 20,000,000 per occurrence as respects direct suppliers to the Insured, unless otherwise endorsed hereon, not operated by the Insured, which wholly or partially prevents the delivery of materials or provision of services to the Insured or to others for the account of the Insured.

Contingent Business Interruption coverage is becoming more important in the energy industry, as recent cases demonstrate. *See Lion Oil Co. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa.*, No. 13-CV-1071, 2015 WL 5305231 (W.D. Ark. Sept. 10, 2015) (discussing contingent business interruption coverage); *Lion Oil Co. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa.*, No. 13-CV-1071, 2015 WL 6680899 (W.D. Ark. Nov. 2, 2015) (same); *Millennium Inorganic Chems., Ltd., v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa.*, 744 F.3d 279 (4th Cir. 2014) (defining "direct" supplier); *Park Electrochem. Corp., v. Cont'l Cas. Co.*, No. 04-CV-4916 (ENV)(ARL), 2011 WL 703945 (E.D.N.Y. Feb. 18, 2011) ("direct supplier" not defined in policy). *See also Air Liquide*, 132 F.3d at 38, *2-*3("[T]he Contingent Time Element Endorsement, which Air Liquide did not purchase . . . provides the very coverage sought here. . .").

F. BROKER-DRAFTED POLICY LANGUAGE

Most Onshore Energy Package Policies in the United States, especially for larger risks such as power-generating plants and oil refineries, are quota-share subscription policies drafted by specialized insurance brokers that are issued by a combination of Lloyd's Syndicates, domestic insurers, and foreign insurers based in Bermuda, Germany, and Switzerland. Although the Lloyd's Wordings Repository is filled with suggested policy language that has been vetted by experts in the particular sector of insurance coverage, the suggested Lloyd's Wordings are often not used. For that reason, especially with these individually tailored insurance policies, it is imperative to

⁴⁸ See Claude L. Stuart III, *Offshore Energy Insurance Coverage: Physical Damage and Business Interruption/Contingent Business Interruption*, 17th Annual Admiralty and Law Conference, University of Texas (Oct. 24, 2008).

analyze the actual language used by the broker in the policy at issue. It is not unusual for the language included in the manuscript policy wording to be inconsistent with underwriters' intent.

One example of the broker-drafted policy language which lead to a dispute between the Insurers and Insured was:

3. Arbitration

If the Insured and the Underwriters fail to agree on the amount of loss, each will, on the written demand of either, select a competent and disinterested appraiser after:

- a. The Insured has fully complied with all provisions of this Policy, and
- b. The Underwriters have received a signed and sworn proof of loss from the Insured.

Each will notify the other of the appraiser selected within 20 days of such demand.

The appraisers will first select a competent and disinterested umpire. If the appraisers fail to agree upon an umpire within thirty (30) days then, on the request of the Insured or the Underwriters, the umpire will be selected by a judge of a court of record in the jurisdiction in which the *arbitration*⁴⁹ is pending. The appraisers will then appraise the amount of loss, stating separately the Actual Cash Value and replacement cost value as of the date of loss and the amount of loss, for each item of *physical loss or damage coverage of this Policy*.

If the appraisers fail to agree, they will submit their differences to the umpire. An award agreed to in writing by any two (2) will determine the amount of loss.

The Insured and the Underwriters will each:

- a. Pay its chosen appraiser; and
- b. Bear equally the other expenses of the *arbitration* and umpire.

A demand for *arbitration* shall not relieve the Insured of its continuing obligations to comply with the terms and conditions of this Policy.

The Underwriters will not be held to have waived any of its rights by any act relating to *arbitration*.

The Insured and the Underwriters shall each bear the expenses of their own appraisers and shall bear equally the expenses of the umpire.

The seat of *arbitration* shall be the State of New York.

This wording is not a model of clarity, and led to years of litigation regarding whether the coverage issues would be resolved in court or in arbitration. After examining the intent of all involved in the development of the manuscript policy wording, the court found the clause required the arbitration of all disputes in a New York arbitration. See *Aker Kvaerner/IHI v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa.*, Nos. 2:10-CV-00278, 2:10-CV-1041, 2014 WL 547042 (W.D.

⁴⁹ Bold type was included in the Policy.

La. Feb. 10, 2014); *Aker Kvaerner/IHI v. National Union Fire Ins. Co. of Pittsburgh, Pa.*, Nos. 2:10-CV-00278; 2:10-CV-1041, 2013 WL 3458194 (W.D. La. July 9, 2013); *Aker Kvaerner/IHI v. National Union Fire Ins. Co. of Pittsburgh, Pa.*, 599 F. App'x 208 (5th Cir. 2015).

The point is that broker manuscript forms or wording can sometimes be an amalgamation of different wordings that have been interpreted by courts and carry definite legal concepts. Underwriters should attempt to clarify these types of issues on the front end in order to avoid unnecessary confusion in the interpretation or application of the policy provisions.

IV. CONCLUSION

The authors hope that this high-level, high-speed fly-by has enabled the reader to gain a sense of the scope of the energy industry and the insurance coverages involved in the energy “package” policy, while also providing some starting points for the authorities construing and applying them.

Exhibit A

PROPERTY & PLANT TESTING & COMMISSIONING CLAUSE

1. It is hereby noted and agreed that this (Re)insurance does not cover destruction of or damage to property in course of construction or erection, dismantling, revamp or undergoing testing or commissioning including mechanical performance testing and any business interruption resulting therefrom.
2. Acceptance of property hereon is subject to satisfactory completion of the following:
 - 2.1. Mechanical Completion.
 - 2.2. Testing and Commissioning.
 - 2.3. Performance Testing conforming to 100% Contract Design Criteria having been maintained by the entire plant in a stable and controlled manner for a continuous period of a minimum of 72 hours duration.
 - 2.4. Official acceptance by the Insured following formal hand over without reservation or waiver of guarantee conditions.
 - 2.5. Any deficiencies identified during the testing, commissioning and start-up that may affect the mechanical integrity, process safety or reliability of the plant, having been declared to (Re)Insurers prior to attachment.
3. NOTWITHSTANDING the above, attachment of property and plant hereon to be agreed by (Re)Insurers. It is further noted and agreed that terms and conditions to be reviewed, if required by (Re)Insurers.
4. It is further noted and agreed that the above provisions do not apply to normal routine maintenance activities, scheduled turnarounds and / or minor works (as defined in the policy).

Additionally, (Re)Insurers request completion of the attached information request template "INFORMATION TO SUPPORT THE TRANSFER OF ONSHORE OIL, GAS & PETROCHEMICAL ASSETS FROM CONSTRUCTION TO OPERATIONAL INSURANCE".

INFORMATION TO SUPPORT THE TRANSFER OF ONSHORE OIL, GAS & PETROCHEMICAL ASSETS FROM CONSTRUCTION TO OPERATIONAL INSURANCE

Purpose

The purpose of the following information request template is to facilitate the transfer of a newly constructed Onshore Oil, Gas & Petrochemical asset from a construction policy to an operational policy.

The information provided is intended to:

- Support paragraphs 2.1 to 2.5 of the Testing & Commissioning Clause.
- Help define items of critical importance to (Re)Insurers for the initial safe operation of an asset following start-up.
- Help (Re)Insurers understand the risks to be transferred thus allowing an informed judgement to be made.
- Be of mutual benefit to the Insured, Broker and (Re)Insurers by clarifying expectations for the transfer to operational cover.

Any issues identified within this information request template are not necessarily a barrier to transfer but more likely can form the basis for discussion between the Insured and (Re)Insurers.

This information request template is not intended to replace any other information which may be provided within the Insured's/Broker's submission.

Process

It is intended that this information request template will be completed by persons knowledgeable in the specific topic areas. By definition, therefore, completion of the template may require coordination between a number of different departments.

It is expected that the template will be completed for each and every applicable endorsement to a policy.

The completed template should be submitted to (Re)Insurers shortly before the anticipated operational policy inception date. The intent is that the information contained herein reflects the status of the asset as close to inception as possible whilst allowing a reasonable time for the information to be reviewed by (Re)Insurers.

Operational Insured's Name

Project Name

Proposed Date of Inception of
Operational Cover

Endorsement Reference Number

Date Information Completed

Please provide attachments where necessary to support the following information requests.

0 Overview

0.1 Provide details of the full scope of assets to be transferred to the operational policy under this endorsement.

0.2 Provide details of the start-up plan including a schedule with the order and approximate dates in which units will be/were started up.
Include details of any units which will be started up and subsequently idled.

0.3 Provide details of any restrictions on the ability to demonstrate 100% Contract Design Criteria (e.g. feedstock availability).

1 Mechanical Completion *

** A contractual milestone and can be the point of transfer of care, custody and control from the (EPC) Contractor to the Owner. Normally prior to this only 'cold testing' has been completed (i.e. non energised/pressurised systems but would include flushing and cleaning, hydrostatic and pneumatic testing and 'bumping' of electric motors). Some of these activities are typically called pre-commissioning.*

1.1 Was a certificate of Mechanical Completion issued to the Owner?

YES ☐ NO ☐

1.2 Provide details of any significant quality related issues with materials or equipment (e.g. major fabrication defects, material non-conformity) which could affect the mechanical integrity of the plant and provide a summary of what has been done to rectify these faults.

2 Testing & Commissioning *

** This is normally regarded as 'hot testing' and comprises:*

- *Commissioning - including all dynamic and energised checking and test work such as starting up of machinery and function testing.*
 - *Start-Up - milestone at which hydrocarbon feedstock is introduced with subsequent ramp-up to operating conditions, optimisation and troubleshooting.*
-

2.1 Have there been any insurance claims to the Construction policy?

If yes, provide details below.

YES ☐ NO ☐

2.2 Have there been any significant incidents, not necessarily resulting in an insurance claim, during the project?

Examples would include a significant Loss of Primary Containment (LOPC), fire, explosion, machinery breakdown, dropped load or equipment damage.

If yes, provide details below.

YES ☐ NO ☐

2.3 Are there any significant remaining construction works taking place on the plant that could present a risk to the plant when handed over to Operations i.e. simultaneous construction and operation (SIMOPS)?

If yes, provide details below.

YES ☐ NO ☐

2.4 Provides details of the current status of Safety Critical Equipment as per the definitions below and the following table.

(i) **Tested** - all such systems have been tested against a predefined performance standard. This should include the full loop from detection device (e.g. sensor) to final element (e.g. isolation valve). In the case of fire protection systems, this should include a full 'wet test'. In the case of mechanical relief devices, this is taken to mean the items have been bench tested and certified as per the original design specification.

(ii) **Available** - all such systems are available to the process should a demand be placed upon them i.e. no impairment/override/bypass of individual systems.

(iii) **Deviations/Impairments** - record any individual systems which do not meet the Tested and/or Available criteria as outlined above. Details of any long term impairments should be provided here.

Safety Critical Equipment	100% Tested ⁽ⁱ⁾	100% Available ⁽ⁱⁱ⁾	Deviations/Impairments ⁽ⁱⁱⁱ⁾
Safety Instrumented Functions for example: <ul style="list-style-type: none"> Emergency Shut Down (ESD), Isolation & Depressurisation systems Reactor kill & dump systems Safety trips & interlocks Safety critical alarms Safety critical analysers Machinery protection systems (overspeed, vibration etc.) Fired heater protection systems (fuel supply low pressure etc.) Any safety instrumentation as part of a vendor supplied package 	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	
Mechanical Relief Devices for example: <ul style="list-style-type: none"> Over Pressure Protection Devices Vacuum Relief Devices Thermal Relief Devices 	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	
Mechanical Interlocks	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	
Emergency Power Supply for example: <ul style="list-style-type: none"> Uninterruptible Power Supply (UPS) Emergency Diesel Generator(s) 	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	
Remotely Operable Emergency Isolation Valves (ROIVs)	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	
Fire & Gas Detection systems for example: <ul style="list-style-type: none"> Smoke detection in business critical buildings Flammable gas detection in open plant & enclosures Flame & heat detection in open plant & enclosures 	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	
Fire Protection systems for example: <ul style="list-style-type: none"> Firewater storage, pumps & distribution Hydrants, monitors & deluge systems Foam & powder systems Gaseous extinguishing systems 	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	

3 Performance Testing * conforming to 100% Contract Design Criteria ** having been maintained by the entire plant in a stable and controlled manner for a continuous period of a minimum of 72 hours duration.

** Performance Testing is demonstration of plant operation at 100% Contract Design Criteria for a minimum time period.*

*** Contract Design Criteria are the plant design specifications as stipulated in the project design basis.*

3.1 Provide daily production data from the start of operations to date for the plant and identify the 100% / 72hrs Performance Test within the data.

3.2 If it is not possible to achieve the 100% / 72hrs Performance Test, provide details as to the reasons why not and provide daily production data to indicate the maximum throughput achieved to date.

3.3 Are there any major equipment items which have not yet been subject to Performance Test but are to be attached under this endorsement?

This is not intended to cover installed spare equipment (e.g. pump A & B) but rather major equipment items which have not yet been utilised, for example, due to product grade runs.

If yes, provide details below.

YES ☐ NO ☐

4 Official acceptance by the Insured following formal hand over without reservation or waiver of guarantee conditions.

4.1 Has the project been officially accepted by the Owner following formal handover without reservation or waiver of guarantee conditions?

If no, provide details below.

YES ☐ NO ☐

5	Any deficiencies identified during testing, commissioning and start-up that may affect the Mechanical Integrity ^{5.1} , Process Safety ^{5.2} or Reliability ^{5.3} of the plant.			
5.1	Mechanical Integrity			
5.1.1	Are there any equipment faults, warranty issues, fabrication defects, temporary modifications or punch list items remaining which could potentially affect the Mechanical Integrity of the plant? If yes, provide details below.			
	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
5.1.2	Provide a copy of the latest status of any punch list items which could potentially affect the Mechanical Integrity of the plant.			
5.2	Process Safety			
5.2.1	Was a formal Pre Start-up Safety Review (PSSR) completed for the project?			
	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
	Were the following items considered during the PSSR (or equivalent procedure) <u>and</u> their status deemed adequate by the Owner:			
	Status of all Process Hazard Analysis (PHA) (e.g. HAZOP) actions?	YES	<input type="checkbox"/>	NO <input type="checkbox"/>
	Availability of Start-Up, Shutdown & Emergency Operating Procedures?	YES	<input type="checkbox"/>	NO <input type="checkbox"/>
	Delivery of training to Operators and Maintenance technicians?	YES	<input type="checkbox"/>	NO <input type="checkbox"/>
	Availability of as-built P&IDs to Operational staff?	YES	<input type="checkbox"/>	NO <input type="checkbox"/>
	If no to any of the above, provide details below.			
5.2.2	Is there a formal and documented Management of Change (MoC) procedure in place for the operational phase covering all permanent, temporary and emergency changes?			
	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
5.2.3	Is there an operational procedure in place to manage and authorise the temporary override/bypass of Safety Instrumented Functions?			
	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
5.2.4	Is there an operational procedure in place to manage and authorise the temporary impairment of fire protection systems and any other Safety Critical Equipment?			

YES ☐ NO ☐

- 5.2.5 Is the Operations organisation fully staffed versus the agreed headcount? Is additional management and technical resource available during start-up? Are overtime hours being monitored and controlled?

If no to any of the above, provide details below.

YES ☐ NO ☐

- 5.2.6 Is the Emergency Response Team (ERT) fully staffed, equipped and trained? Is the ERT aware of current plant status and any special procedures necessary? Is free and uninhibited access to the plant possible?

If no to any of the above, provide details below.

YES ☐ NO ☐

5.3 Reliability

- 5.3.1 Are there any current known recurring process or equipment (Mechanical, Electrical and Instrumentation) issues affecting the reliability of plant operation?

If yes, provide details below.

YES ☐ NO ☐

- 5.3.2 Are major spares available for large unsparred long delivery equipment items which could, if they failed, result in a significant Business Interruption impact (several months plant shutdown). Examples of these 'Insurance' spares are compressor or turbine shafts, large electric motors or large transformers.

If no, provide details below.

YES ☐ NO ☐

Exhibit B

Power & Utilities

**Property Damage
and Business Interruption
Wording**

(USA)

RISK DETAILS

UNIQUE MARKET
REFERENCE :

<<insert>>

TYPE:

PROPERTY DAMAGE/BUSINESS INTERRUPTION INSURANCE

INSURED:

<< insert>>

BUSINESS:

The Business of the Insured as declared to Insurers at inception.

ADDRESS:

<<insert>>

PERIOD OF INSURANCE:

<<insert>>

Both dates at 12.01 a.m. Local Standard Time at the address of the Insured as shown above, and such further period or periods as may be mutually agreed upon

INTEREST:

SECTION 1 - PROPERTY DAMAGE

All risks of direct physical loss of or physical damage to the Property Insured by a Peril not excluded by this Contract, but excluding the following coverages unless it is indicated here that they are insured by this Contract: <<Select>>

ACCIDENT (MACHINERY
BREAKDOWN/EXPLOSION/COLLAPSE) (Y/N)

EARTH MOVEMENT (Y/N)

FLOOD (Y/N)

WINDSTORM (INCLUDING NAMED WINDSTORM) (Y/N)

If any of the above perils are not insured by this Contract, additional Exclusions apply (see Additional Exclusions to Section 1 below).

SECTION 2 - BUSINESS INTERRUPTION

BUSINESS INTERRUPTION (CONTRACTED SALES) (Y/N)

BUSINESS INTERRUPTION (MERCHANT SALES) (Y/N)

COMMISSIONS, PROFITS AND ROYALTIES (Y/N)

DEBT SERVICE CHARGES AND OPERATIONAL AND
MAINTENANCE CHARGES (Y/N)

EXTRA EXPENSE (NON-GENERATION)

EXTRA EXPENSE (REPLACEMENT POWER CAPACITY) (Y/N)

RENTAL INSURANCE (Y/N)

LIMITS OF LIABILITY:

The Insurers' maximum limit of liability in an Occurrence, including any insured Business Interruption loss shall not exceed *<<insert Total Sum Insured>>* and shall be subject to the Limit of Liability General Provisions stated within the General Conditions.

Subject, however, to Sub-Limits of Liability as follows:

SECTION 1 - PROPERTY DAMAGE

ACCOUNTS RECEIVABLE	<i><<insert applicable limit/none>></i>
AUTOMATIC COVERAGE (time limit)	<i><<insert applicable time limit in days/ none>> days</i>
DATA REPRODUCTION COST	<i><<insert applicable limit/none>></i>
DEBRIS REMOVAL	<i><<insert applicable limit/none>></i>
DEFERRED PAYMENTS	<i><<insert applicable limit/none>></i>
DEMOLITION AND INCREASED COST OF CONSTRUCTION	<i><<insert applicable limit/none>></i>
EARTH MOVEMENT in the aggregate during the Period of Insurance, Property Damage and Business Interruption Combined	<i><<insert applicable limit/none>></i>
ELECTRONIC DATA PROCESSING MEDIA	<i><<insert applicable limit/none>></i>
ERRORS AND OMISSIONS	<i><<insert applicable limit/none>></i>
EXPEDITING COSTS	<i><<insert applicable limit/none>></i>
FINE ARTS	<i><<insert applicable limit/none>></i>
FIRE BRIGADE CHARGES AND EXTINGUISHING EXPENSES	<i><<insert applicable limit/none>></i>
FLOOD in the aggregate during the Period of Insurance, Property Damage and Business Interruption Combined	<i><<insert applicable limit/none>></i>
HAZARDOUS SUBSTANCES OR CONTAMINANTS	<i><<insert applicable limit/none>></i>
LAND AND WATER CONTAMINANT OR POLLUTANT CLEANUP, REMOVAL AND DISPOSAL in the aggregate during the Period of Insurance	<i><<insert applicable limit/none>></i>
LEASEHOLD INTEREST	<i><<insert applicable limit/none>></i>
MISCELLANEOUS UNNAMED LOCATIONS	<i><<insert applicable limit/none>></i>
NEW BUILDINGS AND ADDITIONS UNDER INCIDENTAL COURSE OF CONSTRUCTION (ESTIMATED CONTRACT VALUE)	<i><<insert applicable limit/none>></i>
PROFESSIONAL FEES (CLAIMS PREPARATION COSTS)	<i><<insert applicable limit/none>></i>

RADIOACTIVE CONTAMINATION (SUDDEN AND ACCIDENTAL)	<<insert applicable limit/none>>
SERVICE INTERRUPTION PROPERTY DAMAGE and SERVICE INTERRUPTION BUSINESS INTERRUPTION combined	<<insert applicable limit/none>>
TEMPORARY REMOVAL OF PROPERTY (OFFSITE STORAGE)	<<insert applicable limit/none>>
TRANSPORTATION	<<insert applicable limit/none>>
VALUABLE PAPERS AND RECORDS	<<insert applicable limit/none>>
WINDSTORM (INCLUDING NAMED WINDSTORM), Property Damage and Business Interruption Combined	<<insert applicable limit/none>>
NAMED WINDSTORM (NOT INCLUDED IN WINDSTORM ABOVE), Property Damage and Business Interruption Combined	<<insert applicable limit/none>>
SECTION 2 - BUSINESS INTERRUPTION	
AVAILABILITY PAYMENTS as declared to and agreed by the Insurers	<<insert applicable limit/none>>
BUSINESS INTERRUPTION (CONTRACTED SALES) Monthly Cap basis as declared to and agreed by the Insurers	<<insert applicable limit/none>>
BUSINESS INTERRUPTION (MERCHANT SALES) Monthly Cap basis as declared to and agreed by the Insurers	<<insert applicable limit/none>>
BUSINESS INTERRUPTION (CONTRACTED SALES) Revenue Profile basis as declared to and agreed by the Insurers	<<insert applicable limit/none>>
BUSINESS INTERRUPTION (MERCHANT SALES) Revenue Profile basis as declared to and agreed by the Insurers	<<insert applicable limit/none>>
CAPACITY AND/OR BONUS PAYMENTS as declared to and agreed by the Insurers	<<insert applicable limit/none>>
COMMISSIONS, PROFITS AND ROYALTIES	<<insert applicable limit/none>>
CONTINGENT BUSINESS INTERRUPTION	<<insert applicable limit/none>>

Named Direct Customers/Named
Direct Suppliers:

<<names of customers>>

<<names of suppliers>>

DEBT SERVICE CHARGES AND
OPERATIONAL AND MAINTENANCE
CHARGES

<<insert applicable limit/none>>

EXTRA EXPENSE (NON-
GENERATION)

<<insert applicable limit/none>>

EXTRA EXPENSE (REPLACEMENT
POWER CAPACITY)

<<insert applicable limit/none>>

RENTAL INSURANCE

<<insert applicable limit/none>>

SERVICE INTERRUPTION (day limit)

<<insert maximum no of days>>

DEDUCTIBLES:

Subject to the Deductible General Provisions stated within the General Provisions, in each case of loss covered by this Contract, the following Deductibles apply:

SECTION 1 - PROPERTY DAMAGE

Deductible(s): << insert category and applicable amounts>>

<< insert category and applicable amounts>>

SECTION 2 - BUSINESS INTERRUPTION

Deductible(s): << insert dd>> days worth of the otherwise indemnifiable business interruption at the average daily value of the loss.

<< insert category and applicable amounts>>

INDEMNITY PERIOD:

SECTION 2 - BUSINESS INTERRUPTION

Maximum Indemnity Period(s):

In addition to any Maximum Indemnity Periods shown elsewhere in the Contract, the following shall apply:

<<insert dd>> day period BUSINESS INTERRUPTION COVERAGES other than

<<insert dd>> day period AVAILABILITY PAYMENTS

<<insert dd>> day period BUSINESS INTERRUPTION (CONTRACTED SALES)

<<insert dd>> day period BUSINESS INTERRUPTION (MERCHANT SALES)

<<insert dd>> day period CIVIL OR MILITARY AUTHORITY

<<insert dd>> day period CONTINGENT BUSINESS INTERRUPTION
<<insert dd>> day period DEBT SERVICE CHARGES AND
OPERATIONAL AND MAINTENANCE CHARGES
<<insert dd>> day period INGRESS/EGRESS
<<insert dd>> day period ORDINARY PAYROLL

**TERRITORIAL
LIMITS:**

<<insert>>

NOTICES:

<< Insert if appropriate, if none state "None">>

**CHOICE OF LAW
AND JURISDICTION:**

Choice of Law: <<insert applicable data here>>

Service of Suit Nominee: <<insert here if applicable>>

Arbitration

Rules of Arbitration: LCIA << amend here if not appropriate>>

Seat of Arbitration: London, England << amend here if not
appropriate >>

Language of Arbitration: English << amend here if not appropriate>>

Governing Law: England and Wales << amend here if not
appropriate >>

PREMIUM:

<<insert details>>

**PREMIUM PAYMENT
TERMS:**

<<insert details>>

**TAXES PAYABLE BY
INSURED AND
ADMINISTERED
BY INSURERS:**

<<insert details>>

ENDORSEMENTS (IF ANY):

<<insert details of any variations from the pre-printed form>>

CONTRACT DEFINITIONS

The terms used in this Contract shall have the following meanings or as they are defined elsewhere. To the extent that any terms are differently defined here and in any section hereof the definition to be adopted is that which the context so requires:

ACCIDENT

the term Accident wherever used in this Contract means any sudden direct physical loss of or physical damage to the Property Insured by this Contract which the Insured could not reasonably have foreseen and which occurs at an Insured Location at any specific time during the Period of Insurance due to any Machinery Breakdown, Explosion or Collapse not specifically excluded and which results in the Property Insured needing to be repaired or replaced.

ACCRUALS BASIS

the term Accruals Basis wherever used in this Contract means accruals basis as defined by the International Accounting Standards Board (IASB).

ACTUAL CASH VALUE

the term Actual Cash Value wherever used in this Contract means the cost to repair or replace Property Insured, on the date of loss, with material of like kind, operating capacity and quality, with proper deduction for obsolescence, age and physical depreciation.

AVAILABILITY PAYMENTS

the term Availability Payments wherever used in this Contract means those payments that would have accrued during the Indemnity Period if the direct physical loss of or physical damage to the Property Insured by a Peril not excluded by this Contract had not occurred, and which would have been receivable by the Insured under the Power Purchase Agreement and identified as Availability Payments within the Power Purchase Agreement.

For those payments that are receivable by the Insured on a rolling availability basis, all loss of Gross Earnings attributable wholly to interruption of business on a single day shall, for the purpose of applying the Indemnity Period and Deductible, be deemed to have been lost on that day notwithstanding that under the terms of the rolling availability agreement the cash may be payable at a later date.

AVERAGE DAILY VALUE

the term Average Daily Value wherever used in this Contract means the average daily value for the affected power unit calculated in accordance with the Revenue Profile provided by the Insured at inception.

CAPACITY AND/OR BONUS PAYMENTS

the term Capacity and/or Bonus Payments wherever used in this Contract means excess payments that become receivable by the Insured in return for attaining (Capacity Payments) or exceeding (Bonus Payments) certain production levels required in a Power Purchase Agreement between the Insured and the Offtaker.

These excess payments represent the amount that the Offtaker would pay to the Insured in excess of the then avoided cost of power purchase rates made under the terms of the Power Purchase Agreement.

COLLAPSE

the term Collapse as specified under the Accident Definition means the sudden and dangerous distortion of any part of a boiler or pressure vessel caused by the crushing stress of external steam or fluid pressure, whether attended by rupture or not; it shall not mean any slowly developing deformation due to any cause.

CONSTRUCTION

the term Construction wherever used in this Contract means incidental construction or erection of buildings or machinery, other than hot testing or commissioning, with an estimated contract value not exceeding that specified in the Risk Details.

DEDUCTIBLE

the term Deductible wherever used in this Contract means the amount specified in the Risk Details. The Insurers will be liable only if the Insured sustains a loss in a single Occurrence greater than the applicable Deductible specified in the Risk Details, and only for its share of that greater amount.

EARTH MOVEMENT

the term Earth Movement wherever used in this Contract means any natural or man-made earth movement including, but not limited to earthquake, seaquake, volcanic eruption, landslide or subsidence and any ensuing tsunami, regardless of any other cause or event contributing concurrently or in any other sequence of loss. Earthquake means a shaking or trembling of the earth that is tectonic in origin.

However, direct physical loss or physical damage by fire, explosion, or sprinkler leakage resulting from Earth Movement will not be considered to be loss by Earth Movement within the terms and conditions of this Contract.

EXPLOSION

the term Explosion as specified under the Accident Definition means the sudden and violent rending or tearing apart or rupture of the structure of a boiler or pressure vessel; or any part or parts thereof, by force of internal steam, air or fluid pressure, causing bodily displacement of said structure or part thereof accompanied by the forcible ejection of its contents, or part thereof.

Explosion in this sense shall not mean any damage to the structure of a boiler or pressure vessel by force of the combustion or explosion of ignited furnace or flue gases.

FINE ARTS

the term Fine Arts wherever used in this Contract means paintings; etchings; pictures; tapestries; rare or art glass; art glass windows; valuable rugs; statuary; sculptures; antique furniture; antique jewellery; bric-a-brac; porcelains; and similar property of rarity, historical value, or artistic merit, but does not include automobiles, coins, stamps, furs, jewellery, precious stones, precious metals, watercraft, aircraft, money and securities.

FLOOD

the term Flood wherever used in this Contract means flood; rising waters; waves; tide or tidal water; the release of water, the rising, overflowing or breaking of boundaries of natural or man-made bodies of

water; or the spray therefrom, surface waters or sewer back-up resulting from any of the foregoing; regardless of any other cause or event contributing concurrently or in any other sequence of loss. However direct physical loss or physical damage by:

- 1 fire, explosion or sprinkler leakage resulting from Flood;
- 2 Storm Surge;

is not considered to be loss by Flood within the terms and conditions of this Contract.

HAZARDOUS SUBSTANCES OR CONTAMINANTS

the term Hazardous Substances or Contaminants wherever used in this Contract means any solid, liquid, gaseous, or thermal irritant, contaminant, or pollutant, which includes, but is not limited to, smoke, soot, vapour, fumes, acids, alkalis, chemicals, and waste. Waste includes materials to be reconditioned, recycled, or reclaimed.

INSURED LOCATION

the term Insured Location wherever used in this Contract means:

- 1 that listed on a Schedule of Insured Locations on file with the Insurers during the Period of Insurance.
- 2 that which is covered as a Miscellaneous Unnamed Location. However, a Miscellaneous Unnamed Location will not include tracks, trestles, bridges, tunnels; transmission and distribution lines including wire, cables, poles, pylons, standards, towers, or other supporting structures which may be attendant therewith; pipes; wind turbine units and any apparatus or equipment attendant therewith.

If not so specified or if a Miscellaneous Unnamed Location, a building, yard, dock, wharf, pier or bulkhead (or any group of the foregoing) bounded on all sides by public streets, clear land space or open waterways, each not less than fifty (50) feet wide. For the purpose of this provision any bridge or tunnel crossing such street, space or waterway will render such separation inoperative.

- 3 that covered under the terms and conditions of the Automatic Coverage or Errors and Omissions Extensions.

LIMIT OF LIABILITY

the term Limit of Liability wherever used in this Contract means the Insurers' maximum liability in a single Occurrence regardless of the number of Insured Locations or coverages involved. However, when a Sub-Limit of Liability for an Insured Location or other specified property or coverage is specified in the Risk Details, such Sub-Limit of Liability will be the maximum amount payable for any Property Damage or Business Interruption loss at such Insured Location or involving such other specified property or such coverage.

MACHINERY BREAKDOWN

the term Machinery Breakdown as specified under the Accident Definition means the actual breaking or burning out of any component of the Property Insured by this Contract, as a direct result of its own internal electronic, electrical or mechanical defect, defective or faulty materials or workmanship causing stoppage of Normal operation and necessitating repair or replacement before Normal operation can be resumed.

MAXIMUM INDEMNITY PERIOD

the term Maximum Indemnity Period wherever used in this Contract shall be the applicable Maximum Indemnity Period as specified in the Risk Details.

MONTHLY CAP

the term Monthly Cap wherever used in this Contract means the Schedule of Monthly Caps declared to and agreed by Insurers at inception for the relevant power generating Insured Location.

NAMED WINDSTORM

The term Named Windstorm wherever used in this Contract means a Windstorm that has been identified and named by the National Oceanic and Atmospheric Administration's National Hurricane Center or any similar weather organization.

NORMAL

the term Normal wherever used in this Contract means the condition that would have existed had no direct physical loss of or physical damage to the Property Insured by a Peril not excluded by this Contract occurred.

OCCURRENCE

the term Occurrence wherever used in this Contract means the sum of all individual losses or series of individual losses resulting from or arising out of and directly occasioned by any one insured event regardless of the number of Insured Locations affected.

Reference to Machinery Breakdown, Explosion or Collapse wherever used in this Contract means that form of an Occurrence which is an Accident.

In respect of the following perils Occurrence shall be limited to:

- 1 72 consecutive hours as regards a Windstorm;
- 2 72 consecutive hours as regards Earth Movement;
- 3 72 consecutive hours and within the limits of one city, town or village as regards riots, strikes, civil commotions and malicious damage;
- 4 72 consecutive hours as regards any Occurrence which includes individual loss or losses from any of the causes mentioned in 1, 2 and 3 above;

and no individual loss from whatever insured cause, which occurs outside these periods or areas, shall be included in that Occurrence.

The Insured may choose the date and time when any such period of consecutive hours commences and if any event is of greater duration than the above period, the Insured may divide that event into two or more Occurrences provided no two periods overlap and provided no period commences earlier than the date and time of the happening of the first recorded individual loss to the Insured in that event during the Period of Insurance.

In respect of Flood, Occurrence means all losses, wherever occurring, which arise between the time of movement of water into, onto, or over the Property Insured and the receding of the same, regardless of the period of time so embraced; except, no Occurrence shall be deemed to commence earlier than the date and time of the happening of the first recorded individual loss to the Insured in that occurrence during the Period of Insurance, nor to extend to beyond thirty (30) days after the expiry of this Contract.

OFFTAKER

the term Offtaker wherever used in this Contract means any customer who purchases electricity from the Insured.

ORDINARY PAYROLL

the term Ordinary Payroll wherever used in this Contract means the entire payroll expense for all employees of the Insured except officers, executives, department managers, qualified engineers and employees under contract.

PROFITABLE OUTPUT

the term Profitable Output wherever used in this Contract means the difference between the selling price of power and the purchase price of fuel, together with the Insured's usual profit margin and criteria that would be sufficient to make it economic to generate power for sale on the Spot Market.

REMAINING USEFUL LIFE

the term Remaining Useful Life wherever used in this Contract means the Normal useful life of the material in months minus the number of months that the material had been in use at the date of loss divided by the Normal useful life of the material in months.

SPOT MARKET

the term Spot Market wherever used in this Contract means a market in which the Insured would normally operate in which electrical energy could have been bought or sold on a short term basis for immediate delivery or delivery in the immediate future with immediate payment.

SPOT PRICE

the term Spot Price wherever used in this Contract means the applicable price on the Spot Market listing.

STORM SURGE

the term Storm Surge wherever used in this Contract means water driven inland from coastal water by high winds or low atmospheric pressure or both.

TAKE OR PAY CONTRACT

the term Take or Pay Contract wherever used in this Contract shall mean the agreement between a buyer and a seller in which the buyer will become contractually bound to pay an agreed amount even if the product or service is not provided.

VALUABLE PAPERS AND RECORDS

the term Valuable Papers and Records wherever used in this Contract means written, printed or otherwise inscribed documents and records, including books, maps, films, drawings, abstracts, deeds, mortgages and manuscripts, all of which must be of value to the Insured.

WINDSTORM

The term Windstorm wherever used in this Contract means:

1. the force or direct action of wind;
2. direct physical loss or physical damage caused by any material, object or debris that is carried, propelled or in any manner moved by wind;

and the term Windstorm shall include:

- i. Storm Surge that is concomitant with a Windstorm;
- ii. tornado;
- iii. hail that is as a result of the actions or effects of a Windstorm;
- iv. rain or water, whether the rain or water is driven by wind or not, that enters into the Property Insured through an opening created by the force or direct action of the wind.

SECTION 1 - PROPERTY DAMAGE

In consideration of the payment of premium specified in the Risk Details and subject to the terms, conditions and exclusions of this Contract, the Insurers agree to cover against risks of direct physical loss of or physical damage to the Property Insured by a Peril not excluded by this Contract occurring during the Period of Insurance.

BASIS OF SETTLEMENT

Adjustment of the physical loss amount under this Contract will be computed as of the date of loss at the location of the loss, and for no more than the interest of the Insured, subject to the following:

- A On stock in process, the value of raw materials and labour expended plus the proper proportion of overhead charges.
- B On finished goods manufactured by the Insured, the regular cash selling price at the Insured Location where the loss happens, less all discounts and charges to which the finished goods would have been subject had no loss happened.
- C On raw materials, supplies and other merchandise not manufactured by the Insured:
 - 1 if repaired or replaced, the actual expenditure incurred in repairing or replacing the property which has sustained direct physical loss or physical damage; or
 - 2 if not repaired or replaced, the Actual Cash Value.
- D On exposed films, records, manuscripts and drawings, that are not Valuable Papers and Records, the value blank plus the cost of copying information from back-up or from originals of a previous generation. These costs will not include research, engineering or any costs of restoring or recreating lost information.
- E On property covered under Deferred Payments, the lesser of the:
 - 1 total amount of unpaid instalments less finance charges;
 - 2 Actual Cash Value of the property on the date of loss; or
 - 3 cost to repair or replace with material of like size, kind and quality.
- F On Fine Arts articles, the lesser of:
 - 1 the reasonable and necessary cost to repair or restore such property to the physical condition that existed immediately prior to the loss;
 - 2 cost to replace the article; or
 - 3 the value, if any, stated on a schedule on file with the Insurers.

In the event a Fine Arts article is part of a pair or set, and the article which has sustained direct physical loss or physical damage cannot be replaced, or repaired or restored to the condition that existed immediately prior to the loss, the Insurers will be liable for the lesser of the full value of such pair or set or the amount specified in the Risk Details. The Insured agrees to surrender the pair or set to the Insurers.
- G On Valuable Papers and Records, the lesser of the:
 - 1 cost to repair or restore the item to the physical condition that existed immediately prior to the loss;
 - 2 cost to replace the item; or
 - 3 amount designated for the item on a schedule on file with the Insurers.

- H On property in transit:
- 1 property shipped to or for the account of the Insured will be valued at actual invoice to the Insured. Included in the value are accrued costs and charges legally due. Charges may include the Insured's commission as selling agent.
 - 2 property sold by the Insured and shipped to or for the purchaser's account will be valued at the Insured's selling invoice amount. Prepaid or advanced freight costs are included.
 - 3 property not under invoice will be valued:
 - (i) for property of the Insured, at the applicable provisions incorporated under the Basis of Settlement of this Contract applying at the location from which the property is being transported; or
 - (ii) for other property, at the actual cash market value at the destination point on the date of Occurrence,less any charges saved which would have become due and payable upon arrival at destination.
- I On catalyst or refractory material, the Actual Cash Value of the material which equals the replacement cost at the date of loss multiplied by the Remaining Useful Life for such material.
- J On machinery, equipment, plant or apparatus used in the generation of power the loss amount will not exceed the lesser of the following:
- 1 all with due diligence and dispatch
 - (i) the cost to repair;
 - (ii) the cost to rebuild or replace on the same site with new materials of like size, operating capacity, kind and quality; or
 - (iii) in respect of such property with an age of fifteen (15) years or more, the Actual Cash Value of said property which equals the replacement cost at the date of loss multiplied by the Remaining Useful Life for the particular machinery, equipment, plant or apparatus involved.
- K On all other property, the loss amount will not exceed the lesser of the following:
- 1 all with due diligence and dispatch
 - (i) the cost to repair;
 - (ii) the cost to rebuild or replace on the same site with new materials of like size, operating capacity, kind and quality;
 - (iii) the cost in rebuilding, repairing or replacing on the same or another site, but not to exceed the size and operating capacity that existed on the date of loss; or
 - (iv) the cost to replace unrepairable electrical or mechanical equipment, including computer equipment, with equipment that is the most functionally equivalent to that which has sustained direct physical loss or physical damage, even if such equipment has technological advantages and/or represents an improvement in function and/or forms part of a program of system enhancement.
 - 2 the selling price of Real Property, other than stock, offered for sale on the date of loss;
 - 3 the increased cost of demolition, if any, resulting from loss covered by this Contract, if such property is scheduled for demolition;
 - 4 the unamortized value of improvements and betterments, if such property is not repaired or replaced at the Insured's expense;
 - 5 the Actual Cash Value if such property is:

- (i) useless to the Insured; or
- (ii) not repaired, replaced or rebuilt on the same or another site within two (2) years from the date of loss.

The Insured may elect not to repair or replace the insured Real and/or Personal Property which has sustained direct physical loss or physical damage. Loss settlement may be elected on the lesser of repair or replacement cost basis if the proceeds of such loss settlement are expended on other capital expenditures related to the Insured's operations within two (2) years from the date of loss. As a condition of indemnity under this item, such expenditure must be unplanned as of the date of loss and be made at an Insured Location under this Contract. This item does not extend to Demolition and Increased Cost of Construction.

PROPERTY INSURED

This Contract insures the following property, unless otherwise excluded elsewhere in this Contract, located at an Insured Location or within one thousand (1,000) feet thereof:

A Real Property, including new buildings and additions under Construction at an Insured Location, in which the Insured has an insurable interest;

B Personal Property:

- 1 owned by the Insured, including the Insured's interest as a tenant in improvements and betterments. In the event of direct physical loss of or physical damage to the Property Insured by a Peril not excluded by this Contract, the Insurers agree to accept and consider the Insured as sole and unconditional owner of improvements and betterments, notwithstanding any contract or lease to the contrary;
- 2 of officers and employees of the Insured;
- 3 of others in the Insured's custody to the extent the Insured is under obligation to keep insured for direct physical loss or physical damage insured by this Contract;
- 4 of others in the Insured's custody to the extent of the Insured's legal liability for direct physical loss or physical damage insured by this Contract. The Insurers will defend that portion of any suit against the Insured that alleges such liability and seeks damages for such direct physical loss or physical damage. The Insurers may, without prejudice, investigate, negotiate and settle any claim or suit as the Insurers deem expedient.

This Contract also insures the interest of contractors and subcontractors in Property Insured during Construction at an Insured Location or within one thousand (1,000) feet thereof, to the extent of the Insured's legal liability for direct physical loss or physical damage to such property. Such interest of contractors and subcontractors is limited to the property for which they have been hired to perform work and such interest will not extend to any Business Interruption coverage provided under this Contract.

PROPERTY EXCLUDED

In addition to the Exclusions elsewhere in this Contract, the following Exclusions apply to this Section:

This Section does not insure:

- A currency, money, precious metal in bullion form, notes, or securities;
- B land, water or any other substance in or on land; except this Exclusion does not apply to:
 - 1 land improvements consisting of landscape gardening, roadways and pavements, but not including any fill or land beneath such property;
 - 2 water that is contained within any enclosed tank, piping system or any other processing equipment;subject to the value of such property being included in the values declared;
- C railway locomotives or rolling stock other than at the Insured Location. However direct physical loss or physical damage to this property caused by Accident is excluded absolutely;
- D animals, standing timber, growing crops;
- E watercraft, aircraft, spacecraft and satellites;
- F vehicles of officers and employees of the Insured or vehicles insured elsewhere for loss or damage;
- G pipelines; open pit or surface mines; underground mines or mine shafts or any property within such mine or shaft; wells or caverns or any property within such well or cavern;
- H dikes, levees;
- I offshore property, except that structures and their contents extending from land or shore, and floating docks permanently moored to a dock, river bank or shore, are not deemed to be offshore. However docks, piers or wharves and property located thereon, shall be insured unless loss is due to ice water pressure or collision;
- J dams, watershafts, power tunnels, gates, and flumes, except this Exclusion does not apply in respect of specified hydroelectric generating stations incorporated in the Schedule of Insured Locations on file with the Insurers;
- K property in transit, except as otherwise specified in this Contract;
- L property sold by the Insured under conditional sale, trust agreement, instalment plan or other deferred payment plan after delivery to customers, other than as provided for by the Deferred Payments coverage of this Contract;
- M transmission and distribution lines including wire, cables, poles, pylons, standards, towers, or other supporting structures which may be attendant therewith except where situated on or within one thousand (1,000) feet of any power generating Insured Location;
- N nuclear reactor power generating plants, including all auxiliary property on the site, or any other nuclear reactor installation; nuclear fuel or raw materials used in the nuclear fuel process at any point in the fuel cycle;
- O in respect of an Accident:
 - 1 any such direct physical loss or physical damage to exchangeable tools (such as dies, moulds, and engraved cylinders); to parts which by their use and/or nature suffer a high rate of wear or depreciation (such as refractory linings, crushing hammers, objects made of glass, belts, ropes, wires, and rubber tyres); to operating media (such as lubricants, fuels or catalysts). However, this Exclusion applies only to the part itself, not to any ensuing direct physical loss or physical damage not otherwise excluded by this Contract;

- 2 any such direct physical loss or physical damage prior to the successful completion of performance/commissioning tests, or hand-over to the Insured, whichever occurs earlier;
- 3 any such direct physical loss or physical damage only discovered during planned maintenance as part of the recommendations of the suppliers or manufacturers of the Property Insured. Such maintenance shall include safety checks, preventative maintenance, rectification of direct physical loss or physical damage or faults arising from Normal operation, or wear and tear, as well as ageing, and shall also include the repair or replacement of components, modules or parts.

EXTENSIONS TO SECTION 1 - PROPERTY DAMAGE

Provided that these Extensions for direct physical loss or physical damage insured by this Contract:

- 1 are subject to the applicable Limit or Sub-Limit of Liability;
- 2 will not increase the Contract Limit of Liability; and
- 3 are subject to the terms, conditions and exclusions of this Contract;

as shown in this Section and elsewhere in this Contract, this Contract extends to include:

A ACCOUNTS RECEIVABLE

- 1 all sums due to the Insured from customers, provided the Insured is unable to effect collection thereof as the direct result of direct physical loss or physical damage by a Peril not excluded by this Contract to records of accounts receivable during the Period of Insurance;
- 2 interest charges on any loan to offset impaired collections pending repayment of such sums made uncollectible by such direct physical loss or physical damage;
- 3 collection expense in excess of Normal collection cost and made necessary because of such direct physical loss or physical damage;
- 4 other expenses, when reasonably incurred by the Insured in re-establishing records of accounts receivable following such direct physical loss or physical damage.

For the purpose of this Extension, credit card company charge media shall be deemed to represent sums due to the Insured from customers, until such charge media is delivered to the credit card company.

Provided that:

When there is proof that a loss covered by this Extension has occurred but the Insured cannot accurately establish the total amount of accounts receivable outstanding as of the date of such loss, such amount shall be based on the Insured's monthly statements and shall be computed as follows:-

- 1 determine the amount of all outstanding accounts receivable at the end of the same fiscal month in the year immediately preceding the year in which the loss occurs;
- 2 calculate the percentage of increase or decrease in the average monthly total of accounts receivable for the twelve (12) months immediately preceding the month in which the loss occurs, as compared with such average for the same months of the preceding year;
- 3 the amount determined under 1 immediately above, increased or decreased by the percentage calculated under 2 immediately above, shall be the agreed total amount of accounts receivable as of the last day of the fiscal month in which said loss occurs;
- 4 the amount determined under 3 immediately above shall be increased or decreased in conformity with the Normal fluctuations in the amount of accounts receivable during the fiscal month involved, due consideration being given to the experience of the business since the last day of the last fiscal month.

There shall be deducted from the total amount of accounts receivable, however established, the amount of such accounts evidenced by records which have not sustained direct physical loss or physical damage, or otherwise established or collected by the Insured, and an amount to allow for probable bad debts which would normally have been uncollectible by the Insured. All unearned interest and service charges shall be deducted.

Excluding:

- 1 loss due to bookkeeping, accounting or billing errors or omissions;
- 2 loss, the proof of which as to factual existence, is dependent upon an audit of records or an inventory computation: but this shall not preclude the use of such procedures in support of

claim for loss which the Insured can prove, through evidence wholly apart therefrom, is due solely to such direct physical loss or physical damage to records of accounts receivable;

- 3 loss due to alteration, falsification, manipulation, concealment, destruction or disposal of records of accounts receivable committed to conceal the wrongful giving, taking, obtaining or withholding of money, securities or other property but only to the extent of such wrongful giving, taking, obtaining or withholding.

B AUTOMATIC COVERAGE

property of the type insured by this Contract at any location rented, leased or purchased by the Insured after the inception date of this Contract. This coverage applies from the date of rental, lease or purchase.

This coverage will apply until whichever of the following occurs first:

- 1 the Insured Location is agreed to be insured by the Insurers;
- 2 agreement is reached that the location will not be insured under this Contract; or
- 3 the Limit of Liability specified as a number of days in the Risk Details has been reached. The Limit of Liability begins on the date of rental, lease or purchase.

Excluding property insured in whole or in part by any other insurance policy.

C DEBRIS REMOVAL

the reasonable and necessary costs incurred to remove debris from an Insured Location that remains as a result of direct physical loss of or physical damage to the Property Insured by a Peril not excluded by this Contract.

Excluding the costs of removal of:

- 1 contaminated uninsured property; or
- 2 the contaminant in or on uninsured property;

whether or not the contamination results from such direct physical loss or physical damage. Contamination includes, but is not limited to, the presence of Hazardous Substances or Contaminants.

D DEFERRED PAYMENTS

Direct physical loss or physical damage by a Peril not excluded by this Contract to Personal Property of the type insured by this Contract sold by the Insured under a conditional sale or trust agreement or any instalment or deferred payment plan and after such property has been delivered to the buyer.

In the event of such loss to property sold under deferred payment plans, the Insured will use all reasonable efforts, including legal action, if necessary, to effect collection of outstanding amounts due or to regain possession of the property.

Excluding loss:

- 1 pertaining to products recalled including, but not limited to, the costs to recall, test or to advertise such recall by the Insured;
- 2 from theft or conversion by the buyer of the property after the buyer has taken possession of such property;
- 3 to the extent the buyer continues payments;
- 4 arising from such direct physical loss or physical damage to such property occurring outside the Territorial Limits.

E DEMOLITION AND INCREASED COST OF CONSTRUCTION

- 1 the reasonable and necessary costs incurred to satisfy the minimum requirements of the enforcement of any law or ordinance regulating the demolition, construction, repair, replacement or use of buildings or structures at an Insured Location,

provided that:

- (i) such law or ordinance is in force on the date of direct physical loss of or physical damage to the Property Insured by a Peril not excluded by this Contract; and
 - (ii) its enforcement is a direct result of such direct physical loss or physical damage;
- 2
 - (i) the cost to repair or rebuild the portion of such property which has sustained Damage with materials and in a manner to satisfy such law or ordinance; and
 - (ii) the cost:
 - a) to demolish the undamaged portion of such Property Insured; and
 - b) to rebuild it with materials and in a manner to satisfy such law or ordinance;

to the extent that such costs result when the demolition of the Property Insured which has sustained such direct physical loss or physical damage is required to satisfy such law or ordinance;

The Insurers' maximum liability for this Extension at each Insured Location in any Occurrence will not exceed the actual cost incurred in demolishing the undamaged portion of the Property Insured in item 1 above plus the lesser of:

- 1 the reasonable and necessary actual cost incurred, excluding the cost of land, in rebuilding on another site; or
- 2 the cost of rebuilding on the same site.

Excluding:

- 1 loss due to any law or ordinance with which the Insured was required to comply had the loss not occurred;
- 2 any costs incurred as a direct or indirect result of enforcement of any laws or ordinances regulating any form of contamination including but not limited to the presence of Hazardous Substances or Contaminants.

F ERRORS AND OMISSIONS

Direct physical loss of or physical damage to the Property Insured by a Peril not excluded by this Contract, to the extent that it would have been included in the coverage had an error or unintentional omission not been made if such direct physical loss or physical damage is not payable under this Contract solely due to an error or unintentional omission:

- 1 in the description of where Property Insured is physically located;
- 2 to include any location:
 - (i) owned, rented or leased by the Insured on the effective date of this Contract; or
 - (ii) rented, leased or purchased by the Insured during the Period of Insurance ;
- 3 that results in deletion of the Property Insured under this Contract.

It is a condition precedent to operation of this Extension that upon discovery of any error or unintentional omission, such error or unintentional omission when discovered shall be reported as soon as practicable by the Insured to the Insurers and corrected.

G EXPEDITING COSTS

the reasonable and necessary costs incurred to pay for the temporary repair of Property Insured which has sustained direct physical loss or physical damage by a Peril not excluded by this Contract and to expedite the permanent repair or replacement of such damaged Property Insured.

Excluding costs:

- 1 recoverable elsewhere in this Contract;
- 2 of permanent repair or replacement of Property Insured which has sustained such direct physical loss or physical damage.

H FINE ARTS

Direct physical loss or physical damage by a Peril not excluded by this Contract to Fine Arts articles while anywhere within the Territorial Limits, including while in transit.

Excluding:

- 1 such direct physical loss or physical damage if the Fine Arts cannot be replaced with other of like kind and quality, unless it is specifically declared to the Insurers;
- 2 such direct physical loss or physical damage from any repairing, restoration or retouching process.

I FIRE BRIGADE CHARGES AND EXTINGUISHING EXPENSES

the reasonable and necessary:

- 1 fire department fire fighting charges imposed as a result of responding to a fire in, on, or exposing the Property Insured;
- 2 costs incurred of restoring and recharging fire protection systems following an insured loss;
- 3 costs incurred for the water used for fighting a fire in, on or exposing the Property Insured.

J HAZARDOUS SUBSTANCES OR CONTAMINANTS

the additional expenses incurred for cleanup, repair or replacement, or dispersal of damaged, contaminated or polluted property, if, as a result of direct physical loss of or physical damage to the Property Insured by a Peril not excluded by this Contract, such Property Insured at an Insured Location is damaged, contaminated or polluted by Hazardous Substances or Contaminants. Additional expenses means expenses incurred beyond those for which the Insurers would have been liable if no Hazardous Substances or Contaminants had been involved in the Occurrence of such direct physical loss or physical damage.

K LAND AND WATER CONTAMINANT OR POLLUTANT CLEANUP, REMOVAL AND DISPOSAL

the reasonable and necessary cost for the cleanup, removal and disposal of contaminants or pollutants from uninsured property consisting of land, water or any other substance in or on land at the Insured Location if the release, discharge or dispersal of contaminants or pollutants is a result of direct physical loss of or physical damage to the Property Insured by a Peril not excluded by this Contract occurring during the Period of Insurance.

Excluding the cost to cleanup, remove and dispose of contaminants or pollutants from such property:

- 1 at any Insured Location for Personal Property only;
- 2 at any Property Insured under any Automatic Coverage, Errors and Omissions or Miscellaneous Unnamed Location or similar coverage as may be provided by this Contract;
- 3 when the Insured fails to give written notice of loss to the Insurers within one hundred and eighty (180) days of the date of such direct physical loss or physical damage.

L LEASEHOLD INTEREST

Leasehold Interest incurred by the Insured of the following:

- 1 if the lease agreement requires continuation of rent; and if the property is wholly untenable or unusable, the actual rent payable for the unexpired term of the lease; or if the property is partially untenable or unusable, the proportion of the rent payable for the unexpired term of the lease;
- 2 if the lease is cancelled by the lessor pursuant to the lease agreement or by the operation of law; the Lease Interest (as defined under item 2(i) below) for the first three (3) months following the loss; and the Net Lease Interest (as defined under item 2(ii) below) for the remaining unexpired term of the lease.

For the purposes of this Extension, the following term(s) means:

(i) Lease Interest:

the excess rent paid for the same or similar replacement property over actual rent payable plus cash bonuses or advance rent paid (including maintenance or operating charges) for each month during the unexpired term of the Insured's lease.

(ii) Net Lease Interest:

that sum which placed at 6% interest rate compounded annually would equal the Lease Interest (less any amounts otherwise payable to the Insured).

Excluding:

- 1 any increase in loss resulting from the suspension, lapse or cancellation of any license, or from the Insured exercising an option to cancel the lease; or from any act or omission of the Insured that constitutes a default under the lease.
- 2 the Insured's loss of Leasehold Interest directly resulting from loss or damage to Personal Property.

M PROFESSIONAL FEES (CLAIMS PREPARATION COSTS)

the actual costs incurred by the Insured, of reasonable fees payable to the Insured's accountants, architects, auditors, engineers, or other professionals and the cost of using the Insured's employees, for producing and certifying any particulars or details contained in the Insured's books or documents, or such other proofs, information or evidence required by the Insurers resulting from an insured loss payable under this Contract for which the Insurers have accepted liability.

Excluding the fees and costs of attorneys, public adjusters, and loss appraisers, all including any of their subsidiary, related or associated entities either partially or wholly owned by them or retained by them for the purpose of assisting them, nor the fees and costs of loss consultants who provide consultation on coverage or negotiate claims.

N PROTECTION AND PRESERVATION OF PROPERTY

the expenses incurred by the Insured in taking reasonable and necessary actions for the temporary protection and preservation of Property Insured hereunder, in case of actual or imminent direct physical

loss or physical damage of the type insured against by this Contract, which expenses shall be added to the direct physical loss or physical damage otherwise recoverable, if any, under the Contract and be subject to the applicable Deductible without increase in the limit provisions contained in this Contract.

The expenses so incurred shall be borne by the Insured and Insurers proportionally to the extent of their respective interests. The Insurers' portion of such expenses shall be limited to the extent that such expenses reduce loss which would otherwise be payable under this Contract.

O SERVICE INTERRUPTION

Direct physical loss of or physical damage by a Peril not excluded by this Contract to Property Insured at an Insured Location when such direct physical loss or physical damage results from the interruption of the specified incoming services consisting of electricity, gas, fuel, steam, water, refrigeration or from the lack of outgoing sewerage service by reason of direct physical loss or physical damage of the type insured by this Contract to property of the type insured by this Contract of the supplier of such service located within the Territorial Limits that immediately prevents in whole or in part the delivery of such usable service.

Provided that the Insured immediately notifies the suppliers of services of any interruption of such services.

Excluding the interruption of such services if caused directly or indirectly by:

- 1 the failure of the Insured to comply with the terms and conditions of any contracts the Insured has for the supply of such specified services;
- 2 loss or damage to incoming overhead transmission lines located beyond one (1) mile from the affected Insured Location.

P TEMPORARY REMOVAL OF PROPERTY (OFFSITE STORAGE)

Property Insured when removed from an Insured Location for the purpose of being repaired or serviced or in order to avoid threatened direct physical loss or physical damage by a Peril not excluded by this Contract.

Such Property Insured is covered:

- 1 while at the location to which it has been moved; and
- 2 for direct physical loss or physical damage as provided at the Insured Location from which it was removed.

This Extension does not apply to Property Insured:

- 1 covered, in whole or in part, elsewhere in this Contract;
- 2 covered, in whole or in part, by any other insurance policy;
- 3 removed for Normal storage, processing or preparation for sale or delivery.

Q TRANSPORTATION

the following Personal Property, except as excluded by this Contract, while in transit within the Territorial Limits of this Contract:

- 1 owned by the Insured;
- 2 shipped to customers under free on board, cost and freight or similar terms. The Insured's contingent interest in such shipments is admitted;
- 3 of others in the actual or constructive custody of the Insured to the extent of the Insured's interest or legal liability;

- 4 of others sold by the Insured, that the Insured has agreed prior to the loss to insure during course of delivery;

during the period from the time the property leaves the original point of shipment for transit.

This Extension provides cover continuously in the due course of transit:

- 1 within the continent in which the shipment commences until the property arrives at the destination within such continent; or
- 2 between Europe and Asia, for land or air shipments only, from when the shipment commences until the property arrives at the destination.

However, coverage on

- (i) export shipments not insured under ocean cargo policies ends when the property is loaded on board overseas vessels or aircraft;
- (ii) import shipments not insured under ocean cargo policies begins after discharge from overseas vessels or aircraft.

Including:

- 1 general average and salvage charges on shipments covered while waterborne.
- 2 physical loss or damage caused by or resulting from:
 - (i) unintentional acceptance of fraudulent bills of lading, shipping or messenger receipts;
 - (ii) improper parties having gained possession of property through fraud or deceit.

Provided that:

- 1 this Extension will not inure directly or indirectly to the benefit of any carrier or bailee;
- 2 the Insured has permission, without prejudicing this insurance, to accept:
 - (i) ordinary bills of lading used by carriers;
 - (ii) released bills of lading;
 - (iii) undervalued bills of lading; and
 - (iv) shipping or messenger receipts;
- 3 the Insured may waive subrogation against railroads under side track agreements;
- 4 except as otherwise stated, the Insured will not enter into any special agreement with carriers releasing them from their common law or statutory liability.

Excluding:

- 1 samples in the custody of salespeople or selling agents;
- 2 Property Insured under import or export ocean marine insurance;
- 3 waterborne shipments, unless:
 - (i) by inland water;
 - (ii) by roll-on/roll-off ferries operating between European ports; or
 - (iii) by coastal shipments;
- 4 airborne shipments unless by regularly scheduled passenger airlines or air freight carriers;
- 5 property of others, including the Insured's legal liability for it, hauled on vehicles owned, leased or operated by the Insured when acting as a common or contract carrier;
- 6 any transporting vehicle;
- 7 property shipped between continents, except by land or air between Europe and Asia.

R VALUABLE PAPERS AND RECORDS

Direct physical loss of or physical damage by a Peril not excluded by this Contract to Valuable Papers and Records while anywhere within the Territorial Limits, including while in transit.

Excluding:

- 1 loss or damage to:
 - (i) currency, money or securities;
 - (ii) property held as samples or for sale or for delivery after sale;
 - (iii) Valuable Papers and Records, if such Valuable Papers and Records cannot be replaced with other of like kind and quality, unless specifically declared to the Insurers;
- 2 errors or omissions in processing or copying unless direct physical loss or physical damage by a Peril not excluded by this Contract results, in which event, only such resulting direct physical loss or physical damage is insured.

EXCLUSIONS TO SECTION 1 - PROPERTY DAMAGE

In addition to the Exclusions elsewhere in this Contract, the following Exclusions apply to this Section:

This Section does not insure:

- A**
- 1 indirect or remote loss or damage;
 - 2 interruption of business;
 - 3 loss of market or loss of use;
 - 4 damage or deterioration arising from any delay;
 - 5 mysterious disappearance, loss or shortage disclosed on taking inventory, or any unexplained loss;
 - 6 loss from enforcement of any law or ordinance:
 - (i) regulating the Construction, repair, replacement, use or removal, including debris removal, of any property; or
 - (ii) requiring the demolition of any property, including the cost in removing its debris;except as specified in the Demolition and Increased Cost of Construction Extension of this Section of this Contract;
 - 7 the cost of removing any product subject to a product recall, whether the removal is voluntarily undertaken by the Insured or mandated by any executive, legislative, administrative or judicial order, and any Business Interruption losses resulting from such removal;
 - 8 in respect of an Accident, any losses arising, directly or indirectly, out of loss of, alteration of, derangement of, or damage to, or a reduction in the functionality, availability or operation of a computer system, hardware, microchip, integrated circuit or similar device in computer or non-computer equipment, unless directly caused by an Accident.
- B** any defect or fault in material, workmanship, specification or design or in planning, zoning, surveying, siting, or developing property. However, if such a defect or fault results in direct physical loss or physical damage by a peril not excluded by this Contract to other property otherwise insured by this Contract, then this Contract shall cover only such resulting direct physical loss or physical damage. The Insurers shall not be liable for the costs of rectifying or making good such defect or fault;
- C**
- 1 any dishonest act, including but not limited to theft, committed alone or in collusion with others, at any time:
 - (i) by an Insured or any proprietor, partner, director, trustee, officer, or employee of an Insured; or
 - (ii) by any proprietor, partner, director, trustee, or officer of any business or entity (other than a common carrier) engaged by an Insured to do anything in connection with Property Insured under this Contract.This Contract does insure acts of direct physical damage intentionally caused by an employee of an Insured or any individual specified in ii) above, and committed without the knowledge of the Insured. In no event does this Contract cover loss by theft by any individual specified in i) or ii) above.
 - 2 lack of the following services:
 - (i) incoming electricity, fuel, water, gas, steam, refrigerant;

- (ii) outgoing sewerage;
- (iii) incoming or outgoing voice, data or video;

all when caused by an Occurrence off the Insured Location, except as provided for in the Service Interruption Extension of the Property Damage or Business Interruption section of this Contract;

- 3 the release, discharge, or disposal of toxic or Hazardous Substances or Contaminants, all whether direct or indirect, except as specifically provided for under the Extensions to Section 1: Hazardous Substances or Contaminants Extension and Land and Water Contaminant or Pollutant Cleanup, Removal and Disposal Extension;

- D 1 loss or damage to stock or material attributable to manufacturing or processing operations while such stock or material is being processed, manufactured, tested, or otherwise worked on;

- 2 deterioration, depletion, rust, corrosion or erosion, wear and tear, inherent vice or latent defect;

- 3 settling, cracking, shrinking, bulging, or expansion of:

- (i) foundations (including any pedestal, pad, platform or other property supporting machinery, boilers, or pressure vessels);
- (ii) floors;
- (iii) pavements;
- (iv) walls;
- (v) ceilings;
- (vi) roofs;

- 4 loss or damage following:

- (i) changes of temperature (except to machinery or equipment); or
- (ii) changes in relative humidity;

all whether atmospheric or not;

- 5 loss or damage caused by insects, animals or vermin;

- 6 electrical breakdown of any electrical machine or electrical apparatus while said equipment is undergoing an insulation breakdown test;

- 7 cracking or fracturing;

but, if direct physical loss or physical damage not excluded by this Contract results to other property otherwise insured by this Contract, then only such resulting direct physical loss or physical damage is insured.

- E unless directly resulting from other direct physical loss or physical damage not excluded by this Contract:

- 1 shrinkage;
- 2 changes in colour, flavour, texture or finish.

ADDITIONAL EXCLUSIONS TO SECTION 1 - PROPERTY DAMAGE

- F The following additional exclusion shall apply if Accident (Machinery Breakdown, Explosion/Collapse) is shown not to be insured by this Contract under the Risk Details:

This Contract does not insure against loss or damage caused by, resulting from, or coincident with an Accident. However, if a cause not otherwise excluded by this Contract results, then any direct physical loss or physical damage arising directly from that cause shall not be excluded under this Contract

- G The following additional exclusion shall apply if Earth Movement is shown not to be insured by this Contract under the Risk Details.

This Contract does not insure against loss or damage caused by, resulting from, or coincident with Earth Movement. However, direct physical loss or physical damage by fire, explosion, or sprinkler leakage resulting from Earth Movement will not be considered to be direct physical loss or physical damage by Earth Movement within the terms and conditions of this Contract.

- H The following additional exclusion shall apply if Flood is shown not to be insured by this Contract under the Risk Details.

This Contract does not insure against loss or damage caused by or resulting from Flood regardless of any other event which contributes concurrently or in any sequence to such loss or damage. However, direct physical loss or physical damage by fire, explosion, or sprinkler leakage resulting from Flood will not be considered to be direct physical loss or physical damage by Flood within the terms and conditions of this Contract.

- I The following additional exclusion shall apply if Windstorm is shown not to be insured by this Contract under the Risk Details.

This Contract does not insure against loss or damage caused by, resulting from, or coincident with Windstorm. However, direct physical loss or physical damage by fire, explosion, or sprinkler leakage resulting from Windstorm will not be considered to be direct physical loss or physical damage by Windstorm within the terms and conditions of this Contract.

SECTION 2 - BUSINESS INTERRUPTION

This Contract insures Business Interruption loss, as provided for in the Business Interruption Coverages, resulting from direct physical loss of or physical damage to the Property Insured by a Peril not excluded by this Contract occurring during the Period of Insurance.

The following Business Interruption Coverages shall only apply if specified as insured in the Risk Details. The individual Business Interruption Coverages may only apply to certain Insured Locations specified in the Schedule of Locations reported to and on file with Insurers or as attached or otherwise endorsed to this Contract.

BUSINESS INTERRUPTION COVERAGES

A BUSINESS INTERRUPTION (CONTRACTED SALES)

Where power is generated and sold under a Power Purchase Agreement between the Insured and an Offtaker following direct physical loss of or physical damage to the Property Insured by a Peril not excluded by this Contract at the power generating Insured Location:

1 Gross Earnings:

- (i) the recoverable Gross Earnings loss is the actual loss of Gross Earnings sustained by the Insured of the following, that the Insured would have accounted for on an Accruals Basis during the Indemnity Period:
 - a) Gross Earnings (as defined below);
 - b) plus all other earnings derived from the operation of the business;
 - c) less all charges and expenses that do not necessarily continue during the interruption of production or suspension of business operations or services;
 - d) less any amount arising from Force Majeure and/or Relief provisions as defined under the Power Purchase Agreement.
- (ii) in determining the indemnity recoverable as the actual loss sustained, the Insurers will consider the continuation of only those Normal charges and expenses (including Ordinary Payroll for a period not to exceed the number of days as specified in the Risk Details) that would have been incurred had no interruption of production or suspension of business operations or services occurred;
- (iii) there is recovery hereunder but only to the extent that the Insured is:
 - a) wholly or partially prevented from producing electricity to comply with any Take or Pay Contract requirements agreed with an Offtaker;
 - b) unable to continue such operations or services during the Indemnity Period;
 - c) able to demonstrate a loss of sales for the operations, services or production prevented;
 - d) wholly or partially prevented from taking advantage of any Take or Pay Contract arrangements for the supply of fuel to generate electricity; and

- e) wholly or partially prevented from producing electricity under any other arrangements.

Any recovery shall be offset to the extent that losses can be recouped by resale of fuel or purchase of replacement electricity for resale from other sources.

2 Expenses to reduce the loss :

expenses reasonably and necessarily incurred by the Insured to reduce the loss otherwise payable under this section of the Contract. The amount of such recoverable expenses will not exceed the amount by which the loss has been reduced;

3 Extra Expense (Replacement Power Capacity)

the increased cost incurred by the Insured for generation, transmission, purchase, replacement, trading or distribution of electrical power, over and above the cost that would have been incurred if the necessary interruption of business had not occurred, and which the Insured is required by contract or otherwise to provide;

Provided that the total of the above (1, 2 and 3) shall not exceed 110% of the Average Daily Value or the Monthly Cap.

Definitions

The following term means:

Gross Earnings, as used in item 1 (i)a):

- (i) the actual loss sustained in respect of the total proceeds from Availability Payments, as itemized and declared to the Insurers,
 - a) less any sums saved during the Indemnity Period in respect of costs of fuel purchase necessitated to ensure adequate stockpiles of fuel;
 - b) less any sums saved in respect of planned outages;
 - c) less any sums saved in respect of Operational and Maintenance Costs;
- (ii) the actual loss sustained in respect of the total proceeds from Capacity and/or Bonus Payments as itemized and declared to the Insurers,
 - a) less the cost of all raw stock, materials and supplies used in such production;
 - b) less any sums saved in respect of planned outages;
 - c) less any sums saved in respect of Operational and Maintenance Costs;

Exclusions

The following Gross Earnings (Contracted Sales) Exclusions shall also apply:

- (i) loss of Availability and/or Capacity and/or Bonus Payments incurred by the Insured which are not a direct result of an Occurrence insured by this Contract;
- (ii) loss of Availability and/or Capacity and/or Bonus Payments, incurred by the Insured after the end of the Indemnity Period.

B BUSINESS INTERRUPTION (MERCHANT SALES)

Where power is generated and to be offered for Spot Market sale where a Profitable Output can be achieved outside of a Power Purchase Agreement following direct physical loss of or physical damage to the Property Insured by a Peril not excluded by this Contract at the Insured Location:

1 Gross Earnings:

- (i) the recoverable Gross Earnings loss is the actual loss of Gross Earnings sustained by the Insured of the following, that the Insured would have accounted for on an Accruals Basis during the Indemnity Period:
 - a) Gross Earnings (as defined below);
 - b) plus all other earnings derived from the operation of the business;
 - c) less all charges and expenses that do not necessarily continue during the interruption of production or suspension of business operations or services.
- (ii) in determining the indemnity recoverable as the actual loss sustained, the Insurers will consider the continuation of only those Normal charges and expenses (including Ordinary Payroll for a period not to exceed the number of days as specified in the Risk Details that would have been incurred had no interruption of production or suspension of business operations or services occurred.
- (iii) there is recovery hereunder but only to the extent that the Insured is:
 - a) wholly or partially prevented from producing goods or continuing business operations or services;
 - b) unable to continue such operations or services during the Indemnity Period;
 - c) able to demonstrate a loss of sales for the operations, services or production prevented; and
 - d) able to demonstrate the extent that Profitable Output could be achieved during the Indemnity Period.

2 Expenses to reduce the loss :

expenses reasonably and necessarily incurred by the Insured to reduce the loss otherwise payable under this section of the Contract. The amount of such recoverable expenses will not exceed the amount by which the loss has been reduced;

3 Extra Expense (Replacement Power Capacity)

the increased cost incurred by the Insured for generation, transmission, purchase, replacement, trading or distribution of electrical power, over and above the cost that would have been incurred if the necessary interruption of business had not occurred, and which the Insured is required by contract or otherwise to provide;

Provided that the total of the above (1, 2 and 3) shall not exceed 110% of the Average Daily Value or the Monthly Cap.

Definitions

The following term means:

Gross Earnings, as used in item 1(i) a):

the net sales value of production less the cost of all raw stock, materials and supplies used in such production.

C COMMISSIONS, PROFITS AND ROYALTIES

Where the Insured has incurred a loss of Commissions, Profits and Royalties:

- 1 Measurement of Loss:
 - (i) the recoverable Commissions, Profits and Royalties loss is the actual loss sustained by the Insured, calculated as:
 - a) Commissions, Profits and Royalties (as defined under item 3 below); less
 - b) non-continuing expenses and charges during the Indemnity Period;
 - (ii) the Commissions, Profits and Royalties payable by Insurers hereunder will be the actual loss sustained of income that the Insured would have accounted for on an Accruals Basis during the Indemnity Period, under any royalty, licensing fee or commission agreement between the Insured and another party which is not realisable due to direct physical loss or physical damage by a Peril not excluded by this Contract to property of the other party, such property being of the type insured by this Contract located within the Territorial Limits;
 - (iii) the Insured will influence, to the extent possible, said party(ies) with whom the agreements described above have been made to use any other machinery, supplies or locations in order to resume business so as to reduce the amount of loss hereunder, and the Insured will cooperate with that party in every way to effect this. This Contract does not cover any cost to effect the above unless authorised in advance by the Insurers;
 - (iv) in determining the indemnity payable hereunder, the Insurers will consider the amount of income derived from such agreements before and the probable amount of income after the date of such direct physical loss or physical damage;
 - (v) there is recovery hereunder but only if such direct physical loss or physical damage interrupts the delivery of goods in whole or in part to the Insured or for their account.
- 2 Exclusion C of the Exclusions to Section 2 does not apply.
- 3 The following term(s) means:
 - (i) Commissions:

The income that would have been received by the Insured from the sale of goods not owned by the Insured.
 - (ii) Profits:

The amount that would have been received by the Insured from the sale of goods belonging to the Insured, in excess of the cost to the Insured of such goods.
 - (iii) Royalties:

The income the Insured is not able to collect under royalty or licensing agreements.

D DEBT SERVICE CHARGES AND OPERATIONAL AND MAINTENANCE CHARGES

Where sales of power are not insured by this Contract:

- 1 Measurement of Loss:

- (i) the recoverable loss is the actual loss sustained by the Insured of the following that the Insured would have accounted for on an Accruals Basis during the Indemnity Period:
 - a) Debt Service Charges;
 - b) Operational and Maintenance Chargesless
 - a) all charges and expenses that do not necessarily continue during the interruption of production or suspension of business operations or services;
 - b) any interest commitment, to the extent included in 1(i) a) above, which is permanently waived or otherwise saved;
 - c) any interest earned on monies invested which would not have been available for investment had no direct physical loss or physical damage occurred;
- (ii) there is recovery hereunder but only to the extent that the Insured is:
 - a) wholly or partially prevented from producing goods or continuing business operations or services;
 - b) unable to continue such operations or services during the Indemnity Period; and
 - c) able to demonstrate a loss of sales for the operations, services or production prevented.

2 The following term(s) means:

(i) Debt Service Charges

the monies payable as interest by the Insured to service the continuing debt in respect of advances made under or monies borrowed applicable to the operations, services or production of the Insured.

(ii) Operational and Maintenance Charges

the fixed charges, costs and overheads that continue to be incurred by the Insured during the interruption of production or suspension of business operations or services.

E EXTRA EXPENSE (NON-GENERATION)

Where Extra Expense is incurred by the Insured other than in the generation or purchase of replacement power capacity:

1 Measurement of Loss:

the recoverable Extra Expense loss will be the reasonable and necessary extra costs incurred by the Insured of the following during the Indemnity Period:

- (i) extra expenses to temporarily continue as nearly Normal as practicable the conduct of the business; and
 - (ii) extra costs of temporarily using property or facilities of the Insured or others;
- less any value remaining at the end of the Indemnity Period for property obtained in connection with the above.

2 The following Extra Expense (Non-Generation) Exclusions shall also apply:

- (i) any loss of income;
- (ii) costs that normally would have been incurred in conducting the business during the same period had no direct physical loss or physical damage occurred;
- (iii) cost of permanent repair or replacement of property that has been damaged or destroyed;
- (iv) any expense recoverable elsewhere in this Contract;
- (v) any cost or expense incurred in the generation or purchase of replacement power capacity.

F EXTRA EXPENSE (REPLACEMENT POWER CAPACITY)

Where Extra Expense is incurred by the Insured in the generation or purchase of replacement power capacity lost during the Indemnity Period following direct physical loss of or physical damage to the Property Insured by a Peril not excluded by this Contract at the power generating Insured Location:

- 1 Measurement of Loss:
the recoverable Extra Expense loss will be the reasonable and necessary extra costs incurred by the Insured of the following during the Indemnity Period:
 - (i) extra expenses to temporarily continue as nearly Normal as practicable the conduct of the business;
 - (ii) extra costs of temporarily using property or facilities of the Insured or others;
 less any value remaining at the end of the Indemnity Period for property obtained in connection with the above.
- 2 the following Extra Expense (Replacement Power Capacity) Exclusions shall also apply:
 - (i) any loss of income;
 - (ii) costs that normally would have been incurred in conducting the business during the same period had no direct physical loss or physical damage occurred;
 - (iii) cost of permanent repair or replacement of property that has been damaged or destroyed;
 - (iv) any expense recoverable elsewhere in this Contract.
- 3 any expense recoverable under this Business Interruption Coverage will be included within and not in addition to the applicable Monthly Cap in respect of Gross Earnings (Merchant Sales) specified elsewhere in this Contract.

G RENTAL INSURANCE

Where costs incurred in respect of Rental Insurance apply:

- 1 Measurement of Loss:
the recoverable Rental Insurance loss is the actual loss sustained by the Insured of the following, that the Insured would have accounted for on an Accruals Basis during the Indemnity Period:
 - (i) the fair rental value of any portion of the property occupied by the Insured;
 - (ii) the income reasonably expected from rentals of unoccupied or unrented portions of such property; and

(iii) the rental income from the rented portions of such property according to bona fide leases, contracts or agreements in force at the time of loss,

all not to include non-continuing charges and expenses.

2 the following Rental Insurance Exclusion shall also apply:

Exclusion A of Exclusions to Section 2 does not apply and the following applies instead:

A any loss of rental income during any period in which the Property Insured would not have been tenantable for any reason other than an insured loss.

CONDITIONS APPLYING TO SECTION 2 - BUSINESS INTERRUPTION

- 1 This Contract insures Business Interruption loss only to the extent it cannot be reduced through:
- (i) the use of any property or service owned or controlled by the Insured;
 - (ii) the use of any property or service obtainable from other sources;
 - (iii) working extra time or overtime; or
 - (iv) the use of inventory,

all whether at an Insured Location or at any other location.

The Insurers reserve the right to take into consideration the combined operating results of all associated, affiliated or subsidiary companies of the Insured in determining the Business Interruption loss.

- 2 Where applicable in the Gross Earnings loss adjustment, the higher of the Spot Price or the contract price as advised to the Insurers in the form of a Revenue Profile (to calculate an Average Daily Value or Monthly Cap) will be used. However, the Gross Earnings loss otherwise payable to the Insured by the Insurers shall not exceed 110% of the applicable Average Daily Value or Monthly Cap declared by the Insured to the Insurers at inception. Interruption of business affecting only part of a month will be adjusted pro rata of the applicable Monthly Cap for the applicable Insured Location. Gross Earnings losses will be adjusted to reflect the number of MegaWatts of production and their impact on total production output of the power generating Insured Location.
- 3 In determining the amount of loss payable, the Insurers will consider the experience and trend of the business before and after and the probable experience during the Indemnity Period.

4 INDEMNITY PERIOD

A the Indemnity Period applying to all Business Interruption Coverages, except as shown below, or if otherwise provided for under the Business Interruption Coverage Extensions, is as follows:

- 1 for building and equipment, the period of time (inclusive of the Deductible):
- (i) starting from the time of direct physical loss or physical damage of the type insured against; and
 - (ii) ending when with due diligence and dispatch the building and equipment could be:
 - a) repaired or replaced; and
 - b) made ready for operations,and the Insured is in the position to achieve the same production as they would have achieved had such direct physical loss or physical damage not occurred, taking due account of variations and special circumstances that would have in any event affected the Insured's Business during the Indemnity Period, save to the extent to which the market for the Insured and its competitors was generally impacted by the underlying Occurrence which caused the direct physical loss or physical damage.
 - (iii) but not to be limited by the expiration of this Contract;
 - (iv) and ending not later than the Maximum Indemnity Period as specified in the Risk Details

2 for stock-in-process and mercantile stock, including finished goods not manufactured by the Insured, the period of time required with the exercise of due diligence and dispatch:

- (i) to restore stock in process to the same state of manufacture in which it stood at the inception of the interruption of production or suspension of business operations or services; and
- (ii) to replace damaged mercantile stock.

This item does not apply to Rental Insurance.

3 for raw materials and supplies, the period of time of actual interruption of production or suspension of operations or services resulting from the inability to get suitable raw materials and supplies to replace similar ones damaged; but limited to that period for which the damaged raw materials and supplies would have supplied operating needs.

4 if water, in respect of specified hydroelectric generating stations incorporated in the Schedule of Insured Locations on file with the Insurers:

- (i) used for any generating purpose, including but not limited to, as a raw material or for power;
- (ii) stored behind dams or in reservoirs; and
- (iii) on any Insured Location;

is released as the result of direct physical loss or physical damage of the type insured against under this Contract to such dam, reservoir or connected equipment, the Insurers' liability for the actual interruption of production or suspension of operations or services due to inadequate water supply will not extend beyond thirty (30) consecutive days after the dam, reservoir or connected equipment which has sustained such direct physical loss or physical damage has been repaired or replaced.

This item does not apply to Rental Insurance.

5 for damaged exposed films, records, manuscripts and drawings, the period of time required to copy from backups or from originals of a previous generation. This time does not include research, engineering or any other time necessary to restore or recreate lost information.

This item does not apply to Rental Insurance.

B the Indemnity Period does not include any additional period of time due to the Insured's inability to resume operations for any reason, including but not limited to:

- 1 making changes to equipment;
- 2 making changes to the buildings or structures except as provided for in the Demolition and Increased Cost of Construction Extension to Section 1;
- 3 restaffing or retraining employees;
- 4 insufficient funds.

C if two or more Indemnity Periods apply such periods will not be cumulative.

D should the Indemnity Period incorporate a planned outage this will be taken into account in calculating the amount payable.

E the Maximum Indemnity Period specified in the Risk Details shall be inclusive of the Deductible specified in the Risk Details.

EXTENSIONS TO SECTION 2 - BUSINESS INTERRUPTION

Provided that the following Extensions:

- 1 are subject to the applicable Limit or Sub-Limit of Liability;
- 2 will not increase the Contract Limit of Liability; and
- 3 are subject to the terms, conditions and exclusions of this Contract;

as shown in this Section and elsewhere in this Contract, this Contract extends to include:

A CHANGE IN TAX TREATMENT

any tax liability incurred by the Insured in the event that the tax treatment of any proceeds of a covered loss under this Contract differs from the tax treatment of Profits that would have been earned by the Insured had no loss occurred. This Contract covers the amount of the increase in actual tax liability, including taxes incurred by the Insured for operations conducted to reduce a covered loss under this Contract that results in a tax liability greater than would have been incurred had no loss occurred.

B CIVIL OR MILITARY AUTHORITY

the actual loss sustained and Extra Expense incurred by the Insured that the Insured would have accounted for on an Accruals Basis during the Indemnity Period due to the necessary interruption of the Insured's business due to prevention of access to the Insured Location by order of a civil or military authority, provided that such order is a direct result of physical damage of the type insured by this Contract, to property of the type insured by this Contract situated within one (1) statute mile of the Insured Location.

Excluding cover for more than the number of consecutive days specified in the Risk Details.

C CONTINGENT BUSINESS INTERRUPTION

the actual loss sustained and Extra Expense incurred by the Insured that the Insured would have accounted for on an Accruals Basis during the Indemnity Period:

- 1 resulting from direct physical loss or physical damage of the type insured by this Contract; and
- 2 to property of the type insured by this Contract,

at any locations of Named Direct Customers or Named Direct Suppliers located within the Territorial Limits as specified in the Risk Details.

The term "customer or supplier" does not include any company supplying to or receiving from the Insured Location, electricity, fuel, gas, water, steam, refrigeration, or sewerage. However this limitation does not apply in respect of contracts for the supply of fuel for the purpose of generating electricity or contracts with Offtakers for the sale of electricity.

Excluding:

- 1 loss resulting from lack of incoming or outgoing transmission of voice, data or video;
- 2 cover for more than the number of consecutive days specified in the Risk Details.

D INGRESS/EGRESS

the actual loss sustained and Extra Expense incurred by the Insured that the Insured would have accounted for on an Accruals Basis during the Indemnity Period due to the necessary interruption of the

Insured's business due to prevention of ingress to or egress from an Insured Location, whether or not the premises or property of the Insured has sustained damage, provided that such prevention is a result of direct physical loss or physical damage of the type insured by this Contract, to property of the type insured by this Contract situated within one (1) statute mile of the Insured Location.

Excluding:

- 1 loss resulting from lack of incoming or outgoing service consisting of electricity, fuel, gas, water, steam, refrigerant, sewerage and voice, data or video;
- 2 loss resulting from picketing or other action by strikers except for direct physical loss or physical damage not excluded by this Contract;
- 3 cover for more than the number of consecutive days specified in the Risk Details.

E ON PREMISES SERVICES

the actual loss sustained and Extra Expense incurred by the Insured that the Insured would have accounted for on an Accruals Basis during the Indemnity Period resulting from direct physical loss or physical damage of the type insured by this Contract to the following property located within one thousand (1,000) feet of the Insured Location:

- 1 electrical equipment and equipment used for the transmission of voice, data or video;
- 2 electrical, fuel, gas, water, steam, refrigeration, sewerage, voice, data or video transmission lines.

This Extension shall only apply in respect of those ancillary services that are provided for the continuation of generation and shall not apply in respect of contracts for the supply of fuel for the purpose of generating electricity or contracts with Offtakers for the sale of electricity.

Excluding cover for more than the number of consecutive days specified in the Risk Details.

F PROTECTION AND PRESERVATION OF PROPERTY

the actual loss sustained by the Insured that the Insured would have accounted for on an Accruals Basis during the Indemnity Period for a period of time not to exceed forty-eight (48) hours after the Insured first takes reasonable action for the temporary protection and preservation of Property Insured by this Contract subject to such action being necessary to prevent immediately impending direct physical loss or physical damage insured by this Contract.

This Extension is subject to the Deductible Conditions that would have applied had such impending direct physical loss or physical damage insured by this Contract occurred.

G SERVICE INTERRUPTION

only in respect of ancillary services provided for the continuation of generation and shall not apply in respect of contracts for the supply of fuel for the purpose of generating electricity or contracts with Offtakers for the sale of electricity:

- 1 the actual loss sustained and Extra Expense incurred by the Insured during the Period of Service Interruption (as defined under item 4 below) at Insured Locations when the loss is caused by the interruption of incoming services consisting of electricity, gas, fuel, steam, water, refrigeration or from the lack of outgoing sewerage service by reason of direct physical loss or physical damage of the type insured by this Contract to property of the type insured by this Contract of the supplier of such service located within the Territorial Limits, that immediately prevents in whole or in part the delivery of such usable services.

- 2 Conditions:
- (i) the Insured will immediately notify the suppliers of services of any interruption of such services;
 - (ii) the Insurers will not be liable if the interruption of such services is caused directly or indirectly by:
 - a) the failure of the Insured to comply with the terms and conditions of any contracts the Insured has for the supply of such specified services;
 - b) loss or damage to overhead transmission lines located beyond one (1) mile from the affected Insured Location;
- 3 excluding cover for more than the number of consecutive days specified in the Risk Details.
- 4 the term Period of Service Interruption wherever used in this Contract means:
- (i) the period starting with the time when an interruption of specified services occurs; and ending when with due diligence and dispatch the service could be wholly restored and the Insured Location receiving the service could or would have resumed Normal operations following the restorations of service under the same or equivalent physical and operating conditions as provided by the Indemnity Period;
 - (ii) the Period of Service Interruption is limited to only those hours during which the Insured would or could have used services(s) if it had been available;
 - (iii) the Period of Service Interruption does not extend to include the interruption of operations caused by any reason other than interruption of the specified service(s).

EXCLUSIONS TO SECTION 2 - BUSINESS INTERRUPTION

In addition to the Exclusions elsewhere in this Contract, this Section does not insure:

- A** any loss during any idle period, (including but not limited to when production, operation, service or delivery or receipt of goods would cease, or would not have taken place or would have been prevented):
- 1 due to planned or scheduled shutdown or outage;
 - 2 due to strikes or other work stoppage;
 - 3 when it is not possible to attain or maintain Profitable Output for reasons other than direct physical loss or physical damage; or
 - 4 for any other reason other than direct physical loss or physical damage insured by this Contract.
- B** the actual loss sustained within the Period of Insurance (but occurring prior to the start of the maintenance period) due to a Delay in completion of the incidental Construction caused by direct physical loss or physical damage insured under this Contract;
- the term Delay means the period during which the Construction was interrupted caused solely by direct physical loss or physical damage to Construction leading to an actual loss sustained during the Period of Insurance.
- C** any increase in loss due to:
- 1 suspension, cancellation or lapse of any lease, contract, license or orders;
 - 2 liquidated damages or any other fines or damages for breach of contract or for late or non-completion of orders;
 - 3 penalties of any nature;
 - 4 any other consequential or remote loss.
- D** any loss resulting from damage to finished goods manufactured by the Insured, nor the time required for their reproduction.

CLAIMS CONDITIONS

The following Claims Conditions apply to this Contract unless specifically amended by endorsement:

A ABANDONMENT

There may be no abandonment of any property to the Insurers.

B COLLECTION FROM OTHERS

The Insurers will not be liable for any loss to the extent that the Insured has collected for such loss from others.

C CURRENCY FOR LOSS PAYMENT

All amounts, including Deductibles and Limits of Liability, indicated in this Contract are in the currency of the United States of America. Losses will be adjusted and paid in the currency of the United States of America, unless directed otherwise by the Insured.

In the event of a loss adjustment involving currency conversion, the exchange selling rate will be calculated as follows:

- 1 As respects the calculation of Deductibles and Limits of Liability, the rate of exchange published in The Wall Street Journal on the date of loss;
- 2 As respects direct physical loss or physical damage to Real and Personal Property:
 - (i) the cost to repair or replace Real and Personal Property will be converted at the time the cost of repair or replacement is incurred based on the rate of exchange published in The Wall Street Journal;
 - (ii) if such property is not replaced or repaired, the conversion will be based on the rate of exchange published in The Wall Street Journal as of the date of loss;
- 3 As respects Business Interruption loss the conversion will be based on the average of the rate of exchange published in The Wall Street Journal on the date of loss and the rate of exchange published in The Wall Street Journal on the last day of the period of interruption.

If The Wall Street Journal was not published on the stipulated date, the rate of exchange will be as published on the next business day.

D INSURERS' OPTION

The Insurers have the option to take all or any part of damaged property at the agreed or appraised value. The Insurers must give notice to the Insured of their intention to do so within thirty (30) days after receipt of proof of loss.

E LOSS ADJUSTMENT/PAYABLE

Loss, if any, will be adjusted with and payable to the Insured, or as may be directed by the Insured. Additional insured interests will also be included in loss payment as their interests may appear when named as additional named insured, lender, mortgagee and/or loss payee in the evidences of Insurance.

F PARTIAL PAYMENT OF LOSS SETTLEMENT

In the event of a loss occurring which has been ascertained to be an insured loss under this Contract and determined by the Insurers' representatives to be in excess of the applicable Deductible specified in the Risk Details, the Insurers will advance mutually agreed upon partial payment(s) on the insured loss, subject to this Contract's other provisions. To obtain said partial payments, the Insured will submit a signed and sworn Proof of Loss as described in Claims Condition G 4 below, with adequate supporting documentation.

G REQUIREMENTS IN CASE OF LOSS

The Insured will:

- 1 give immediate written notice to the Insurers of any loss;
- 2 protect the property from further loss or damage;
- 3 promptly separate the damaged and undamaged property; put it in the best possible order; and furnish a complete inventory of the lost, destroyed, damaged and undamaged property showing in detail the quantities, costs, Actual Cash Value, replacement value and amount of loss claimed;
- 4 give a signed and sworn Proof of Loss to the Insurers within ninety (90) days after the loss, unless that time is extended in writing by the Insurers. The proof of loss must state the knowledge and belief of the Insured as to:
 - (i) the time and origin of the loss;
 - (ii) the Insured's interest and that of all others in the property;
 - (iii) the Actual Cash Value and replacement value of each item and the amount of loss to each item; all encumbrances; and all other contracts of insurance, whether valid or not, covering any of the property;
 - (iv) any changes in the title, use, occupation, location, possession or exposures of the property since the effective date of this Contract;
 - (v) by whom and for what purpose any location insured by this Contract was occupied on the date of loss, and whether or not it then stood on leased ground.
- 5 include a copy of all the descriptions and schedules in all policies and, if required, provide verified plans and specifications of any buildings, fixtures, machinery or equipment which has sustained loss or damage.
- 6 as a condition precedent to Insurers' liability and as often as may be reasonably required:
 - (i) exhibit to any person designated by the Insurers all that remains of any property;
 - (ii) submit to examination under oath by any person designated by the Insurers and sign the written records of examinations; and
 - (iii) produce for examination at the request of the Insurers:
 - a) all books of accounts, business records, bills, invoices and other vouchers, or certified copies if originals are lost;
 - b) maintenance records provided by the Original Equipment Manufacturer (OEM) or as maintained by the Insured;
 - c) contracts with the Original Equipment Manufacturer (OEM);
 - d) contracts with customers;
 - e) contracts with suppliers;

at such reasonable times and places that may be designated by the Insurers or their representative and permit extracts and copies to be made.

H SETTLEMENT OF CLAIMS

The amount of loss, except for Accounts Receivable coverage, for which the Insurers may be liable, will be paid within thirty (30) days after:

- 1 proof of loss as described in this Contract is received by the Insurers; and
- 2 when a resolution of the amount of loss is made either by:
 - (i) written agreement between the Insured and the Insurers; or
 - (ii) the filing with the Insurers of an award as provided for in General Conditions C.

I VALUES LIMITATION CLAUSE

The premium for this Contract is based upon the schedule of values reported to and on file with the Insurers, or as attached or otherwise endorsed to this Contract. In the event of any covered loss under this Contract, the liability of the Insurers relative to Property Damage and Business Interruption loss, as insured by this Contract, shall, notwithstanding anything contained in this Contract to the contrary, be limited to the least of the following:

- 1 The actual adjusted amount of the loss within the coverage of the Contract, less applicable Deductible(s).
- 2
 - (i) for Property Damage loss, 105% of the total property values for each location
 - (ii) for Business Interruption loss, as insured by this Contract, 105% of the Business Interruption values for each location

as reported on the above said schedule of values, less applicable Deductible(s).
- 3 The policy limit of liability or applicable sub-limit(s) of liability, less applicable Deductible(s).

GENERAL CONDITIONS

The following General Conditions apply to this Contract unless specifically amended by endorsement:

A ACCESS TO RECORDS

the Insured shall make available to the Insurers at all reasonable times, and the Insurers through their designated representatives shall have the right to inspect and copy at their own expense, during the Period of Insurance and thereafter, all books, papers and other records of the Insured and its agents or brokers in connection with this Contract or the subject matter hereof.

B ADDITIONAL INSURABLE INTERESTS

additional insured interests are automatically added to this Contract as their interest may appear when named as additional named insured, lender, mortgagee and/or loss payee in the evidences of insurance. Such interests become effective on the date shown in the evidence of insurance and will not amend, extend or alter the terms, conditions, provisions and limits of this Contract.

C ARBITRATION

Any dispute arising out of or in connection with this contract, including any question regarding its existence, validity or termination, shall be referred to and finally resolved by arbitration under the London Court of International Arbitration (LCIA) Rules, or as may be mutually agreed by the parties as indicated within the Risk Details, which Rules are deemed to be incorporated by reference into this clause.

The parties will choose whether to refer any such dispute to a panel of one or three arbitrators. In the event of non agreement there shall be three arbitrators.

If a single arbitrator tribunal is agreed upon, the arbitrator is to be agreed between the parties, or failing agreement within fourteen (14) days, after either party has given to the other a written request to concur in the appointment of an arbitrator, the arbitrator is to be appointed by the President or a Vice President of the LCIA, or the President or a Vice President of the body whose Rules have been mutually agreed by the parties as indicated within the Risk Details.

If a three arbitrator tribunal is agreed upon, each party shall nominate one arbitrator. If a party fails to nominate an arbitrator, the appointment shall be made by the President or a Vice President of the LCIA, or the President or a Vice President of the body whose Rules have been mutually agreed by the parties as indicated within the Risk Details. The third arbitrator, who will act as chairman of the Arbitral Tribunal, shall be appointed by the two party nominated arbitrators after consultation with the parties.

The seat, or legal place, of arbitration shall be London, England, or as may be mutually agreed by the parties as indicated within the Risk Details.

The language to be used in the arbitral proceedings shall be English, or as may be mutually agreed by the parties as indicated within the Risk Details.

The governing law of the contract shall be the substantive law of England and Wales, or as may be mutually agreed by the parties as indicated within the Risk Details.

The parties shall bear the costs of the arbitrator(s) in equal shares.

D CANCELLATION

this Contract may be:

- 1 cancelled at any time at the request of the Insured by surrendering this Contract to the Insurers or by giving written notice to the Insurers stating when such cancellation will take effect;
- 2 cancelled by the Insurers by giving the Insured not less than:
 - (i) ninety (90) days' written notice of cancellation; or
 - (ii) ten (10) days' written notice of cancellation if the Insured fails to remit, when due, payment of premium for this Contract;

Return of any unearned premium will be calculated on the customary short rate basis if the Insured cancels and on a pro-rata basis if the Insurers cancel this Contract. Return of any unearned premium will be made by the Insurers as soon as practicable.

E CHOICE OF LAW

this Contract shall be subject to the applicable law specified in the Risk Details.

F CONFLICT OF STATUTES / LAW

any terms of this Contract which may conflict with applicable statutes (or statutes deemed applicable by a court of competent jurisdiction) are amended to conform to the minimum requirements of such statutes.

In the event that any provision of this Contract is found by a court of competent jurisdiction to be invalid or unenforceable, the other provisions of this Contract and the remainder of the provision in question shall not be affected thereby and shall remain in full force and effect.

G CONTRACT MODIFICATION

the Insured and the Insurers may request changes to this Contract. This Contract can be changed only by endorsements issued by the Insurers and made a part of this Contract.

Notice to any agent or knowledge possessed by any agent or by any other person will not:

- 1 create a waiver, or change any part of this Contract; or
- 2 prevent the Insurers from asserting any rights under the provisions of this Contract.

H CONTROL OF DAMAGED PROPERTY

this Contract gives control of Property Insured that sustains direct physical loss or physical damage by a Peril not excluded by this Contract as follows:

- 1 the Insured will have full rights to the possession and control of damaged Property Insured in the event of damage to such property provided independent non-destructive testing has been completed and the appropriate reports are available for inspection to show which property has sustained damage;
- 2 any salvage proceeds received will go to the:
 - (i) Insurers at the time of loss settlement; or
 - (ii) Insured if received prior to loss settlement and such proceeds will reduce the amount of loss payable accordingly.

However if the Property Insured is catered for under an Original Equipment Manufacturer Contract it is understood that the Insured and Insurer shall waive control of the Property Insured which has sustained

damage, provided that independent non-destructive testing has been completed and the appropriate reports are available for inspection to show which property has sustained damage.

I DEDUCTIBLE GENERAL PROVISIONS

in each case of direct physical loss of or physical damage to the Property Insured by a Peril not excluded by this Contract, the Insurers will be liable only if the Insured sustains a loss in a single Occurrence greater than the applicable Deductible specified in the Risk Details, and only for its share of that greater amount.

Unless otherwise stated below:

- 1 when this Contract insures more than one location, the Deductible will apply against the total loss covered by this Contract in any one Occurrence;
- 2 if two or more Deductibles provided in this Contract apply to a single Occurrence, the total to be deducted will not exceed the largest Deductible applicable, unless otherwise provided.

However any Deductibles applicable to Business Interruption coverages shall apply in addition to the applicable Property Damage Deductible.

Any Business Interruption Deductibles expressed as a number of hours or days which are not otherwise defined or which are not intended to be converted into monetary equivalents shall be applied so that, in the event of direct physical loss or physical damage of the type insured by this Contract, the Insurers shall not be liable for the amount of any Business Interruption loss sustained during the number of consecutive hours or days, as specified in the Risk Details, which immediately follow the Occurrence of such direct physical loss or physical damage.

J INSPECTIONS

the Insurers, at all reasonable times, will be permitted, but will not have the duty, to inspect the Property Insured.

The Insurers':

- 1 right to make inspections;
- 2 making of inspections; or
- 3 analysis, advice or inspection report,

will not constitute an undertaking, on behalf of or for the benefit of the Insured or others, to determine or warrant that the Property Insured is safe or healthful. The Insurers will have no liability to the Insured or any other person because of any inspection or failure to inspect.

K LIMIT OF LIABILITY GENERAL PROVISIONS

the Insurers' maximum liability in a single Occurrence regardless of the number of Insured Locations or coverages involved will not exceed the Limit of Liability as specified in the Risk Details. However, when a Sub-Limit of Liability for an Insured Location or other specified property or coverage is shown, such Sub-Limit of Liability will be the maximum amount payable for any direct physical loss or physical damage at such Location or involving such other specified property or such coverage.

The Sub-Limits of Liability specified in the Risk Details are programme Sub-Limits of Liability and are part of and not in addition to the programme Limit of Liability over this Contract and all other programme policies combined.

The Sub-Limits of Liability specified in the Risk Details shall apply on a per Occurrence basis, unless otherwise specified as being on an aggregate basis, for all Insured Locations and coverages combined.

L MISREPRESENTATION AND FRAUD

this entire Contract and any loss or claim thereunder will be void if, whether before or after a loss, an Insured has:

- 1 wilfully concealed or wilfully misrepresented any material fact or circumstance;
- 2 engaged in fraudulent conduct; or
- 3 made false statements;

relating to this Contract or any loss or claim thereunder.

In the event that any provision of this Condition is found by a court of competent jurisdiction to be invalid or unenforceable, the other provisions of this Condition and the remainder of the provision in question shall not be affected thereby and shall remain in full force and effect.

M OTHER INSURANCE

- 1 if there is any other insurance that would apply in the absence of this Contract, this Contract will apply only after such insurance whether collected or not;
- 2 the Insured is permitted to have other insurance over any Limits or Sub-Limits of Liability specified elsewhere in this Contract without prejudice to this Contract. The existence of any such insurance will not reduce any Limit or Sub-Limit of Liability in this Contract. Any other insurance that would have provided primary coverage in the absence of this Contract will not be considered excess;
- 3 the Insured is permitted to have other insurance for all, or any part, of any Deductible in this Contract. The existence of such other insurance will not prejudice recovery under this Contract. If the Limits of Liability of such other insurance are greater than this Contract's applicable Deductible, this Contract will apply only after such other insurance has been exhausted;
- 4 in the event this Contract is deemed to contribute with other insurance, the Limit of Liability applicable at each Insured Location, for purposes of such contribution with other insurers, will be the latest amount described in this Contract or the latest Schedule of Insured Locations on file with the Insurers.

N REASONABLE PRECAUTIONS

the Insured shall take all reasonable precautions to prevent loss or damage to the Property Insured; to comply with relevant statutory requirements, sound engineering practices and manufacturers' recommendations; and to maintain the Property Insured in good working condition.

O REDUCTION BY LOSS

claims paid under this Contract will not reduce the Limit of Liability, except claims paid will reduce any aggregate Limit of Liability for the Period of Insurance.

P SUSPENSION

on discovery of a dangerous condition, the Insurers may immediately suspend this insurance on any machine, vessel or part thereof by giving written notice to the Insured. The suspended insurance may be reinstated by the Insurers. Any unearned premium resulting from such suspension will be returned by the Insurers.

Q SALVAGE AND RECOVERIES

all salvages, recoveries and payments recovered or received subsequent to a loss settlement under this Contract shall be applied as if recovered or received prior to the said settlement and all necessary adjustments shall be made by the parties hereto.

R SERVICE OF SUIT

this Service of Suit Condition will not be read to conflict with or override the obligations of the parties to arbitrate their disputes as provided for in General Conditions C. This General Condition is intended as an aid to compelling arbitration or enforcing such arbitral award, not as an alternative to General Conditions C for resolving disputes arising out of this Contract.

It is agreed that in the event of the failure of the Insurers hereon to pay any amount claimed to be due hereunder, the Insurers hereon, at the request of the Insured, will submit to the jurisdiction of a Court of competent jurisdiction within the United States. Nothing in this Condition constitutes or should be understood to constitute a waiver of the Insurers' rights to commence an action in any Court of competent jurisdiction in the United States, to remove an action to a United States District Court, or to seek a transfer of a case to another Court as permitted by the laws of the United States or of any State in the United States.

It is further agreed that service of process in such suit may be made upon the person or persons specified in the Risk Details for this purpose, and that in any suit instituted against any one of them upon this Contract, the Insurers will abide by the final decision of such Court or of any Appellate Court in the event of an appeal.

The person or persons specified in the Risk Details are authorised and directed to accept service of process on behalf of the Insurers in any such suit and/or upon the request of the Insured to give a written undertaking to the Insured that they will enter a general appearance upon the Insurers' behalf in the event such a suit shall be instituted.

Further, pursuant to any statute of any State, territory or district of the United States which makes provision therefor, the Insurers hereon hereby designate the Superintendent, Commissioner or Director of Insurance or other officer specified for that purpose in the statute, or his successor or successors in office, as their true and lawful attorney upon whom may be served any lawful process in any action, suit or proceeding instituted by or on behalf of the Insured or any beneficiary hereunder arising out of this Contract, and hereby designate the person or persons as specified in the Risk Details as the person to whom the said officer is authorised to mail such process or a true copy thereof.

S SUBROGATION

the Insured is required to cooperate in any subrogation proceedings. The Insurers may require from the Insured an assignment or other transfer of all rights of recovery against any party for loss to the extent of the Insurers' payment.

The Insurers will not acquire any rights of recovery that the Insured has expressly waived prior to a loss, nor will such waiver affect the Insured's rights under this Contract.

Any recovery from subrogation proceedings, less costs incurred by the Insurers in such proceedings, will be payable to the Insured in the proportion that the amount of:

- 1 any applicable Deductible; and/or
- 2 any provable uninsured loss;

bears to the entire provable loss amount.

T SUIT AGAINST THE INSURERS

no suit, action or proceeding for the recovery of any claim will be sustained in any court of law or equity unless:

- 1 the Insured has fully complied with all the provisions of this Contract; and
- 2 legal action is started within twelve (12) months after inception of the loss.

If under the insurance laws of the jurisdiction in which the property is located, such twelve (12) months' limitation is invalid, then any such legal action needs to be started within the shortest limit of time permitted by such laws.

U TITLES

the titles in this Contract are only for reference. The titles do not in any way affect the provisions of this Contract.

GENERAL EXCLUSIONS

The following General Exclusions apply to this Contract unless specifically amended by endorsement:

This Contract does not insure any loss, damage, claim, cost, expense or other sum of whatsoever nature directly or indirectly caused by, resulting from, arising out of, in connection with or relating to:

A BIOLOGICAL OR CHEMICAL MATERIALS

the actual or threatened malicious use of pathogenic or poisonous biological or chemical materials regardless of any other cause or event contributing concurrently or in any other sequence thereto.

B MICROORGANISM

mould, mildew, fungus, spores or other micro-organism of any type, nature, or description, including but not limited to any substance whose presence poses an actual or potential threat to human health.

This Exclusion applies regardless of whether there is:

- 1 any physical loss or damage to Property Insured;
- 2 any insured peril or cause, whether or not contributing concurrently or in any sequence;
- 3 any loss of use, occupancy, or functionality; or
- 4 any action required, including but not limited to repair, replacement, removal, cleanup, abatement, disposal, relocation, or steps taken to address medical or legal concerns.

C RADIOACTIVE CONTAMINATION

any of the following regardless of any other cause or event, whether or not insured under this Contract, contributing concurrently or in any other sequence to the loss, nuclear reaction or nuclear radiation or radioactive contamination. However:

- 1 if direct physical loss or physical damage by fire or sprinkler leakage results, then only that resulting direct physical loss or physical damage is insured; but not including any loss or damage due to nuclear reaction, nuclear radiation or radioactive contamination;
- 2 this Contract does insure loss or damage directly caused by sudden and accidental radioactive contamination, including resultant radiation damage, from material used or stored or from processes conducted on the Insured Location, provided that on the date of loss, there is neither a nuclear reactor nor any new or used nuclear fuel on the Insured Location.

D TERRORISM

any Act of Terrorism regardless of any other cause or event contributing concurrently or in any other sequence to the loss.

For the purpose of this Exclusion an Act of Terrorism means an act, including but not limited to the use of force or violence and/or the threat thereof, of any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organisation(s) or government(s), committed for political, religious, ideological or similar purposes including the intention to influence any government and/or to put the public, or any section of the public, in fear.

This Exclusion also excludes loss, damage, cost or expense of whatsoever nature directly or indirectly caused by, resulting from or in connection with any action taken in controlling, preventing, suppressing or in any way relating to any Act of Terrorism.

If the Insurers allege that by reason of this Exclusion, any loss, damage, cost or expense is not covered by this insurance the burden of proving the contrary shall be upon the Insured.

In the event any portion of this Exclusion is found to be invalid or unenforceable, the remainder shall remain in full force and effect.

E WAR AND POLITICAL RISKS

- 1 hostile or warlike action in time of peace or war, including action in hindering, combating or defending against an actual, impending or expected attack by any:
 - (i) government or sovereign power (de jure or de facto);
 - (ii) military, naval or air force; or
 - (iii) agent or authority of any party specified in (i) or (ii) above.
- 2 discharge, explosion or use of any nuclear device, weapon or material employing or involving nuclear fission, fusion or radioactive force, whether in time of peace or war and regardless of who commits the act;
- 3 insurrection, rebellion, revolution, civil war, usurped power, or action taken by governmental authority in hindering, combating or defending against such an event;
- 4 seizure or destruction under quarantine or custom regulation, or confiscation by order of any governmental or public authority;
- 5 risks of contraband, or illegal transportation or trade;

regardless of any other cause or event contributing concurrently or in any other sequence to the loss.

GENERAL ENDORSEMENTS

The following General Endorsements shall apply unless specifically overridden by subsequent Endorsements.

A. ASBESTOS

- 1 This Contract only insures asbestos physically incorporated in an insured building or structure, and then only that part of the asbestos which has been physically Damaged during the Period of Insurance by one of the following Listed Perils:

fire; explosion; lightning; Windstorm; hail; direct impact of vehicle, aircraft or vessel; riot or civil commotion, vandalism or malicious mischief; or accidental discharge of fire protective equipment.

This coverage is subject to each of the following specific limitations:

- (i) The said building or structure must be insured under this Contract for damage by that Listed Peril.
- (ii) The Listed Peril must be the immediate, sole cause of the damage of the asbestos.
- (iii) The Insured must report to the Insurers the existence and cost of the damage as soon as practicable after the Listed Peril first damaged the asbestos. However, this Contract does not insure any such damage first reported to the Insurers more than twelve (12) months after the expiration, or termination, of the Period of Insurance.
- (iv) Insurance under this Contract in respect of asbestos shall not include any sum relating to:
 - a) any faults in the design, manufacture or installation of the asbestos;
 - b) asbestos not physically damaged by the Listed Peril including any governmental or regulatory authority direction or request of whatsoever nature relating to undamaged asbestos.

- 2 Except as set forth in the foregoing Part 1, this Contract does not insure asbestos or any sum relating thereto.

B. ELECTRONIC DATA

1 Electronic Data

- (i) this Contract does not insure loss, damage, destruction, distortion, erasure, corruption, or alteration of Electronic Data from any cause whatsoever (including but not limited to Computer Virus) or loss of use, reduction in functionality, cost, expense of whatsoever nature resulting therefrom, regardless of any other cause or event contributing concurrently or in any other sequence to the loss.

Electronic Data means facts, concepts and information converted to a form useable for communications, interpretation or processing by electronic and electromechanical data processing or electronically controlled equipment and includes programmes, software and other coded instructions for the processing and manipulation of data or the direction and manipulation of such equipment.

Computer Virus means a set of corrupting, harmful or otherwise unauthorised instructions or code including a set of maliciously introduced unauthorised instructions or code, programmatic or otherwise, that propagate themselves through a computer system or network of whatsoever nature. Computer Virus includes but is not limited to 'Trojan Horses', 'worms' and 'time or logic bombs'.

- (ii) However, in the event that a peril listed below results from any of the matters described in paragraph (i) above, this Contract, subject to all its terms, conditions and exclusions, will cover physical damage occurring during the Period of Insurance to Property Insured by this Contract directly caused by such Listed Peril.

Listed Perils

- a) fire
- b) explosion

2 Electronic Data Processing Media Valuation

Should electronic data processing media insured by this Contract suffer physical loss or damage insured by this Contract, then the basis of valuation shall be the cost to repair, replace or restore such media to the condition that existed immediately prior to such loss or damage, including the cost of reproducing any Electronic Data contained thereon, providing such media is repaired, replaced or restored. Such cost of reproduction shall include all reasonable and necessary amounts, not to exceed the Sub-Limit of Liability specified in the Risk Details any one loss, incurred by the Insured in recreating, gathering and assembling such Electronic Data. If the media is not repaired, replaced or restored the basis of valuation shall be the cost of the blank media. However this Contract does not insure any amount pertaining to the value of such Electronic Data to the Insured or any other party, even if such Electronic Data cannot be recreated, gathered or assembled.

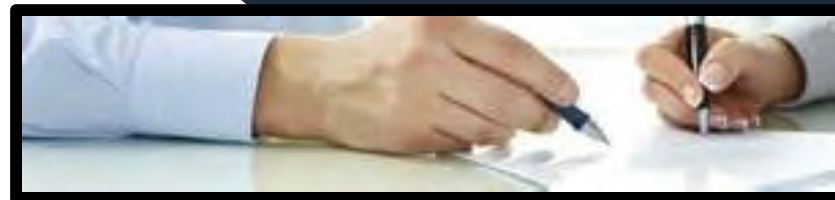
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12 October 2012

Reps & Warranties Insurance: A Primer & Selected Advanced Issues

Speaker:

Scott C. Hecht, Stinson Leonard Street LLP



REPRESENTATIONS & WARRANTIES INSURANCE

**American College of Coverage and
Extracontractual Counsel**

**Annual Meeting
May 5, 2015**

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REPRESENTATIONS & WARRANTIES INSURANCE

- What is RWI?
 - Insurance that guarantees the Seller's Reps & Warranties in an M&A-type transaction.
- RWI around since late 1990s.
- RWI now part of many of "Middle Market" deals (*i.e.*, deal values of \$25 million to \$2 billion)
- The existence of RWI was once viewed as a positive distinction, but now the absence is viewed as a detriment

REPRESENTATIONS & WARRANTIES INSURANCE

- Why is RWI popular now?
 - It took a while for deal players (execs, attorneys, advisors) to become comfortable with RWI on many fronts . . .
 - ◆ Evolution of RWI negotiation and placement process accommodating to deal timing
 - ◆ Standardization of concepts and terms
 - ◆ Familiarity with product, how it works, and that it works
 - ◆ Pricing at levels that make sense in the deal
 - Post-credit crisis increasing deal volume coincided with deal player comfort with RWI

EXAMPLES OF R&W SUBJECT MATTER

- Seller has power, authority and consents
- Deal will not violate articles, bylaws, contracts, court/regulatory orders, or law
- Accurate Financial Statements, Books & Records
- Adequate Internal Controls
- Solvency
- Assets are clear and in good condition
- Compliance with Labor & Employment/Employee Benefits Laws
- Contingent Liabilities including Litigation
- Taxes, Environmental and other exposures

WHAT HAPPENS IF R&W ARE FALSE?

- Buyer deprived of benefit of bargain
 - Buyer sues Seller
- Third Parties have rights against/sue Buyer
 - e.g., IRS, Regulators, Employees
 - e.g., Tax, Labor & Employment/Employee Benefits, Environmental

TRADITIONAL SOLUTIONS v. RWI

- Traditional Solutions: Risk allocated with sales proceeds
 - Buyer pays discounted purchase price
 - Buyer holds back portion of purchase price
 - Parties escrow portion of purchase price
- RWI: Insurer assumes risk in exchange for premium
 - Need for Traditional Solutions mitigated or eliminated

WHY USE RWI INSTEAD OF TRADITIONAL SOLUTIONS?

- Seller
 - More cash out of deal and quicker
 - Mitigate need for post-closing involvement
 - Relationship issues
 - ◆ e.g., Seller's ownership/management may continue as Buyer's management – awkward for Buyer to sue Seller
- Buyer
 - Wants more security than Seller is willing to give
 - Concerns about validity of reps & warranties
 - Concerns about Seller's ability to pay damages resulting from a breach
 - Concerns about costs of pursuing Seller for breach
 - Concerns about logistics pursuing Seller (e.g., cross border transactions)

ALTERNATE FORMS OF RWI:

“SELL-SIDE” RWI

- “Sell-Side” RWI
 - Seller is insured
 - Sell-Side RWI provides Liability coverage
 - Liability coverage
 - Applies in the event of a claim or suit against the Seller based on an alleged breach of R&W
 - Reimburses Seller for Defense Costs
 - Reimburses Seller for Settlements/Judgments

ALTERNATE FORMS OF RWI:

“BUY-SIDE” RWI

- “Buy-Side” RWI
 - Buyer is insured
- “Buy-Side” RWI provides First Party and Liability coverage
 - First Party Coverage
 - ◆ Insurer reimburses Buyer for losses associated with Seller’s breach of R&W
 - Liability coverage
 - ◆ Applies in the event of a claim or suit against the Buyer related to Seller’s breach of R&W
 - ◆ Reimburses Buyer for Defense Costs
 - ◆ Reimburses Buyer for Settlements/Judgments

BUY-SIDE RWI v. SELL-SIDE RWI

- Buy-Side RWI used substantially more frequently than Sell-Side RWI
 - Seemingly easier way to shift exposure to insurer
 - ◆ If there's a breach that results in a loss to the Buyer, the Insurer pays
 - ◆ Eliminates need for Buyer to sue Seller to trigger Sell-Side coverage
 - ◆ Eliminates prospect of litigation against Seller -- Insurer's subrogation rights are usually limited to cases of fraud or other dishonest conduct

BUY-SIDE RWI v. SELL-SIDE RWI

- Sell-Side RWI Disadvantages
 - Merely indirect, if any, benefit to Buyer; Traditional Solutions (e.g., discount, escrow, holdback) still required
 - Riskier to underwrite Sell-Side Policy--RW validity/breach is within Insured's control
 - ◆ Placement period is likely extended
 - ◆ Markets do not have access to buyer's due diligence
 - Exclusions and other limitations are stricter
 - Likely no price break over Buy-Side Policy

RWI and DEAL STRUCTURE

- RWI is most often used in “Middle Market Deals” -- \$25 million to \$2 billion
 - Middle Market deal size is sufficient to bear RWI costs
 - Insurer capacity and appetite diminishes with substantially larger deals
 - Insurers reluctant to do smaller deals because margin is thin based on transaction costs
 - Check the market because insurers are adapting and some may be willing to underwrite smaller deals

RWI and DEAL STRUCTURE

- RWI is subject to a retention – i.e., the insurance proceeds are only available in excess of specified losses
- Buyer and Seller structure deal agreement in collaboration with Insurer
 - Buyer and Seller may agree that Seller is responsible for first \$X,000,000 of losses
 - Insurer would set retention at \$X,000,000
 - Buyer and Seller consult with Insurer in structuring agreement to ensure that Insurer will provide coverage subject to retention of \$X,000,000 (Insurer typically agrees to 1-2% of deal value)

RWI and DEAL STRUCTURE

- RWI is subject to a limit – i.e., the insurer will only provide \$XX,000,000 in coverage for the deal.
- Buyer and Seller structure deal working with Insurer
 - Buyer and Seller may agree to limit damages to the limit of the RWI insurance.
 - ◆ Insurer would set limit at \$XX,000,000
 - ◆ Buyer and Seller consult with Insurer in structuring agreement to ensure that damages are limited to the amount of the coverage limit, which is \$XX,000,000.
 - Buyer and Seller may agree not to limit damages to limit of the RWI insurance.

RWI POLICY LIMITS and PRICING

- Pricing and availability of limits varies based on market conditions, but . . .
 - Many insurers offer \$10MM as a minimum limit
 - Fewer insurers offer \$5MM-\$100MM
 - Handful may offer \$2.5MM-\$5MM
- Pricing is in the range of . . .
 - ~4.5-5.5% for limit of \$2.5MM-\$5MM
 - ~3.0-4.5% for limit of \$5MM-\$10MM
 - ~3.0- ~4.0% for limit >\$10MM

LIMITATIONS/EXCLUSIONS

- Coverage is provided during the pertinent Policy Period.
 - Policy may have multiple Policy Periods corresponding to particular Reps & Warranties
 - Policy Periods typically multiple years in duration
- Coverage is provided net of other recoveries to insured

LIMITATIONS/EXCLUSIONS

- Exclusions
 - Matters identified in underwriting and described in schedule to policy
 - Matters of which members of “Deal Team” had knowledge
 - Matters disclosed in the deal documents
 - Fraud by the insured or a member of the Deal Team
 - Specific indemnity obligations
 - Employee benefit liability or withdrawal liability
 - Claims based on forward looking statements

RWI PLACEMENT PROCESS--PLAN AHEAD

- Process takes time (usually at least two weeks)
- Broker is key facilitator of placement process
- Engagement of broker should occur in advance
- Experienced brokers and insurers are accustomed to lawyers and deadlines
- Placement process involves many steps

STEPS IN RWI PLACEMENT PROCESS

- Execute Non-Disclosure Agreements with prospective insurers
- Provide deal documents, financials and related information to prospective insurers for purpose of getting indication of pricing and other terms for RWI
- Insurers provide indications of pricing and other terms to broker at (no cost)
- Broker works with Buyer (Seller) and lawyers to evaluate insurer indications and compatible integration with deal
- Buyer (Seller) selects insurer and pays non-refundable due diligence fee (\$15-30,000) which primarily goes to law firm hired by insurer
- Insurer (Insurer's counsel) is given access to relevant due diligence information, which provides basis for insurer quote
- Buyer (Seller), Broker and Counsel consult, negotiate and finalize details of coverage with insurer
- Coverage is finalized and bound at closing, when premium is paid

COMMENTARY

- It is vital to work with a Broker that has RWI and M&A expertise, as well as current knowledge of market players and conditions, which are fluid
- Insurers seem to be more flexible and nimble/responsive in placing this coverage than other types of coverage
- Insurers are willing to tailor policy terms and ability to recognize/implement reasonable and mutually beneficial terms and changes in language
- Favorable conditions are probably attributable to relative immaturity of RWI product, and new insurer entrants to the market
- Unlikely that the favorable conditions will be permanent – stay tuned

Global Implications from Climate Change

Speakers:

David Halbreich Reed Smith

Neil Rambin Sedgwick LLP

GLOBAL COVERAGE IMPLICATIONS FROM CLIMATE CHANGE

David M. Halbreich, W. Neil Rambin, Al Warrington & Benjamin R. Fliegel¹

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I. INTRODUCTION

The goal of this paper is to consider the effects that a changing global climate will have on insurance claims, disputes and the marketplace for insurance. One of the fundamental premises of this paper is that global climate change is a real phenomenon, with actual effects on the world's economy and ecosystems. No attempt is made herein to address why climate change is happening. Regardless of the cause, global realities and perceptions of the changing climate will have an effect on the coverage community.

In Part II, we summarize recognized definitions and effects of contemporary global climate change. Part III of the paper looks briefly at coverage disputes arising from destructive storms, including Hurricanes Katrina and Superstorm Sandy. Both of these storms generated enormous interest in property coverage issues. In Part IV the authors consider how climate change phenomena may result in new and costlier legal disputes implicating other lines of insurance.

II. CLIMATE CHANGE IS CHANGING WEATHER BASED MODELS AND GLOBAL BUSINESS INFRASTRUCTURES

It is hard ignore the ongoing and increasingly heated debate in modern economic, political and scientific spheres about the cause and effects of recent changes to the Earth's climate. Discussions on the topic of global climate change reached a fever pitch last year (2015) and included both the Roman Catholic Churches encyclical, *Laudato Si*,² and the 2015 United Nations Framework Convention on Climate Change, resulting in the 196 country approved Paris

² Encyclical Letter, Pope Francis, *Laudato Si*' On Care for Our Common Home (May 24, 2015), available at http://w2.vatican.va/content/francesco/en/encyclicals/documents/papa-francesco_20150524_enciclica-laudato-si.html.

Accords,³ in which both global political and religious leaders called for swift action to respond to global climate change.⁴

(a) **Physical Manifestations of Climate Change**

Put simply, climate change is a change in the usual weather found in a place.⁵ Based on studies reviewed at the international level by the Intergovernmental Panel on Climate Change (“IPCC”):

Warming of the climate system is unequivocal, as is now evident from observations of increases in global average air and ocean temperatures, widespread melting of snow and ice and rising global average sea level.⁶

³ Paris Agreement, Dec. 12, 2015, *available at* https://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtdsg_no=XXVII-7-d&chapter=27&lang=en; Joby Warrick & Chris Mooney, *196 countries approve historic climate agreement*, the Washington Post, Dec. 12, 2015, *available at* <https://www.washingtonpost.com/news/energy-environment/wp/2015/12/12/proposed-historic-climate-pact-nears-final-vote/>.

⁴ Warrick & Mooney, *supra* note 3; Jim Yardley & Laurie Goodstein, *Pope Francis, in Sweeping Encyclical, Calls for Swift Action on Climate Change*, New York Times, June 18, 2015, *available at* <http://www.nytimes.com/2015/06/19/world/europe/pope-francis-in-sweeping-encyclical-calls-for-swift-action-on-climate-change.html>.

⁵ Dan Stillman & JoCasta Green, *What is Climate Change?*, NASA, <http://www.nasa.gov/audience/forstudents/k-4/stories/nasa-knows/what-is-climate-change-k4.html> (last updated Sept. 4, 2015). A more complex definition has been used by the Intergovernmental Panel on Climate Change:

a change in the state of the climate that can be identified (e.g. using statistical tests) by changes in the mean and/or the variability of its properties, and that persists for an extended period, typically decades or longer. It refers to any change in climate over time, whether due to natural variability or as a result of human activity.

Climate Change 2007: Synthesis Report, Section 1.1: Observations of climate change, IPCC, http://www.ipcc.ch/publications_and_data/ar4/syr/en/mains1.html (last visited Apr. 7, 2016) [hereinafter *Climate Change 2007*].

⁶ *Climate Change 2007*, *supra* note 5; see also *Massachusetts v. EPA*, 127 S. Ct. 1438, 1448, 1455-56 (2007) (describing the IPCC as “a multinational scientific body organized under the auspices of the United Nations” and citing climate scientist Michael MacCracken’s opinion

This paper does not attempt to resolve the causes of climate change, whether man-made or natural. However, it can be safely said that there is a consensus in the scientific community that the climate is changing.⁷ Several different ways in which climate change manifests itself have been posited.

(i) *Warming of Surface and Water Temperatures*

One of the most significant changes to the Earth's climate is the measured increase in Land-Ocean temperatures. The 10 warmest years on record have occurred since 2000 (with the exception of 1998 tying 2009 at 6th place).⁸ Similarly, 2000-2015 (plus 1998) were the sixteen warmest years since records first started being kept in 1880.⁹ As of April 2016 (the date of submission of this paper), "February [2016] was the warmest month in recorded history, surpassing the previous ... record set in December [2015]."¹⁰

on the scientific consensus connecting global warming to a rise in sea levels, changes to ecosystems, increase in disease and a possible contribution to the ferocity of hurricanes.).

⁷ *Climate Change 2007*, *supra* note 5; *Massachusetts*, 127 S. Ct. at 1448, 1455-56; *see also* Jason Samenow, *Meteorologists overwhelmingly conclude climate change is real and human-caused*, The Washington Post, Mar. 24, 2016, *available at* <https://www.washingtonpost.com/news/capital-weather-gang/wp/2016/03/24/meteorologists-overwhelmingly-conclude-climate-change-is-real-and-human-caused/> (citing a survey conducted by George Mason University indicating that "more than 95 percent of meteorologists think climate change is happening"); Global Climate Change Vital Signs of the Planet, *Scientific consensus: Earth's climate is warming*, NASA, <http://climate.nasa.gov/scientific-consensus/> (last visited April 7, 2016).

⁸ NOAA National Centers for Environmental Information, *State of the Climate: Global Analysis for Annual 2015* (Jan. 2016), <http://www.ncdc.noaa.gov/sotc/global/201513> [hereinafter *State of the Climate*].

⁹ *Id.*

¹⁰ Robin Mckie, *February was the warmest month in recorded history, climate experts say*, the Guardian, Mar. 19, 2016, *available at* <http://www.theguardian.com/environment/2016/mar/20/february-was-the-warmest-month-in-recorded-history-climate-experts-say>.

(ii) *Sea Level Rise*

The most commonly discussed effect of the increase in global temperatures is the rise of sea levels. There are reportedly two factors that contribute to the rise in sea levels around the globe: (1) run-off from land ice and (2) thermal expansion.¹¹

First, scientists have observed a significant melting of land ice (glaciers and ice sheets).¹² For example, the 2016 annual maximum coverage of Arctic winter sea ice appeared to occur in March, and was “the lowest in the satellite record, with below-average ice conditions everywhere except in the Labrador Sea, Baffin Bay, and Hudson Bay.”¹³ Glaciers and ice sheets account for approximately 68% of the world’s freshwater,¹⁴ and it has been claimed that melting of the glaciers and ice sheets is causing sea levels to rise in various parts of the world.

The second factor, “thermal expansion,” is a result of the physical properties of water; as water increases in temperature above a certain point, the volume of water expands, even if no additional water is added.¹⁵

Together, melting land ice and thermal expansion are believed to have increased sea levels along the U.S. gulf coast and the eastern seaboard.

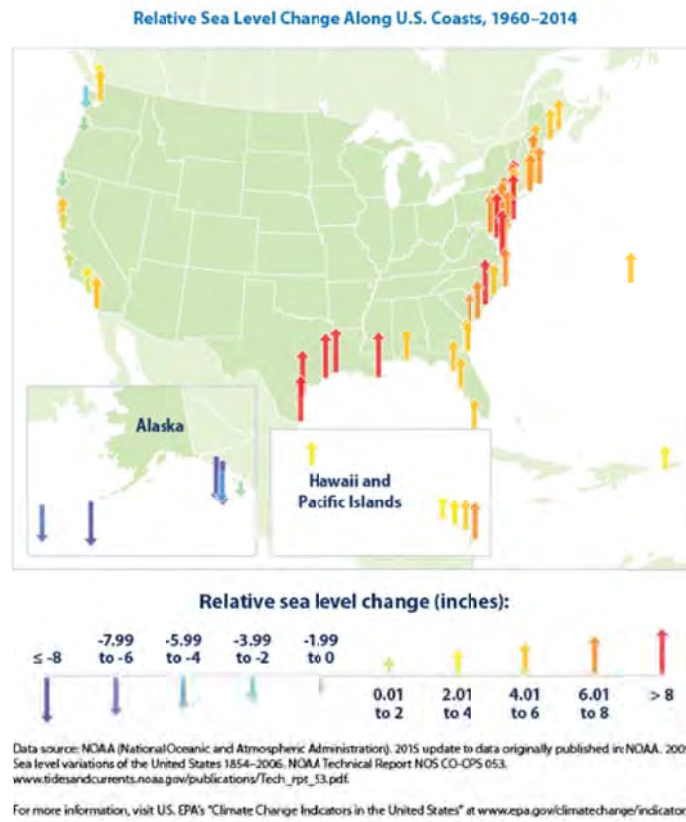
¹¹ See generally R. Warrick & J. Oerlemans, *Sea Level Rise*, in *Climate Change: The IPCC Scientific Assessment* (1990) 257, 261 (J.T. Houghton et al. eds., Cambridge University Press 1990), available at https://www.ipcc.ch/ipccreports/far/wg_I/ipcc_far_wg_I_chapter_09.pdf.

¹² See Earth Observatory, *Global Warming and Land Ice*, NASA, http://earthobservatory.nasa.gov/Features/PolarIce/polar_ice2.php (last visited Apr. 7, 2016). In contrast, melting sea ice does little to contribute to sea level rise “because the sea ice is floating on the ocean already and is in equilibrium with it.” *Id.*

¹³ National Snow & Ice Data Center, *Another record low for Arctic sea ice maximum winter extent*, NSIDC (Mar. 28, 2016), <http://nsidc.org/arcticseaicenews/>.

¹⁴ See Igor Shiklomanov, *World fresh water resources*, in *Water in Crisis: A Guide to the World’s Fresh Water Resources* 13 (Peter H. Gleick, ed., 1993).

¹⁵ See Church, J.A. et al., 2013: *Sea Level Chang.* in *Climate Change 2013: The Physical Science Basis. Contribution of Working Group I to the Fifth Assessment Report of the Intergovernmental Panel on Climate Change* 1139 (Stocker, T.F et al., eds., Cambridge University Press 2013).



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(iii) Hurricanes

Many scientists also claim that climate change is increasing the intensity of hurricanes.¹⁷

Recent theories and computer models predict a 5% increase in wind speeds for every 1 degree Celsius increase in tropical ocean temperature.¹⁸ Other projections suggest that:

¹⁶ *Climate Change Indicators in the United States*, EPA, <https://www3.epa.gov/climatechange/science/indicators/oceans/sea-level.html> (last updated June 2015).

¹⁷ Kerry A. Emanuel, *The dependence of hurricane intensity on climate*, 326 Nature No. 6112, 483-85, 483 (1987), available at <http://www.nature.com/nature/journal/v326/n6112/pdf/326483a0.pdf>; Thomas R. Knutson & Robert E. Tuleya, *Impact of CO₂-induced warming on simulated hurricane intensity and precipitation: Sensitivity to the choice of climate model and convective parameterization*, 17 J. Climate No. 18, 3477-95, 3477 (2004), available at <http://journals.ametsoc.org/toc/clim/17/18>; Gabriel A. Vecchi & Thomas R. Knutson, *Historical Changes in Atlantic Hurricane and Tropical Storms*, GFDL, <http://www.gfdl.noaa.gov/historical-atlantic-hurricane-and-tropical-storm-records> (last visited Apr. 5, 2016). It remains an open question as to whether global climate

global warming could lead to a 2 to 5 percent increase in hurricane peak wind speeds over the next 20 years, which in turn could result in a 30 to 40 percent increase in property insurance losses.¹⁹

The combination of increased intensity hurricanes and rising sea levels may mean higher associated “storm surges.” A storm surge is “an abnormal rise of water generated by a storm, over and above the predicted astronomical tides” driven by a storm’s wind velocity and air pressure differential.²⁰

Results of this “double whammy” – increased hurricane intensity and storm surge – can be seen in the devastation caused by Hurricane Katrina in 2005 and by Superstorm Sandy in 2012. Hurricane Katrina displaced over 250,000 people, caused an estimated 1,833 deaths, over \$152 billion (adjusted) in damages, destruction of 30 oil platforms, 53 levees, and precipitated riots and looting.²¹ Sandy caused approximately \$67 billion in damages. It eliminated power for 5 million New Jersey customers, prevented fire fighters from accessing a fire in Breezy Point,

change increases the *frequency* of hurricanes as well. This is in part due to the fact that there is no clear consensus on what factors cause hurricanes in the first place.

¹⁸ Knutson & Tuleya, *supra* note 24, at 3477.

¹⁹ Insurance Information Institute, Inc., *Climate Change: Insurance Issues* (Sept. 2014), <http://www.iii.org/issue-update/climate-change-insurance-issues>.

²⁰ National Hurricane Center, *Storm Surge Overview*, NOAA, <http://www.nhc.noaa.gov/surge/> (last visited Apr. 7, 2016). The Hurricane Research Division of the Atlantic Oceanographic & Meteorological Laboratory at NOAA, shows the degree of vulnerability to the gulf coast and the eastern corridor to a “worst case scenario” Category 4 hurricane. Hurricane Research Division, *Frequently Asked Questions Subject E26) How vulnerable is my coast to storm surge?*, NOAA, <http://www.aoml.noaa.gov/hrd/tcfaq/E26.html> (last updated May 14, 2010).

²¹ See National Centers for Environmental Information, *Billion-Dollar Weather and Climate Disasters: Table of Events*, NOAA, <http://www.ncdc.noaa.gov/billions/events> (follow “Hurricane Katrina” hyperlink) (last viewed Apr. 5, 2016); National Weather Service, *Hurricane Katrina - A Look Back 10 Years Later*, NOAA, http://www.srh.noaa.gov/lix/?n=katrina_anniversary (last visited Apr. 7, 2016); National Oceanic and Atmospheric Administration, *Wave Heights – Hurricane Katrina 2005: Description*, NOAA, <http://sos.noaa.gov/Datasets/dataset.php?id=490> (last visited Apr. 2016); National Weather Service, *Service Assessment Hurricane Katrina*, NOAA 4 (June 2006), www.nws.noaa.gov/.

Queens, which burned more than 110 homes, and was described by the chairman of the MTA as the “worst disaster in the 108-year history of the [NYC] subway system.”²²

Many contend that these events are not isolated incidents. The year 2015 saw a record 25 global tropical cyclones in the Northern Hemisphere reaching Category 4 or 5; the previous record of 18 was set in 2004.²³ Hurricane Patricia (making land fall in October 2015) was the strongest tropical cyclone ever recorded when measured by maximum sustained winds.²⁴ Thankfully, Hurricane Patricia made landfall in a rural and sparsely populated area of Mexico.²⁵ While various efforts are under review to manage sea level rise (e.g. barriers, higher levees and walls, elevated development, etc.), none is certain to provide near-term protection.

(iv) *Wind/Hail Storms, Crop Damage, and Other Effects*

There could also be a correlation between climate change and other extreme events such as wind/hail storms or tornados. European scientists concluded in 2010 that climate change will lead to a 25 to 50 percent increase in outdoor crop damage due to hailstorms by 2050 in parts of

²² National Centers for Environmental Information, *Billion-Dollar Weather and Climate Disasters: Table of Events*, NOAA, <http://www.ncdc.noaa.gov/billions/events> (follow “Hurricane Sandy” hyperlink) (last viewed Apr. 5, 2016); Reuven Fenton, *At least 111 houses burn as blaze rages in Breezy Point*, New York Post, Oct. 30, 2012, available at <http://nypost.com/2012/10/30/at-least-111-houses-burn-as-blaze-rages-in-breezy-point/>; Reuters, *Sandy leaves unprecedented challenges for New York City subways*, (Oct. 30, 2012), <http://www.reuters.com/article/us-storm-sandy-subway-idUSBRE89T0SU20121030>.

²³ Earth Observatory, *Records Fall in 2015 Cyclone Season*, NASA (Dec. 5, 2015), <http://earthobservatory.nasa.gov/IOTD/view.php?id=87092>; see also Phil Klotzbach, *The Northern Hemisphere’s record-shattering tropical cyclone season, by the numbers*, The Washington Post, Nov. 4, 2015, available at <https://www.washingtonpost.com/news/capital-weather-gang/wp/2015/11/04/the-northern-hemispheres-record-shattering-tropical-cyclone-season-by-the-numbers/>.

²⁴ Todd Kimberlain et al., *National Hurricane Center Tropical Cyclone Report Hurricane Patricia*, NOAA 1, 4, 7, 26 (February 4, 2016) www.nhc.noaa.gov/data/tcr/EP202015_Patricia.pdf.

²⁵ *Id.* at 7-8.

Europe.²⁶ The Warning Coordination Meteorologist at the Storm Prediction Center at NOAA has stated:

NOAA's position is that extreme precipitation events are increasing, and that does appear to be a result of climate change...But we can't tell you that there's necessarily a correlation between a warmer climate and more hailstorms.²⁷

According to one recent article, reinsurer Munich Re has reported that "94 percent of loss-relevant natural catastrophes in 2015 were weather related events."²⁸

(b) **Impact of Physical Manifestations**

In addition to losses directly caused by the above weather events, property insurers potentially face increased losses indirectly caused by global weather events in the form of business interruption and contingent business interruption coverage. Allianz Global Corporate and Specialty issued a report in 2015 detailing the increase in frequency and severity of business interruption losses arising out of climate change, due to the increasingly interconnected nature of systems industries and supply chains.²⁹ Axel Theis, a Member of Allianz SE's Board of Management, put it succinctly:

²⁶ Robert Krier, *As Drought Punishes, Some Americans Reeling from Billion-Dollar Hail Damage*, Inside Climate News (Jul. 18, 2012), <http://insideclimatenews.org/news/20120718/hailstorms-extreme-weather-texas-billion-dollar-losses-insurers-climate-change-global-warming-> (citing W.J.W. Botzen et al., *Climate change and hailstorm damage: Empirical evidence and implications for agriculture and insurance*, 32 Resource & Energy Econ., Issue 3, 341-362 (2010), available for a fee at <http://www.sciencedirect.com/science/article/pii/S0928765509000517..>

²⁷ *Id.*

²⁸ Agence France-Presse, *Natural catastrophes losses \$90b in 2015*, Newage (Jan. 5, 2016), <http://newagebd.net/190361/natural-catastrophe-losses-90b-in-2015/>.

²⁹ Erin Ayers, *Business interruption losses increasing in frequency, severity, Allianz report finds*, Advisen (Dec. 10, 2015), <http://www.advisenltd.com/2015/12/10/business-interruption-losses-increasing-in-frequency-severity-allianz-report-finds/>.

Companies can expect to face further disruption from technological innovation, while also being exposed to climate change impact as an underlying risk which is not within their direct control.³⁰

Swiss Re cautioned that “the costs of natural disasters, aggravated by global warming, threatened to spiral out of control forcing the human race into a catastrophe of its own making” and predicted that within ten years costs attributable to climate related disasters could double to \$150 billion a year, with the insurers’ share of those losses estimated at \$35 to \$40 billion annually (20% of the industry’s entire net worth).³¹

Similarly, in 2006, Lloyd’s noted that it expected climate change “not only to produce extreme capital damaging events, but also to increase uncertainty around corporate business plans and potentially reduce asset values.”³² A 2008 survey conducted by Ernst & Young of top industry analysts from around the world deemed climate change to be the number one risk facing the insurance industry.³³ “The question,” phrased succinctly by Swiss Re CEO John Coomber, “is no longer whether global warming is happening, but how it will affect our business, as well as our personal lives.”³⁴

All of this boils down to an expected increase in losses over time, without certainty as to the scope and rate of the increase of insured losses. It is reasonable to anticipate that a significant increase in losses, in unanticipated ways, will result in novel or more frequent disputes between insurers and policyholders.

³⁰ Press Release, Allianz, Allianz Risk Barometer 2015: Businesses exposed to increasing number of disruptive scenarios (Jan. 14, 2015), *available at* <http://www.agcs.allianz.com/about-us/news/press-riskbarometer2015/>.

³¹ Greg Munro, *Insurance Consumer Counsel’s Column: Insurance and Climate Change*, Trial Trends, Summer 2010, 26-30, at 27, *available at* <http://www.umt.edu/law/files/munro/InsuranceandClimateChange.pdf>.

³² *Id.*

³³ *Id.*

³⁴ *Id.*

III. MULTIPLE CAUSES OF LOSS

One of the key coverage issues in storm loss cases is how the courts handle claims involving multiple causes of loss, some of which are covered and some of which are not. Below is an overview of this issue, followed by two case studies arising out of Hurricane Katrina and Superstorm Sandy. It should be noted that which causation doctrine applies (and whether there are any modifications) depends on the law of the forum applied to the policy.

(a) Causation Theories

(i) *Concurrent Causation Doctrine*

Causation theories can vary by jurisdiction. In insurance law, concurrent causation occurs when a loss is brought about by two or more potential causes. The cause, or causes, of a loss dictate whether or not an insured has insurance coverage for that specific loss. The causation question is complicated in situations of concurrent causation because one cause of the loss may be covered under the applicable insurance policy while another cause either is not covered or is specifically excluded from coverage

Although different jurisdictions apply the doctrine in different ways, an expansive view of coverage in the concurrent causation situation holds that where there is more than one cause of a loss, the loss is covered as a matter of law as long as one of the causes is a covered peril (or, in the case of an open perils form, a peril not specifically excluded or limited). This doctrine developed out of the 1973 decision in *State Farm Mutual Auto Insurance Co. v. Partridge*,³⁵ wherein the Court was confronted with a coverage dispute for injuries jointly caused by two negligent acts. The insured had negligently modified the trigger mechanism of a pistol and

³⁵ 10 Cal. 3d 94, 514 P.2d 123 (Cal. 1973).

stored it in his vehicle.³⁶ One day, when he was driving in the countryside hunting rabbits with two passengers, the insured went off-road, hitting a bump that discharged the pistol which shot and paralyzed the center passenger.³⁷

Under the terms of the homeowner's policy an injury caused by the negligent modification of the pistol's trigger mechanism would be covered, but a "bodily injury ... arising out of the ... use of ... any motor vehicle" would be excluded.³⁸ The Court found that "that when two such risks constitute concurrent proximate causes of an accident, the insurer is liable so long as one of the causes is covered by the policy."³⁹

Although *Partridge* addressed causation in a third party liability insurance policy claim, following this ruling California courts began applying the concurrent causation principles asserted in *Partridge* to first party property claims until 1989, when it began applying the "efficient proximate cause" doctrine described *infra*.⁴⁰

Texas adheres to a version of the concurrent causation doctrine which provides that when covered and uncovered perils combine to cause a loss, the insured is entitled to recover only that portion of the loss caused solely by the covered peril.⁴¹

³⁶ *Id.* at 97.

³⁷ *Id.* at 98.

³⁸ *Id.* at 99.

³⁹ *Id.* at 102.

⁴⁰ The application of *Partridge* to property insurance claims was addressed and modified by *Garvey v. State Farm Fire & Cas. Co.*, 48 Cal. 3d 395, 399 n. 1, 770 P.2d 704, 705 (1989) (citing as examples *Farmers Ins. Exchange v. Adams*, 170 Cal. App. 3d 712, 722, 216 Cal. Rptr. 287 (Cal. App. 1985); *Premier Ins. Co. v. Welch*, 140 Cal. App. 3d 720, 728, 189 Cal. Rptr. 657 (Cal. App. 1983); *Safeco Ins. Co. of America v. Guyton*, 692 F.2d 551, 554–555 (9th Cir. 1982)).

⁴¹ See *Lyons v. Millers Cas. Ins. Co. of Texas*, 866 S.W.2d 597, 601 (Tex. 1993); see also *Hamilton Props. v. American Insurance Co.*, No. 3:12-cv-5046-B, 2014 WL 3055801 (N.D. Tex. Jul. 7, 2014).

(ii) *Anti-Concurrent Causation (“ACC”) Clause*

In response to a body of cases finding coverage as long as one cause of a loss was covered, carriers began adding language to their policies stating that where a loss involves a non-covered cause, it is excluded regardless of sequence. The effect of provisions referring to sequential and/or concurrent causes of loss is frequently that any contribution by any excluded peril, however insignificant, eliminates coverage for the resulting loss, even if the proximate cause of the loss. The Texas Supreme Court recently came to this conclusion in *JAW The Pointe, LLC v. Lexington Ins. Co.*, which involved the following ACC clause:

B. EXCLUSIONS.

1. We will not pay for loss or damage caused directly or indirectly by any of the following. Such loss or damage is excluded regardless of any other cause or event that contributes concurrently or in any sequence to the loss.⁴²

Insurers have had some success in enforcing ACC clauses, with the result that loss caused by a non-covered peril is excluded regardless of any other joint cause of the loss or damage.⁴³

(iii) *Proximate Causation Doctrine*

Not all courts consider anti-concurrent clause causes to be enforceable. California Insurance Code § 530, for example, provides that “[a]n insurer is liable for a loss of which a peril insured against was the proximate cause, although a peril not contemplated by the contract may have been a remote cause of the loss; but he is not liable for a loss of which the peril insured against was only a remote cause.” The California Supreme Court has construed § 530 as

⁴² *JAW The Pointe, LLC v. Lexington Ins. Co.*, 460 S.W. 3d 597, 604 (Tex. 2015).

⁴³ *See, e.g., id.* at 608-10.

incorporating into California law the efficient proximate cause doctrine, and precluding the enforcement of anti-concurrent cause provisions.⁴⁴

As such, in California an exclusion can only operate to deny coverage for losses resulting from causal chains in which excluded perils are the only proximate causes, or chains in which an excluded peril is the efficient proximate cause.⁴⁵ The term “efficient proximate cause” means the predominate or most important cause, not merely the moving cause.⁴⁶ Other jurisdictions, such as Mississippi, have essentially rejected ACC clause exclusions as conflicting with the reasonable expectations of the insured.⁴⁷

(b) **Hurricane Katrina -- *Sher v. Lafayette Ins. Co.*, 988 So.2d 186 (La. 2008)**

(i) *Facts*

The policyholder was the owner of a five-unit apartment building in New Orleans before Katrina hit land.⁴⁸ Following the levee breaks the water level on the lower levels of the building rose as high as 4 feet, damaging personal property as well as the building itself.⁴⁹ The policyholder timely tendered her claim to her insurer.⁵⁰

The insurer conducted two property inspections to determine the cause of the loss and concluded that most of the claimed damage was due to poor maintenance, disrepair, and

⁴⁴ See *Julian v. Hartford Underwriters Ins. Co.*, 35 Cal. 4th 747, 110 P.3d 903 (Cal. 2005) (citation omitted); *Howell v. State Farm Fire & Cas. Co.*, 218 Cal. App. 3d 1446, 1456, 267 Cal. Rptr. 708, 714 (Cal. Ct. App. 1990) disapproved of by *Reid v. Google, Inc.*, 50 Cal. 4th 512, 235 P.3d 988 (2010).

⁴⁵ See generally *Montgomery v. Safeco Ins. Co. of Am.*, No. A094277, 2001 WL 1452776, at *3, 2001 Cal. App. Unpub. Lexis 1582 (Cal. Ct. App. Nov. 15, 2001).

⁴⁶ *Garvey v. State Farm Fire & Cas. Co.*, 48 Cal. 3d 395, 403, 770 P.2d 704, 707 (1989).

⁴⁷ See generally *Corbin v. United Services Automobile Association*, 20 So. 3d 601 (Miss. 2009).

⁴⁸ *Sher v. Lafayette Ins. Co.*, 988 So.2d 186, 191 (La. 2008).

⁴⁹ *Id.* at 191-92.

⁵⁰ See *id.* at 191.

flooding, estimated the damages to be approximately \$3,300, and paid \$2,700 of that amount as covered losses.⁵¹

(ii) *Policy Language & Arguments*

The policy contained a surface water exclusion that excluded from coverage losses from damage caused by:

Flood, surface water, waves, tides, tidal waves, overflow of any body of water, or their spray, all whether driven by wind or not.⁵²

The policyholder argued that the exclusion for flooding was ambiguous as it related to the flooding of New Orleans following the levee breaks from Katrina.⁵³ Specifically, the policyholder argued that the flooding of New Orleans was a “man-made” flood because it was the result of the failure of the levees and not a natural flood.⁵⁴ The term “Flood” in the policy was arguably ambiguous as to whether it excluded only natural floods or whether it was meant to include “man-made” floods precipitated by “man-made” accidents and occurrences.⁵⁵

The insurer argued that the meaning of “flood” was unambiguous.⁵⁶ The policy made no distinction between “man-made” and natural flooding, and was not susceptible to two reasonable interpretations.⁵⁷ Thus, the insurer argued, any losses from damage caused by the flooding of the lower levels of the policyholder’s building were excluded on the face of the policy.⁵⁸

⁵¹ *See id.*

⁵² *Id.* at 193.

⁵³ *Id.* at 192.

⁵⁴ *Id.* at 191, 194-95.

⁵⁵ *Id.* at 194-96.

⁵⁶ *Id.* at 192.

⁵⁷ *Id.* at 194-96.

⁵⁸ *Id.*

(iii) *Legal History*

In the trial court, the policyholder won a motion for summary judgment on the flood exclusion issue.⁵⁹ The court found that the flood exclusion was ambiguous as to whether it excluded “man-made” floods as well as natural floods.⁶⁰ The policyholder eventually won a verdict for approximately \$553,000 for losses from building damage, lost rents, damaged personal property, and other non-payment penalties.⁶¹ The court also awarded additional costs and fees of approximately \$317,000.⁶² The appellate court affirmed the lower court’s ruling on the flood exclusion issue, but adjusted the verdict down to reflect a total recovery (inclusive of all fees, costs and penalties) of approximately \$515,000.⁶³

The Louisiana Supreme Court overturned the lower courts’ decisions, finding the exclusion for “flood” damages to be unambiguous:

The plain, ordinary and generally prevailing meaning of the word “flood” is the overflow of a body of water causing a large amount of water to cover an area that is usually dry.⁶⁴

Accordingly, the court agreed with the insurer’s argument that this policy exclusion applies regardless of the cause of the flood; the issue is whether the damage was caused by a flood.⁶⁵

The court also found the damages were due to natural rather than man-made causes:

[T]he flood was caused by Hurricane Katrina, *not* by man. The levees did not cause the flood, they, whether through faulty design, faulty construction, or some other reason, failed to *prevent* the flood.⁶⁶

⁵⁹ *Id.* at 194-96.

⁶⁰ *Id.* at 191.

⁶¹ *Id.* at 192.

⁶² *Id.*

⁶³ *Id.*

⁶⁴ *Id.* at 194.

⁶⁵ *Id.* at 195-96.

⁶⁶ *Id.* at 195.

The Court then relied on the expert testimony proffered by the policyholder to conclude that the damage to the lower levels of the building was caused entirely by excluded flood damage.⁶⁷ The Court reduced the award to approximately \$247,000.⁶⁸

(c) **Superstorm Sandy -- Doerfler v. Chubb Ins. Co. (Pending in NJ)**⁶⁹

(i) *Facts*

The policyholder was the owner of a multi-million dollar beachfront property in Mantoloking, New Jersey, which was completely destroyed in 2012 by Sandy.⁷⁰ The policyholder timely tendered her claim to the insurer.⁷¹

The insurer and an engineer inspected the property to determine the cause of the loss.⁷² The engineer issued a report to the insurer concluding that the property experienced “severe storm surge” and ultimately “collapsed due to the force of storm surge waves and rushing flood water.”⁷³ The insurer denied coverage pursuant to the flood/surface water exclusion.⁷⁴

⁶⁷ *Id.* at 196.

⁶⁸ *Id.* at 208.

⁶⁹ Reed Smith LLP represents the policyholder in this pending action; however the authors are not personally involved in any aspects of case. All discussion herein is based upon the materials filed with the Court, which are publically available.

⁷⁰ Plaintiff’s Response to Defendant’s Statement of Undisputed Facts at 1, *Doerfler v. Chubb Insurance Company of New Jersey*, No. OCN-L-00483-14 (N.J. Supr. Ct. Law Div. Feb. 1, 2016).

⁷¹ Plaintiff’s Brief in Support of Motion for Partial Summary Judgment at 2, *Doerfler v. Chubb Insurance Company of New Jersey*, No. OCN-L-00483-14 (N.J. Supr. Ct. Law Div. Jan. 7, 2016).

⁷² *Id.*

⁷³ *Id.*

⁷⁴ *Id.* at 3.

(ii) *Policy Language*

The policy provided coverage for windstorm damage.⁷⁵ However, the pertinent exclusion reads as follows:

Surface water. We do not cover any loss caused by:

- flood, surface water, waves, tidal water, overflow of water from a body of water, or water borne material from any of these, including when any such waters or water borne material enters and backs up or discharges from or overflows from any sewer or drain located outside of or on the exterior of a fully enclosed structure;
- run off of water or water borne material from a paved surface, driveway, walkway, patio, or other similar surface; or
- spray from any of these, even if driven by wind.

But we do insure ensuing covered loss unless another exclusion applies.⁷⁶

The policy further defined “caused by” to mean “any loss that is contributed to, made worse by, or in any way results from that peril.”⁷⁷

(iii) *Arguments*

The policyholder argued that the loss was caused by a “storm surge” which is meteorological phenomena associated with a storm, and distinct from the specific types of causations enumerated in the surface water exclusion.⁷⁸ Moreover, following the Katrina cases, many insurers specifically included a storm surge exclusion, which was not done in this case, even though the insurer knew about storm surges, and added storm surge exclusions to other

⁷⁵ See *id.* at 1.

⁷⁶ *Id.* at 3.

⁷⁷ *Id.*

⁷⁸ *Id.* at 8.

policies.⁷⁹ As a result of the way the policy was written, the policyholder asserted a reasonable expectation of coverage for this type of loss.⁸⁰

The policyholder contended that the damage to the property was proximately caused by the wind.⁸¹ Relying on New Jersey law finding coverage if a covered event is the first or last step in the chain of causation, the policyholder contended that the damage was covered and not precluded by the anti-concurrent causation clause in the policy.⁸² The policyholder contended in the alternative that, even if storm surge had been excluded, the property collapse was an ensuing loss from the storm surge and should be covered.⁸³

The insurer urged the court to follow the Katrina related cases, such as *Sher v. Lafayette* detailed above, and hold that the storm surge was a flood because it was “an inundation of normally dry land with water.”⁸⁴ Alternatively, the insurer argued that the damage was caused by “waves” that rode on top of the sea water during the storm, and was similarly excluded under the language in the surface water exclusion.⁸⁵ As a third alternative, the insurer argued that the storm surge constituted an “overflow of water from a body of water” as was thereby excluded as well.⁸⁶

Ultimately, the insurer argued, the collapse was caused by water.⁸⁷ The insurer relied on the policy’s ACC clause that excluded losses caused even only in part by non-covered events and

⁷⁹ *Id.* at 19.

⁸⁰ *Id.* at 11-12.

⁸¹ *Id.* at 12-18.

⁸² *Id.* at 12-15.

⁸³ *Id.* at 18-20.

⁸⁴ Defendant’s Cross Motion for Summary Judgment and In Opposition to Plaintiff’s Motion for Summary Judgment at 1, 8-10, *Doerfler v. Chubb Insurance Company of New Jersey*, No. OCN-L-00483-14 (N.J. Supr. Ct. Law Div. Jan. 26, 2016).

⁸⁵ *Id.* at 2,10.

⁸⁶ *Id.* at 11.

⁸⁷ *Id.* at 11-12.

rejected the policyholder's contention that the damage was an ensuing loss because it was a direct and immediate result of the excluded perils.⁸⁸

The parties also disputed whether the tender and payment of the policyholder's claim to FEMA under the National Flood Insurance Policy estopped the policyholder's arguments.⁸⁹

At the time this paper is submitted, the dispute is pending.

(d) **Other Property Coverages Potentially Triggered**

In addition to claims for physical damage to property, catastrophic storms often result in claims under other types of property coverages, including those providing time element coverage, such as business interruption, contingent business interruption, and extra expense. "Business interruption" insurance is intended to reimburse the policyholder for lost income when its business is interrupted by loss or damage to of property due to an insured peril. If a company's suppliers or customers suffer loss or damage of the type insured by its property insurance policy, the business may look to its insurer for "contingent business interruption" or "CBI" coverage. These provisions generally provide coverage for loss of earnings at the insured's premises as a result of a supplier's or customer's inability to deliver or receive goods or supplies due to damage to its property. "Extra expense insurance" indemnifies the insured for costs in excess of normal operating expenses that the business incurs in order to continue operations while its damaged property is repaired or replaced. Such expenses typically include the cost to rent substitute facilities, move equipment and personal property, and pay overtime wages.

⁸⁸ *Id.* at 3.

⁸⁹ *See* Plaintiff's Response to Defendant's Statement of Undisputed Facts, *supra*, at 8-9.

But other types of coverages can also be implicated. When a governmental entity issues an order restricting access to a policyholder's property, the order may trigger a policy's "civil authority" coverage. Ingress/egress clauses may provide coverage where property damage in the area surrounding the policyholder's property restricts access to or egress from the policyholder's premises.

The magnitude of some of these disruptions, particularly with respect to contingent business interruption losses, can be surprising. The 2011 Japan Earthquake and Thai floods affected factories all around the world – and not only in automobile and electronics industries.

(e) **Appraisal Awards**

Massive storms seem to increasingly lead to massive numbers lawsuits which can leave courts struggling to find efficient ways to handle them. The appraisal process can help, but also presents some challenges. In most jurisdictions insurers will be able to argue that the timely payment of a valid appraisal award eliminates claims for breach of contract and bad faith. In *Blum's Furniture Co. Inc. v. Certain Underwriters at Lloyds London*,⁹⁰ the Fifth Circuit set out three elements necessary to establish an estoppel of a breach of contract claim: (1) the existence and enforceability of an appraisal award, (2) the timely payment of the award by the insurer, and (3) acceptance of the appraisal award by the insured.

In the case of *United Neurology, P.A. v. Hartford Lloyd's Ins. Co.*,⁹¹ the insured argued that the third element above was not met because it did not accept the payment of the appraisal award tendered to it by Hartford. In considering the insured's argument, the court noted that the issue had been previously addressed by several courts which had determined that if the appraisal

⁹⁰ 459 Fed. App'x. 366, 368 (5th Cir. Jan. 24, 2012).

⁹¹ 101 F. Supp. 3d 584 (S.D. Tex. 2015), *aff'd*, No. 15-20241, 2015 WL 8593311 (5th Cir. Dec. 11, 2015).

award had been reached in accordance with the terms of the insurance policy and the carrier had timely tendered the full amount awarded by the appraisers, the insurer was entitled to summary judgment on the breach of contract claim.⁹² Based on that precedent, the *United Neurology* court held that the award was binding and enforceable and that, despite United Neurology's refusal to accept the payment tendered, it had failed to show that Hartford breached the contract.⁹³ The court further held that, because United Neurology's breach of contract claim failed, so did its extra-contractual claims for the common law breach of good faith and fair dealing, violation of the DTPA, and the Texas Insurance Code.⁹⁴

In Florida, however, the policyholder can maintain a claim for bad faith even after the carrier's payment of the appraisal award. Under this line of cases, a bad faith claim follows a determination of the insurer's liability and the policyholder's damages. The appraisal award is often cited as evidence of liability and the extent of damage. The Florida Supreme Court has

⁹² See, e.g., *Providence Lloyds Ins. Co. v. Crystal City Indep. Sch. Dist.*, 877 S.W.2d 872, 875–76 (Tex. App. 1994) (holding that the appraisal award was made in substantial compliance with the terms of the contract, was not made without authority, and was not the result of fraud, accident or mistake, and is therefore binding, and that appellee should take nothing on its breach of contract claim); *Brownlow v. United Services Automobile Assoc.*, No. 13–03–758–CV, 2005 WL 608252 at *2 (Tex. App. Mar. 17, 2005) (“USAA participated in the appraisal process and tendered the amount awarded by the umpire. Because USAA complied with the requirements of the contract it cannot be found in breach.”); *Caso v. Allstate Texas Lloyds*, Civ. A. No. 7:12–CV–748, 2014 WL 528192 at *5 (S.D. Tex. Feb. 7, 2014) (“[T]he award remains both binding and enforceable until it is set aside, notwithstanding Plaintiffs’ rejection of Allstate’s tender, an apparently baseless rejection for which Plaintiffs have not offered an explanation.”).

⁹³ *United Neurology*, *supra*, 101 F. Supp. 3d at 620.

⁹⁴ *Id.*; see also *Breshears v. State Farm Lloyds*, 155 S.W.3d 340 (Tex. App. 2004) (“Under Texas law, timely payment of an appraisal award under the policy precludes an award of statutory penalties under the Texas Insurance Code §§ 541 and 542 as a matter of law.”); *Waterhill Cos. Ltd. v. Great Am. Assurance Co.*, Civ. A. No. 05–4080, 2006 WL 696577 at *2 (S.D. Tex. Mar. 16, 2006) (once appraisal process is invoked, a delay in payment pursuant to the appraisal process does not constitute a violation of the Texas Insurance Code). *But see, Graber v. State Farm Lloyds*, No. 3:13–CV–2671–B, 2015 WL 3755030 at *10 (N.D. Tex. June 15, 2015) (concluding that State Farm’s full and timely payment of the appraisal award did not preclude the insured’s claim for statutory interest under the Texas Prompt Payment of Claims Act as a matter of law).

held that a bad faith action cannot accrue until the underlying lawsuit seeking insurance benefits is resolved in the insured's favor:

[A]n insured's underlying first-party action for insurance benefits against the insurer necessarily must be resolved favorably to the insured before the cause of action for bad faith in settlement negotiations can accrue....⁹⁵

IV. OTHER POTENTIAL INSURANCE RISKS PRESENTED BY CLIMATE CHANGE

The anticipated increase in weather related losses and damages (whether in the form of flood, windstorm, hail, wildfire due to drought conditions, subsidence, or perhaps even disease or injuries to people may very well have a continued and profound effect on the insurance industry. It doubtless presents significant underwriting challenges. Whether climate change is certain enough to be considered an inevitable risk, lacking in fortuity, is beyond the scope of this paper and probably better saved for the cocktail reception. Nevertheless, one can foresee climate change related claims being brought under policies other than property policies. These could include:

- Claims under CGL policies in respect of damages allegedly caused by insured carbon or greenhouse gas emitters;
- Environmental liability policy claims for damages to the environment itself, or for knock-on effects such as toxic releases or mold;
- Crop insurance losses;
- Health and Life Policies and claims related to heat stress and respiratory disease; and
- D&O Claims;

⁹⁵ *Blanchard v. State Farm Mutual Automobile Insurance Co.*, 575 So.2d 1289, 1291 (Fla. 1991). *See also Trafalgar at Greenacres, Ltd. v. Zurich Am. Ins. Co.*, 100 So.3d 1155, 1158 (Fla. Dist. Ct. App. 2012) (“An arbitration award establishing the validity of an insured’s claim satisfies the condition precedent required to bring a bad faith action.”)

(a) **Directors and Officers Insurance Policies**

This last category warrants special attention. Following the destruction brought by Hurricane Katrina, fourteen plaintiffs who owned property damaged in Hurricane Katrina attempted to certify a plaintiff class of all owners of property damaged in the hurricane.⁹⁶ Plaintiffs also asked the Court to certify several classes of defendants including a “Chemical Manufacturer Defendant Class” and an “Oil Company Defendant Class.”⁹⁷ These two proffered defendant classes were included in the lawsuit based upon their alleged “actions that have contributed to global warming.”⁹⁸

Although the Court did not decide this issue specifically, it identified several evidentiary difficulties, including potential issues with proving which specific actions of an individual company contributed to global warming, and the difficulty of showing that global warming affected the weather system that caused Hurricane Katrina.⁹⁹ It is conceivable that similar actions will be brought for future weather events if and when the burden of proving those points is lowered, or addressed by expert analysis.

Government justice departments have also recently begun investigations into company practices and executive actions. Attorneys General from New York, California, Massachusetts, and the Virgin Islands have reportedly announced that they would be conducting an investigation into whether Exxon Mobil misrepresented the threat of climate change to investors and the public.¹⁰⁰ Similarly, requests by two members of congress for investigation into Exxon Mobil’s

⁹⁶ See *Comer v. Nationwide Mut. Ins. Co.*, No. 1:05 CV 436, 2006 WL 1066645 (S.D. Miss. Feb. 23, 2006).

⁹⁷ *Id.* at *1.

⁹⁸ *Id.*

⁹⁹ *Id.* at *2.

¹⁰⁰ John Schwartz, *Exxon Mobil Climate Change Inquiry in New York Gains Allies*, The New York Times, Mar. 29, 2016, available at <http://www.nytimes.com/2016/03/30/science/new-york-climate-change-inquiry-into-exxon-adds-prosecutors.html>; Ivan Penn, *California to*

practices had been referred to the criminal division of the Federal Bureau of Investigation for an initial assessment of the facts.¹⁰¹ Whether and how these allegations are made, i.e. based upon individual knowledge and representations or corporate actions and responsibility, has the potential to create new disputes on what had been considered to be standard policy language.

For example, federal courts in California and New York have permitted claims to go forward based upon the alleged failure to disclose polluting activities and the resultant non-compliance with environmental regulations.¹⁰² An appellate court in New Jersey found that a claim for failure to disclose potential liabilities for pollution claims in SEC filings was covered under the securities claim liability coverage within a D&O policy, and not excluded under the pollution exclusion clause.¹⁰³ However, in Virginia, the Supreme Court found that the plaintiff's allegations that a company "intentionally emits millions of tons of carbon dioxide and other greenhouse gases into the atmosphere annually[, and] knew or should have known of the impacts of [its] emissions" did not constitute an "accident" for the purposes of D&O coverage.¹⁰⁴ The

investigate whether Exxon Mobil lied about climate-change risks, Los Angeles Times, Jan. 20, 2016, available at <http://www.latimes.com/business/la-fi-exxon-global-warming-20160120-story.html>.

¹⁰¹ Michael Phills & Susanne Rust, *Congressmen want probe of Exxon Mobil 'failing to disclose' climate change data*, Los Angeles Times, Oct. 15, 2015, available at <http://www.latimes.com/local/lanow/la-me-ln-investigation-exxonmobil-20151015-story.html>; David Hasemyer, *Justice Department Refers Exxon Investigation Request to FBI*, Inside Climate News (Mar. 2, 2016), <http://insideclimatenews.org/news/02032016/justice-department-refers-exxon-investigation-request-fbi-climate-change-research-denial>.

¹⁰² See *Loritz v. Exide Techs.*, No. 2:13-CV-2607-SVW-EX, 2014 WL 4058752 at *1; 2014 U.S. DIST LEXIS 111491, (C.D. Cal. Aug. 7, 2014) (alleging failure to disclose the emission of high levels of arsenic into the air and leaking hazardous materials into the groundwater); *Meyer v. Jinkosolar Holdings Co.*, 761 F.3d 245 (2d Cir. 2014) (alleging failure to disclose injurious and non-compliant disposal of hazardous waste in an prospectus accompanying public offerings).

¹⁰³ *Sealed Air Corp. v. Royal Indem. Co.*, 404 N.J. Super. 363, 380, 961 A.2d 1195, 1206 (N.J. App. Div. 2008).

¹⁰⁴ See *AES Corp. v. Steadfast Ins. Co.*, 283 Va. 609 (Va. 2012).

law is not yet settled as to which types of climate change related claims might be covered under current D&O policy language.

Executives and directors may also be face shareholder lawsuits arising from climate change related losses. Businesses that choose to enter international markets that are particularly vulnerable to the effects of climate change may face claims challenging those decisions if they are shut down by natural disasters—whether or not they can be directly attributable to climate change. As scientists learn more about the predictable effects of climate change, affirmative defenses based upon the business judgment rule may be challenged. Even where a decision is warranted, policyholders may assert claims based upon a company’s failure to make adequate contingency plans to ensure the continued success of the business after a “predictable” weather related catastrophe.

The fact that scientists (and other climate related experts) do not fully understand the consequences of a changing climate means new disputes based upon changing science is likely, even if the specific manifestation of these future claims are not yet foreseeable.

V. CONCLUSION

In conclusion, coverage counsel on both sides of a weather-related claims need to recognize that climate change is likely to affect standard business practices in the insurance industry. Insurers need to take this into account both on the business end, in terms of capitalization, and profitability projections. As insurers become increasingly concerned about these risks, and seek to exclude coverages based upon new and costly disputes, the insurance market for such coverages likely will expand. In the event the risks and losses become too high to reasonably insure against, insurers and coverage counsel may turn to government agencies as well—either seeking a federally sponsored insurance/reinsurance program (such as TRIA or

NFIP) or requesting that foreign developing governments share some of the risks of global climate change in order to attract investment in their countries and to off-set a corresponding decrease in their national GDP because of these changes.

Insurer Guidelines & Third Party Bill
Reviews:
Ethical & Practical Ramifications

Speakers:
Douglas McIntosh, McIntosh Sawran &
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ACCEC 2016 ANNUAL MEETING

Insurer Guidelines and Third Party Bill Reviews: Ethical and Practical Ramifications

By:

Douglas M. McIntosh*, Neil Posner and James R. Sutterfield

Introduction

Legal oversight has grown significantly in the past 40 years. With the advent of technology, billing guidelines and third party bill audits and reviews are the norm in the insurance defense business. “Managed care” has hit the arena with provision of legal services in the insurance industry.

Defense counsel hired by insurers to defend policy holders are met with billing guidelines¹ and file handling requirements, as means of cost control and effective claims management practices by insurance carriers. Sometimes, guidelines may be considered to restrict the independent exercise of professional judgment or affect the quality of an insured’s representation. Additionally, many insurers utilize external billing review vendors (“fourth party” legal auditors) or computer programs, for electronic review of defense counsel’s bills for determination of the reasonableness of charges for services rendered to their policyholders. In some cases, the external bill reviews can compromise the privileges shared between an attorney and their clients.

This paper explores the practical effects of these practices, and the dynamics of the impact that such practices have on the insurer-insured contractual relationship, with focus on the tripartite relationship, as well as the potential that such practice might invite extra-contractual exposure in certain instances.

I. The Nature of the Tripartite Relationship and Fourth Party Legal Audits [McIntosh]

Conceptually, every party involved in the tripartite relationship would share the same objectives and strategize accordingly. In fact, the tripartite relationship is not generally considered a conflict of interest because ideally the insured, insurer, and attorney are all working

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¹ See Appendix I, DRI, The Voice of the Defense Bar, Standard Insurer Billing Guidelines, as an example of guidelines that have been adopted on a wide scale by many insurers.

toward the common goal of defending the insured as contracted.² Unfortunately, reality is much more nuanced.

Each party has its own goals that influence the development of each segment of the tripartite relationship, whether it is cost efficiency, settlement, or providing quality legal representation. In order to comply with ABA Rules of Professional Conduct and to shield from malpractice, an insurance defense attorney must delineate each client's objective to ensure no conflicts of interest exist amongst them.³

A. Objectives of Each Party

The Insurer

The objectives of the insurer derive from its contractual obligations to the insured.⁴ This contractual relationship may trigger the insurer's "duty to defend" the insured.⁵ The "duty to defend" is determined by analyzing the "four corners of the complaint."⁶ Any breach of this duty to defend may result in bad faith litigation; therefore, the insurer shares the common objective in providing a comprehensive and zealous defense for the insured.

The expense of the defense, however, is a different story. While the insurer is obliged to provide a defense on behalf of the insured, the insurer is under no such obligation to provide the highest quality or most expensive defense.⁷ Many insurers seek to secure "panel counsel" that will provide the most cost effective legal representation for their insured. Some carriers, with use of overly restrictive billing or file handling guidelines, place burdensome restrictions on defense counsel to accommodate their expense objectives. This can effectively impact the professional, independent representation of a client.

² *Am. Mut. Liab. Ins. Co. v. Super. Ct.*, 113 Cal. Rptr. 561, 571 (Cal. 3d DCA 1974) ("the attorney has two clients whose primary, overlapping and common interest is the speedy and successful resolution of the claim and litigation"); *U.S. v. Schwimmer*, 892 F.2d 237 (2d Cir. 1989) (Tripartite parties may engage in a "common legal enterprise" for the defense of the insured.)

³ MODEL RULES OF PROF'L CONDUCT R. 1.6-1.8 and 5.4 (2015).

⁴ *Allstate Ins. Co. v. RJT Enterprises, Inc.*, 692 So. 2d 142 (Fla. 1997) (the duty to defend has no roots in common law, "it is purely a contractual duty"); *Peterson v. Ohio Cas. Group*, 272 Neb. 700, 724 N.W.2d 765 (Neb. 2006); *Maxwell v. Hartford Union High Sch. Dist.*, 341 Wis. 2d 238 (Wis. 2011); *Allstate Ins. Co. v. Campbell*, 334 Md. 381 (Md. 1994).

⁵ *Peterson* at 709 (In determining its duty to defend, an insurer must not only look to the petition or complaint filed against its insured).

⁶ *Higgins v. State Farm Fire and Cas. Co.*, 894 So. 2d 5, 10 (Fla. 2004); *Truck Ins. Exch. v. Prairie Framing, LLC*, 162 S.W.3d 64 (Mo. W.D. 2005) ("As long as the petition against the insured demonstrates the potential or possible statement of a claim within insurance coverage, even if inartfully drafted, it triggers the liability insurer's duty to defend").

⁷ *State Farm Mut. Auto. Ins. Co. v. Traver*, 980 S.W. 2d 633 (Tex. 1998) ("some insureds who have paid for a "Chevrolet" defense are getting a "Yugo" defense").

The Insured

The insured's objectives are fairly straightforward: swift disposition of the claims against them without having to come out of pocket on any expenses. Of course, there are other more particular considerations that may vary on a case-by-case basis, such as settlement affecting the licensing of an insured or its future insurability due to loss-run history, but for the most part the insured wants the litigation to end quickly without any excess judgment exposure.

Another insured objective, which may more indirectly be sought, is the reduction of premium rates. Many advocates of the use of fourth party billing audits reason that cutting legal expenses through the use of audits reduces insured premium rates in the long run. For this reason, the insured may seek to promote its carrier scrutinizing legal costs for these more tangible benefits.

The Attorney

The defense attorney walks a narrow line in considering the interests of the insured and insurer. The attorney must provide competent representation on behalf of the insured, as his or her client, while concurrently being conscientious of the cost and expense objectives of the insurer. At the same time, defense attorneys run businesses that are for profit. The notion of what is an acceptable profit margin should be in the realm of the business owner, driven by standard free market competition. Interference by outside sources can impact a business significantly.

Some states, in order to prevent conflicts or other problems evolving from this legal balancing act, published opinions specifically finding that the attorney's client is strictly the insured and not the insurer.⁸ To protect these interests, defense counsel must be aware of any arising conflicts of interest and tread carefully when planning his client's defense.

The Bill Auditor

Some courts and commentators have suggested that bill auditors or auditing computer programs endeavor to justify their existence by drastically cutting legal expenses to reduce legal costs for insurers.⁹ All auditors share the same objective of cutting legal expenses.¹⁰ However,

⁸ See, e.g., Fla. Bar Staff, Op. 20591 (1997) (finding that "an insurance defense lawyer's client is the insured, not the insurance company"); In re Rules of Professional Conduct and Insurer Imposed Billing Rules and Procedures, 299 Mont. 321 (Mont. 2000) (holding that the insurance defense attorney only works for the insured); Wash. State Bar Ass'n. Formal Op. 195 (1999) (stating that "legally and ethically the client of the lawyer is the insured"); *Costley v. State Farm Fire and Cas. Co.*, 894 S.W.2d 380, 385 (Tex. App.--Amarillo 1994), writ denied (Dec. 1, 1994) (defense counsel owes "the same type of unqualified loyalty [to the insured] he would owe if originally employed by [the insured]").

⁹ California has developed regulations on how a legal auditor is to be compensated as result of the concerns surrounding how legal auditors may cut costs of legal bills. Specifically, California forbids the use of any percentage based compensation scheme that may incentivize a legal auditor to reduce legal bills drastically without just cause. See Ca. Ins. Code 11580.02.

¹⁰ 299 Mont., supra. note 8 at 333.

there are no widely utilized methods of legal auditing, most legal auditors vary widely in their background and experience, and all auditors go relatively unregulated in executing their cost cutting services.¹¹

The concerns involving the use of legal bill auditors have caused more than thirty states to publish ethical opinions regarding the use of legal bill audits and billing guidelines, all of which closely examine and recognize the inherent risks of insurance companies using such services.¹² A “fourth party” to the relationship, the bill auditor has none of the obligations imposed by law or ethics on the insurer and defense counsel in the tripartite relationship. The potential for heightened risk and exposure seems poised to strike, in today’s “managed care,” cost control of legal services.

B. Relationships that May be Adversarial in Nature

Insurer v. Insured

In most cases, the insured and insurer’s interests are aligned to provide an effective and efficient defense. However, efficiency and quality don’t always go hand in hand.¹³ These issues are especially apparent in analyzing the relationship between an insured and the insurer’s hired bill auditor. What are the financial incentives of the insurer? What are the financial rewards for the auditor? How do these financial issues impact the insured, who is sued and needs full and complete representation?

¹¹ James P. Schratz, Cross-Examining a Legal Auditor, 20 Am. J. Trial. Advoc. 91 (1996).

¹² Alabama Ethics Op. RO-98-02 (1998); Alaska Bar Ass’n Ethics Comm., Ethics Op. 99-1 (1999); Arizona State Bar Comm. on the Rules of Prof’l Conduct, Formal Op. 99-08 (1999); Colorado Bar Ass’n Ethics Comm., Formal Op. 107 (1999); Connecticut Bar Ass’n Comm. on Prof’l Ethics, Informal Op. 00-20 (2000); District of Columbia Bar Legal Ethics Comm., Op. 290 (1999); Florida Bar Staff Op. 20762 (1998); Georgia State Bar Proposed Advisory Op. 99-R2 (2000); Hawaii Formal Ethics Comm., Op. 36 (1999); Idaho State Bar Formal Ethics Op. 136 (1999); Indiana State Bar Op. 4 (1998); Iowa Supreme Court Bd. of Ethics and Conduct, Op. 99-1 (1999); Kentucky Advisory Ethics Op. KBA E-404 (1998); Louisiana Bar Ethics 45 La. B.J. 438 (1998); Maine Bar Ass’n Ethics Op. 164 (1998); Maryland State Bar Ass’n Comm. on Ethics, Op. 99-7 (1998); Massachusetts Bar Ethics Op. 2000-4 (2000); Mississippi State Bar Ass’n Op. 246 (1999); Missouri Informal Op. Summary 980188 (1998); Nebraska Advisory Comm., Advisory Op. 00-1 (2000); New Hampshire Ethics Op. 2000-02/05 (2000); New Mexico State Bar Formal Advisory Op. 2000-02 (2000); New York State Bar Ass’n Comm. on Prof’l Ethics, Op. 716 (1998); North Carolina State Bar, Formal Ethics Op. 11 (2000); Ohio Supreme Court Bd. of Comm’rs on Grievances and Discipline, Op. 2000-2 (2000); Oklahoma Bar Ass’n Legal Ethics Comm., Proposed Revised Advisory Op. 1998-04 (1998); Oregon Formal Op. 1999-157 (1999); Pennsylvania Informal Op. 97-119 (1997); Rhode Island Supreme Court Ethics Advisory Panel, Op. 99-17 (1999); South Carolina Bar Ethics Advisory Op. 98-36 (1998); State Bar of South Dakota Ethics Op. 99-2 (1999); Tennessee Supreme Court Bd. of Prof’l Responsibility, Formal Ethics Op. 99-F-143 (1999); Texas Ethics Op. 532 (2000); Utah State Bar Ethics Advisory Op. Comm., Op. 98-03 (1998); Vermont Bar Ass’n Ethics Op. 98-7 (1998); Virginia Bar Legal Ethics Op. LEO 1723 (1998); Washington State Bar Ass’n Formal Op. 195 (1999); West Virginia Lawyer Disciplinary Bd., L.E.I. 99-02 (1999); Wisconsin State Bar Prof’l Ethics Comm., Ethics Op. E-99-1 (1999).

¹³ 299 Mont., *supra*. note 8 at 333.

A common conflict of interest between insured and insurer emerges when an attorney wants take depositions of certain people in order to thoroughly develop her case.¹⁴ Typically in order to prevent exorbitant costs, insurers “don’t allow” attorneys to take the deposition of non-essential people. While this serves the insurer’s interests of reducing expenses, this does not always effectuate the insured’s objectives of having a quality defense and pertinent information could be lost as a result.¹⁵ Defense counsel can also find such “restrictions” as impacting his or her exercise of independent, professional judgment in the case, as discovery needs are indentified and pursued, or not. Add to this the potential that some fourth party is going to “audit” the work, and determine if it is “essential” to the defense, and a climate is created for dispute and potential satellite litigation.

Attorney v. Bill Auditor

At least one court has noted that an insurance defense attorney stands investigatory, at best, and adversarial at worst with legal bill auditors or outside auditing companies.¹⁶ Legal bill auditors arguably exist purely to challenge and often cut the costs that were already predetermined by the attorney to be legitimate costs incurred while serving the needs of their client. The chasm between defense counsel, and a fourth party auditor, can be enormous.

The inherent polarization between these two parties has generated tort cases between auditors and attorneys. In 2003, a California law firm sued an auditing firm for negligence and intentional tort, alleging the auditing firm caused the law firm’s contract with an insurance company to end.¹⁷ While the complaint was dismissed under California law, the case stands to illustrate the depth of the adversarial nature between a fourth-party bill auditor and insurance defense attorney.

C. Where will this go from here?

As shown above, and further explored by the co-authors of this paper hereafter, the potential for disruption of the historical tripartite relationship in the insurance defense arena, is real. The impact on privileges, and consideration of ethical issues, must be explored. Lawyers that represent insurers, directly, and those that represent policyholders, must be mindful of the effects that modern-day business practices have on the historical tripartite relationship. This is explored in more detail in the next two sections of this paper.

¹⁴ Amy S. Moats, A Bermuda Triangle in the Tripartite Relationship: Ethical Dilemmas Raised by Insurers' Billing and Litigation Management Guidelines, 105 W. Va. L. Rev. 525, 533 (2003).

¹⁵ *Id.* See also 299 Mont., supra note 8 at 333.

¹⁶ *Glenn K. Jackson Inc. v. Roe*, 273 F. 3d 1192 (9th Cir. 2001).

¹⁷ *Glenn K. Jackson Inc.* 273 F. 3d at 1199.

II. Effect of Tripartite Relationship in Insurance Defense Cases on Attorney-Client Privilege and Work Product Privilege [Sutterfield]

A. Where does privilege exist and who forms the magic circle?

The submission of detailed attorney billings to an independent, third party billing service for review and approval of a defense attorney's services relative to an insured may not only constitute a breach of client confidentiality, but may also result in a waiver of attorney-client or work product privileges.

Because the issue of privilege is a legal issue, as opposed to exclusively a question of ethics, guidelines regarding the implications of third-party auditing of lawyers' billings and its effect on attorney-client privilege and work product privilege often fall outside the purview of many state bar advisory committees.¹⁸

The attorney-client privilege is the oldest privilege in the common law.¹⁹ Its purpose is "to encourage full and frank communication between attorneys and their clients ..."²⁰ An offshoot of the attorney-client privilege and its legal coequal, the work product doctrine protects the materials prepared by an attorney or the attorney's agent in anticipation of litigation or for trial use.²¹

As a result of the highly protective nature of both privileges, a body of law has developed in recent years addressing the role of a third party, in relation to the basic attorney-client relationship. Examining the tripartite relationship, in the context of defense counsel (e.g. the insured-lawyer relationship, the insurer-lawyer relationship, common interests of the insurer-insured relationship, and their interplay with role of the outside auditor) makes the question even more difficult and often yields differing results.

Each of these relationships begins with a concept informally dubbed the "magic circle". As coined by the United States First Circuit Court of Appeals, the "magic circle" consists of a small circle of "others" with whom information may be shared without loss of privilege (e.g., secretaries, interpreters, counsel for a cooperating co-defendant, a

¹⁸ Confidentiality issues raised by the subject are often resolved by applying ABA Model Rule 1.6 - Confidentiality of Information.³⁹ Subsection (a) of this rule states, "A lawyer shall not reveal information relating to representation of a client unless the client consents after consultation, except for disclosures that are impliedly authorized in order to carry on the representation, and except as stated in paragraph (b)." ABA Model Rules of Professional Conduct R. 1.6(a) (2000).

¹⁹ See generally David J. Fried, Too High a Price for Truth: The Exception to the Attorney-Client Privilege for Contemplated Crimes and Frauds, 64 N.C. L. Rev. 443 (1986) (historical overview).

²⁰ *Upjohn Co. v. United States*, 449 U.S. 383, 389 (1981).

²¹ *Hickman v. Taylor*, 329 U.S. 495 (1947); see also *United States v. MIT*, 129 F.3d 681, 687 (1st Cir. 1997) ("The [attorney-client] privilege . . . is designed to protect confidentiality, so that disclosure outside the magic circle is inconsistent with the privilege; by contrast, work product protection is provided against 'adversaries,' so only disclosing material in a way inconsistent with keeping it from an adversary waives work product protection.")

parent present when a child consults a lawyer).²²

The “magic circle” also necessarily examines the purpose of the work for which privilege is sought. Discussing a United States Second Court of Appeals addressing privilege for third-parties, one commentator summarized the case accordingly:

In *United States v. Kovel*²³, this matter was considered in the case of an accountant. There, a client sent relevant paperwork to an accountant at a law firm seeking help with a matter that later came to the IRS's attention. When the IRS sought the document from the accountant, the document was considered privileged. The court found that the relevant question as to whether the information was still privileged was whether the information was given to the accountant with the purpose of gaining the accountant's advice or the attorney's. If the accountant was brought into the relationship to interpret financial documents for the attorney so that the attorney could give legal advice or counsel, the attorney-client privilege stood-whereas it would not stand if the accountant was given the information so that the accountant could give advice or if the accountant's interpretation was not necessary for the attorney.²⁴

The magic circle represents a functional concern, in that the lawyer must be able to consult with others necessary for competent representation of the client.²⁵ However, the consult should be directly relevant.

Accordingly, considering the nature of the tripartite relationship, the privileges therein and the extension of privilege even further to communications with a third party, such as a billing company, yields a complicated path.

i. Privilege within the context of the insured- lawyer relationship.

All jurisdictions would agree that lawyer hired by an insurance company to represent its insured must represent the insured as his/her client with undivided loyalty.²⁶

Some jurisdictions characterize insurance defense as a one-client situation, with

²² *MIT*, 129 F.3d at 684.

²³ *United States v. Kovel*, 296 F.2d 918 (2d Cir. 1961).

²⁴ Spencer Rand, *Hearing Stories Already Told: Successfully Incorporating Third Party Professionals into the Attorney-Client Relationship*, 80 *Tenn. L. Rev.* 1, 38-39 (2012)(citations omitted).

²⁵ *Id.*

²⁶ See ABA Standing Comm. on Ethics and Prof. Responsibility, Formal Op. 96-403 (1996); Florida Bar Prof. Ethics Comm. Op. 97-1 (1997).

defense counsel paid by a third party, the insurer.²⁷ This approach represents the minority view, but the single-client theory, under which the policyholder alone is the attorney's client, is gaining popularity.

The majority of jurisdictions prefer a joint client approach, meaning that the lawyer represents both the insured and the insurer.²⁸ In these cases, the defense lawyer has two clients--the insurer and the insured.²⁹ This is the well-known "dual client doctrine," under which the defense lawyer owes fiduciary duties to both the insurer and insured.³⁰ However, there is a general perception that the defense attorney will show ultimate alliance to the business practicalities of courting the insurer.³¹

The benefits and complications of the dual client doctrine were explained by one commentator accordingly:

This joint client construct solves some problems and creates others. It gives the insurance company financing the engagement more clout with the lawyer; some would say too much clout. It also cements claims of privilege for communications with the insurance company. On the other hand, if it is a joint representation, the lawyer, from the beginning, has to worry about conflicts between the insurance company and the insured. As a result, some of these proposed joint representations will be non-starters because issues relating to coverage are already present. And if those conflict issues are not apparent in the beginning they can develop at any time. In addition, the joint representation model means that issues relating to the confidentiality of information must be addressed. When the lawyer could learn from the insured client confidential information that could provide a policy defense (such as intentional misconduct or lack of cooperation), the lawyer is barred from sharing that information with the co-client insurance company.³²

To that extent, an attorney is not free to disclose potential coverage issues that may exist and impact the insured's status with insurer. For example, in a Massachusetts case, defense counsel was charged with malpractice for disclosing intentional acts by

²⁷ See *Wolpaw v. Gen. Accident Ins. Co.*, 639 A.2d 338, 340 (N.J. Super. Ct. App. Div. 1994). (See also, footnote 8, *supra*.)

²⁸ Restatement (Third) of the Law Governing Lawyers at §134 cmt. f. (2000).

²⁹ *Jerry & Richmond*, *supra* note 17, § 114, at 887 (describing this view as the majority rule).

³⁰ *Id.* (quoting *Nat'l Union Fire Ins. Co. v. Stites Prof'l Law Corp.*, 1 Cal. Rptr. 2d 570, 575 (Ct. App. 1991)).

³¹ *Purdy v. Pacific Auto. Ins. Co.*, 203 Cal. Rptr. 524, 533-34 (Ct. App. 1984) ("As a practical matter, however, there has been recognition that, in reality, the insurer's attorneys may have closer ties with the insurer and a more compelling interest in protecting the insurer's position, whether or not it coincides with what is best for the insured").

³² Susan R. Martyn, *Accidental Clients*, 33 Hofstra L. Rev. 913, 937 (2005).

insured to insurer.³³

For this reason, regardless of the single or dual-client approach, some jurisdictions advocate the appointment of separate independent counsel to avoid a conflict of interest. According to one court, “[c]onflict of interest between jointly represented clients occurs whenever their common lawyer's representation of the one is rendered less effective by reason of his representation of the other.”³⁴ Ultimately, it falls to counsel to recognize when a conflict develops. In some jurisdictions, where a conflict of interest arises between a liability insurer and its insured because the insurer provides a defense under a reservation of rights, the insurer has a duty to provide its insured with independent counsel of the insured's choosing, or “Cumis counsel.”³⁵ In others, such as my home state of Louisiana, the insurer can appoint separate counsel for the insured so long as the counsel can defend the insured without doing so in a way that may affect the coverage issues.³⁶ However, there is case law in Louisiana that should the insurer deny coverage but decide to defend the case, the insurer is responsible for the reasonable costs of the insured's independent counsel.³⁷

ii. Privilege within the insurer-insured relationship.

There is no recognized insured-insurer privilege that, in of itself, protects communications between an insured and the insurer.³⁸ As a result, the only privilege that can arise between the insured and the insurer is that which arises from the attorney-client privilege of the insured-lawyer relationship.

In order to perfect attorney-client privilege, there are two views as to the mechanism giving rise to attorney-client privilege for communications between an insured and its insurer, dubbed the broad view and the narrow view.

Under the broad view, an insured's communication to its liability or indemnity insurer as to an incident possibly giving rise to liability covered by the policy is protected

³³ Massachusetts Elec. Co. v. Fletcher, Tilton & Whipple, P.C., 394 Mass. 265 (Mass. 1985).

³⁴ Spindle v. Chubb/Pacific Indem. Group, 89 Cal.App.3d 706, 713, 152 Cal.Rptr. 776, 780-81 (1979).

³⁵ West's Ann.Cal.Civ.Code § 2860. Compulink Management Center, Inc. v. St. Paul Fire and Marine Ins. Co., 169 Cal. App. 4th 289, 87 Cal. Rptr. 3d 72 (2d Dist. 2008).

³⁶ See Storm Drilling Co. v. Atl. Richfield Corp., 386 F.Supp. 830, 832 (E.D. La.1974).

³⁷ Belanger v. Gabriel Chemicals, Inc., 2000-0747 (La.App. 1 Cir. 5/23/01, 7); 787 So.2d 559, 565 writ denied, 802 So.2d 612 (La.2001)

³⁸ Some states have chosen to adopt bright line rules, acknowledging that all parties to the tripartite relationship enjoy a degree of attorney-client privilege. See Bank of Am., N.A. v. Superior Court of Orange Cnty., 151 Cal. Rptr.3d 526 (2013) (“confidential communications between either the insurer or the insured and counsel are protected by the attorney-client privilege, and both the insurer and insured are holders of the privilege.”); see also Ratcliff v. Sprint Missouri, Inc., 261 S.W.3d 534, 548 (Mo. Ct. App. 2008).

from disclosure by the attorney-client privilege.³⁹ From a practical standpoint, it is understood that such insured-insurer communications are made for the purpose of the insured's reporting responsibilities, as well as triggering the insured's duty to defend.⁴⁰

Even under the broad view, the assumption of privilege is not without limitation. For example, under an Illinois state ruling, there was no attorney-client privilege protecting an insured's communications to an independent insurance adjuster, retained by the insurer to investigate the accident.⁴¹ Likewise, the Iowa Supreme Court found there was no privilege for communications unrelated to the defense of the claim.⁴²

Under the narrow view, there is no per se attorney-client privilege in insured-insurer communications. Rather, the attorney-client privilege applies only to communications made for the dominant purpose of the insured's defense by the insurer-appointed attorney and under circumstances in which the insured has a reasonable expectation of confidentiality. This test, while stricter, often results in a privilege being extended to communications between an insured and its insurer-appointed attorney.

Regardless of the broad or the narrow view, an attorney-client privilege extending to communications between an insured and its liability or indemnity insurer may be waived by the insured's voluntary disclosure of the communication to a third person. Voluntary disclosure may constitute a waiver of both the attorney-client privilege and work product protection and each requires a separate analysis for waiver.

iii. Privilege arising from a common interest.

Under the common interest privilege (or "joint defense privilege") the attorney client privilege is extended to protect communications that are "part of an on-going and joint effort to set up a common defense strategy."⁴³ Under the common interest doctrine, privilege may extend to information shared with third parties when "the parties engage in a common legal enterprise and the communications are a part of an ongoing and joint effort to set up a common defense strategy."⁴⁴

In order to establish the existence of a joint defense privilege, the party asserting the privilege must show that (1) the communications were made in the course of a joint

³⁹ See e.g. *Finegold v Lewis* (1965, 2d Dept) 22 App Div 2d 447, 256 NYS2d 358 (a statement made by an insured to his insurer, before commencement of the suit, was held not available for discovery).

⁴⁰ See e.g. *White v. City of Ladue*, 422 S.W.3d 439 (Mo. Ct. App. E.D. 2013), reh'g and/or transfer denied, (Jan. 30, 2014) and transfer denied, (Mar. 25, 2014) (privilege covers, and excludes from discovery, any communication between insured and insurer which relates to the former's duty to report incidents and the latter's duty to defend and to indemnify).

⁴¹ See e.g. *Shere v Marshall Field & Co.* (1974, 1st Dept) 26 Ill App 3d 728, 327 NE2d 92.

⁴² See *in Re Munsell's Guardianship* (1948) 239 Iowa 307, 31 NW2d 360.

⁴³ *Weinstein v. Eisenberg*, 474 U.S. 946, 106 S.Ct. 342, 88 L.Ed.2d 290 (1985).

⁴⁴ *US v. Schwimmer*, 892 F.2d 237, 243 (2d Cir. 1989).

defense effort, (2) the statements were designed to further the joint effort, and (3) the privilege has not been waived.⁴⁵ Where a “joint defense effort or strategy has been decided upon and undertaken by the parties and their respective counsel,” communications may be deemed privileged whether litigation has been commenced against both parties or not.⁴⁶

Interpreting a broad cooperation clause, the Illinois Supreme Court applied the common interest doctrine, when it found that the insured and insurers shared a common interest in defeating or settling a plaintiff’s underlying claims, despite the fact that coverage was in dispute as well. The court rejected the insured’s claims of attorney-client privilege (for independently retained counsel) and permitted discovery by insurers. The court also found the work product doctrine inapplicable because the materials sought were prepared for the benefit of both the insurer and insured in the underlying action, not in anticipation of the coverage litigation.⁴⁷

The benefit of a “common interest” defense, like that in *Waste Management*, is that communications between insured and insurer fall within the protection of the attorney-client privilege with respect to underlying plaintiffs and other third parties. Accordingly, while perhaps limiting the independence of the insured or insurer, the Illinois viewpoint promotes insured/insurer cooperation, while protecting communications from discovery by third parties.

In terms of third party protections under the common interest doctrine, in *Bellmann v. County of Arapahoe*, 531 P.2d 632 (Colo. 1975), the district attorney in a criminal matter sought discovery of statements made by an insured to an investigator hired by defense counsel in a civil matter. The Colorado Supreme Court held that statements made to a third party (investigator) fell under the ambit of attorney-client relationship and was therefore privileged.

However, the minority viewpoint held by some states indicates that they are reluctant to extend attorney-client privilege so far. In *Langdon v. Champion*, 752 P.2d 1004 (Alaska 1988), the Alaska Supreme Court held that the insured’s communications to a third party (the insurance adjuster) would only qualify as attorney-client privilege if it can be shown that “the adjuster received the communication at the express direction of counsel for the insured”.

B. The Auditor, a common interest, and the “magic circle”.

In *United States v. MIT*, a First Circuit Court of Appeals case decided in 1997,

⁴⁵ *Matter of Bevill, Bresler & Schulman Asset Management Corp.*, 805 F.2d 120, 126 (3rd Cir. 1986) (citations omitted).

⁴⁶ *Schwimmer*, 892 F.2d at 244.

⁴⁷ *Waste Management, Inc. v. International Surplus Lines Ins. Co.*, 144 Ill. 2d 178 (Ill. 1991).

the court held that privileged information disclosed to an outside government auditing service was discoverable.⁴⁸ The court found that MIT waived the attorney-client privilege when it disclosed documents to government auditors, which the court considered outside the “magic circle”.⁴⁹ In MIT, the IRS requested billing statements from law firms for MIT. Pursuant to a defense contract requirement, MIT had already disclosed the very same billing statements to the auditing agency.⁵⁰ MIT provided the billings to the IRS, but redacted portions claiming attorney-client privilege, the work product doctrine, or both.⁵¹ The district court ruled that MIT's disclosure of legal bills to the audit agency forfeited its attorney-client privilege.⁵²

This opinion was echoed by the Montana Supreme Court, when they rejected the notion that third-party billing auditors are part of a privileged community or the “magic circle” within which confidential information may be shared without waiver of attorney-client or work product privilege.⁵³

The MIT court also rejected the idea that a common interest concept applied to an audit agency, because their interests are not common:

In a rather abstract sense, MIT and the audit agency do have a ‘common interest’ in the proper performance of MIT's defense contracts and the proper auditing and payment of MIT's bills. But this is not the kind of common interest to which the cases refer in recognizing that allied lawyers and clients—who are working together in prosecuting or defending a lawsuit or in certain other legal transactions—can exchange information among themselves without loss of the privilege. To extend the notion of MIT's relationship with the audit agency, which on another level is easily characterized as adversarial, would be to dissolve the boundary almost entirely.⁵⁴

However, it should be noted that in MIT, the court did note that a strong policy argument could be made for protecting against disclosure of the mental

⁴⁸ U.S. v. Massachusetts Institute of Technology, 129 F.3d 681, 48 Fed. R. Evid. Serv. 66, 39 Fed. R. Serv. 3d 4 (1st Cir. 1997).

⁴⁹ Id.

⁵⁰ Id.

⁵¹ Id.

⁵² Id.

⁵³ In re Rules of Prof'l Conduct & Insurer Imposed Billing Rules & Procedures, 299 Mont. 321, 340, 2 P.3d 806, 818 (2000); see also U.S. v. South Chicago Bank, 1998 WL 774001, *2, 3 (N.D. Ill. 1998) (“[A]uditors are not generally part of the circle of persons, including secretaries and interpreters, for example, with whom confidential information may be shared without destroying the privilege. ... Here, the banks' year-end audit team—as opposed to the fraud audit team—was outside the circle of persons with whom confidential information could be shared because they were performing work in the ordinary course of business, not for the sake of legal advice. By voluntarily disclosing the minutes from the meetings of the boards of directors and special fraud committees to the year-end auditors in full and to their insurance company in part, the banks have relinquished the right to assert the privilege now against the government.”).

⁵⁴ 129 F.3d at 686.

impressions and legal theories of an attorney.⁵⁵ The court refused to consider the issue because it was not raised or briefed for the court's review.⁵⁶ Therefore, to the extent that detailed attorney billings are submitted to external billing auditors, they still may represent work product subject to privilege.

Nonetheless, some commentators are reluctant to extend the First Circuit's rationale concerning auditor to the defense billing context, arguing that the insured, insurer, and auditor interests are aligned because the auditor promotes fiscal efficiency, resulting in lower premiums, and promotes an incentive for counsel to "take the most direct route to resolution", ostensibly encouraging litigators not to drag their feet in order to pad billing.⁵⁷

C. Conclusion

Arguably, it is questionable if third party billing services retained by insurance companies could fall within the ambit of "others" within the "magic circle" with which information may be shared without loss of privilege. While argument may exist to paint the role as adversarial and umbrella it under a larger policy concern advocating speedy resolution of litigation, the issue is nonetheless clouded by uncertain and contradictory case law.

Unlike purely ethical considerations, such as client confidentiality, because the issue of privilege is a legal issue, practicing attorneys must wait for the issue to be ripe within the courts, as opposed to adopting state bar sanctioned guidelines for third-party auditing of lawyers' billings. In light of increasingly complex and intrusive billing management requirements, defense attorneys are left with an open question of "how much is too much?" in order to breach attorney-client privilege, and "how much is just enough?" to preserve work product privilege.

III. Ethical Issues Raised by Billing Guidelines and Legal Fee Audits in Tripartite Relationships [Posner]

A. Billing Auditors and the Attorney-Client Privilege and Work-Product Doctrine

The following issues are implicated when an insurer uses outside billing auditors to review the bills submitted by defense counsel:

⁵⁵ Id. at 688.

⁵⁶ Id.

⁵⁷ See John P. Killacky, *Expanding the Tripartite Relationship: Extending Evidentiary Privilege to Fourth-Party Legal Audits*, 2000 U. Ill. L. Rev. 1339, 1357 (2000); Kent D. Syverud, *The Ethics of Insurer Litigation Management Guidelines and Legal Audits*, 21 No. 7 Ins. Litig. Rep. 180, 192 (1990) ("the MIT decision actually supports insurers' use of outside auditors, because disclosure of billing information is necessary to facilitate the insured's representation and because the insurer and insured have a common interest in efficient, cost-effective and appropriate representations.")

- The Attorney-Client Privilege
- The Attorney-Work Product Doctrine
- ABA Model Rule of Professional Conduct 1.2 (Scope of Representation and Allocation of Authority between Client and Lawyer)⁵⁸
- M.R. 1.4 (Communication)
- M.R. 1.6 (Confidentiality of Information)
- M.R. 1.7 (Conflict of Interest: Current Clients)
- M.R. 1.8(f) (Conflict of Interest: Current Clients: Specific Rules, particularly with respect to where the fees are being paid by someone other than the client)
- M.R. 5.4 (Professional Independence of a Lawyer)
- M.R. 5.5 (Unauthorized Practice of Law)
- M.R. 5.7 (Responsibilities Regarding Law-Related Services)
- M.R. 8.4 (Misconduct)

Any lawyer defending an insured cannot ignore these rules and doctrines, lest she put herself at significant professional and disciplinary risk.

Insurers also should be mindful of these concerns. While no one can argue that insurers have a right to manage their costs, insisting on the use of outside billing auditors in connection with the defense of an insured has some potential to result in claims against insurers for breach of contract, professional negligence, and bad faith, which in turn could lead to liability for extracontractual damages and regulatory proceedings.

1. Risks

Billing auditors have been described as the “fourth party” in the tripartite relationship.⁵⁹ While many jurisdictions have recognized that communications among the client, defense counsel, and the insurance company paying for such counsel, are or should be protected from disclosure to plaintiffs by the attorney-client privilege and/or the work-product doctrine,⁶⁰ as is more fully discussed below, many jurisdictions also have declined to extend those protections when such information is shared with the “fourth party.”

Similarly, some jurisdictions also have expressed concerns about the limitations imposed on defense counsel by so-called “billing and litigation guidelines.” The use of such guidelines and of outside billing auditors have been contributing to an atmosphere of tension, distrust, and

⁵⁸ Hereinafter the ABA Model Rules of Professional Conduct will be abbreviated to “M.R.” For the complete text of and comments to the Model Rules, as well as annotations to them, see E.J. BENNETT, E.J. COHEN & H.W. GUNNARSSON, ABA ANNOTATED MODEL RULES OF PROFESSIONAL CONDUCT (8th ed. 2015) (hereinafter ANNOT. M.R.). The reader also is invited to consult the applicable Rules in all jurisdictions in which the reader is licensed and or is otherwise admitted to practice.

⁵⁹ See, e.g., John P. Killacky, *Expanding the Tripartite Relationship: Extending Evidentiary Privilege to Fourth-Party Legal Audits*, 2000 U. ILL. L. REV. 1339 n. d1.

⁶⁰ See, e.g., Stephen Gillers, *Ethical Issues in Monitoring Insurance Defense Fees: Confidentiality, Privilege and Billing Guidelines*, monograph furnished to Law Audit Services, Inc. (1998). For an expanded discussion of this topic, see Amber Czarnecki, *Ethical Considerations Within the Tripartite Relationship of Insurance Law—Who is the Real Client?*, 74 DEF. COUN. J. 172 (April 2007).

concern for quite some time, contributing to the rise of an adversarial relationship between insurers and defense counsel.⁶¹ But while cost control is a legitimate business concern, from the point of view of the insured, as well as insured's defense counsel, there's also the ethical and evidentiary concerns regarding privilege.

First is the question of whether documents shared with outside billing auditors may be discovered by plaintiffs in the underlying action. Second is the question of whether documents *mentioned* in documents that are shared with outside billing auditors may be discoverable. Put another way, does sharing such information with outside billing auditors waive the attorney-client privilege, the protections of the work-product doctrine, or both? A somewhat extensive selection from a leading law-review article on this subject may be helpful at this juncture:

The waiver argument advanced by the insurance defense bar is meritorious. This claim has found acceptance among state bar associations, many of which have issued ethics opinions forbidding the disclosure of information to fourth-party auditors. [Citation to Michael Booth, *State Ethics Bans on Outside Fee Audits Mounting*, 154 N.J. L.J. 93, 93 (1998).] However, the issue is far from settled. At least one state bar has held that such disclosures are permissible. [*Id.*] Additionally, legal auditors feel that violation of confidentiality arguments against fourth-party auditing "are too often shills for defense attorneys who don't want their bills audited Insurance companies have always audited bills All they are doing now is outsourcing this function." [*Id.* (quoting Ted Ringle, auditor at Law Audit Services).]

Recently, the courts have added to the controversy. In 1997, the First Circuit Court of Appeals decided *United States v. Massachusetts Institute of Technology (MIT)* [129 F.3d 681 (1st Cir. 1997)], which addresses waiver of attorney-client privilege by disclosure of documents to auditors outside the insurance context. The *MIT* decision is often cited by the insurance defense bar to support their view that disclosure of billing statements to auditors waives any privilege. [Citation to Claire Hamner Maturro, *Auditing Attorneys' Bills: Legal and Ethical Pitfalls of a Growing Trend*, FLA. B.J., May 1999, at 22, 24.] In *In re Rules of Professional Conduct and Insurer Imposed Billing Rules and Procedures (In re Rules Case)* [2 P.3d 806 (Mont. 2000)], the Montana Supreme Court directly applied *MIT* to answer the question of whether disclosure of billing statements to insurer-hired auditors violates client confidentiality. [*Id.* at 818-20.] The court concluded fourth-party auditors do not fall within the "magic circle" of persons covered by the attorney-client privilege. [*Id.* at 820-21.] Additionally, a number of other suits have been filed by insurance defense lawyers seeking restrictions on the ability of insurers to review and control bills. [Citations to Anne Berryman, *Suits Challenge Audits of Insurance Defense Bills*, FULTON CO. DAILY REP. Mar. 8, 1999, at 7; *Smith v. Law Audit Servs.*, No. 164549 (San

⁶¹ See, e.g., Chris S. Stacy, *Life of the Triparty: Why Flat-Fee Independent Counsel Might Just Make Everyone (More or Less) Happy*, 19 REV. LITIG. 323, 325 (Spring 2000).

Francisco Super. Ct., filed Feb. 11, 1999); *Smith v. Legalgard*, No. 164548 (San Francisco Super. Ct., filed Feb. 11, 1999).]⁶²

While this commentator advocates for an extension of the privilege to fourth-party auditors, his advocacy necessarily must acknowledge that the privilege, in most situations, does *not* extend to fourth-party auditors. Accordingly, a review of potential preventive measures follows.

2. Prophylactic Measures

(a) Stop Using Billing Auditors

While defense counsel likely will not want to hear this, it is not unreasonable for an insurance company to want to exercise some control over the amount of money spent on defending insureds. If the function could be brought in-house, then the issue essentially evaporates.

This may be a difficult concept to sell to insurance companies because there likely are significant cost savings and benefits associated with outsourcing this function. Those benefits, however, need to be weighed against the risks discussed above.

(b) Obtain Informed Consent of Insured Before Disclosing Detailed Bills to Billing Auditors

M.R. 1.6(a) provides in pertinent part that “[a] lawyer shall not reveal information relating to the representation of a client unless the client gives informed consent”⁶³ M.R. 1.0(e) defines “informed consent” to denote “the agreement by a person to a proposed course of conduct after the lawyer has communicated adequate information and explanation about the material risks of and reasonably available alternatives to the proposed course of conduct.”⁶⁴

While the definition of “informed consent” is arrestingly brief, the comments to that definition disclose how serious this concept is to the drafters:

[6] Many of the Rules of Professional Conduct require the lawyer to obtain the informed consent of a client or other person (e.g., a former client or, under certain circumstances, a prospective client) before accepting or continuing representation or pursuing a course of conduct. See, e.g., Rules 1.2(c), 1.6(a) and 1.7(b). The communication necessary to obtain such consent will vary according to the Rule involved and the circumstances giving rise to the need to obtain information consent. The lawyer must make reasonable efforts to ensure that the client or other person possesses information reasonably adequate to make an informed decision. Ordinarily, this will require communication that includes a

⁶² John P. Killackey, *Expanding the Tripartite Relationship: Extending Evidentiary Privilege to Fourth-Party Legal Audits*, 2000 U. ILL. L. REV. 1339, 1340-41.

⁶³ ANNOT. M.R. 101.

⁶⁴ ANNOT. M.R. 15.

disclosure of the facts and circumstances giving rise to the situation, any explanation reasonably necessary to inform the client or other person of the material advantages and disadvantages of the proposed course of conduct and a discussion of the client's or other person's options and alternatives. In some circumstances, it may be appropriate for a lawyer to advise a client or other person to seek the advice of other counsel. A lawyer need not inform a client or other person of facts or implications already known to the client or other person; nevertheless, a lawyer who does not personally inform the client or other person assumes the risk that the client or other person is inadequately informed and the consent is invalid. In determining whether the information and explanation provided are reasonably adequate, relevant factors include whether the client or other person is experienced in legal matters generally and in making decisions of the type involved, and whether the client or other person is independently represented by other counsel in giving the consent. Normally, such persons need less information and explanation than others, and generally a client or other person who is independently represented by other counsel in giving the consent should be assumed to have given informed consent.

[7] Obtaining informed consent will usually require an affirmative response by the client or other person. In general, a lawyer may not assume consent from a client's or other person's silence. Consent may be inferred, however, from the conduct of a client or other person who has reasonably adequate information about the matter. A number of Rules require that a person's consent be confirmed in writing. See Rules 1.7(b) and 1.9(a). For a definition of "writing" and "confirmed in writing," see paragraphs (n) and (b). Other Rules require that a client's consent be obtained in a writing signed by the client. See, e.g., Rules 1.8(a) and (g). For a definition of "signed," see paragraph (n).⁶⁵

The "Financial and Billing Information" annotation to M.R. 1.6(a) addresses this issue more directly:

The rule also prohibits a lawyer from revealing a client's financial or billing information without the client's consent. *See, e.g.,* R.I. Ethics Op. 2002-02 (2002) (lawyer for municipal council may not comply with individual council member's request for unredacted itemized billing statement unless council consents). The issue arises often in the context of insurance representation, when a lawyer hired by an insurance company to represent an insured is asked to submit information supporting the lawyer's bills to the insurer or a third-party auditor hired by the insurer Ethics committees commonly find that a lawyer is impliedly authorized to give billing information to an insurer if it will not adversely affect the interests of the insured, but not to submit this information to a third-party auditor without the informed consent of the insured. *See, e.g.,* ABA Formal Ethics Op. 01-421 (2001); *accord In re Rules of Prof'l Conduct*, 2 P.3d 806 (Mont. 2000) (insurance defense counsel may not give detailed description of legal services to third-party auditors absent fully informed consent of insureds);

⁶⁵ ANNOT. M.R. 17-18.

Alaska Ethics Op. 2006-3 (2006) (insurance defense counsel may not give confidential bills to noninsurer contractors for electronic or computerized screening); *see also* Conn. Informal Ethics Op. 2011-7 (2011); Fla. Ethics Op. 12-04 (2013); Mass. Ethics Op. 2000-4 (2000); Neb. Ethics Op. 2000-1 (2000); N.H. Ethics Op. 2000-01/05 (2000); N.Y. State Ethics Op. 987 (2013); Pa. Ethics Op. 01-200 (2001); S.C. Ethics Op. 12-08 (2012). *But see* D.C. Ethics Op. 290 (1999) (lawyer may not provide client billing information to insurer or insurer's auditing agency without client's informed consent).

On the other hand, billing information and fee agreements are generally not protected by either confidentiality or the evidentiary attorney-client privilege unless disclosure would reveal the substance of confidential communications between a lawyer and a client. *See, e.g., DiBella v. Hopkins*, 403 F.3d 102 (2d Cir. 2005) (time records and billing statements not privileged when they do not contain detailed accounts of legal services rendered); *United States v. Naegle*, 468 F. Supp. 2d 165 (D.D.C. 2007) (lawyer's billing statements that were general and did not reveal any litigation strategy or other specifics of representation not protected by attorney-client privilege); *Att'y Grievance Comm'n v. Zdravkovich*, 852 A.2d 82 (Md. 2004) (lawyer's bank statements not attorney-client communications and neither confidential nor privileged); *Hewes v. Langston*, 853 So. 2d 1237 (Miss. 2003) (simple invoice normally not protected by attorney-client privilege, but "itemized legal bills necessarily reveal confidential information and thus fall within the privilege"); *In re Dyer*, 817 N.W.2d 351 (N.D. 2012) (lawyers' bank trust account records not confidential).⁶⁶

This is a minefield, to say the least. Is the information that the insurer requests from defense counsel confidential? What is contained in it? What analysis of these documents must be undertaken in order to determine whether the information contained therein is confidential? Who will undertake that analysis? Should the defense lawyer do it? Is it a conflict of interest for her to do it? Should the insured hire independent counsel to do it? Who would pay for that?

And to the question of informed consent, who should make the request to the insured? How likely is it that the insured will understand the importance of the question? Will an insured—who likely is much more concerned about having been sued and about being defended and, hopefully, exonerated—going to go to the trouble and expense of hiring an independent lawyer to review the request? And how many independent lawyers will advise the insured to give such consent?

While it always is a mistake to use the word "clearly" in legal writing, it appears clear to this author that the likelihood is quite small that any consent obtained from an insured under the condition of being a defendant in a lawsuit would be deemed "informed."

(c) Give Insured Option to Choose In-House Auditor versus Outside Auditor, Subject to Higher Premium

⁶⁶ ANNOT. M.R. 111-12.

This self-explanatory option calls into question whether an insured that selects the less-costly option has been provided with sufficient information to make an informed decision to take that option. This raises the question of whether “consent in advance” ever can be effective. *See, e.g., In re Rules Case*, in which the Montana supreme court held that, “under Rule 1.6, [Mont.] R. Prof. Conduct, for an insured to make a fully informed consent to disclosure of detailed professional billing statements, the consent must be contemporaneous with the facts and circumstances of which the insured should be aware.”⁶⁷ Thus, where an insured chooses the less-costly option (a likely scenario), the problem does not go away.

(d) Go to Fixed-Fee Arrangements

In a case where the insurer is defending without a reservation of rights, then a flat-fee or fixed-fee arrangement certainly would solve the problem for there would be nothing to audit.

In the frequent case, however, where the defense is being provided subject to a reservation of rights that gives rise to the insured’s right to independent counsel, this becomes a more challenging issue. One commentator, however, has offered the following food for thought:

The arguments for independent counsel are easy to conceptualize, but there remain practical problems that prevent independent counsel from being a panacea for the problems of conflicting interests. The primary problem is that by vesting policyholders with the right of independent counsel without saddling them with the costs of independent counsel, inefficient defenses are likely to result.⁶⁸ These inefficiencies are manifested both by the policyholder’s choice of a defense counsel who charges high hourly rates and by the policyholder’s incentive to maximize the number of hours that are spent defending the claim. [Citation to Jeffrey B. Ellis, *Revisiting the “Cumis” Rule*, 11 CAL. LAW. 55, 55-56 (1991) (discussing problems arising from a statute requiring use of independent defense counsel when a conflict of interest exists between the insurer and the insured).]

Utilizing flat-fee arrangements for compensating the defense attorney can solve the second problem of over-working a claim and thereby remove the need for oversight by billing auditors. By separating the attorney’s compensation from the amount of time spent working on the defense, the attorney has incentives to suggest efficient defense strategies. But this still leaves the question of who gets to set the flat-fee sum. The insurer will still want to select the cheapest, the policyholder will still want to select the most expensive, and the attorney will still want to make sure that he can make money on the defense.

There are many possible solutions to the question of who gets to set the level of compensation for independent counsel. To name a few, the choice could be regulated by the state or vested in either the policyholder or the insurer. The problem is in keeping the chooser honest, so that he has to internalize the costs as well as the benefits of the choice. This situation parallels the classic “I cut, you

⁶⁷ *In re Rules Case*, 2 P.3d 806, 822 (Mont. 2000).

⁶⁸ Author’s comment: Many independent defense lawyers would take issue with this statement!

choose” situation familiar to many parents who have been required to moderate a dispute between two children fighting over the last remnants of a birthday cake. The problem is solved by vesting the right to divvy the resource in one child, while vesting the right of first choice between the divvied pieces in the other child. The cutter is kept honest by the prospect that he will be left to suffer the consequences of an unfair allocation. The solution would be only slightly more complicated in a tripartite relationship utilizing a flat-fee agreement.

One possible solution could involve giving defense attorneys the right to cut by submitting flat-fee bids for bundles of independent counsel cases to an independent defense referral service. Defense counsel could be given first bite at the apple by agreeing to continue the representation as independent counsel for a fee amount equal to that of the bid that is closest to, but less than, the mean bid. If counsel declines, then the attorney that submitted the just-below-the-mean bid would be given the opportunity to represent the policyholder. Using the bid that is closest to, but below, the mean as the benchmark would exert downward pressure on the market flat-fee rate while preventing insurers and unscrupulous defense attorneys from setting a rate that is too low to provide a reasonably effective defense. At the same time policyholders would be precluded from demanding rates that are higher than what is justified by the value of the claim. To ensure the consensual basis of the attorney-client relationship, policyholders could be given the right to choose a higher bidder and pay for the difference or to bargain for any extra services not contemplated in the attorney’s bid.

* * *

By allowing for independent counsel after a reservation of rights is issued by the insurer, the likely expectations of the policyholder are most fully realized. The policyholder is provided with unconflicted representation, and insurers are precluded from obtaining back-door disclosure of information that could be used against the insured. An independent counsel system relying on a competitive, flat-fee bid process and administered through an independent referral service accounts for the market imperfections inherent in the insurer-insured relationship, while providing for some measure of cost control. Furthermore, the system rescues insurance defense attorneys from the thorny situation of having to serve two masters with divergent interests.

All of this is achieved in a way that avoids the pitfalls of trying to fit the square peg of insurer-insured relations into the round hole of professional responsibility law. Instead of trying to formulate a rule that works in both conflicted and unconflicted situations, and which depends on the designation of the insurer as either a client or a third-party payor, the solution recognizes that the

three parties' posture relative to one another is more important than the titles they hold.⁶⁹

This commentator's suggestion is worth further consideration and discussion among those of us who practice in the insurance-coverage area. While this suggestion, as written, may not comport completely with the law in some jurisdictions that give insureds close-to-unfettered rights with respect to the selection of independent counsel in a reservation-of-rights situation, creative coverage practitioners on both sides of the insurer-insured divide, acting in good faith, should be capable of coming up with variations on this theme that may not require a revision of applicable law. Such a solution, if one could be agreed upon, would eliminate the need for outside billing auditors, which in turn would reduce the risks of waiver of the attorney-client privilege and the protections of the work-product doctrine. And it also might make insurers' billing guidelines somewhat less onerous for defense attorneys to comply with.

3. And if the Insured Refuses to Consent to Outside Billing Review?

If the insured refuses to give its informed consent for defense counsel to share documents with outside billing auditors, then defense counsel may not do so. The Florida Bar has addressed this question, stating:

Given the requirements of Rule 4-1.6 [Florida's equivalent to M.R. 1.6 (Confidentiality)], Florida Ethics Opinion 93-5, and other applicable precedent, the inquiring [defense] attorney cannot allow the insurer or third party auditing companies to audit and review detailed billing statements and/or files of his clients who are insured by this insurance company without first obtaining permission from his clients. Whether the insurance contract between insurer and insured grants such permission to the insurer is a legal question upon which Bar ethics counsel cannot provide an opinion.⁷⁰

An answer to the closing question in the above-quoted passage may be found in *In re Rules Case*, as discussed above, wherein the Montana supreme court held that "for an insured to make a fully informed consent to disclosure of detailed professional billing statements, the consent must be contemporaneous with the facts and circumstances of which the insured should be aware."⁷¹ In other words, it is quite foreseeable that some courts will decline to enforce a provision in an insurance contract that could be construed as an "advance consent."

In any event, if defense counsel does not obtain his client's informed consent, but the insurer insists on having the documents anyway, then defense counsel has no choice but to withdraw. And that could lead to bad-faith litigation. That is an untenable situation for everyone.

⁶⁹ Chris S. Stacy, *Life of the Triparty: Why Flat-Fee Independent Counsel Might Just Make Everyone (More or Less) Happy*, 19 REV. LITIG.323, 352-54 (Spring 2000).

⁷⁰ Claire Hamner Maturro, *Auditing Attorneys' Bills: Legal and Ethical Pitfalls of a Growing Trend*, FLA. B.J., May 1999, at 22, 24, citing FLA. B. ETHICS COUNS. ADV. OP. 20762 (Mar. 9, 1998).

⁷¹ *In re Rules Case*, 2 P.3d 806, 822 (Mont. 2000).

B. Auditor Playing the Role of Lawyer: Effect of Auditing on the Quality of Representation

Some courts have turned a gimlet eye toward billing guidelines. One such case is *Frederick v. Unum Life Insurance Company of America*.⁷² In *Frederick*, the parties moved to vacate the scheduled trial date because “discovery issues ‘have arisen which have significantly delayed discovery in this matter which will prevent the parties from being prepared to proceed to trial . . . as presently scheduled.’”⁷³ The judge declined the motion.

After “commending” counsel for both sides for cooperating in discovery, the judge stated that he was “troubled by exhibit 6 supporting the motion, (*Unum Life Insurance Company of America* GUIDE FOR OUTSIDE COUNSEL, December 1995’) and the potential role it might have in these proceedings to date, and in the problems experienced by counsel of record.”⁷⁴ Judge Molloy stated further:

A. The defendant’s apparent litigation policy

UNUM, not its local counsel, has formulated a business plan for dealing with litigation. That business plan is bottom line oriented on its face. For instance, consider the following points:

- No legal services should be provided unless authorized in advance.
- We expect to be informed before you make any commitments on UNUM’s behalf, and as developments occur.
- Unless you are otherwise advised, a UNUM attorney or *paralegal* must review all briefs, motions, substantive pleadings, *discovery responses* and settlement offers.
- **UNUM will not pay for the following:** any legal work which is not required by the litigation or which does not “advance the ball”
- **UNUM will not pay for the following:** forwarding documents to UNUM
- **UNUM will not pay for the following *unless approved in advance by UNUM*:** Work which could have more cost-effectively been performed by UNUM.

B. The obligation of local counsel

By contrast the local rules provide the duties and responsibilities of the Montana lawyer representing the out of state party.

⁷² 180 F.R.D. 384 (D. Mont. 1998).

⁷³ *Id.* at 385.

⁷⁴ *Id.* (italics and all-caps in original).

“The attorney shall also designate in the application a member of the Bar of this Court with whom the Court and opposing counsel may readily communicate regarding the conduct of the case and upon whom papers shall be served.” **Local rule 110-1(f)**.

While the rule is couched in light of the *pro hac vice* procedure, it provides a suitable analogy here where the GUIDE FOR OUTSIDE COUNSEL suggests that “inside counsel” will control UNUM’s “case leadership.”

“UNUM’s Philosophy (sic) is to actively co-counsel with Outside Counsel, working as a team. This may mean that UNUM’s inside counsel will provide case leadership. In some case, Outside Counsel will provide that leadership.” (Ex. 6 pg. 2, U-007481).

The problem as I see it is that UNUM’s bottomline GUIDE is in conflict, not only with the local rules of practice, but also with the Federal Rules of Civil Procedure. The GUIDE hamstring the lawyer charged with defending the claim. The GUIDE seems to be based on the erroneous presumption that litigation is like chess, the object is to win by anticipating the opponents moves to the point that the opponent has no place to turn and must then concede.

C. Rule 1, F.R.Civ.P.

Litigation is not a game in which counsel are paid only where they “advance the ball.” The rules of discovery and the rules of procedure serve one salutary purpose: “They shall be construed and administered to secure the just, speedy, and inexpensive determination of every action.” Rule 1, F.R.Civ.P. * * *

The Rules of Civil Procedure, the public interest and the interests of both parties to this litigation, demand a seemly and efficient use of judicial resources to achieve the goals articulated in Rule 1. [Citation omitted.] As I read the materials before me two things are clear. Counsel of record are vigorously representing their respective clients while simultaneously making an effort to comport with the rules. The problem on the horizon stems from UNUM’s apparent bottomline based litigation policy.⁷⁵

Other jurisdictions are in accord. For example, it is the opinion of the Iowa Supreme Court Board of Professional Ethics and Conduct that: “(1) it would be improper for an Iowa lawyer to agree to, accept or follow Guidelines which seek to direct, control or regulate the lawyer’s professional judgment or details of the lawyer’s performance; dictate the strategy or tactics to be employed; or limit the professional discretion and control of the lawyer” and “(2) it would be improper for an Iowa lawyer to agree to, accept or follow such proposed service-log requirements in any form that causes the attorney-client privilege to be placed in jeopardy, if the service-log is sent to a third party. An Insurer may require a lawyer to identify the services rendered and time spent, so long as it does not control the lawyer’s professional judgment or

⁷⁵ *Id.* at 385-86 (italics, boldface, and all-caps in original).

undermine the attorney-client privilege.”⁷⁶ As to the more specific question of outside auditors, the Iowa Board stated: “A lawyer is required to protect the confidences and secrets of a client and they may not generally be revealed without the client’s consent, after full disclosure. DR 4-101. Any requirement that the lawyer obtain the insured’s consent to such a disclosure creates an ethical dilemma for the lawyer. As the Washington State Bar Association has stated, ‘This is because it is almost inconceivable that it would ever be in the client’s best interests to disclose confidences or secrets to a third party.’ WSBA Formal Opinion 195, 6/24/99. ‘If there is the slightest risk of embarrassment to the client or waiver of privileged information, independent counsel could have an affirmative duty to recommend against disclosure.’ *Id.*”⁷⁷

Tennessee has issued similar guidance. In Tenn. Ethics Op. 99-F-143,⁷⁸ the Board of Professional Responsibility of the Supreme Court of Tennessee stated that prior to allowing auditors to review attorney’s bills and case files, client consent must be given, and also stated that attorneys are not allowed to enter into any agreement to represent an insured whereby the insurance company has the power to direct the manner of the attorney’s representation.⁷⁹ In response to a request for clarification of that Ethics Opinion, the Board was asked whether an attorney may comply with that opinion simply by “redacting” the confidences and secrets from the clients’ files and bills prior to submitting them to the auditors.⁸⁰ The Board answered “no,” stating:

It should be reiterated that if a client consents, there is no problem submitting any file to an auditor. DR 4-101(a) requires a lawyer to keep not only information protected by the attorney/client privilege confidential, but also any “secret”. “Secrets” include “other information gained in the professional relationship that the client has requested to be held inviolate or the disclosure which would be embarrassing or would likely to be detrimental to the client.” “A secret” can therefore be almost anything the client does not wish to be disclosed. For instance, in Board of Professional Responsibility Formal Opinion No. 82-F-25 (February 22, 1982), the Board noted that even zip codes, birth dates, race, sources of referral, etc., may be considered “secrets”. It is not up to the attorney to determine what the client wishes to keep confidential or secret. Thus an attorney cannot unilaterally make redactions based on his/her personal judgment as to the confidentiality of certain information in his/her file. Client consent remains necessary for any disclosure.⁸¹

The Board also was asked whether the attorney complies with the requirements by sending the bill not directly to the audit service, but to the insurance company with the knowledge that the insurance company may forward the bill to the auditor.⁸² The Board’s answer to this question also was “no,” stating: “DR 1-102(a) states that lawyer ‘shall not circumvent the disciplinary rules through actions of another.’ Therefore, a lawyer cannot evade the requirements

⁷⁶ IOWA S. CT. BD. OF PROF. ETHICS & CONDUCT OP. No. 99-01 (Sept. 8, 1999).

⁷⁷ *Id.* (underscore in original).

⁷⁸ 1999 WL 406886 (June 14, 1999).

⁷⁹ *Id.* at *3-4.

⁸⁰ TENN. ETHICS OP. 99-F-143(a), 1999 WL 961452, *1 (Sept. 10, 1999).

⁸¹ *Id.* (underscore in original).

⁸² *Id.*

of the aforesaid opinion by participating in a scheme whereby the insurance company forwards the bill to the auditor.”⁸³

The third question relates to a proposed insurance company requirement that an attorney who feels he/she cannot provide competent representation to a client under the insurer’s litigation guidelines, must first discuss the situation with the insurance company.⁸⁴ The answer to this question is yes on the condition that “confidential communications or information cannot be disclosed without the client’s consent. If after the discussion the attorney and the insurance company continue in disagreement as to specific aspects of the attorney’s representation, Opinion No. 99-F-143 requires the attorney to disregard the insurance company’s directives and to proceed in the direction he/she believes to be in the best interest of his/her client.”⁸⁵

C. Conclusion

No reasonable person can argue that: (1) insurance companies should be allowed to control their costs; (2) insureds are entitled to defense counsel that is diligent, competent, and conducts herself in conformity with the applicable rules of professional conduct and the rules of court; and (3) that defense counsel has an ethical obligation to conduct the defense without outside parties interfering with counsel’s independent professional judgment.

It is becoming increasingly well settled that efforts on the part of insurance companies to dictate how defense counsel is to conduct the defense, through such documents as “billing and litigation guidelines,” may and often do interfere with the independent professional judgment of defense counsel. And it also is becoming increasingly well settled that the use of outside billing auditors raises serious concerns about loss or waiver of the attorney-client privilege and/or the protection of the work-product doctrine.

It is the view of this author that coverage counsel from both sides of the insurer-insured divide should work together to acknowledge that these problems exist and to devise solutions that benefit all three parties to the tripartite relationship.

⁸³ *Id.*

⁸⁴ *Id.*

⁸⁵ *Id.*

APPENDIX I

DEFENSE RESEARCH INSTITUTE RECOMMENDED CASE HANDLING GUIDELINES FOR INSURERS

DEFENSE RESEARCH INSTITUTE RECOMMENDED CASE HANDLING GUIDELINES FOR INSURERS

I. PREFACE

Philosophy

[Insurer] expects to work with the Firm and the insured to achieve the best result for the insured in an efficient and cost-conscious manner consistent with the Firm's ethical obligations. Nothing contained herein is intended to nor shall restrict Counsel's independent exercise of professional judgment in rendering legal services for the Insured or otherwise interfere with any ethical directive governing the conduct of counsel.

II. CASE DEVELOPMENT

An effective and strategically sound legal defense is the responsibility of counsel and [insurer] and should be developed in a timely manner.

A. A goal is to identify, timely, those claims for which there is liability, and to discuss settlement opportunities early. The activities necessary to defend a given claim and bring it to appropriate resolution should be addressed early and the steps necessary to achieve that resolution should be jointly agreed upon as between the [Insurer] and defense counsel.

B. An early resolution of lawsuits is desirable and the use of alternative dispute resolution is encouraged.

C. If defense counsel is involved in settlement negotiations, settlement authority must be obtained from [Insurer] and requests for authority should be made timely.

III. STAFFING PHILOSOPHY

Your firm should designate one attorney to have primary responsibility for each case on which your services are requested. The case should be staffed economically and effectively. Obviously, a balance must be struck between the efficiency a more experienced lawyer at your firm brings to a given task and the advantages of having the task performed by a junior lawyer or a paralegal. Duplication of effort within the firm should be avoided.

To achieve the best efficiency and value, the role and responsibilities of the staff members should be clearly defined and appropriate to each individual's qualifications, level of experience and billing rate. Defense counsel should delegate work to subordinates wherever possible to achieve efficiency and cost-effectiveness without compromising quality.

IV. REPORTING REQUIREMENTS

A. Reports

Unless otherwise requested, reporting is required for three events: Acknowledgment, Initial Evaluation, and Significant Developments. Reports should be provided to both [insurer] and [insured].

1. Acknowledgment:

Upon receipt of a new case, counsel should send an acknowledgment letter regarding receipt of the file and designating the legal team assigned to the case. Any matters of immediate concern or information that may result in early resolution of the case should be addressed in the acknowledgment letter.

2. Initial Report:

Within _____ days after receipt of the assignment, counsel should send an initial report with the following information:

- a. A summary of the allegations in the complaint, the factual basis for the litigation, a summary of the information developed during the preliminary investigation and a preliminary evaluation of liability and damages.
- b. A Litigation Plan providing the following:
 1. Identify each significant activity counsel proposes to initiate. (e.g., investigation, motion, discovery, legal research, etc.).
 2. Identify discovery and motions which have been or are likely to be initiated by other parties.
 3. Estimate the completion date for each activity.
 4. State the estimated expenses of each activity.
- c. Discussion of the potential for early disposition of the case by settlement, and recommendations with respect to arbitration, mediation or direct settlement negotiations.
- d. Discussion of the potential success of dispositive motions prior to, or after, the commencement of discovery and when motions to dismiss or for summary judgment are appropriate.
- e. An estimate of the probable trial date.

3. Significant Development Report:

Defense counsel should communicate and apprise of significant developments as soon as practical. This will include reports on summaries of depositions, and pre-trial reports, and if applicable:

- a. Settlement options and/or dispositive motions.
- b. Updated evaluation of the client's liability and damages.
- c. An updated Litigation Plan.
- d. Trial Report: If it is anticipated the case will proceed to trial, 30 days before the scheduled trial date, a detailed report should be submitted, detailing the issues and an analysis of same and any other information requested by [Insurer].

B. Documentation

Reporting shall not include copies of the following documents, unless specifically requested:

1. Research Memorandum, Motion Papers and Legal Briefs;
2. Deposition Transcripts;
3. Expert Reports;
4. Medical Reports.

Counsel should provide copies of all pleadings and amended pleadings filed by or against the party whom you are defending and Releases and Orders of Dismissal for Final Judgments. Counsel will consult with [Insurer] on the appropriate means of communication, whether by e-mail, fax or regular mail to avoid duplication.

Counsel should comply with all reasonable requests for information and documents, provided however, that any documents or information that are privileged or intended by the insured to be confidential shall not be disclosed, absent consent from the Insured.

C. Consultation

After submission of the Initial Report, counsel welcomes discussion with and input and comment from the insurer. Counsel and [Insurer] will endeavor to agree on the proposed activities outlined in the Litigation Plan. However, in the event of disagreement, the final decision will remain the independent professional judgment of defense counsel.

V. BILLING

A. Billing Procedure

1. Frequency of Billing
 - a. Bills should be issued at intervals to be agreed upon by counsel and [Insurer].

2. Billing Format

- a. **Heading.** The first page of the bill must state: (a) the firm's IRS number; (b) the caption of the case; (c) the name of the insured; and (d) the claim number.
- b. **Body.** The bill must be prepared with daily entries showing: (a) the date the work was performed; (b) the initials of the person providing the service; (c) a description of the work performed (single activities); and (d) the actual time in tenths of an hour.
- c. **End of Bill Summary.** The bill must include: (a) the full name of each attorney/paralegal; (b) the status of each timekeeper (i.e., partner, associate, paralegal); (c) the hourly rate of each timekeeper; and (d) the total hours and total amount charged for each timekeeper during the billing period.
- d. **Task Codes.** Task coding is not required, unless requested. Where requested, the uniform billing codes as currently endorsed by the American Bar Association shall be used.

B. Charges for Service

1. **Time Charges. Actual Time in One-Tenth Increments.** All charges for services by attorneys and paralegals must be recorded daily based upon their actual time in one-tenth hour increments.
2. **Single Entry Timekeeping.** Unless otherwise directed, the time for each activity should be separately stated. Grouping multiple activities under a single time charge greater than one-tenth of an hour ("block billing") is not acceptable, absent authorization from the [Insurer].
3. **Information Descriptions of Services.** Descriptions of services should inform of the nature, purpose or subject of the work performed, and the specific activity or project to which it relates.
4. **Compensation.** Counsel should consult with [Insurer] regarding any increase in the rate of compensation.
5. **In-Firm Conferences.** Where counsel consults with another attorney in the firm to obtain specific advice or counsel on substantive or procedural aspects of the case that result in a more effective defense, said reasonable and necessary conference time will be reimbursed, provided that sufficient detail of the subject of the communication is set forth to demonstrate its relevance and value.
6. **Multiple Attendance.** Counsel should consult with insurer where it is anticipated that more than one attorney's attendance is necessary at trial, court appearances, meetings, depositions, witness interviews, inspections and other functions.

7. Depositions. Counsel should consult with [Insurer] before initiating depositions other than that of the plaintiff(s), the insured, and other depositions already approved in the initial Litigation Plan or supplement thereto and shall advise the [Insurer] of upcoming depositions initiated by other parties that Counsel plans to attend.
8. Legal Research. Counsel should consult with Insurer before undertaking a legal research project requiring over three hours of research. Copies of all research memoranda shall be provided to [Insurer] upon request.
9. Motions. Counsel should consult with [Insurer] before filing any motions not previously identified and approved in the initial Litigation Plan or supplement thereto.
10. Revising Standardized Forms/Pleadings. Only the actual time spent in personalizing standardized pleadings, documents, or discovery responses or requests to the case at hand should be billed, rather than the time originally spent drafting standard language.

C. Disbursement

1. Internal Expenses. [Insurer] shall advise counsel of its guidelines as to reimbursement of internal expenses.
2. External Expenses. Charges for service by outside vendors will be reimbursed at their actual cost. Expenses over \$ _____ may be forwarded to [Insurer] for payment. Disbursements should be itemized on the law firm's statement with the following information, unless back-up documentation is provided: (a) the name of the vendor; (b) the date incurred; and (c) a specific description of the expense. Where back-up documentation is provided, the law firm statement need only set forth a description of the expense and amount incurred.
3. Travel Expenses. Counsel should consult with [Insurer] prior to incurring travel expenses. [Insurer] will reimburse defense counsel for reasonable travel expenses. All expenditures of \$25 or more must be supported with receipts attached to the law firm's statement.
4. Professional Services. Counsel should consult with [Insurer] prior to incurring expenses for experts, consultants, investigators, temporary attorneys or outside paralegals, or other professional services.
5. Secretarial and clerical activities. Secretarial and clerical work is not billable to [Insurer]. As examples and not as a complete list, secretarial and clerical work includes receipt and distribution of mail, new file set up, maintenance of office and attorney calendars, transcribing, copying, posting, faxing, e-mailing, inserting documents into and retrieving documents from the file, maintaining order in the file, stamping documents, tabbing sub-files and assembling materials.

VI.

BILL AND FILE REVIEW

[Insurer] reserves the right to review all charges for services and disbursements pertaining to litigation, including without limitation all charges paid by the insured with respect to such litigation, whether pursuant to self-insured retentions or deductibles under [Insurer's] insurance policies or otherwise. [Insurer] reserves the right to conduct audits and to review the defense file and/or defense bills, consistent with the defense attorney's ethical obligations, and in a manner that will not compromise the attorney-client or work product protection accorded material in the file or communications by and between counsel, the client and [Insurer] or otherwise interfere with any ethical directive governing the conduct of counsel. Counsel agrees to comply with all reasonable requests for information and documents, provided that such documents or information are not privileged or intended by the insured to be confidential. In such instance, the [Insurer] must obtain the consent of the Insured. [Insurer] fully reserves all rights to decline to pay or to seek reductions and/or refunds with respect to charges that fail to comply with the requirements set forth herein, and which are not fully explained or documented by the firm after reasonable inquiry. The [Insurer] shall allow the law firm to appeal any declination of payment by [Insurer]. [Insurer] agrees to pay the undisputed portion of bills received from Counsel Counsel within _____ days.

This is an example of case handling guidelines which promotes uniformity in reporting and billing and effective and efficient case management, consistent with the defense attorney's professional responsibilities. Nothing contained herein constitutes or shall be construed as a standard of care.

What Happens after the Duty to Defend has been Breached?

Speakers:

Janet Davis, Cozen O'Connor

John Vishneski, Reed Smith

Issues Arising After Breach of the Duty to Defend

By John S. Vishneski III and Marli F. Reifman

I. INTRODUCTION

The duty to defend is an integral part of most third party liability policies. Prevailing on the question of whether a defense is owed is a primary objective in any third party coverage litigation, and as much time, if not more, may be spent litigating the question of whether the duty to defend exists as is spent litigating indemnification. Attorneys and their clients often view adjudication of the duty to defend as the apex of a case. But once a breach has been found and the dust settles, there are still unanswered questions facing the litigants. While ample case law has developed concerning determination of a breach, there is by comparison precious little consensus regarding the consequences of the breach. This often overlooked territory has given rise to an uncertain legal landscape that can befuddle even the most experienced coverage attorney.

In this article we will examine three such questions that arise in relation to breach of the duty to defend: First, we will discuss circumstances under which the duty to defend may cease such that an insurer may withdraw representation during an ongoing case. Second, we look at the various implementations (or rejections) of the “estoppel doctrine,” which holds that an insurer who breaches the duty to defend is estopped from raising coverage defenses. Finally, we review the case law regarding how and when an insurer may challenge the reasonableness of the policyholder’s defense fees in the underlying case after the insurer has breached the duty to defend.

II. BACKGROUND

The issues discussed herein are fundamentally issues of compensation and damages. It is

well-settled that the damages recoverable for a breach of the duty to defend include the defense costs incurred by the insured. *See* 14 Steven Plitt et al., *Couch on Insurance* § 205:75 (3d ed.) (hereinafter *Couch on Insurance*). What is less well-settled is whether there are any additional repercussions where an insurer breaches the duty to defend. In other words: what is required to adequately compensate an insured after the breach of a duty to defend? If the answer is that more than money damages are required, then how do we fashion a remedy that remains fair to the insurer? In investigating these issues we must begin with a brief examination of the nature of the duty to defend.

In the typical commercial general liability policy, the insurer agrees to defend the insured against any claim for damages resulting from an occurrence or injury that is covered by the policy. *See* Ins. Servs., Inc. Form No.: CG 00 01 04 13 § I(1)(a). At the outset, this agreement presents a Catch-22: the defense of the claim is an immediate need of the insured; however it depends upon a predicate (coverage under the policy) that has not yet been determined. As the Supreme Court of California put it:

[T]he nature of the obligation to defend is itself necessarily uncertain. . . . The carrier's obligation to indemnify inevitably will not be defined until the adjudication of the very action which it should have defended. Hence, the policy contains its own seeds of uncertainty; the insurer has held out a promise that by its very nature is ambiguous.

Gray v. Zurich Ins. Co., 419 P.2d 168, 173 (Cal. 1966). By the time the underlying action is resolved and the determination of whether the claim is covered can be made, the need for a defense has ceased. The insurer can reimburse the insured for the costs incurred in the defense, but the insured would argue that it has not been compensated for the loss of receiving a defense from the carrier.

In an effort to resolve this problem, the law has developed to hold that the duty to defend is broader than the duty to indemnify and an insurer is obligated to defend any claim that

potentially triggers coverage. *See Couch on Insurance* § 200:3. Thus, an insurer may be liable to provide a defense even where the insurer is ultimately found to have no duty to indemnify the insured against the judgment. *Id.* This rule solves the problem of an insured having to wait until the resolution of an underlying action in order to determine if its claim should have been defended; instead, the defense must be provided if there is any potential that the insurer will become liable for the claim.

Inherent in this rule is the recognition that, in purchasing liability insurance, the insured is purchasing more than a right to be reimbursed for monetary losses related to a defense. Instead, the provision of the defense is itself a valuable asset that the insured purchases. This asset has many intangible components. For example:

In purchasing his insurance the insured would reasonably expect that he would stand a better chance of vindication if supported by the resources and expertise of his insurer than if compelled to handle and finance the presentation of his case. He would, moreover, expect to be able to avoid the time, uncertainty and capital outlay in finding and retaining an attorney of his own.

Gray, 419 P.2d at 168. Not only does an insurer have the resources and expertise to defend a claim and hire a competent attorney, but also most insurance companies have negotiated rates with leading trial counsel throughout the country. Furthermore, by collecting premiums, insurers are able to build a reserve that can be utilized to fund a defense, whereas an insured has paid its premiums in lieu of building such a reserve.

In light of these intangible benefits inherent in the duty to defend, we turn back to the topics at hand: how do courts compensate an insured for an improper denial of a defense? Some courts have determined that economic compensation is sufficient and have not imposed any greater consequences on insurers other than reimbursing an insured for defense costs. Other courts have recognized an intangible benefit in the duty to defend and have fashioned remedies that attempt to compensate in some way for the loss of that benefit. As discussed below, as with

the nature of the duty to defend itself, there is uncertainty amongst the courts as to how and when these remedies should be applied.

III. EXTINGUISHING THE DUTY TO DEFEND

Issues regarding remedies for breach of the duty to defend typically arise when an insurer has wrongfully refused to provide a defense. However, there are instances where courts hold that insurers breach their defense duties even after a defense was provided. These situations generally arise in one of two ways: (i) where the insurer defends under a reservation of rights, but subsequently determines that there is no coverage for the underlying claim; and (ii) where the insurer ceases defending after a determination that the policy limits have been exhausted. In either case, the insurer must decide either to cease defending immediately or to seek judicial declaration that its duty to defend has ended. In some instances, an insurer will be permitted simply to cease defending based on its unilateral determination that coverage no longer exists. In other situations, however, an insurer will be held to have breached its duty by failing to file a declaratory judgment action to determine coverage. In order to avoid a breach, an insurer must be able to reliably determine whether its duty to defend has in fact concluded. Unfortunately, the case law has not provided a clear answer to this question. Thus, we begin our discussion of the duty to defend by focusing on when that duty ends: how does an insurer know when its duty to defend has been extinguished?

A. Extinguishing Duty to Defend Based on Coverage Determination

We turn first to the situation in which an insurer defends under a reservation of rights and then stops defending once it determines that there is no coverage for the underlying claim. This typically occurs when part of the underlying claim is dismissed or abandoned by the plaintiff or when factual development of the underlying claim indicates that there is no coverage.

Take for example a case in which an underlying complaint alleged unlawful termination

and negligence against the insured. See *Conway Chevrolet Buick, Inc. v. Travelers Indem. Co.*, 136 F.3d 210 (1st Cir. 1998). In *Conway*, Travelers accepted the claim and undertook the defense of its insured, Conway, under a reservation of rights, noting that the negligence claims were potentially covered, but that the unlawful termination claims were excluded. When summary judgment was granted for the defendant on the negligence claims, Travelers withdrew its defense because the remaining termination-related claims were not covered under the policy. Conway then filed a coverage action alleging breach of contract against Travelers. The First Circuit, applying Massachusetts law, held that Travelers was permitted to unilaterally withdraw because the remaining claims in the complaint were not “reasonably susceptible” to an interpretation that fell within coverage, but instead “unambiguously exclude[d] coverage.” *Id.* at 214. The *Conway* court reasoned that, if an insurer provided a defense but subsequently learned that the claim was excluded, it should “not be bound to obtain a release” from the court because “no obligation to defend ever existed”¹ *Id.*

As stated by the California Court of Appeal in a similar case, an insurer is not required to obtain a declaratory judgment before withdrawing a defense where “there *never was* a potential for coverage and, hence, [it] never had a duty to defend from the outset.” *Ringler Assocs. Inc. v. Maryland Cas. Co.*, 80 Cal. App. 4th 1165, 1192 (2000).² In *Ringler*, the insurer undertook the

¹ It should be noted that, in *Conway*, Travelers conceded that an obligation to defend had existed as to the third party complaint at the time when the negligence claim was pending. It was only as to the unlawful termination claims that Travelers argued there had not been a duty to defend. As such, Travelers was not seeking reimbursement of defense costs that it had incurred during the time that it defended. The question of whether an insurer may recover defense costs expended for a claim that was subsequently determined not to have been covered is another thorny issue that “has been the subject of much debate, and there is a split in authority.” *Chiquita Brands Int’l, Inc. v. Nat’l Union Fire Ins. Co. of Pittsburgh*, -- N.E.3d --, 2015 WL 9594035, at *9 (Ohio Ct. App. Dec. 30, 2015). A number of courts have permitted reimbursement of defense costs based on the theory that the insurer was not contractually obligated to provide a defense for uncovered claims. See, e.g., *Buss v. Superior Ct.*, 16 Cal. 4th 35 (1997). A minority of jurisdictions, on the other hand, have refused to allow an insurer to recover defense costs absent an express provision in the policy allowing reimbursement. See, e.g., *Gen. Agents Ins. Co. of Am., Inc. v. Midwest Sporting Goods Co.*, 828 N.E.2d 1092 (Ill. 2005).

² As with *Conway*, there is no indication in the *Ringler* case that the insurer sought reimbursement of defense costs incurred during the time it defended. The language used by the *Conway* and *Ringler* courts is a source of confusion.

defense in an action alleging defamation against the insured. After discovery revealed that all allegations of defamatory statements were excluded under the “prior publication” exclusion, the insurer withdrew from the defense. The court rejected Ringler’s argument that a duty to defend existed because of the “potential” that later allegations of defamation could surface. *Id.* at 1176. Instead, the court held that there was no duty to defend “[u]nder the undisputed record.” *Id.* at 1187. The court stated that, “[a]lthough it took time for discovery to reveal that there were in fact *no* claims made in this case that were not barred from coverage by the first-publication exclusion, this passage of time did not lock [insurers] into continuing to defend Ringler once that discovery was completed.” *Id.* at 1192. Thus, the court held that the insurer had not committed a breach by unilaterally withdrawing. *Id.*

Based on these cases and others like them, it would seem reasonable for an insurer to conclude that its duty to defend generally ceases where “no obligation to defend ever existed” or there “never was a potential for coverage.” But this articulation of the rule leads to a fair amount of uncertainty. For example, in *Prichard v. Liberty Mutual Insurance Co.*, 84 Cal. App. 4th 890 (2000), Liberty Mutual defended Prichard in an underlying suit alleging defamation. At the close of evidence in the underlying trial, Liberty Mutual stated that it believed it no longer had a duty to defend, but continued to defend the appeal under a reservation of rights. Liberty Mutual contended that its duty to defend had been extinguished because the “uncontroverted evidence” at trial showed that the defamatory statement had been made before the policy period and thus the claim fell under the “prior publication” exclusion.

By stating that no duty to defend ever existed or that there never was a potential for coverage, the courts seem to be invoking the rule followed by some jurisdictions that an insurer is entitled to reimbursement of defense costs after an adjudication that there never was a duty to defend. And yet, the insurers in *Conway* and *Ringler* do not appear to have sought such reimbursement. It is peculiar and difficult to reconcile why the courts would use this particular language when the issue in *Conway* and *Ringler* was whether the duty to defend had been extinguished and not whether the insurer was entitled to reimbursement.

In light of the rule articulated in *Ringler* and *Conway*, it would seem as though Liberty Mutual's position was correct – that it had no duty to defend once it became clear after the close of evidence that the only allegedly defamatory statements were made before the policy period. Thus, just as in *Ringler*, the “undisputed record” showed that there “*never was* a potential for coverage.” *Ringler*, 80 Cal. App. 4th at 1187, 1192. And yet, that is not how the *Prichard* case was decided. The *Prichard* court first attempted to distinguish *Ringler* by stating that Ringler's insurers had acted “mistakenly” by defending in the first place; thus the *Prichard* court conceded that there was no duty to defend at the outset in *Ringler*. *Prichard*, 84 Cal. App. 4th at 902-03. In *Prichard*, on the other hand, the court held that there was a duty to defend at the outset of the underlying case. *Id.* at 901, 903. The court did not elaborate on this point and it is curious given that each case appears to have involved the same material circumstances: (i) allegations that were unclear as to the first publication; and (ii) the eventual development of undisputed evidence showing first publication before the policy period. Regardless, the court held that Liberty Mutual's duty to defend did not cease after the close of evidence, but continued until all appeals had been exhausted. *Id.* at 903-04. The court reasoned that “a new trial might have been granted. Witnesses might have changed their stories or their memories might have improved.” *Id.* Luckily for Liberty Mutual, it continued to provide a defense to its insured despite its apparently erroneous determination that the duty to defend had extinguished. Had Liberty Mutual followed the “rule” as articulated in *Ringler*, it may have found itself in breach.

The same confusion arises in attempting to apply the reasoning in *Conway* to similar situations. For example, in *Wells' Dairy, Inc. v. Travelers Indemnity Co. of Ill.*, 336 F. Supp. 2d 906 (N.D. Iowa 2004), Wells brought a breach of contract action against its insurer alleging breach of the duty to defend. Wells had been sued by two customers for breach of contract and

negligence. Travelers accepted the defense. However, after summary judgment was granted to Wells on the negligence claim, Travelers attempted to withdraw from the defense on the basis that the breach of contract claim was not covered under the policy. Wells argued that Travelers' duty to defend continued after the summary judgment ruling because the order was an interlocutory ruling that could be appealed. Under the standard set forth in *Conway*, it would seem that Travelers should be entitled to withdraw. Just as in *Conway*, the remaining claims in the underlying complaint "unambiguously exclude[d] coverage." The *Wells* court disagreed. Relying on decisions of the Minnesota Supreme Court and the Hawaii Supreme Court, the *Wells* court held that "an insurer is not relieved of its duty to defend as a result of the granting of a partial summary judgment until no further rights to appeal arguably covered claims exist." *Id.* at 911. Thus, Travelers was obligated to continue providing a defense to Wells in the underlying action despite the fact that no potentially covered claims were currently remaining.³ See also *Meadowbrook, Inc. v. Tower Ins. Co.*, 559 N.W.2d 411, 417 (Minn. 1997); *Servidone Constr. Corp. v. Security Ins. Co. of Hartford*, 64 N.Y.2d 419, 422 (1985).

These conflicting cases do not give the clearest guidance to an insurer in determining whether its duty to defend has been extinguished. Nor do they allow an insured to make a reliable assessment as to whether its rights have been breached. Some of these inconsistencies may be chalked up to the expected variances between different jurisdictions. But it is also possible that the uncertainty in the case law is a direct result of the uncertain nature of the duty to defend. Where the duty to defend is at the outset measured by the mere potential for coverage,

³ In both *Prichard* and *Wells* the issues determining coverage had been already determined in the underlying cases, but the court reasoned that the duty to defend continued until all rights to appeal had been exhausted. A different question arises when the issues determining coverage are still being litigated in the underlying case. In those situations, courts generally will not permit an insurer to rely on evidence purportedly undermining the duty to defend where that evidence "tends to determine an issue crucial to the determination of the underlying lawsuit." *Couch on Insurance* § 202:3.

“the question is, how does anyone – the court, the policyholder, the insurer – *know* when the duty ceases.” *Prichard*, 84 Cal. App. 4th at 903. The answer may be that there is no one-size-fits all rule. *See id.* Instead, a good rule of thumb for insurers contemplating the withdrawal of a defense may be that articulated by the California Court of Appeal:

[T]here is no particular requirement that an insurer ask the permission of a trial court before withdrawing from a defense, once the insurer has determined that no potential for indemnification liability exists. However, . . . it may be prudent to do so. Indeed, an insurer that withdraws a defense without first obtaining a judicial declaration that a potential for coverage no longer exists does so at its own risk.⁴

Great Am. Ins. Co. v. Super. Ct., 178 Cal. App. 4th 221, 234 n.19 (2009) (internal citations omitted).

B. Extinguishing Duty to Defend Based on Exhaustion of Policy Limits

The second situation is one in which an insurer provides a defense but ceases defending when it determines that the policy limits have been exhausted. This would seem to be a straightforward analysis: “Where the insurer has exhausted its indemnity limits . . . the insurer *cannot* ultimately be obligated to indemnify the insured. . . . [Thus, when] the insurer has no potential obligation to indemnify it has no duty to defend.” *Zurich Ins. Co. v. Raymark Indus., Inc.*, 514 N.E.2d 150, 163 (Ill. 1987). Despite this basic premise, courts have generally not permitted insurers to withdraw from a defense automatically once the policy limits have been tendered, but instead, courts have held that the tender of policy limits does not alleviate the insurer from its defense duties.

⁴ Not all commentators appear to agree with this advice. As one treatise stated:

Insurance companies should rarely file declaratory judgment actions seeking an adjudication as to whether they have a duty to defend the insured. . . . Moreover, even if the [denial of coverage] proves to have been incorrect, assuming the company acted in good faith and diligently, the adverse consequences to the company are rarely significant enough to warrant the cost of routinely playing it safe by instituting declaratory judgment actions.

2 Allan D. Windt, *Insurance Claims & Disputes* § 8:2 (6th ed.).

This situation is likely to arise in cases where the potential costs of providing a defense are likely to far exceed the limits of the policy. For example, in *Douglas v. Allied American Insurance*, 727 N.E.2d 376 (Ill. App. Ct. 2000), Allied issued an automobile liability policy to the insured with policy limits of \$40,000 per accident. The insured was subsequently involved in an automobile accident and was sued by four individuals injured in the accident. Allied accepted the defense but quickly realized that it was in a peculiar situation: defending its insured against four plaintiffs could easily cost more than the \$40,000 that it would be obligated to pay even if the insured was held liable. But the insurance policy provided that Allied's obligations to the insured ceased after the policy limits had been expended. Thus, Allied took advantage of what appeared to be a permissible solution. Soon after accepting the defense, Allied deposited the policy limits with the court for disbursement to the underlying plaintiffs. Believing that it had properly fulfilled its obligations under the policy, Allied withdrew its defense.

The Appellate Court of Illinois was not persuaded that this tactic was appropriate, and held that Allied breached the duty to defend by depositing the policy limits with the court. The court looked to the language of the policy, which stated that Allied was obligated to pay "all sums which the insured shall become legally obligated to pay as damages It is understood and agreed that the company has no obligation to any insured after the applicable limits of the policy have been exhausted by payment." *Id.* at 380. Allied argued that it had no further duties because the policy limits had been "exhausted by payment." The court determined that the phrase "exhausted by payment" was ambiguous and that it must be read in conjunction with the phrase "legally obligated to pay." *Id.* When read together, the court reasoned that the policy limit could be exhausted only by payments made pursuant to a legal obligation of the insured. *Id.* A voluntary payment by the insurer of the policy limits did not qualify as such a payment,

and thus, Allied had breached the duty to defend by withdrawing the defense. *Id.* at 380-83. *See also Cty. of Santa Clara v. U.S. Fid. & Guar. Co.*, 868 F. Supp. 274, 278 (N.D. Cal. 1994) (holding that tender of policy limits did not extinguish duty to defend because exhaustion required that “payment must be made to satisfy an obligation arising out of either an adjudication or a compromise of a third party claim”); *but see Carolina Cas. Ins. Co. v. Estate of Studer*, 555 F. Supp. 2d 972 (S.D. Ind. 2008) (holding that filing interpleader action and depositing policy limits with court extinguished insurer’s duty to defend where insurer relinquished any claim to the funds and continued to defend pending outcome of interpleader action).

At first glance, the result in *Douglas* appears unfair to an insurer. After all, the insurer attempted to do the right thing by paying the insured the maximum amount owed. However, this holding appears to arise from the argument that the duty to defend is a separate and distinct right from the right to indemnification, and, as such, the mere tender of the funds by the carrier is not enough – it is not what the insured purchased and it does not compensate the insured for its loss.

As one court noted:

[T]he primary insurer cannot extinguish its defense obligation simply by tendering its indemnity limits to the insured and walking away from the fray—a tempting maneuver when it appears that defense costs will exceed indemnity limits. A leading insurance authority explains why courts look askance at this ploy: “Such action invites a change of attorneys and other staff, condemned in other decisions, and can subject the insured to questions as to who will provide him with a defense. It also allows the primary insurer to abandon the insured simply because it finds the costs of handling burdensome and thus escape its responsibility under the policy.”

County of Santa Clara, 868 F. Supp. at 277 (quoting Appleman, *Insurance Law and Practice*, § 4682). Thus, it can be argued that a finding that the insurer does not extinguish its defense duties by simply tendering policy limits prevents the insurer from circumventing the duty that it is contractually bound to provide. This would protect the insured’s bargained for right to receive a defense from the carrier, even where the carrier determines that the defense would be a costly

one.

Notably, at least one court has recently held that parties cannot contract around the rule enunciated in *Douglas*. In *Doublevision Entertainment, LLC v. Navigators Specialty Insurance Co.*, 2015 WL 5821414 (N.D. Cal. Oct. 6, 2015), the insurance policy stated that the insurer was not obligated to defend after it had deposited the remaining policy limits with a court. In that case, Navigators had issued an errors and omissions policy to Commercial Escrow Services (“CES”) and its principal Antoinette Hardstone. The policy had a limit of \$1 million, which was depleted by the defense costs paid. Beginning in 2010, CES and Hardstone were sued by a number of customers alleging improper escrow handling. After CES and Hardstone tendered to Navigators, Navigators assumed the defense of the claims.

While the claims were pending, the California Department of Corporations conducted an investigation into CES and determined that there was a shortage of \$195,750 in CES’ escrow accounts. The Department of Corporations appointed a receiver to liquidate CES’ business. The receiver also had authority to collect any insurance proceeds due to CES in order to cover the \$195,750 shortage.

The underlying claims against CES and Hardstone remained pending into 2012, at which time Navigators offered to tender the remaining policy limits directly to CES and Hardstone. However, the Department of Corporations notified Navigators that the CES shortage had not been satisfied and thus, the Department had a claim against any policy proceeds in the amount of \$195,750. In light of the fact that there were two entities claiming the policy proceeds – the insured and the Department of Corporations, Navigators filed a complaint for interpleader and deposited the \$466,358 remaining policy limits with the court. Navigators then ceased defending CES and Hardstone in the ongoing cases. Left with no money to fund their defense, CES and

Hardstone were forced to hire inexperienced substitute counsel on short notice and ultimately had judgments of over \$1.5 million awarded against them. One such verdict was obtained by Doublevision, who took an assignment of CES and Hardstone's rights against Navigators as partial satisfaction of the judgment.

Doublevision then instituted a coverage action against Navigators, alleging that Navigators had breached its duty to defend by interpleading the entirety of the policy limits rather than only the \$195,750 over which there were competing claims by the insured and the Department of Corporations. In response, Navigators argued that the policy explicitly permitted it to cease defending the insured once it had "deposited the remaining available limit of liability into a court of competent jurisdiction." *Id.* at *1, 4. The court rejected Navigators' argument. Relying on the "supreme importance of the duty to defend," the court held that "the insurance policy in question should be read as erasing the duty to defend only to the actual extent that conflicting claims [on the policy proceeds] are pending." *Id.* at *4. The court stated that Navigators could not simply interplead the funds and abandon its insured "at the moment of her greatest peril. . . . Navigators simply had no right under the contract to cut off the supply of oxygen to the defense" *Id.* at *1, 5. Thus, the court held that Navigators had breached the duty to defend by withdrawing its defense after interpleading the policy limits, even though the policy expressly allowed such an action. The court noted that Navigators may have been permitted to interplead only the \$195,750 over which the Department of Corporations and the insured had conflicting claims, but it could not interplead the entirety of the remaining limits. The court stated that it based its ruling on the "fundamental principle . . . [of] the supreme importance of the duty to defend" *Id.* at *4. This ruling instructs that an insurer may not unilaterally extinguish its duty to defend by tendering policy limits – even if the policy appears

to explicitly authorize such a maneuver. Instead, this holding prioritizes the “supreme importance” of the provision of the defense itself and imposes a consequence protecting the non-economic aspects of that right.

The *Doublevision* opinion appears to advocate a public policy prohibition against a allowing the withdrawal of a defense upon the interpleading of policy limits. Curiously, unlike the other cases discussed in this section, the policy in *Doublevision* was a “wasting limits” policy under which the policy limits were reduced by the costs spent on the defense. This means that, if Navigators spent \$1 million on the defense, it could have sought to withdraw at that time and would not have been liable for any additional indemnification on the underlying judgments. This is unlike a defense outside limits policy, where the insurer would be bound to provide a defense regardless of the cost and still indemnify the judgment or settlement up to the policy limits. In this latter situation, allowing a provision like the one in the *Doublevision* policy would collapse the duty to defend into the indemnity limits of the policy, thus, in effect, placing a limit on the duty to defend that was not explicitly stated in the policy. This could be viewed as deceptive practices because it invites the insurer to abandon the obligation that it made to defend outside of policy limits.

IV. DISPUTING COVERAGE AFTER A BREACH OF THE DUTY TO DEFEND

The next question we examine is whether an insurer may contest that a claim is covered by a policy once the insurer has been found to have breached the duty to defend. With the duty to defend adjudicated, the parties turn to the question of whether the insurance company is liable to indemnify the insured for amounts paid as a result of a judgment or settlement in the underlying action. The broad standard for determining the duty to defend, *i.e.*, any potential for coverage, no longer applies. Instead, an insurer generally is liable to indemnify the insured only if the judgment or settlement is in fact covered by the policy. Thus, one would think that the

litigation would proceed normally after the adjudication of the duty to defend, with the insurer arguing that the judgment or settlement is not covered on the actual facts and the insurer has no obligation to indemnify the insured.

And yet, some courts have held that, as a consequence of the breach of the defense duty, the insurer may not assert coverage defenses. This rule is often referred to as a “forfeiture rule” or an “estoppel doctrine” based on the premise that the insurer’s breach acts to forfeit or estop it from asserting coverage defenses. This rule is the subject of much criticism and has been rejected in the majority of jurisdictions. But, as discussed herein, many argue that to abandon this rule outright may be ignoring the uncertain and intangible nature of the duty to defend.

This section shall discuss the implications and justifications of the three approaches generally taken by courts in this situation: (i) rejection of the estoppel doctrine, stating that an insurer can raise coverage defenses regardless of a breach; (ii) the automatic estoppel rule, stating that a carrier is automatically estopped from contesting coverage by breaching; and (iii) the limited estoppel doctrine, stating that a carrier is estopped from raising coverage defenses only if the breach was wrongful or unreasonable.

A. Rejection of the Estoppel Doctrine

The majority of jurisdictions have rejected the estoppel doctrine and held that an insurer may raise coverage defenses even after the breach of the duty to defend.⁵ In so holding, most

⁵ See, e.g., *Ala. Hosp. Ass’n Trust v. Mut. Assur. Soc. of Ala.*, 538 So. 2d 1209 (Ala. 1989); *Sentinel Ins. Co. v. First Ins. Co. of Haw.*, 875 P.2d 894 (Haw. 1994); *Hirst v. St. Paul Fire & Marine Ins. Co.*, 683 P.2d 440, 447 (Idaho Ct. App. 1984); *Lee Builders, Inc. v. Farm Bureau Mut. Ins. Co.*, 104 P.3d 997 (Kan. Ct. App. 2005); *Arceneaux v. Amstar Corp.*, 66 So. 3d 438 (La. 2005); *Elliott v. Hanover Ins. Co.*, 711 A.2d 1310 (Me. 1998); *Mesmer v. Md. Auto. Ins. Fund*, 725 A.2d 1053 (Md. 1999); *Polaroid Corp. v. Travelers Indem. Co.*, 610 N.E.2d 912, 922 (Mass. 1993); *Kirschner v. Process Design Assocs., Inc.*, 592 N.W. 2d 707 (Mich. 1999); *Shannon v. Great Am. Ins. Co.*, 276 N.W.2d 77 (Minn. 1979); *Ross v. Home Ins. Co.*, 773 A.2d 654 (N.H. 2001); *Med. Protective Co. v. Fragatos*, 940 N.E.2d 1011 (Ohio Ct. App. 2010); *Nw. Pump & Equip. Co. v. Am. States Ins. Co.*, 925 P.2d 1241 (Or. Ct. App. 1996); *Am. States Ins. Co. v. State Auto Ins. Co.*, 721 A.2d 56 (Pa. Super. Ct. 1998); *Utica Nat’l Ins. Co. v. Am. Indem. Co.*, 141 S.W.3d 198 (Tex. 2004); *Potesta v. U.S. Fid. & Guar. Co.*, 504 S.E.2d 135 (W. Va. 1998).

courts cite to the basic tenets of contract interpretation and damages law, with some appeal to equitable principles. The most common rationales supporting the rejection of the estoppel doctrine can be broken down into four arguments, each discussed in turn.⁶

First, courts rejecting estoppel find that prohibiting coverage defenses goes beyond the permissible damages that should be awarded as a result of a breach. “When a contract is breached, the injured party is entitled to receive what would have been obtained if there had been no breach; the injured party is not entitled to receive more.” 1 Windt, *Insurance Claims and Disputes*, §4:37. Under this rubric, the “proper measure of damages for breach of a contractual duty, including an insurer’s duty to defend, is contract damages.” *Deluna v. State Farm Fire & Cas. Co.*, 233 P.3d 12, 17 (Idaho 2008). Such damages are simply the costs incurred in providing one’s own defense. *Id.* Unless specifically pled and proven, no further repercussions follow from the breach, and according to these jurisdictions, any other result would be improper.⁷ *Id.* As one insurance scholar noted, if the insurer had defended and there had been no breach, then at the end of the day the insured still would be liable for a judgment based on a non-covered claim. The fact of the breach should not relieve the insured of the costs of a

⁶ Most criticism of the estoppel doctrine is based on a fundamental disagreement with its justifications. However, at least one commentator has argued that the existence of the rule itself was simply a mistake. See Todd J. Weiss, *A Natural Law Approach to Remedies for the Liability Insurer’s Breach of Duty to Defend: Is Estoppel of Coverage Defenses Just?*, 57 Alb. L. Rev. 145, 149-54 (1993) (arguing that the case establishing the “modern estoppel rule” involved a “misunderstanding and misapplication of earlier cases”).

⁷ These jurisdictions appear to leave open the possibility that an insured may recover the amount of a judgment or settlement regardless of coverage if he can show that the liability arose as a consequence of the breach of the duty to defend. See *Sentinel Ins. Co.*, 875 P.2d at 913 (“Certainly, in individual cases, the application of waiver or estoppel will be appropriate – for example, where the insured has been prejudiced in some way by the insurer’s failure to provide a defense or where the insurer has taken inconsistent positions with regard to defense and coverage.”) (citations omitted); *Deluna*, 233 P.3d at 17 (stating that damages for breach of the duty to defend are “attorney fees and costs for defending the claim, together with any other damages shown to be a result of the breach”); see also 1 Windt, *Insurance Claims and Disputes*, §4:37 (“It is less than logical, therefore, to hold insurers that have breached their duty to defend automatically liable for all judgments and settlements simply because, in certain highly unusual circumstances, it is possible that the insurer’s actions may have contributed to the entry or amount of a judgment or settlement. The better rule, and the one followed by most courts, is to award such consequential damages only when they can be proved by the insured.”).

judgment that “would have been his responsibility regardless.” Appleman, *Insurance Law and Practice*, § 4689, n.13.

Second, courts often reject the estoppel doctrine on the basis that it improperly conflates the separate and distinct duties of defense and indemnity. In *Servidone Construction Corp.*, the New York Court of Appeals emphasized that the obligation to defend is “measured against the allegations of pleadings,” but the duty to indemnify is “determined by the actual basis for the insured’s liability to a third person.” 64 N.Y.2d at 424 (citation omitted). The court held that the lower court erred by imposing indemnity liability based on a finding that there had been a duty to defend because it had “in effect applied the same standard” to both the duty to defend and the duty to indemnify. *Id.* In doing so, the lower court ignored the fact that the duty to indemnify is “distinctly different” from the duty to defend. *Id.* Thus, an estoppel rule is improper because it “subverts any meaningful distinction between the duty to defend and the separate duty to indemnify” *Sentinel Ins. Co.*, 875 P.2d at 912.⁸

The third rationale supplied by courts rejecting estoppel is that preventing the insurer from raising coverage defenses would violate basic contract interpretation principles. It is well settled that, when interpreting an insurance policy, the policy language “must be accorded its natural and ordinary meaning, and courts cannot indulge in forced construction ignoring provisions or so distorting them as to accord a meaning other than that evidently intended by the parties.” *Couch on Insurance* § 22:9. Thus, estoppel-rejecting jurisdictions argue that imposing

⁸ In *Sentinel*, the Supreme Court of Hawaii rejected the estoppel doctrine, but it did impose some repercussion as a result of a breach of the duty to defend. The court stated that “fairness to both parties requires that the equities be balanced in each case” and held that a breach of the duty to defend results in a rebuttable presumption that the claim is covered, with the insurer bearing the burden of proof to negate coverage. 875 P.2d at 914; *see also Polaroid Corp. v. Travelers Indem. Co.*, 610 N.E.2d 912, 922 (Mass. 1993). While the Hawaii Court may have been attempting to concede some victory to the insured, the result is cold comfort at best. This ruling merely relieves the insured of the obligation to show that the claim falls within the scope of coverage; however, given that the claim was already found to potentially be covered such that there was a duty to defend, this burden would in the vast majority of cases already be satisfied.

liability where none exists under the terms of the policy would “enlarge the bargained-for coverage” *Servidone Constr. Corp.*, 477 N.E.2d at 424. The insured would in fact obtain a “windfall” by receiving a “benefit it did not bargain for.” *Sentinel Ins. Co.*, 875 P.2d at 912. As one scholar colorfully put it:

A breach of contract . . . does not nor should it create a new contract. To say that because the insurer breached the contract he cannot rely on a policy exclusion pertaining to coverage is the same as to say that because the wholesaler refused to sell hamburger as he had agreed he can be forced to sell steaks instead at the same price.

Appleman, *Insurance Law and Practice*, § 4689, n.13.

The final rationale commonly cited by courts is that precluding coverage defenses is improperly punitive. The general rule in compensating for breach of contract is to make the plaintiff whole, “not to punish the breaching party.” *Hirst*, 683 P.2d at 447. Prohibiting an insurer from raising coverage defenses as a result of the breach does not compensate the insured, but “serves no more than to punish the insurer for the breach of a contractual duty.” *Sentinel Ins. Co.*, 875 P.2d at 912; *see also Servidone Constr. Corp.*, 477 N.E.2d at 424; *Hirst*, 683 P.2d at 447 (“We question the propriety of utilizing a form of estoppel as a punitive measure against an insurer for breach of a contractual duty to defend.”). These courts have rejected the argument that estoppel acts as a deterrent to prevent insurers from disavowing their duty to defend. This deterrent, these courts argue, already exists in that, by refusing to defend, an insurer loses the right to control defense costs and strategy, which ultimately exposes it to higher payments as a result of the breach of the duty to defend than it would have incurred had it defended in the first place. *Sentinel Ins. Co.*, 875 P.2d at 913. In addition, an insurer may be liable for tort damages if its breach was in bad faith. Such “[r]esort to tort concepts where fitting, rather than the regulatory estoppel penalty, preserves the traditional distinction between tort and contract remedies.” *Id.* Further, these courts note that, where the underlying case involved the

adjudication of facts determinative of coverage, the insurer will be collaterally estopped from re-litigating those facts in a subsequent coverage action.⁹ *Id.* Thus, the estoppel doctrine is not needed to protect an insured from re-litigating already decided facts. In the absence of any other reasonable justification for estoppel, these courts hold that the rule's only purpose is punitive. As such, they contend that estoppel cannot be used as a contractual remedy.

B. Automatic Estoppel Rule

Despite these arguments, many courts continue to apply the automatic estoppel rule, holding that a breach of the duty to defend precludes any coverage defenses and automatically imposes liability on the insurer for any judgment or settlement.¹⁰ There are three main justifications for this rule: (i) breach of the policy as to the duty to defend equitably estops the insurer from asserting coverage defenses; (ii) estoppel is a needed remedy in jurisdictions with little or no bad faith liability; (iii) estoppel deters insurance companies from breaching their duties and protects the intangible benefits inherent in the duty to defend.

The most common explanation for the estoppel doctrine is that it is an equitable remedy needed to protect an intangible asset. As discussed above, the nature of the duty to defend is a unique one in that it is inherently uncertain. When purchasing coverage containing a duty to defend, the insured purchases more than just the right to an economic benefit. The policyholder purchases the right to obtain a service, which brings with it a number of intangible benefits. For one, the policyholder purchases the ability to take advantage of the insurer's resources and

⁹ While the breaching insurer would not have been a party to the underlying action, it would have been "given the opportunity to appear on behalf of the insured [and] . . . will be bound by that judgment." *Farmers Ins. Co. of Ariz. v. Vagnozzi*, 675 P.2d 703, 706 (Ariz. 1983).

¹⁰ See, e.g., *Missionaries of the Co. of Mary, Inc. v. Aetna Cas. & Sur. Co.*, 230 A.2d 21 (Conn. 1967); *Emp'rs Ins. of Wausau v. Ehlco Liquidating Trust*, 708 N.E.2d 1122 (Ill. 1999); *Am. Gen. Fire & Cas. Co. v. Progressive Cas. Co.*, 799 P.2d 1113 (N.M. 1990); *Pulte Home Corp. v. Am. S. Ins. Co.*, 647 S.E.2d 614 (N.C. Ct. App. 2007); *Farmers Union Mut. Ins. Co. v. Staples*, 90 P.3d 381 (Mont. 2004); *Se. Wis. Prof'l Baseball Park Dist. v. Mitsubishi Heavy Indus. Am., Inc.*, 738 N.W.2d 87 (Wis. Ct. App. 2007).

experience in defending a claim. In addition, the insurance provides peace of mind to the insured that it will have access to a robust defense in case of a lawsuit. Further, because it purchases the insurance and pays the premiums, the policyholder foregoes setting aside any funds in case of a lawsuit – that is precisely the purpose of the insurance. The insurer on the other hand is able to build a reserve through the collection of those premiums such that it is prepared to litigate in the case of a claim. For these reasons, from the insured’s perspective, the recovery of defense costs may not adequately compensate for the loss of the intangible benefits derived from an insurer’s defense.

Courts applying the estoppel doctrine adopt these arguments and hold that monetary damages alone are not adequate. Ordinarily in such a situation, a court might apply the equitable remedies of rescission or specific performance. It is well-settled that “[w]here damages are an inadequate remedy and the nature of the contract is such that specific enforcement of it will not be impossible or involve too great practical difficulties, such as long, drawn out and extensive supervision, equity will grant a decree of specific performance.” Williston on Contracts § 67:1. A breach of the duty to defend is just such a situation – damages are inadequate and specific performance in most instances is impossible because the underlying case will have concluded. Similarly, rescission would merely return premiums to the insured, but would not remedy the lack of defense. Faced with a situation where typical equitable remedies are not available courts have invented a creative solution in the form of estoppel or forfeiture. The insurer, “after breaking the contract by its unqualified refusal to defend, should not thereafter be permitted to seek the protection of that contract in avoidance of its indemnity provisions.” *Missionaries of the Co. of Mary, Inc.*, 230 A.2d at 26. To put it another way, “an insurer’s duty to defend under a liability insurance policy is so fundamental an obligation that a breach of that duty constitutes a

repudiation of the contract.” *Employers Ins. of Wausau*, 708 N.E.2d at 1135.

The second justification for estoppel is that it is a necessary remedy in jurisdictions that limit bad faith damages. The anti-estoppel courts have argued that estoppel is not a necessary remedy because the insured can recover additional damages under tort law. However, this argument is undermined in a state where the damages available as a result of an insurance company’s bad faith are strictly limited by statute. For example, in Illinois, an insured’s bad faith damages are capped at either a percentage of the overall recovery, \$60,000, or the excess amount of a settlement offer over the amount actually recovered. *See* 215 ILCS 5/155. In a case where an insured’s defense costs are substantially less than the ultimate judgment against it, this bad faith remedy will fall far short of fully compensating the insured. This is likely an explanation for why Illinois was an early and ardent adopter of the estoppel doctrine.

Limited bad faith remedies are also a factor in the third justification for the estoppel doctrine, which is that the rule deters insurance companies from breaching the duty to defend. If there are minimal repercussions as a result of bad faith, then an insurer does not risk much by unreasonably refusing to defend. For example, in Illinois, if an insured faces a consequence only a \$60,000 penalty in addition to defense costs, it may view a breach as the more “efficient” option. After all, not every insured will pursue a coverage lawsuit, so there may be no risk at all in breaching. In addition, potential punitive damages will act as a deterrent only if the insurer has no reasonable basis to deny a defense. If the insurer has a reasonable basis to believe that the claim does not raise a potential for coverage, then a denial would generally not expose the insurer to bad faith liability. In such a case, potential tort liability is no deterrent at all. Thus, in a non-estoppel jurisdiction, if there is any question as to whether a duty to defend exists, then the insurer has less of an incentive to provide a defense. Denying the defense and later being held to

have breached subjects the insurer to the exact same exposure that it had at the outset – paying the defense fees. And as an added benefit, the insurer has had use of the funds in the interim. Courts in estoppel jurisdictions have concluded that such a result disregards the benefit purchased by the insured. It renders the duty to defend nothing more than a duty to reimburse defense costs – and yet, these are distinctly different contractual obligations, as recognized by the fact that insurers charge different premiums for each type of coverage. By imposing an equitable remedy for the breach of the duty to defend, courts applying the estoppel doctrine have found that a further remedy is needed to make breaching more costly and to protect the intangible benefits of the duty to defend.

In addition to these three main justifications, courts applying estoppel have rejected the argument that an insured is protected because it may recover the amount of a judgment or settlement as consequential damages. As noted above, some courts have suggested that the estoppel doctrine is not necessary because where the conduct of the insurer in refusing a defense prejudiced the insured, the insured is able to seek the amount of the judgment as consequential damages. *See Sentinel Ins. Co.*, 875 P.2d at 913; *Deluna*, 233 P.3d at 17. However, in order to obtain such a ruling, an insured would have to prove that the failure of the carrier to provide a defense was the direct cause of the judgment. Perhaps an insured could meet this burden in a case where it could not afford underlying counsel and a default judgement was entered or the counsel retained was woefully inadequate. Apart from such an extreme circumstance, it is difficult to ascertain how such a showing could be made. The insurer should not be “permitted, by its breach of the contract, to cast upon the plaintiff the difficult burden of proving a causal relation between the defendant’s breach of the duty to defend and the results which are claimed to have flowed from it.” *Missionaries of the Co. of Mary, Inc.*, 230 A.2d at 26. Thus, it may be

argued that the insured's potential ability to seek recovery of a judgment as consequential damages of the breach is a minimal protection at best.

It should be noted that, even within jurisdictions that adopt the automatic estoppel rule, it is not without its limits. For example, the Supreme Court of Connecticut has recently narrowed its application of the estoppel doctrine. In *Capstone Building Corp. v. American Motorists Insurance Co.*, 67 A.3d 961 (Conn. 2013), the court reaffirmed its earlier holding that a breaching insurer may not raise coverage defenses. However, it created what could be argued is a rather large exception. The court held that, where the insured settled all claims in the underlying litigation, the breaching insurer was liable for only the settlement amounts proportionate to the potentially covered claims. The court reasoned that "holding an insurer liable for the settlement of claims which it had no duty to defend is per se unreasonable" *Id.* at 999. It is not clear how this ruling can be reconciled with the automatic estoppel rule, and it does not appear that Connecticut courts have thus far had occasion to try. If it is unreasonable to hold a breaching insurer liable for amounts paid to settle claims for which it had no duty to defend, then how can it be held liable for amounts awarded as a judgment for claims for which it had no duty to defend. The court did not provide much guidance in this regard, and it remains to be seen if courts will use the *Capstone* holding as a means to further erode the protections to insureds provided by the estoppel doctrine.

A second limitation that has been placed on estoppel is an exception for late notice defenses. For example, in *Pulte Home Corp. v. American S. Ins. Co.*, 647 S.E.2d 614 (N.C. Ct. App. 2007), the insurer argued first that there was no duty to defend because the underlying claim did not fall within the scope of coverage and second, that even if there was a duty to defend, it was not liable for defense and indemnity costs because the insured provided late notice

of the claim. The Court of Appeals of North Carolina began by stating that it was “well established in North Carolina that when an insurer without justification refuses to defend its insured, the insurer is estopped from denying coverage and is obligated to pay the amount of any reasonable settlement” *Id.* at 617 (quotations omitted). The court then held that the third party claim did fall within the scope of the policy and that American Surety did have a duty to defend Pulte. *Id.* at 620. One would think that, under the estoppel doctrine, this would end the inquiry – as a result of the breach, American Surety would be liable for the defense costs and the underlying settlement. However, the court allowed American Surety to raise the coverage defense that Pulte’s late notice of the claim defeated any claims under the policy. While American Surety was ultimately unsuccessful based on the facts of the case, the court’s allowance of the insurer to argue that its breach was “justified” would seem to undermine the estoppel doctrine.

In fact, courts in other jurisdictions facing the same question have unequivocally held that the estoppel doctrine prohibits all defenses, even that of late notice. In *Employers Insurance of Wausau*, the Supreme Court of Illinois rejected the insurer’s argument that it could still raise the defense of late notice after it had breached the duty to defend. The insurer, relying on earlier Illinois appellate court decisions, argued that the notice provision in the policy was a condition precedent to coverage. Thus, it argued, because that condition had not been fulfilled, the duty to defend was never triggered and the estoppel rule could not apply. The court refused to adopt this rule and overruled the appellate cases that had done so. *Emp’rs Ins. of Wausau*, 708 N.E.2d at 1136. The court reasoned that when an insurer believes that late notice negates its obligations under the policy, the proper recourse is to defend under a reservation of rights and bring a declaratory judgment action. *Id.* To hold otherwise would allow the insurer to “abandon its

insured” and would “seriously undermine the effectiveness of the estoppel doctrine and its intended enforcement of the duty to defend.” *Id.*¹¹

Finally, even where a jurisdiction appears to have unequivocally adopted the estoppel doctrine, it may not be universally applied. In *Conanicut Marine Services, Inc. v. Insurance Co. of North America*, 511 A.2d 967 (R.I. 1986), the Supreme Court of Rhode Island held that “where an insurer refuses to defend an insured pursuant to a general-liability policy, the insurer will be obligated to pay, in addition to the costs of defense and attorneys’ fees, the award of damages or settlement assessed against the insured.” *Id.* at 971. This would seem to be an unequivocal adoption of the estoppel doctrine by the Supreme Court of Rhode Island. However, when a federal district court in Rhode Island considered the estoppel question in 2007, it held that the estoppel doctrine did not apply. *Emhart Indus., Inc. v. Home Ins. Co.*, 515 F. Supp. 2d 228 (D.R.I. 2007).

In *Emhart*, the court acknowledged the holding in *Conanicut*, but noted that the “mechanical application of *Conanicut* to these facts would impose an astronomical penalty on Century. . . . Considering the fact that the jury has already absolved Century of any indemnity obligation, this penalty would be more than unreasonable – it would be completely irrational.” *Emhart Indus., Inc.*, 515 F. Supp. 2d at 260. The court noted that a Rhode Island state court may be “inclined” to follow the rule enunciated in *Conanicut*; however, “a federal judge is not a ventriloquist dummy; . . . a federal court may, in a sense, ‘overrule’ an outmoded decision by predicting that the state’s highest court would, if presented with the opportunity, do the same.” *Id.* at 260-61 (citations omitted).

¹¹ Illinois does recognize a “narrow exception to the estoppel doctrine . . . where there is a serious conflict of interest that precludes the insurer from assuming the insured’s defense.” See *Employers Ins. of Wausau*, 708 N.E.2d at 1137. Even in such a case, however, in order to avoid the estoppel rule, the insurer must reimburse the insured for the costs of the defense as they are incurred. *Id.*

And that is exactly what the district court did. It stated that the estoppel doctrine had not been applied by a Rhode Island court since *Conanicut* (although it does not appear it has been rejected) and it pointed to statements by the Rhode Island Supreme Court that “estoppel could *not* be invoked to expand the scope of coverage in an insurance policy” (although the court did not consider the specific issues before the court in those cases). *Id.* (citations omitted). For these reasons, the *Emhart Industries* court suggested that the estoppel doctrine as pronounced in *Conanicut* “has lost its persuasive force.” *Id.* at 262. In rejecting the estoppel doctrine, the court stated that:

If the Rhode Island Supreme Court wishes to impose such a drastic penalty on breaching insurers as a mechanism to police the *limites* of the duty to defend, it could of course, do so in this or any other context. But federal courts are not sounding boards for avant-garde theories of insurance law.

Id. On appeal, the First Circuit upheld the rejection of the estoppel doctrine and stated that it “doubted” that *Conanicut* “could be read as imposing a bright line rule for the imposition of damages.” *Emhart Indus., Inc. v. Century Indem. Co.*, 559 F.3d 57, 77 (1st Cir. 2009).

C. Limited Estoppel Doctrine

The cases discussed above demonstrate that there remains some uncertainty in the application of the estoppel doctrine. This uncertainty is further evidenced by the fact that some jurisdictions have carved out a middle ground between rejecting and accepting automatic estoppel. This approach can be generally thought of as a “limited” estoppel doctrine, and has been adopted most notably in California. Courts applying this limited estoppel doctrine recognize that some consequence beyond defense costs must be borne by the breaching insurer, but they do not go so far as to hold that insurers waive coverage defenses in all cases. Instead, the estoppel rule will not apply unless the insurer acted unreasonably or in bad faith.

Early cases discussing the estoppel rule in California appear to apply the rule without any

limitation. In the well-known case *Gray v. Zurich Insurance Co.*, 419 P.2d 168 (Cal. 1966), the Supreme Court of California made the sweeping proclamation that “the general rule [is] that an insurer that wrongfully refuses to defend is liable on the judgment against the insured.” *Id.* at 179. This statement that an insurer forfeits coverage defenses by “wrongfully” denying a defense is the exact same language employed in jurisdictions applying the automatic estoppel rule. For example, in *Employers Ins. of Wasau*, the Supreme Court of Illinois stated that where an insurer “wrongfully denied coverage, the insurer is estopped from raising policy defenses to coverage”). 708 N.E.2d at 1135. While Illinois and California articulate the standard the same way, the law has developed differently in practice. Illinois appears to interpret the word “wrongfully” to mean that estoppel shall be applied where the denial of a defense was “wrong,” or incorrect. Thus, whenever the insurer has breached the duty to defend, estoppel applies. In California on the other hand, courts have interpreted the term “wrongful” to mean “in bad faith.” Thus, estoppel will only apply if the insurer unreasonably or in bad faith denied a defense. *See, e.g., Amato v. Mercury Cas. Co.*, 53 Cal. App. 4th 825 (Cal. Ct. App. 1997) (holding that insured could recover cost of underlying judgment after breach of duty to defend even though judgment was not on a covered claim because insurer acted unreasonably and in bad faith in denying defense); *see also Mut. of Enumclaw Ins. Co. v. Dan Paulson Constr., Inc.*, 169 P.3d 1, 10 (Wash. 2007) (“if the insured prevails on the bad faith claim, the insurer is estopped from denying coverage”) (citation omitted).

This limited version of the estoppel doctrine is the subject of much confusion. In fact, some commentators have stated that California has adopted the estoppel doctrine, while others proclaim that California has rejected it.¹² Not only does the rule not lend itself to easy

¹² Compare Weiss, *supra*, n.6, at 154 with Gary L. Gassman et al., *Potential Consequences of Breaching the Duty to Defend: Key Considerations for Insurers and their Attorneys*, The Brief, Vol. 45, Fall 2015, at 33.

classification, but also it appears difficult to enforce. If estoppel in California requires a showing of bad faith, then how is it different from a tort claim for bad faith? What benefit does the insured derive from the estoppel rule that it could not already obtain from a bad faith action? The answer appears to be simply that the insured need not plead a tort claim, but could instead use the bad faith estoppel principle as a means for obtaining tort damages in a contract action. The rule in California invites even further confusion by creating a scenario in which two lines of cases regarding bad faith develop – one addressing tort claims and the other addressing estoppel. This result could lead to inconsistencies in the law and uncertainty for both the insured and the insurer.

Despite this confusion, the “limited” estoppel doctrine appears to be gaining traction. In 2014, the American Law Institute (“ALI”) proposed the creation of the first Restatement of the Law of Liability Insurance.¹³ As the draft currently stands, it adopts a limited estoppel doctrine, which states: “An insurer that lacks a reasonable basis for its failure to defend a legal action also loses the right to contest coverage for the action.”¹⁴ The comments elaborate that “a reasonable basis” “means that the insurer has a reasonable legal theory pursuant to which, giving the insured the benefit of the doubt with regard to any and all disputed facts, the insurer has no duty to defend as a matter of law.”¹⁵

In sum, the limited estoppel doctrine appears to impose a consequence on insurers for breaching the duty to defend, but in reality it does so only in certain circumstances. The limited

¹³ At the time of the drafting of this Article, the Council of the American Law Institute had drafted and approved two of the four chapters of the proposed Restatement, including Section 19, “Consequences of Breach of the Duty to Defend,” subject to the approval of ALI membership. For a thorough and compelling analysis of a preliminary draft of the Restatement, see Timothy P. Law & Lisa A. Szymanski, *Reserving the Right to Contest Coverage under the Proposed Restatement of the Law of Liability Insurance*, 68 Rutgers U. L. Rev. 29 (2015).

¹⁴ Restatement of the Law of Liab. Ins. § 19(2) (Am. Law Inst., Council Draft No. 2, December 28, 2015).

¹⁵ Restatement of the Law of Liab. Ins., *supra* note 14 at comment d.

estoppel doctrine changes the equation only by allowing some additional recovery if the insurer acted in bad faith. In a state with strong bad faith protections, this may not add much to the equation – the insured can already recover potentially substantial punitive damages that would compensate for the amount of the judgment or settlement. The added protection may be a material difference only in states with limited bad faith recoveries. On the other hand, the limited estoppel doctrine provides no added protection for an insured where the insurer had a reasonable basis to deny coverage. Thus, the insured would still be left without any protections for the intangible benefits that it was denied. If the limited estoppel doctrine adds protections in only a narrow set of circumstances, one may question whether it is worth having at all.

V. CHALLENGING UNDERLYING ATTORNEY FEES AFTER BREACH

Having examined the nuances in determining a breach and litigating coverage, we now turn back to the uncontroversial remedy for the breach of the duty to defend: the recovery of attorneys' fees incurred in the underlying litigation. Generally, most jurisdictions allow an insurance carrier to challenge the reasonableness of attorney fees incurred in the underlying litigation.¹⁶ However, some states impose a presumption that the fees were reasonable, thus shifting the burden to the carrier to prove that the fees were unreasonable.¹⁷

The main rationale for application of the burden shifting scheme is that, when an insurer has breached the duty to defend and the policyholder has secured, supervised, and paid for a

¹⁶ See *House of Clean, Inc. v. St. Paul Fire & Marine Ins. Co.*, 775 F. Supp. 2d 302, 309 (D. Mass. 2011) (“Even where the insurer has breached its duty to defend, the insured must prove the existence and amount of the expenses and that those expenses were reasonable and necessary defense costs.”); *Emhart Indus., Inc.* 515 F. Supp. 2d at 251 (“the general rule in these situations is that the initial burden is on the insured to prove that its fees were reasonable”); *Etchell v. Royal Ins. Co.*, 165 F.R.D. 523, 545 (N.D. Cal. 1996) (stating that, even after a breach, insureds bear “the burden of proving that the hourly rates on which the fee claims are based were reasonable”).

¹⁷ See *Taco Bell v. Cont'l Cas. Co.*, 388 F.3d 1069, 1075-77 (7th Cir. 2004); *Gustafson v. Am. Family Mut. Ins. Co.*, 2012 WL 5904301, at *5 (D. Colo. Nov. 26, 2012) (“The Court finds that, in accordance with general principles of contract law, the Colorado Supreme Court would place the burden of proving the reasonableness of attorneys' fees on the insurer who breached its duty to defend.”); *Shore Chan Bragalone Depumpo LLP v. Greenwich Ins. Co.*, 904 F. Supp. 2d 592, 603 (N.D. Tex. 2012) (“insurer who abdicates its duty to defend is also barred from directly challenging the reasonableness and necessity of the insured's attorney's fees”).

defense without any assurance that it would be reimbursed by the insurer, those costs are “market tested” and are presumed to be reasonable and necessary. *See Taco Bell v. Continental Cas. Co.*, 388 F.3d 1069, 1075-77 (7th Cir. 2004). This is because a policyholder, who is spending its own money without any assurance that it will ever be reimbursed by an insurer, is already motivated to be as efficient as possible, and thus its efforts to economize its own defense provide a market-based check on the amounts spent.

In *Taco Bell*, the insurer – having been found to have breached the duty to defend – argued that the insured had overpaid its lawyers in the underlying litigation. The Seventh Circuit rejected the argument:

When Taco Bell hired its lawyers, and indeed at all times since, Zurich [has] vigorously den[ied] that it had any duty to defend –any duty, therefore, to reimburse Taco Bell. Because of the resulting uncertainty about reimbursement, Taco Bell had an incentive to minimize its legal expenses (for it might not be able to shift them); and where there are market incentives to economize, there is no occasion for a painstaking judicial review.

Id. at 1075-76. The court explained that “the duty to defend would be significantly undermined if an insurance company could, by the facile expedient of hiring an audit firm to pick apart a law firm’s billing, obtain an evidentiary hearing on how much of the insured’s defense costs it had to reimburse.” *Id.* at 1077. The court reasoned that it is unfair to let a breaching insurer quibble over costs when it could have initially directed the defense in any reasonable way it wished if it had honored its duty to defend in the first place. *Id.* at 1076-77; *see also Knoll Pharm. Co. v. Auto. Ins. Co. of Hartford*, 210 F. Supp. 2d 1017, 1025 (N.D. Ill. 2002) (insureds’ payment of all defense costs sought from insurer “strongly implies commercial reasonableness of the fees, especially in light of the fact that ultimate recovery of these fees was uncertain because [the insurers] repeatedly refused to pay”); *Medcom Holding Co. v. Baxter Travenol Labs., Inc.*, 200 F.3d 518, 520 (7th Cir. 1999) (“The fees in dispute here are not pie-in-the-sky numbers that one

litigant seeks to collect from a stranger but would never dream of paying itself. These are bills that [the plaintiff] *actually paid* in the ordinary course of its business.”). Thus, these courts reason that an insured’s contemporaneous efforts to minimize its own defense expenses are superior to any hindsight review applied by a breaching insurer.

It is crucial to note that while these cases appear to discourage a “painstaking judicial review” of the insured’s defense fees, they do not unequivocally preclude such an undertaking. Instead, the remedy applied is merely a shift of the burden of proof – the insurer is still entitled to present evidence of unreasonableness. Thus, courts applying the burden shifting analysis often must still undergo an examination of the individual expenses incurred. For example, in *Thomson Inc. v. Insurance Company of North America*, 11 N.E.3d 982 (Ind. Ct. App. 2014), the trial court held that, due to the breach of the duty to defend, the insured’s defense costs were “presumed to be reasonable and necessary” and “the insurer cannot second guess the work done or amounts paid” *Id.* at 1024. However, the trial court still allowed the insurer to present expert evidence criticizing the general billing practices employed by the insured’s underlying counsel. A battle of the experts ensued in which the insurer presented an expert who was not a litigator, but specialized in “reviewing legal bills and identifying practices he claims lead to overbilling.” *Id.* at 1025. The insured’s expert, on the other hand, was a partner at Vinson & Elkins who had defended similar cases in similar jurisdictions. The court found the insured’s expert to be more persuasive, particularly because he applied the factors for determining the reasonableness of fees as set forth in the Indiana Code of Professional Conduct, which requires that the court consider “novelty, difficulty, skill, experience, reputation, and ability.” *Id.* Thus, despite the application of the burden shifting presumption, the parties were still permitted to submit detailed expert opinions analyzing the particulars of the insured’s attorneys’ billing practices and the court

undertook an analysis of that evidence. The Court of Appeals agreed with this approach and affirmed the trial court's opinion. *Thomson* is a prime example of the fact that, even where courts apply the presumption of reasonableness, it may not substantially alter the proceedings. The insurer is still entitled to submit evidence that the defense fees were unreasonable, which results in the same detailed analysis of the legal fees and battle of the experts that would take place in the absence of the presumption.

VI. CONCLUSION

The issues and cases discussed herein represent only part of the many complications facing litigants after the duty to defend has been breached. A possible explanation for the myriad and conflicting responses to these issues may simply be that the underlying problems are difficult ones. As such, intelligent litigators and courts reasonably disagree as to the outcome of such controversies. Courts struggling with different problems are bound to come up with different resolutions. In an area where many rationalizations and justifications may have traction, good advocacy and an understanding of the fundamental issues could make all the difference.

Keeping Policyholder Firms Off Panel Counsel Lists—Is This Legal?

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Keeping Policyholder Firms Off Panel Counsel Lists: Are There Disclosure Obligations?

by

John H. Mathias, Jr.

For Presentation at the Annual Meeting of the ACCEC

Chicago, May 5-6, 2016

This paper addresses the frustrating circumstances experienced by policyholder counsel in large law firms with a diverse litigation practice, including securities litigation defense, when confronted with an insurer's practice of placing restrictions upon law firms as a condition of being listed as "panel counsel" on their D&O insurance policy forms. These restrictions may broadly include a prohibition against any lawyer in that law firm representing any client in any matter adverse to the insurer, even if completely unrelated to matters covered by the D&O policy form. The insurer then rigidly enforces the D&O policy requirement that policyholders use only listed "panel counsel," declining to consent to a policyholder's request to engage non-panel counsel law firms, even where such counsel have existing, longstanding relationships with the policyholder.

A typical D&O policy "panel counsel" provision is something like this:

Affixed as Appendix A hereto and made a part of this D&O Coverage Section is a list of Panel Counsel law firms ("Panel Counsel Firms") from which a selection of legal counsel shall be made to conduct the defense of any Securities Claim against an Insured pursuant to the terms set forth in this Clause. In the event the Insurer has assumed the defense, then the Insurer shall select a Panel Counsel Firm to defend the Insureds. In the event the Insureds are already defending a Securities Claim, then the Insureds shall select a Panel Counsel Firm to defend the Insureds.

The insurer requires law firm management to make a choice: Either agree that no lawyer in the firm will represent any client in any matter adverse to the insurer, or else understand that the firm will not be listed as panel counsel and will not be able to obtain the insurer's consent to serve as securities defense counsel even if requested by long standing firm clients. This strategy has the intended effect of pitting law firm securities litigation and insurance coverage litigation practice leaders and groups against each other in anticipatory fashion, even when there are no existing client conflicts.

Many large U.S. law firms have outstanding securities litigation defense practices offered at competitive rates to clients. Similarly, many of these same law firms have outstanding policyholder side insurance coverage litigation practices. Securities litigation practice leaders in these firms are understandably upset if they are excluded from an insurer's D&O panel counsel list, especially if that insurer has a substantial share of the D&O insurance market for public companies. They are even more upset if and when a longstanding firm client wants to engage them as securities litigation defense counsel, but the insurer refuses to give consent, instead requiring the engagement of "panel counsel." Similarly, policyholder side insurance coverage practice leaders are understandably upset if their firm agrees to the restrictions required by the insurer to be listed as "panel counsel," thereby foreclosing them from representing any existing

or future clients with interests adverse to the insurer, even though the insurer is not a firm client and regardless of what line of insurance may be involved.

It is an understatement to say that this “panel counsel” practice threatens the ability of securities litigation and policyholder side insurance practices to function side by side together in large law firms and to compete with other law firms having no such restrictions. These are very serious, very difficult law firm issues often leading to the effective marginalization of one or the other of these practices. Accordingly, it should be unsurprising to anyone when questions arise concerning what, if anything, can be done to stop or otherwise ameliorate what appears to be an insurer’s punitive practice directed at law firms with policyholder side insurance practices.

Having been privy to a great many conversations among policyholder side insurance counsel hypothesizing one theory or another about why this practice should be “illegal” (antitrust, group boycott, unfair competition, interference with contract, etc.), this paper will eschew all of them for the time being in favor of considering a market based inquiry focused upon both (a) the kind of full disclosure an insurer should make to customers at the time of sale of D&O insurance policies with “panel counsel” provisions; and (b) the duties law firms listed as “panel counsel” on these D&O policies may have to assure full disclosure is made by the insurer to customers at the time of sale.

Hypothetical

Assume as follows:

1. An insurer offers a D&O insurance policy (“Policy”) which indemnifies the policyholder as an entity for “loss” defined to include the cost of defense in excess of a \$1,000,000 retention for securities claims.
2. The Policy provides: “The insureds shall defend and contest any claim made against them. The insurer does not assume any duty to defend or investigate.”
3. The Policy requires the policyholder to use specifically listed law firms and individual lawyers (“panel counsel”) as a condition of coverage.
4. To be listed in the Policy, all panel counsel have been required by the insurer to orally agree (a) that no lawyer in their firm will represent any client in any coverage matter adverse to the insurer; or (b) that no lawyer in their firm will represent any client asserting a bad faith claim against the insurer, even if completely unrelated to matters covered by the Policy (“non-adversity agreements”).
5. Prior to sale and issuance of the Policy, the insurer does not disclose to its policyholder customers the non-adversity agreements it has required from listed panel counsel.

Questions

1. Has the insurer breached any duty of disclosure owed to its policyholder customers prior to the sale and issuance of the Policy?
2. If so, are panel counsel complicit in this breach by acceding to being listed by the insurer without disclosure to policyholder customers of their non-adversity agreement?
3. Are there any other legal or ethical issues implicated?

Potential Conflicts

Once claims are asserted, it is commonly understood that there are at least three areas where the interests of the policyholder and the insurer potentially diverge:

1. The policyholder is interested in having all asserted claims completely covered, whereas the insurer may contest coverage or reserve its rights regarding a denial or allocation of coverage for some or all of the claims alleged.
2. The policyholder is interested in having all claims resolved within the limits of the Policy, whereas the insurer may resist settlement of claims for amounts it deems unreasonable within Policy limits.
3. The policyholder may want to defend against baseless claims for reputational or other business reasons rather than settle them, whereas the insurer may insist upon settlement within the self insured retention.

Should any one or more of these areas be implicated, a tension arises in which it would be seemingly impossible for defense counsel not to “take sides” in some respect.

Customer Expectations

Absent some warning or disclosure to the contrary, a policyholder would normally expect that defense counsel selected from the panel counsel list would have the conventional ethically imposed duty of undivided loyalty. A policyholder would have no reason to suspect that its counsel would be inhibited in any way from providing a comprehensively zealous representation of all its interests. Here, however, panel counsel with undisclosed non-adversity agreements would be impaired from providing the policyholder with undivided loyalty and a comprehensively zealous representation of all the policyholder’s interests, including the three areas listed above where the interests of the policyholder and the insurer might diverge.

Furthermore, here the policyholder is being contractually required to pay its own money to conflicted panel counsel firms for the first \$1,000,000 of legal expense within the Policy’s self insured retention. The Policy imposes an affirmative duty upon the policyholder to defend itself using panel counsel, whereas the insurer has no contractual duty to provide a defense. (“The insureds shall defend and contest any claim made against them. The insurer does not assume any duty to defend or investigate.”) However, without complete advance disclosure of the full details of the non-adversity agreements reached between panel counsel and the insurer, the policyholder has no way of knowing the full extent of undisclosed conflicts. Indeed, the relatively unlimited duty of loyalty secretly pledged by panel counsel to the insurer extends far more broadly than just one case, whereas the loyalty provided by panel counsel to the policyholder is materially limited.

Surely any policyholder would want to know these facts before paying the premium for a D&O policy with baked in conflicts for the panel counsel it will be required to retain and pay with up to \$1,000,000 of its own money. These would certainly be material facts affecting any purchase decision. The failure of an insurer to disclose these material facts, about which it is fully informed while a prospective customer is completely ignorant, should be subject to the same

scrutiny as in any commercial transaction. Ordinarily, a seller would have a duty to disclose all material facts to a buyer. By not disclosing these material facts, the insurer is foreclosing the policyholder from making a fully informed decision about whether to purchase this Policy or a different one from a competing insurer on the open market not having such restrictions upon defense counsel.

Full Disclosure in Marketing

It is the central premise of this paper that the attorney-client relationship is among the most sacrosanct of all in our state and federal legal systems. Long ago, the U.S. Supreme Court stated:

There are few of the business relations of life involving a higher trust and confidence than that of attorney and client, or, generally speaking, one more honorably and faithfully discharged; few more anxiously guarded by the law, or governed by sterner principles of morality and justice; and it is the duty of the court to administer them in a corresponding spirit, and to be watchful and industrious, to see that confidence thus reposed shall not be used to the detriment or prejudice of the rights of the party bestowing it. *Stockton v. Ford*, 52 U.S. (11 How.) 232 (1850).

Nearly forty years ago, the Idaho Supreme Court put it this way:

The relationship of client and attorney is one of trust, binding an attorney to the utmost good faith in dealing with his client. In the discharge of that trust, an attorney must act with complete fairness, honor, honesty, loyalty, and fidelity in all his dealings with his client. An attorney is held to strict accountability for the performance and observance of those professional duties and for a breach or violation thereof, the client may hold the attorney liable or accountable. *Beal v. Mars Larsen Ranch Corp., Inc.*, 99 Idaho 662, 667-668, 586 P.2d 1378, 1383-1384 (1978) (citation omitted).

The rules of professional responsibility for every state address conflicts of interest and the duty of undivided loyalty owed by attorneys to their clients. For example, Rule 1.7 of the Illinois Rules of Professional Conduct provides:

CONFLICT OF INTEREST: CURRENT CLIENTS

(a) Except as provided in paragraph (b), a lawyer shall not represent a client if the representation involves a concurrent conflict of interest. A concurrent conflict of interest exists if:

(1) the representation of one client will be directly adverse to another client; or

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

(b) Notwithstanding the existence of a concurrent conflict of interest under paragraph (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 claim by one client against another client represented by the lawyer in the same litigation or other proceeding before a tribunal; and

(4) *each affected client gives informed consent.*

(emphasis added).

Comment 9 to Rule 1.7 of the Illinois Rules of Professional Conduct elaborates:

Lawyer's Responsibilities to Former Clients and Other Third Persons:

[9] In addition to conflicts with other current clients, *a lawyer's duties of loyalty and independence may be materially limited* by responsibilities to former clients under Rule 1.9 or *by the lawyer's responsibilities to other persons*, such as fiduciary duties arising from a lawyer's service as a trustee, executor or corporate director.

A fair reading of this Rule 1.7 would seem to require at a minimum that, prior to engagement as defense counsel, panel counsel must both (a) make full disclosure of any oral or written agreement they have made with an insurer which might in any way materially limit their duty of loyalty and independence to the policyholder; and (b) obtain the policyholder's informed consent, which may be reasonably withheld.

It stands to reason that an insurer similarly should make full advance disclosure to prospective policyholder customers of whatever oral or written agreements they have made with panel counsel which might in any way materially limit their duty of loyalty and independence to the policyholder. If an insurer is not making such full disclosure, and if listed panel counsel are aware that no such disclosure is being made to prospective policyholder customers, then a further question (unanswered by this paper) arises concerning the level of complicity and exposure panel

counsel may have for whatever complaints policyholder customers might assert against insurers for non-disclosure of such obviously material facts in marketing.

Conclusion

This paper is not intended to be a comprehensive legal analysis of the “panel counsel” practices of any insurer. The questions raised herein are simply intended to shed daylight on the underwriting, marketing, and claims handling practices of insurers using “panel counsel” lists to punish law firms with policyholder side practices. A fully informed and free market place should be allowed to determine in the first instance whether policyholder customers have any appetite for “panel counsel” policies with baked in non-adversity agreements. If not, then the issue is moot. If so, however, then further inquiry into the legality of these contractual trade restraints, including the full scope of oral agreements between panel counsel and insurers, can follow.

At a bare minimum, no policyholder should ever have the experience of learning for the first time, after a securities claim has already been filed against it, that the “panel counsel” law firm it is being contractually compelled by its D&O insurer to retain has material limitations upon its duties of loyalty and independence.



*DISCOVERY OF OTHER CLAIMS-
PATTERNS AND PRACTICES
IN INSURANCE*

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DISCOVERY OF OTHER CLAIMS-PATTERNS AND PRACTICES IN INSURANCE

I. WHAT ARE WE TALKING ABOUT?

Is evidence of an insurance company's treatment of coverage issues in handling other similar claims discoverable and/or relevant in an action for contractual and extra-contractual liability against the insurer? For example, a carrier is suspected of having repeatedly paid and/or defended claims under primary or excess employers liability coverage for claims against an insured for committing torts that were "substantially certain" to result in harm, despite the "accident" requirement and the intended or expected harm exclusion. The suspected reason is that assertion of these policy defenses and denying coverage would result in the employer's liability coverage being illusory and could potentially lead to class actions for return of premiums.

For a policyholder, evidence the carrier has previously settled or defended similar claims is relevant and illustrates that the insured's interpretation of the policy presents a reasonable alternative construction and thus illustrates that the policy is ambiguous. Evidence that the carrier has carefully tried to obtain confidentiality agreements in other cases where such claims have been settled reflects knowledge that the policy is ambiguous or the coverage illusory. Moreover, where the insured or its agents have raised the issue of the carrier's inconsistent treatment of claims, the failure of the carrier to consider the issue and determine if it has acted inconsistently would seem to be evidence of knowledge of the lack of a reasonable basis for denial or delay and thus evidence of bad faith.

One thing is for sure: seeking evidence regarding the treatment of other claims is sure to draw an avalanche of objections and a prolonged and intense discovery battle. It gets the carrier's attention, and for policyholders, that is always a good thing. In this paper, we will seek to provide some relevant background information on the insurance industry and some practical tips for inquiring into "other claims." Our focus will ultimately be on legal bases for obtaining and admitting such evidence in a coverage and/or bad faith action.

For the reader's convenience, we have attached an appendix including critical evidentiary rules set forth in the Federal Rules of Evidence.

II. THE COVERAGE DECISION-MAKING PROCESS AND SOURCES

A. DECISION-MAKERS

The adjuster has a number of persons available to assist in coverage decision-making:

- Outside coverage counsel
- Supervisor
- Underwriting

- Corporate legal
- In-house captive coverage counsel

B. SOURCES OF DOCUMENTS REFLECTING VARYING POSITIONS

In addition, there are a number of potential documentary or digital sources:

- Individual adjuster collections of prior coverage opinions in other cases
- Other similar coverage cases being handled by the adjust; the same adjuster may use a coverage opinion from one case to decide a coverage issue in another case, avoiding the cost of hiring another coverage lawyer for the second repeat case involving the same coverage issue.
- Company coverage data banks of prior coverage opinions
- Litigation information kept by corporate management, the adjuster, or corporate counsel involving the carrier and the same or similar coverage issues
- Records relating to company decisions on significant national coverage questions, such as trigger of coverage and/or how the company intends to approach the insurability of punitive damages.
- Information regarding subrogation cases where the company may have taken a contrary position regarding coverage against another carrier.
- Underwriting files relating to the development of new policy forms and endorsements, which are sometimes kept in the corporate legal department. In our employer's liability example, the company developed forms that had an express exclusion for "substantial certainty" torts in addition to intended and expected acts or omissions. If "substantial certainty" torts were not covered as something less than intended harm, then why develop the express exclusion?
- The files of outside coverage counsel, which are certainly subject to privilege issues, will often be rich sources since the carriers will often use the same firm in the same jurisdiction on the same coverage question.

C. UNDERSTANDING THE INCONSISTENCIES AND WHERE THEY CAN BE FOUND

I. Big Picture Issues

a. Jurisdictional Variations—Take It As You Find It

Because many states vary in their approach to particular coverage issues, some carriers adopt a “take it as you find it” approach, taking one coverage position in one jurisdiction and another position in other jurisdictions on the same coverage issue. Other carriers seek to achieve some form of consistency.

b. Excess/Primary Positions

Regarding trigger, many quickly found that they could take positions as primary carriers against excess carriers that would be harmful if used against them when they were in the position of the excess carrier. The same was true regarding issues such as joint and several liability, horizontal versus vertical exhaustion, etc.

c. Subrogation

In some circumstances, carriers will take positions regarding coverage in connection with subrogation claims that are different from positions taken directly to the policyholder. We have seen multiple cases where a carrier sought punitive damages and argued for coverage for punitive damages in a subrogation action, while at the same time they would fight their own policyholders wherever there was a chance coverage for punitives would be found at least against public policy. We have also seen cases where an insured settled claims involving potentially uncovered punitive damages and then sought such damages in a subrogation action, in one instance an action for malpractice against the defense lawyer. Paying uncovered damages can make the suing carrier subject to the volunteer doctrine and thus defeat such inconsistent claims.

d. Different Adjusters and Worsening Circumstances

We have encountered many situations where an initial adjuster on the case found coverage existed, rejecting particular policy interpretations. The opposite can occur as well, where coverage is contested and then accepted depending on the adjuster at the helm. We have also seen situations where the underlying suit was thought to be a no-liability suit, and it later turned out to be a potential high exposure case. Coverage issues that were ignored and not even reserved will all of a sudden rear their ugly heads in such cases.

e. Using A Coverage Opinion In One Case To Resolve A Different Case

We recently encountered a situation where the adjuster chose not to seek a coverage opinion in case number 1. Instead, she chose to use an earlier opinion she received in case number 2. The circumstances in case number 1 were very different from number 2. The opinion

wound up being discussed in some detail in an email produced from a “personal file” kept by the supervisor of the adjuster in question. As a result, the court found the privilege had been waived and require production of the coverage opinion, all supplements, and all reservation of rights letters and drafts. The initial draft reservation in case number 1 was cut and pasted from the reservation letter in case number 2. As a bonus, materials produced from other cases can be used to show corporate knowledge and appreciation of rules that were violated, such as the need to provide a timely reservation of rights and consequences of the failure to timely reserve.

D. Targeting Relevance

The most obvious targets for making “relevant” discovery requests regarding other claims include the following:

- Pattern, practice or scheme
- Inconsistent coverage positions
 - Shows ambiguity
 - Discrimination
- Improper coverage decisions
 - Use of opinions in other claims to decide the one at hand
- Motive or intent
- Habit
- Bad faith
 - Lack of reasonable basis based on inconsistency
 - Pretext
 - Use of experts in other cases
 - Cookie cutter opinions
 - Result-oriented
 - Frequency/Repeated bad acts
 - Carrier acted knowingly
- Punitive damages
 - Standard factors

- The nature of the wrong
 - The character of the conduct involved.
 - The degree of culpability of the wrongdoer.
 - The situation and sensibilities of the parties concerned.
 - The extent to which such conduct offends a public sense of justice and propriety.
- Review factors under *BMW of North America, Inc. v. Gore*, 517 U.S. 559, 116 S. Ct. 1589, 134 L.Ed.2d 809 and *State Farm Mut. Auto. Ins. Co. v. Campbell*, 538 U.S. 408, 420, 123 S. Ct. 1513, 155 L.Ed.2d 585 (2003):
 - The degree of reprehensibility of the defendant's misconduct
 - Whether the harm caused was physical as opposed to economic;
 - Whether the tortious conduct evinced an indifference to or a reckless disregard of the health or safety of others;
 - Whether the target of the conduct had financial vulnerability;
 - Whether the conduct involved repeated actions or was an isolated incident; and
 - Whether the harm was the result of intentional malice, trickery, or deceit, or mere accident.
 - The disparity between the actual or potential harm suffered by the plaintiff and the punitive damages award; and
 - The difference between the punitive damages awarded by the jury and the civil penalties authorized or imposed in comparable cases.

From a due process standpoint, the focus of analysis should be the conduct directed towards the plaintiff, not nationwide conduct to a vast number of other policyholders. *State Farm Mut. Auto. Ins. Co. v. Campbell*, *supra*, at 420. A state cannot punish a defendant for conduct that may have been lawful where it occurred. *Gore, supra*, at 572, 116 S.Ct. 1589; *Bigelow v. Virginia*, 421 U.S. 809, 824, 95 S. Ct. 2222, 44 L.Ed.2d 600 (1975). Nor, as a general rule, does a State have

a legitimate concern in imposing punitive damages to punish a defendant for unlawful acts committed outside of the State’s jurisdiction. *Campbell, supra*, at 421. Lawful out-of-state conduct may be probative when it demonstrates the deliberateness and culpability of the defendant’s action in the State where it is tortious, but that conduct must have a nexus to the specific harm suffered by the plaintiff. A jury must be instructed, furthermore, that it may not use evidence of out-of-state conduct to punish a defendant for action that was lawful in the jurisdiction **1523 where it occurred.” *Campbell, supra*, at 422.

III. Leading Texas Decision—*In re National Lloyds*

A. Background

I. Nature of Claims

The Supreme Court in *In Re National Lloyds Insurance Company*, In re National Lloyds Insurance Company, 449 S.W.3d 486, 487 (Tex. 2014) (orig. proceeding) (per curiam), the Court framed the issue presented as “whether a trial court abused its discretion in ordering the defendant insurer to produce evidence related to insurance claims other than the plaintiff’s.” The insured in that case suffered storm damage and sued the carrier because the carrier allegedly “performed an outcome based investigation of Plaintiff’s claims and grossly undervalued her claims.” The causes of action included:

- breach of contract,
- breach of duty of good faith and fair dealing,
- fraud, conspiracy to commit fraud, and
- violations of the Texas Deceptive Trade Practices Act and chapters 541 and 542 of the Texas Insurance Code.

2. Discovery Sought Regarding Other Claims

The discovery sought by the policyholder included the following:

- “production of all claim files from the previous six years involving three individual adjusters”;
- “all claim files from the past year for properties in Dallas and Tarrant Counties involving Team One Adjusting, LLC, and Ideal Adjusting, Inc., the two adjusting firms that handled” the plaintiff’s claims.
- “via interrogatory the names, addresses, phone numbers, policy numbers, and claim numbers associated with the requested claim files.”

Id. at 489.

3. Objections

The carrier lodged the following objections to the discovery sought:

- overbroad,
- unduly burdensome, and
- seeking information that was neither relevant nor calculated to lead to the discovery of admissible evidence.

Id.

4. Trial Court Disposition and Mandamus

The trial court “ordered production of the files for claims handled by Team One and Ideal Adjusting, “the adjusting firms that assessed the damage to [the policyholder’s] home.” The trial court also limited the order to claims related to properties in Cedar Hill, where the claimants were located and to the storms that caused the damage to the policyholder’s home. *Id.*

5. Briefs on the Merits

The tone for *National Lloyds* was set early on by the Brief on the Merits filed by former Supreme Court Justice Scott Brister:

Bad-faith claims against insurers in hail and windstorm cases in Texas are out of control. After every storm, a small group of attorneys file hundreds of lawsuits asserting bad-faith claims in pleadings so nearly identical that many lead to MDL proceedings. They routinely seek discovery of every other claim file relating to that storm, and often many others. This turns every property claim, small or large, into expensive litigation that often exceeds the value of the insureds' property.

In re National Lloyds, Relator’s Brief on the Merits, at 4 (“RBOM”)(footnotes omitted). Judge Brister’s brief for the carrier went on to state:

First, a person's claim stands on its own merits; better, worse, or different treatment of someone else doesn't change that. For example, in the biblical Parable of the Generous Employer, laborers who got exactly what they bargained for grumbled when other laborers who worked less got paid the same amount; yet as the vineyard owner explained, he did them no wrong by his generosity to someone else.[FN19 See Matthew 20: 1-16.] The highest authorities have recognized this principle for millennia: whether Ms. Erving has been wronged depends on the handling of her case, not the handling of others.

Id. at *7. Insurance law by parable is something only Woody Allen could fully appreciate. The problem is that the parable does not deal with the situation where one worker is paid nothing

and the other gets full pay. It also does not deal with the situation where premiums are paid by one worker for coverage against unfortunate events. As Woody Allen once observed in his own parables, “The lion and the sheep shall lie down together, and the sheep will be very nervous.” Also, the second Allen parable is that “the wicked know something.”

The carrier’s brief on the merits adds:

Second, allowing discovery on other claims changes the discovery process, making it more expansive and thus more expensive. It shifts pretrial investigation from what happened in the plaintiff’s case to what happened in all the others. It drags other people into the process who may not want to be involved in a lawsuit against their own insurer.

Third, it changes the dynamics of trial. Other claims or incidents are admissible at trial only if they are shown to be reasonably similar.^[FN20 See Nissan Motor Co. Ltd. v. Armstrong, 145 S.W.3d 131, 138 (Tex. 2004).] But that means proving the facts in each of those other cases. A mini-trial about other incidents is likely “to distract a jury’s attention from what happened in the case at hand.”^[FN21 Id.]

Fourth, fishing for patterns in a stack of claim files may turn coincidence into conspiracy. By way of example, several double-sales of cemetery plots are no evidence of intentional misconduct when different employees and different companies were involved in the different incidents.^[FN22 See Service Corp. Int’l v. Guerra, 348 S.W.3d 221, 235 (Tex. 2011).] In this case, different adjusters were involved in Ms. Erving’s two claims, so the trial court compelled production from two different adjusting firms. Independent acts by different adjusters and firms are no evidence of a scheme.

For these and other reasons, this Court has repeatedly held that until a plaintiff establishes a relevant connection, discovery in one case should not include discovery in numerous others.^[FN23 See, e.g., In re Allstate County Mut. Ins. Co., 227 S.W.3d at 670 (holding discovery requests overbroad as to time, location, and scope where plaintiff sought every court order finding wrongful adjustment in value of a damaged vehicle among other things); KMart Corp., 937 S.W.2d at 431 (holding overbroad a request for every criminal act that occurred on the defendant’s premises for the last seven years); Dillard Dep’t Stores, 909 S.W.2d at 491-92 (holding overbroad a request for every false imprisonment case in the last five years throughout twenty states).] That rule applies to hail and windstorm claims too.

Id. at *7-*8.

The frustrating thing in reviewing the *In re Lloyds* decision and the related briefing is that the precise purpose of the discovery was not clearly stated and emphasized. Thus, from the outset, the rule of the case must be understood as disallowing discovery of other claims

where examination of those other claims provides no assistance in the analysis and determination of breach of contract, bad faith and statutory claims.

B. The Supreme Court's Decision—Rule 401 Relevance

The Court began by observing that “National Lloyds objected to the requests as [A] overbroad, [B] unduly burdensome, and [C] seeking information that was neither relevant nor calculated to lead to the discovery of admissible evidence.” The court resolved the case on the basis that the discovery requested was “overbroad,” not that it sought irrelevant material or that it was unduly burdensome. *Id.* Again, the problem was that the reason given for the discovery did not make sense. The court noted:

Essentially, then, Erving has proposed to compare National Lloyds' evaluation of the damage to her home with National Lloyds' evaluation of the damage to other homes to support her contention that her claims were undervalued. *But we fail to see how National Lloyds' overpayment, underpayment, or proper payment of the claims of unrelated third parties is probative of its conduct with respect to Erving's undervaluation claims at issue in this case.*

Id. at 487 (emphasis added.) The payments did not identify something as definitive as an interpretation of a policy clause that could then be used to show that interpretations urged as unreasonable by the carrier have actually been used by them as a basis for making payment. Further, the evidence sought, while geographically and temporally limited, was wide-open as to the type of damage. One would think that something more precise, with an identifiable purpose, would have succeeded. For example, a carrier accepting coverage for replacement of all carpet, some physically damaged and some not, because the carpet could not be matched would show an inconsistent policy interpretation in a later case where the carrier urged that the inability to match did not justify replacement of the undamaged portion of the carpet.

The court appears to have gone to significant lengths to avoid any impression it was adopting the Book of Matthew rule urged by the insurance company:

Scouring claim files in hopes of finding similarly situated claimants whose claims were evaluated differently from Erving's is at best an “impermissible fishing expedition.” Sanderson, 898 S.W.2d at 815. *Without more*, the information sought does not appear reasonably calculated to lead to the discovery of evidence that has a tendency “to make the existence of any fact that is of consequence to the determination of the action more probable or less probable.” TEX. R. EVID. 401; TEX. R. CIV. P.. 192.3(a).

Id. (emphasis added). Importantly, the court added:

We do not hold that evidence of third-party insurance claims can never be relevant in coverage litigation. We simply hold that, in this case, on this plaintiff's allegations, there is at best a remote possibility that such claims could

lead to the discovery of admissible evidence. That possibility is not sufficient to render the claims discoverable under Rule 192.3(a).

....

Because the information Erving seeks is not reasonably calculated to lead to the discovery of admissible evidence, the trial court's order compelling discovery of such information is necessarily over-broad. TEX. R. CIV. P. 192.3(a).

Id. (emphasis added). The court of appeals granted mandamus relief and vacated the trial court's order compelling production of the requested discovery "to allow RPI the opportunity to tailor the requests for production as discussed at the hearing on the motion to compel [more narrowing tailoring request number 4], to allow Relators to file a privilege log for the documents that they claim are privileged, and to allow Respondent the opportunity to then review the documents in camera to determine which are not privileged." The court found the reference to "all" documents in the request to be facially overbroad.

IV. Other Texas Cases

A. *In re Allstate Ins. Co.*—Rules 401 and 404

The supreme court in *In re Allstate Mutual Insurance Company*, 227 S.W.3d 667 (Tex. 2007), held the requests from the policyholder in that case were (a) not justified or explained, and (b) were not reasonably tailored or limited to an appropriate time and geographical area. The insurance claim involved the carrier reneging on a \$13,500 settlement. "The plaintiffs sent the insurer and its adjuster a total of 89 requests for production, 59 interrogatories, and 65 requests for admission, including requests for:"

- transcripts of all testimony ever given by any Allstate agent on the topic of insurance;
- every court order finding Allstate wrongfully adjusted the value of a damaged vehicle;
- personnel files of every Allstate employee a Texas court has determined wrongfully assessed the value of a damaged vehicle; and
- legal instruments documenting Allstate's status as a corporation and its net worth.

Id. at 669. The *Allstate* court noted that the cause of action upon which the discovery was sought was barred as a matter of law by its decision in *Allstate Ins. Co. v. Watson*, 876 S.W.2d 145, 149 (Tex.1994) (prohibiting unfair settlement claims by third parties).

The court held that "all those requests, the plaintiffs' requests here are overbroad as to time, location, and scope, and could easily have been more narrowly tailored to the dispute at hand." *Id.* at 669. The court also found that it found the requests sought information that sought

proof of “other wrongs” in order to “show action in conformity therewith.” *Id.* at 669-70. The court noted that while such “evidence might be discoverable in some cases (e.g., to prove motive or intent, see *id.*), it is hard to see why reneging on some other settlement offer makes it more or less probable that the insurer reneged on this one. TEX.R. CIV. P. 192.3; TEX.R. EVID. 401.” As reflected by Tex. R. Evid. 404, “American jurisprudence goes to some length to avoid the spurious inference that defendants are either guilty or liable if they have been found guilty or liable of anything before.” *Id.* at 669.

In the end, the court was moved to bar the discovery because it was in no way tailored to the case presented below. *“Reasonable tailoring” and some sense of proportion must be considered in drafting such discovery.* *Id.* at 670.

B. *In re Farmers*

The court in *In re Texas Farmers Ins. Co.*, 2014 WL 345677 (Tex. App.—Fort Worth 2014), the following discovery was requested:

Request No. 4: Please produce complete copies of all claims manuals or training materials, or other materials that address the handling of liability claims under homeowners policies.

....

Request No. 6: Please produce all documents pertaining to the “Motor Vehicle” exclusion in the homeowners policy issued to the Jarvis[] family.

....

Request No. 9: Provide all documents pertaining to any and all liability claims for which a *defense was provided with reservations* to one of your insureds because of the exceptions to the “Motor Vehicle” exclusion in the homeowners policy with the language used in the policy issued to the Jarvis [] family.

....

Request No. 10: Provide all documents pertaining to any and all liability claims for which a *defense was provided without reservation* to one of your insureds because of the exceptions to the “Motor Vehicle” exclusion in the homeowners policy with the language used in the policy issued to the Jarvis [] family.

....

Request No. 11: Provide all documents pertaining to any and all liability claims for which *indemnity payments were paid on behalf of your insured because of the exceptions to the “Motor Vehicle” exclusion* in the homeowners policy with the language used in the policy issued to the Jarvis[] family.

....

Request No. 12: Provide all documents pertaining to the types of vehicles for which liability coverage was provided because of the language of the exceptions to the “Motor Vehicle” exclusion in the homeowners policy with the language used in the policy issued to the Jarvis[] family.

....

Request No. 13: Provide all documents pertaining to any [sic] and motor vehicles included as an exception to the “Motor Vehicle” exclusion in the homeowners policy since the vehicle was lawn, garden or farm equipment.

Id. at *1-*3.

C. *Underwriters Life v. Cobb*--Admissibility

In *Underwriters Life Ins. Co. v. Cobb*, 746 S.W.2d 810 (Tex. App.—Corpus Christi 1988, no writ), the trial court admitted evidence of denials of other similar claims by the defendant insurer. The carrier challenged the admissibility of this evidence and evidence of complaints about the insurer to the Texas Department of Insurance. The court disagreed, noting:

Underwriters’ denial of other claims around the same time as its denial of the Cobbs’ claim, and on the same basis, was admissible to show that Underwriters’ refusal to pay the Cobbs’ claim was “ ‘commit[ted] or perform[ed] with such frequency as to indicate a general business practice.’ ” *Chitsey*, 738 S.W.2d at 643. *Such a showing was necessary to recover under the Cobbs’ pleaded cause of action for breach of Underwriters’ duty to reasonably investigate. Id. It is also relevant and material under Arnold to prove the Cobbs’ cause of action for Underwriters’ breach of duty of good faith and fair dealing; these routine denials on the same grounds were sufficiently similar to indicate a failure by Underwriters to determine whether there was any basis to deny the Cobbs’ claim. See Arnold*, 725 S.W.2d at 167; *see also Texas Farm Bureau Mutual Insurance Co. v. Baker*, 596 S.W.2d 639, 643 (Tex.Civ.App.—Tyler 1980, writ ref’d n.r.e.); *cf. Group Hospital Services, Inc. v. Daniel*, 704 S.W.2d 870, 879–80 (Tex.App.—Corpus Christi 1985, no writ).

Id. at 815 (emphasis added). Importantly, the court found the evidence admissible despite the fact that the “frequency” requirement of *Chitsey*, which has been deleted from the board order in question, was not the basis of recovery. Instead, the common law duty of good faith was the theory of recovery used at the court of appeals.

The *Cobb* court flatly rejected arguments that the doctrine of *res inter alios acta* prevented admissibility:

Further, the doctrine of *res inter alios acta* does not prevent admissibility, as Underwriters asserts. This rule provides that each act or transaction sued on must be established by its own particular facts and circumstances. *State v. Buckner Construction Co.*, 704 S.W.2d 837, 848 (Tex.App.—Houston [14th Dist.] 1985, writ ref'd n.r.e.). However, an exception to this rule exists; *prior acts or transactions with other persons are admissible to show a party's intent where material, if they are so connected with the transaction at issue that they may all be parts of a system, scheme or plan.* See, e.g., *Baker*, 596 S.W.2d at 642–43; *Payne v. Hartford Fire Insurance Co.*, 409 S.W.2d 591, 594 (Tex.Civ.App.—Beaumont 1966, writ ref'd n.r.e.); *Texas Osage Co-Operative Royalty Pool, Inc. v. Cruze*, 191 S.W.2d 47, 51 (Tex.Civ.App.—Austin 1945, no writ). Underwriters' intent in denying the Cobbs' claim was an important issue in the instant case.

Id. (emphasis added).

D. *Aztec*—Other Claims and Complaint Log

The court in *Aztec Life Ins. Co. of Texas v. Dellana*, 667 S.W.2d 911 (Tex. App.—Austin, 1984, no writ), examined whether the trial court abused its discretion in ordering (a) the production of an insurance claims denial journal and (b) refusing to compel the production of certain other claims files pursuant to TEX. R. CIV. P. ANN. 167. The insured in that case sued for breach of a credit life and disability insurance policy. The insured that he became disabled after the purchase of the insurance policy, but Aztec Life refused to pay the benefits to which he was entitled. He sought relief under contract, common law good faith, the Insurance Code and the DTPA.

The insured in Aztec sought recovery based on a common plan or scheme, specifically identifying the need for discovery of other claims:

[Aztec's] selective and prejudicial handling of [Jennings'] claim evidences a common scheme and design on [Aztec's] part to avoid liability. [Aztec's] insureds are all purchasers of credit life and disability policies from automobile and truck dealerships throughout Texas owned in many instances by the same persons who owned [Aztec]. All such claims are reviewed by [Aztec's] informal “claims committee,” which is made up of two of [Aztec's] employees and two attorneys whose firm represents [Aztec] and the automobile and truck dealerships [Aztec] owns. This committee routinely handles disability claims in a way that weighs the subjective interpretation of medical data in favor of [Aztec] and against the insured, which [Jennings] believes is done with the intention of denying legitimate claims.

Id.

The insured sought the following from Aztec in discovery:

First, the request sought production of a “claims denial journal” which contains entries for the years 1977 to date. Second, the request called for production of all files maintained by Aztec which related to claims which had been denied under the same pre-existing illness or condition exclusion under which Jennings' claim had been denied.

Id. at 913. The court noted: “The claims denial journal reveals the names of Aztec's insureds who have had claims denied, their business dealings with Aztec, their physical or mental illnesses and injuries, and their insurance policy numbers. Apparently, the policy claimants' addresses are not contained in this document.” *Id.* n.1. As further justification for the discovery, the insured explained:

“Aztec's claims handling in connection with the [exclusion] is a decision-making process that places a high premium on analysis and the exercise of judgment. Built into the procedure is the danger of a subjective and self-serving evaluation of medical data that, when applied to the technical language of the exception, may demonstrably lead to an inordinate number of improper disability claims denials. How claims decisions are made generally within the scope of the [exclusion] bears heavily upon how a decision was made in any particular case.”

Id. at 915.

The court of appeals held that the evidence sought was discoverable to show (a) a plan or scheme and (b) in proving intent. The court reasoned:

[T]his Court knows of no bar to the admission of evidence, if such exists, that Aztec had consistently denied claims upon the basis of the exclusion without reasonable investigation. Such character evidence is generally admissible when the other acts are so closely connected with the act charged so as to disclose a plan or scheme. 2 Ray, Texas Law of Evidence § 1522 (3rd ed. 1980). Moreover, a showing that Aztec consistently follows such a claims practice could be relevant as tending to show that the company had purposely denied Jennings' claim without reasonable investigation.

Id. The court added that if there were privacy concerns regarding other insureds, then in camera review could be used to protect against unwarranted disclosures. *Id.* The court also found the claims denial journal was discoverable, noting:

As this Court understands, the claims denial journal is no more than an index identifying the name of each claimant, the date of each claim, and the policy exclusion under which each claim was denied. We understand further that by use of the journal, it is possible within a short time to identify those claims which the company denied pursuant to the pre-existing illness or condition exclusion. To our knowledge, there is no privileged information contained in the claims denial journal.

Id.

E. ***Paramount***—Admissibility of Other Lawsuits and Complaints

In *Paramount Nat. Life Ins. Co. v. Williams*, 772 S.W.2d 255 (Tex. App.—Hou. [14 Dist.], 1989, no pet. hist.), the insurer asserted on appeal that the trial court erred in “admitting petitions, pleadings and discovery from lawsuits filed against [it], as well as complaints to the State Board of Insurance regarding the company's actions on claims of other insureds.” The court of appeals emphasized that the trial “court admitted the evidence ‘not for the truth of the matter stated therein, but for the purpose of aiding you, if they do, in determining whether the Defendant has a custom of denying things because of prior existing medical conditions.’” *Id.* at 259-60. The court held that the trial court did not err in admitting the evidence, reasoning:

Based on the rationale of [*Underwriters Life Ins. Co. v. Cobb*, 746 S.W.2d 810, 815 (Tex.App.—Corpus Christi 1988, no writ)], and the trial court's limiting instruction, the evidence was properly admitted. In the *Aztec* case, the court noted that the evidence in dispute “is generally admissible when the other acts are so closely connected with the act charged so as to disclose a plan or scheme.” 667 S.W. 2d at 915. The court also stated that a showing that Aztec consistently followed such a claims practice could be relevant as tending to show that the company had *purposely denied the subject claim without reasonable investigation*. *Id.* Furthermore, Paramount had the opportunity to refute or mitigate the evidence of the lawsuits and complaints and show if there had been some favorable resolution. The relevancy of the evidence outweighed any prejudicial effect. Point of error one is overruled.

Id. at 260.

F. ***In re Interinsurance Exchange of the Automobile Club***—Discovery Of Expert Opinions in Other Claims Of The Same Expert Used

In *In re Interinsurance Exchange of the Automobile Club*, 2016 WL 144784 (Tex. App.—Houston [1st Dist.] 2016, no pet.), the carrier denied the claim based on the finding of its expert, Hancock, that the foundation problems were the result of settling rather than a plumbing leak. The policyholders sued the insurer and other entities, claiming fraud, conspiracy to commit fraud, breach of contract, negligent misrepresentation, gross negligence, and violations of the Deceptive Trade Practices Act and Insurance Code. The plaintiffs deposed the expert used by the insurer, who had done over 50 evaluations for the carrier, resulting in denial 70-80% of the time. The insured sought discovery of all reports prepared by this expert for the insurer. *Id.* at *1. The carrier objected to the request on the ground that it was overly broad, unduly burdensome, and an impermissible fishing expedition. The policyholders moved to compel, arguing that the information was necessary to prove bias. *Id.*

The court held that the trial court erred in ordering the discovery in question. *It must be noted that the sole claim to which the discovery related was breach of contract, with the trial court abating the bad faith claims.* Thus, the court found that discovery of

information directly relating to the claim was proper and all else unnecessary. The court does not appear to have recognized the fact that no explanation was provided as to the relevance of the information sought in *In re National*. The court refused to allow the discovery in order to reveal the methodology of the expert. The court also found that evidence of bias had already been in the deposition of the expert, where he admitted he had testified to having found 70-80% of the time in favor of no coverage. *Id.* at *2.

G. *In re Nolle* and *Engleke*—Discovery Of Other Lawsuits

In *In re Nolle*, 265 S.W.3d 487 (Tex. App.—Houston [1st Dist.] 2008, no pet.), the court held that in order for discovery of other lawsuits against the defendant to be discovered, there must have “a direct, material connection to the instant litigation.” *Id.* at 496; see *Allen v. Humphreys*, 559 S.W.2d 798 (Tex.1977); *Humphreys v. Caldwell*, 881 S.W.2d 940, 945 (Tex.App.—Corpus Christi 1994, orig. proceeding) (concluding that relator failed to meet burden to show that responding to interrogatory “regarding all lawsuits in Texas within the last five years involving similar claims in which State Farm had been a party” was overbroad or unduly burdensome); *State Farm Mut. Auto. Ins. Co. v. Engelke*, 824 S.W.2d 747, 751 (Tex.App.—Houston [1st Dist.] 1992, orig. proceeding) (compelling answer to interrogatory about lawsuits for five-year period). Even where such discovery is permitted, it may not involve information found to be confidential or protected under a confidentiality order in the other litigation. *Nolle, supra*, at 496.

The court in *State Farm Mut. Auto. Ins. Co. v. Engelke*, 824 S.W.2d 747 (Tex. App.—Houston [1st Dist.] 1992, no pet.), the claimant requested the following:

Identify fully each and every lawsuit filed against you in the past five (5) years involving an allegation of “bad faith,” Deceptive Trade Practices, unfair practices in the business of insurance, unconscionable action or course of action, violations of Article 21.22 of the Texas Insurance Code, breach of the duty of good faith and fair dealing, or any violation of any statute, rule or regulation relating to the business of insurance, or any similar claim, state the following:

- a) the style, cause number, court, county, and state of the lawsuit;
- b) the identity of the person(s) bringing suit against you;
- c) the identity of the attorney representing the person(s) who brought suit against you;
- d) the nature of the claims against you;
- e) the resolution, if any, to such lawsuit (e.g., the type of judgment rendered, the amount of any judgment, or the amount of any settlement);
- f) whether or not Dr. Gary C. Freeman had performed independent medical examination in the case.

Id. at 749. State Farm objected to this interrogatory based on burdensomeness. At a hearing, a company representative admitted a substantial portion of the information could be generated by a computer report. Thus, the court held:

Based upon this evidence, we hold that the trial judge did not abuse his discretion in ordering State Farm to answer interrogatory seven *insofar as that order requires State Farm to provide the requested information for the state of Texas in the form of a computer generated response.*

Id. at 751.

H. *In re National Lloyds Insurance Company*—Using MDL

In *In re National Lloyds Insurance Company*, 2015 WL 3751701 (Tex. App.—Corpus Christi 2015, no pet.), the trial court ordered National Lloyds, in multi-district litigation combining multiple claims related to the same weather events, to produce fifteen categories of management reports and associated emails that were responsive to specific requests for production pertaining to the hail litigation that is the subject of this lawsuit. The court noted:

The plaintiffs in the underlying cases, real parties herein, alleged that National Lloyds violated the Texas Insurance Code by, inter alia, refusing to pay their claims without conducting reasonable investigations and by failing to affirm or deny coverage of the claims or submit a reservation of rights within a reasonable period of time. The plaintiffs further alleged that their experiences were not “isolated case[s]” and that the “acts and omissions” that National Lloyds committed in these cases, or similar acts and omissions, occur “with such frequency that they constitute a general business practice” with regard to handling these types of claims. According to plaintiffs, National Lloyds’ “entire process is unfairly designed to reach favorable outcomes for the company at the expense of the policyholders.”

Id. at *1. The requests at issue were as follows:

11. All documents reflecting summaries of total payments made by Defendant on claims for claims arising out of the Hidalgo County hail storms occurring on or about March 29, 2012 and/or April 20, 2012.
12. All documents regarding the generalized assessment, review, evaluation and/or summary of Defendant’s handling of claims arising out of the Hidalgo County hail storms occurring on or about March 29, 2012 and/or April 20, 2012.
13. Any document general in nature which applies to more than one claim created, gathered, or reviewed by Defendant relating to Hidalgo County hail storm claims occurring on or about March 29, 2012 and/or April 20, 2012, including any analysis of the total amount paid on claims, time open, responsiveness, compliance with company policies and procedures, compliance with Texas Insurance Code, the number of reopened claims, the

reason for reopening the claim, and the total amount paid on reopened claims. This request includes any follow-up documents.

Id. at *2 (emphasis added).

In a deposition of a claims adjuster, it was discovered that there were responsive documents that were not produced: “Excel accounting reports delineating the claims filed as a result of the Hidalgo County hailstorms, and institutional job descriptions utilized to determine specific employees’ job duties and responsibilities.” *Id.* at *2. The carrier revised its objections upon discovery of some copies of reports including Hidalgo County information and also other claims in other counties not involved in the litigation. The trial court ordered production, noting the “other claims” information could be redacted.

The court noted the guiding rules for discovery in Texas:

The scope of discovery includes any unprivileged information that is relevant to the subject of the action, even if it would be inadmissible at trial, as long as the information is reasonably calculated to lead to the discovery of admissible evidence. TEX.R. CIV. P. 192.3; *In re CSX Corp.*, 124 S.W.3d at 152; see *In re Natl Lloyds Ins. Co.*, 449 S.W.3d at 488. The phrase “relevant to the subject matter” is to be “liberally construed to allow the litigants to obtain the fullest knowledge of the facts and issues prior to trial.” *Ford Motor Co. v. Castillo*, 279 S.W.3d 656, 664 (Tex. 2009); see *In re Nat’l Lloyds Ins. Co.*, 449 S.W.3d at 488; *In re HEB Grocery Co.*, 375 S.W.3d 497, 500 (Tex.App.–Corpus Christi 2012, orig. proceeding). Information is relevant if it tends to make the existence of a fact that is of consequence to the determination of the action more or less probable than it would be without the information. TEX.R. EVID. 401.

Id. at *5. The court found that the over-breadth objections were waived. The court also noted that even if not waived, they were not well taken. Conflicting evidence from a claims supervisor indicated that the reports at issue were used on the Hidalgo claims. The same adjuster testified to the contrary in an affidavit. The court held the conflict supported the trial court’s decision and thus it was not an abuse of discretion to require the production. The court distinguished the supreme court’s opinion *In re National Lloyds*:

Both in the trial court and in this original proceeding, National Lloyds cites *In re National Lloyds Insurance Company*, 449 S.W.3d 486, 487 (Tex. 2014) (orig. proceeding) (per curiam), in support of its allegations that the order at issue requires the production of irrelevant information. In that case, the Texas Supreme Court held that a trial court abused its discretion in ordering the defendant insurer to produce unrelated third-party claim files. *Id.* at 487. In so holding, the supreme court stated that it “failed to see how National Lloyds’ overpayment, underpayment, or proper payment of the claims of unrelated third parties is probative of conduct with respect to Erving’s undervaluation claims at issue in this case.” *Id.* at 489. Although National Lloyds asserts that our resolution here is controlled by this case, we disagree. In *In re National Lloyds*, the insurer timely

objected to the requests for production on grounds that they were overbroad, unduly burdensome, and sought information that was not relevant or calculated to lead to the discovery of admissible evidence, *see id.* at 488, and National Lloyds did not timely assert these objections herein. Moreover, in *In re National Lloyds*, an individual plaintiff sought the discovery of unrelated third-party claim files, *see id.* at 487, but in this case plaintiffs seek the production of documents expressly limited to “claims “arising out of” or “relating to” “the Hidalgo County hail storms occurring on or about March 29, 2012 and/or April 20, 2012.”

Id. n. 2.

V. War Stories—The *Cactus* Experience in Oklahoma

In *Cactus Drilling Corp. v. National Union Fire Ins. Co., et al.*, 5:12-CV-00191-M (Okla. W.D.), we were successful in obtaining documentary discovery of the handling of other claims in an case involving an excess employer’s liability policy. In our case, the carrier denied that there was coverage for “substantial certainty” torts under an excess employer’s liability policy. We looked to show that the carrier in our case, and other carriers, had frequently defended and/or paid similar claims. In fact, the primary carrier in our case had paid its underlying limits for such claims. We believed that the evidence showed:

- (1) The policyholder’s interpretation of the policy was consistent with the interpretation of the defendant carrier and other carriers, primary and excess, had used in other claims, and was thus a “reasonable” alternative interpretation of the policy supporting a finding of ambiguity.
- (2) The carrier had paid other claims because it allegedly feared that a court would find the coverage illusory if it failed to recognize coverage, and thus the carrier’s interpretation was itself unreasonable.
- (3) The carrier acted in bad faith in ignoring its own prior actions in handling similar claims when it decided to deny coverage in the *Cactus* case.

The defendant carrier had a typical response, objections and motions for protection asserting irrelevance and burdensomeness.

In response, *Cactus* argued:

As to breach of contract, a multitude of cases hold that other claims files can lead to admissible evidence of ambiguity. As to bad faith, the Tenth Circuit and the Western District have found discoverable other claims files as evidence of business practices.

In *Broadway Park*, this Court applied *Vining v. Enterprise Fin. Group*, 148 F.3d 1206, 1218–19 (10th Cir. 1998), in holding that the claims files for similar claims were discoverable. *Broadway Park, L.L.C. v. Hartford Cas. Ins. Co.*, 2006 U.S. Dist. LEXIS 55914, at *4–5 (W.D. Okla. Aug. 9, 2006) (Miles-LaGrange, J., opinion) (citing

Vining for the rule that “evidence of an insurance company's general business practices is relevant in a bad faith case”). In *Broadway Park*, the insured sought discovery of similar claims against the insurer following a hail storm. *Id.* at 4. The request was limited geographically and temporally, as is Cactus’ request here, and the Court compelled the insurer to comply with the Request for Production. *Id.* at 4–5.

In *Sullivan v. USAA Gen. Indemn. Co.*, 2006 U.S. Dist. LEXIS 32670, at *6–7 (W.D. Okla. May 10, 2006) (Miles-LaGrange, J., opinion), this Court held that several years’ worth of claims files were discoverable where the same software and adjuster were used in adjusting the plaintiff’s claim and claims in years past. The Court allowed discovery of three years’ worth of claims files where the particular adjuster was used and that had relied on the same software the Plaintiff was contesting. *Id.* at *7. Here, Cactus’ claim shares important policy language and adjuster/supervisor similarities with numerous other claims.

In *Metzger v. Am. Fid. Assur. Co.*, 2007 U.S. Dist. LEXIS 90235 (W.D. Okla. Dec. 7, 2007), the plaintiff sought discovery of similar claims denied by the insurer. This Court found that “evidence regarding [similar] policies within the state of Oklahoma is relevant and is therefore, admissible.” *Id.* at *4 (emphasis added). The Court’s order was limited to Oklahoma-insureds and similar policies. *Id.* Plaintiff Cactus seeks discovery of similar claims within the bounds set by this Court. These Western District cases upheld discovering other insurance claims files.

(Cactus Response to Motion for Protection (footnotes omitted)).

In *Cactus*, the District Court held that evidence of other claims was discoverable, but the court required substantial topical, temporal and geographical limitations to address the burdensomeness issues raised by the defense:

First, defendants contend that these requests are irrelevant and not reasonably calculated to lead to the discovery of admissible evidence. Specifically, defendants assert that whether National Union may have defended, indemnified, or paid or denied coverage for other substantial certainty claims has no bearing on whether there is coverage for this claim because Cactus did not rely on any payment of any other substantial certainty claim in purchasing this policy and the language of the policy is clear and unambiguous under Oklahoma law and, thus, extrinsic evidence is not allowed.

Second, defendants contend that these requests are overbroad and seek documents that are privileged, or contain trade secrets, proprietary and confidential business records, and/or other protected materials. Specifically, defendants contend that these requests are overbroad because the requests have no geographic limitation, and Request 7 is unbounded by time. In addition, defendants assert that Request Nos. 7 and 8 are not reasonably tailored because

they seek documents relating to all affiliates of National Union and Chartis – which includes ten AIG member insurance companies, primary employer liability policies which have no bearing on the pertinent commercial liability umbrella policy at issue, and to other claims and lawsuits, with no limitation on the type of documents or information sought.

Lastly, defendants assert that complying with these requests would be oppressive and disproportionately costly. Specifically, defendants assert that they have no method of conducting a computer search for files containing “substantial certainty torts”, and as such, searching for these documents through 210,461 identified claim files of National Union and its affiliates would cost approximately \$4,200,000. In addition, the production of such documents involves confidential, privileged, and private information gathered in other claims, and such screening will cost additional money. Moreover, even if the requests were to be limited to excess or umbrella policies, opened between January 1, 2005 through January 22, 2013, for losses in Oklahoma, a search for such documents would still require searching 1,839 files. Thus, defendants conclude that the burden and expense of responding, even if limited by the Court, outweigh any relevant benefit to Cactus. To the extent the Court orders defendants to produce such documents, defendants seek to be allowed to redact privileged, confidential, and other legally protected documents and provide a privilege and confidentiality log to support the redactions.

Having carefully reviewed the parties’ submissions, the Court finds that Request for Production Nos. 7 and 8 seek relevant documents. Specifically, the Court finds the documents requested are relevant to plaintiff’s breach of contract and bad faith claims as they bear directly on whether the policy’s language at issue is clear and unambiguous as defendants assert and may also show that Chartis has held coverage positions that are not advanced by the original drafters of the policy at issue. The Court also finds that these requests are overbroad and not reasonably tailored in scope. Specifically, the Court finds that these requests should be limited to commercial employers excess or umbrella liability policies opened between January 1, 2005 and January 1, 2011, for losses in Oklahoma.

(Cactus, Order on Motion for Protection and to Quash (10-3-13) [Doc. 208] at 5 (emphasis added).)

Fortunately, the Court reconsidered its ruling restricting the production and discovery to excess policies. Because the excess policy “followed the form” of the primary policy, Cactus moved to clarify the Court’s initial order as to whether depositions could examine knowledge of those with knowledge as to whether they were aware of other primary and excess claims for “substantial certainty” torts where either Chartis/AIG or other insurers had paid employers liability indemnity dollars towards settlement or defense. The Court reasoned:

Plaintiff may depose witnesses regarding the witnesses’ personal knowledge/involvement with primary employment liability claims in the context

of substantial certainty claims. There is no undue burden to defendants resulting from the deponents responding to plaintiff's questions during deposition.

Accordingly, the Court finds plaintiff may re-depose [various claims and claims liaison personnel]. The Court also instructs the parties that plaintiff may depose said witnesses on discoverable knowledge of the claim and related matters, including deponents' knowledge of or involvement with other substantial certainty claims in Oklahoma involving primary or excess/umbrella liability.

(Cactus, No. 5:12-CV-00191-M, [Doc. 263] at 2.)

V. Other Jurisdictions—Trends

A. Ambiguity and Reasonableness of Interpretation

In addition to Oklahoma, numerous other jurisdictions have clearly permitted discovery regarding ambiguity and the reasonableness of the policy interpretation. See *Nestle Foods Corp. v. Aetna Cas. & Sur. Co.*, 135 F.R.D. 101, 106–107 (D.N.J. 1990) (Evidence of insurer's varying interpretations of policy “could undermine defendants’ position that the language in question is clear and unambiguous.”), *Rhone-Poulenc Rorer, Inc. v. Home Indem. Co.*, Civ. A. No. 88-9752, 1991 WL 78200, at *3-4 (E.D. Pa. May 7, 1991) (information regarding other insureds with similar claims was “relevant for the purposes of discovery since, 1) it may show that identical language has been afforded various interpretations by the insurer and 2) the interpretations suggested by the insurers may not be the same as those intended by the original drafters”), *modified on other grounds*, 1991 WL 111040 (E.D. Pa. June 17, 1991); *Westport Ins Co. v. Wilkes & McHugh, P.A.*, 264 F.R.D. 368, 371–74 (W.D. Tenn. 2009); *Polygon Northwest Co. LLC v. Steadfast Ins. Co.*, 2009 U.S. Dist. LEXIS 130238, 2009 WL 1437565, at *3–6 (W.D. Wash. May 22, 2009) (“The manner in which [the insurer] has handled the claims of other insureds with identical policy language is potentially relevant” to the ambiguity issue.), *National Union Fire Ins. Co. v. Stauffer Chem. Co.*, 558 A.2d 1091, 1095 (Del. Super. Ct. 1989) (“[T]he claim files and the interpretive materials are relevant to the determination of ambiguity and should be the subject of discovery that is structured to lessen the burden on insurers while protecting the confidentiality of other insureds.”) *Rhone-Poulenc Rorer, Inc. v. Home Indem. Co.*, 1991 U.S. Dist. LEXIS 6215, at *8 (E.D. Penn. May 7, 1991) (finding that handling of other claims was relevant because it could show that identical language had been interpreted in various ways by the insurer and that the insurer's interpretation may not be similar to that intended by the drafters), *J.C. Assocs. v. Fid. & Guar. Ins. Co.*, 2006 U.S. Dist. LEXIS 32919, 2006 WL 1445173, at *1 (D. D.C. May 25, 2006) ([I]nformation as to how defendant interpreted the [particular exclusion . . . is] relevant to the claim presented by plaintiff if that interpretation is difference from the interpretation that the defendant is asserting in this case.”), *Owens-Brockway Glass Container v. Seaboard Sur. Co.*, 1992 U.S. Dist. LEXIS 10337, 1992 WL 696961, at *9 (E.D. Cal. May 28, 1992) (“[S]imilar insurance claims asserted by other insureds against defendant [insurers] may be relevant to the interpretation of the insurance policy language of this case.”); see also *Potomac Elec. Power Co. v. Cal. Union Ins. Co.*, 136 F.R.D. 1, 3 (D.D.C. 1990) (ordering insurers to “provide information on third party claims that were either litigated or ultimately paid” where the policies and claims involved were similar to one another); *Champion*

Int'l Corp. v. Liberty Mut. Ins. Co., No. 87 Civ. 1634 (WCC), 1989 WL 299156, at *2 (S.D.N.Y. Oct. 31, 1989) (authorizing depositions of defendant insurers regarding recordkeeping and filing procedures regarding other claim information); *Indep. Petrochemical Corp. v. Aetna Cas. & Sur. Co.*, 117 F.R.D. 283, 287 (D.D.C. 1986) (granting motion to compel production of documents concerning dioxin claims of other policyholders), *aff'd*, No. Civ. A. 83-3347, 1987 WL 8512, at *2-4 (D.D.C. Mar. 9, 1987); *Carey-Can., Inc. v. Cal. Union Ins. Co.*, 118 F.R.D. 242, 245-46 (D.D.C. 1986) (ruling that insurers must produce certain “policies themselves [of non-party insureds] and all claims and underwriters’ files concerning these policies”).

B. Evidence of Bad Faith

Numerous courts have found that evidence regarding other claims is admissible to show bad faith. See, e.g., *Poneris v. Pa. Life Ins. Co.*, No. 1:06-cv-254, 2007 WL 3047232, at *1 (S.D. Ohio Oct. 18, 2007) (discovery regarding other policyholders relevant to claim for bad faith denial of coverage; claims information regarding other insureds “is relevant to establish whether Defendant had a pattern or practice” of improperly denying claims); *Paolo v. AMCO Ins. Co.*, No. 02-02367 JW (HRL), 2003 WL 24027877, at *1 (N.D. Cal. Sept. 17, 2003) (ordering production of other policyholder information in bad faith breach of contract action); *Fridkin v. Minn. Mut. Life Ins. Co.*, No. 97 C 0332, 1998 WL 42322 (N.D. Ill. Jan. 29, 1998) (same); *First Fid. Bancorp. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa.*, Civ.A. No. 90-1866, 1992 WL 6859 (E.D. Pa. Jan. 13, 1992) (ordering National Union to produce other policyholder files because, “there is no other way for [plaintiffs] to obtain the requested pattern and practice information”); *Colonial Life & Ace. Ins. Co. v. Sup. Ct.*, 647 P.2d 86, 89-90 (Cal. 1982) (same).

C. Exemplary Decisions Involving Discovery and Admission of Other Claims

I. Arizona

In *Hawkins v. Allstate Insurance Company*, 733 P. 2d 1073 (Ariz. 1987), the insured for contract and bad faith in connection with a claim for property coverage. The jury found bad faith. On appeal, Allstate challenged the admissibility of testimony from three former Allstate employees regarding Allstate’s claims practices and procedures, although none of the witnesses had any involvement with the plaintiffs’ claim. The court found that evidence regarding the handling of other claims by these witnesses was relevant and admissible regarding bad faith. ***“Evidence of previous, similar acts alters the probability that the conduct in question was unintentional; the more frequently an act occurs, the more probable it is intentional.”*** *Id.* (emphasis added). Additionally, the court found that the testimony was properly admitted as “other crimes, wrongs, or acts” evidence pursuant to Rule 404(b), for the purpose of showing Allstate’s “motive, intent, or absence of mistake or accident.” *Id.* at 1082. The court held that whether the defendant intended to injure the plaintiff or consciously disregarded the plaintiff’s rights may be suggested by a pattern of similar unfair practices. *Id.* at 1081 (citations omitted); *accord Moore v. American United Life Ins. Co.*, 150 Cal.App.3d 610, 197 Cal. Rptr. 878 (1984). Finally, the testimony was relevant both to establish a case for recovery of punitive damages. It was also used to evaluate the amount of punitive damages found by the jury.

2. Delaware

In *J.C. Associates v. Fidelity & Guaranty Insurance Company*, a policyholder sought discovery regarding “other claims and litigation related to the policy language upon which the defendant relies for its denial of coverage.” 2006 WL 1445173, at *1 (D.D.C. May 25, 2006). The court ruled the information sought was “clearly relevant,” explaining: “For example, the information as to how defendant interpreted the ... exclusion would qualify as an admission under Rule 801 of the Federal Rules of Evidence and [is] relevant to the claim presented by plaintiff if that interpretation is different from the interpretation that the defendant is asserting in this case.” *Id.* See also *S.N.A. Nut Co. v. Nat’l Union Fire Ins. Co. of Pittsburgh, Pa.*, No. 95 C 3999, 1996 WL 31155, at *4 (N.D. Ill. Jan. 24, 1996) (approving Bankruptcy Court’s order sanctioning insurer for failing to produce 50 claim files relating to other policyholders); *Owens-Brockway Glass Container, Inc. v. Seaboard Sur. Co.*, No. CIV. S-91-1044 DFL, 1992 WL 696961, at *3 (E.D. Cal. May 27, 1992) (“similar insurance claims asserted by other insureds against defendants may be relevant to the interpretation of the insurance policy language in this case . . . [and] are appropriate for discovery”).

3. New York

In *Zurich American Ins. Co. v. Ace American Reinsurance Co.*, 2006 WL 3771090 (S.D. N.Y. 2006), Zurich alleged that its reinsurer, as part of an ongoing pattern of behavior, did not pay its share of a settlement reached with Zurich’s policyholder. Zurich moved to compel the reinsurer to produce documents from two claims against it for wrongful denial of such payments. Noting that motive and, thus, “similar acts” evidence is usually immaterial to breach of contract claims, the court nevertheless found that the other claims could provide evidence of how the reinsurer interpreted its duty to settle and to follow the settlements of its reinsureds in similar circumstances by shedding light “on the meaning that the parties ascribed to the terms that they incorporated into the policies at issue.” The court agreed with Zurich and held the requested information regarding other claims relevant and discoverable.

In typical fashion, the reinsurer also opposed the production of “other” claims files on ground that the production would be unduly burdensome, noting that its computer system was incapable of segregating and identifying claims by type or otherwise. While the computer system was clearly inadequate, the court chastised the reinsurer, noting that it should anticipate frequent litigation when it operates a multi-million dollar business with an “opaque data storage” system. The court then held that the parties should propose a “propose a protocol for sampling” the reinsurer’s claim files in order to obtain examples of claims files in question.

4. West Virginia—Discovery of Other Lawsuits

The court in *State Farm Mut. Auto. Ins. Co. v. Stephens*, 188 W.Va. 622, 425 S.E.2d 577, 584 (1992), addressed discovery requests seeking “information on all bad faith, unfair trade or settlement practices, and excess verdict claims filed against State Farm throughout the entire country since 1980.” *Id.* “The plaintiffs also requested data on all complaints filed against State Farm with insurance industry regulators nationwide for the same period.” *Id.* The court limited the discovery to other lawsuits and Insurance Commission complaints in the state where the

primary action was pending. The court held that a nationwide request to State Farm was overbroad.¹ The court rejected arguments that the request involved irrelevant information, noting that the unfair claims handling act required proof of more than one violation of the act. *Id.* The court recognized that this “type of related-acts evidence is admissible at trial under Rule 404(b) of the West Virginia Rules of Evidence.” See generally F. Cleckley, Handbook on Evidence for West Virginia Lawyers § 6.6 (1986 & Cum.Supp.1992).” *Id.*

¹ The court noted numerous decisions finding less broad requests to be unduly burdensome: “*State Farm Mut. Auto. Ins. Co. v. Superior Court*, 167 Ariz. 135, 804 P.2d 1323 (App.1991)(request for documents relating to any bad faith lawsuits against insurer); *Mead Reinsurance Co. v. Superior Court*, 188 Cal.App.3d 313, 232 Cal.Rptr. 752 (1986)(request for information on every bad faith claim made against insurer in six and one-half year period); *Leeson v. State Farm Mut. Auto. Ins. Co.*, 190 Ill.App.3d 359, 137 Ill. Dec. 837, 546 N.E.2d 782 (1989)(request for information concerning all medical exams conducted by auto insurer for medical benefits claims within prior year); *State ex rel. Bankers Life & Casualty Co. v. Miller*, 160 Mont. 256, 502 P.2d 27 (1972)(request for names and addresses of all persons within state whose claims for health and accident disability benefits against insurer were rejected or not fully paid over three-year period).” *Stephens, supra*, at 583.

APPENDIX

1. Federal Rules of Evidence Rule 401:

Evidence is relevant if:

It has any tendency to make a fact more or less probable than it would be without the evidence; and

The fact is of consequence in determining the action.

2. Federal Rules of Evidence Rule 402:

Relevant evidence is admissible unless any of the following provides otherwise:

- The United States Constitution;
- A federal statute;
- These rules; or
- Other rules prescribed by the Supreme Court

Irrelevant evidence is not admissible.

3. Federal Rules of Evidence Rule 403:

The court may exclude relevant evidence if its probative value is substantially outweighed by a danger of one or more of the following: unfair prejudice, confusing the issues, misleading the jury, undue delay, wasting time, or needlessly presenting cumulative evidence.

4. Federal Rules of Evidence Rule 404;

(a) Character Evidence.

Prohibited Uses. Evidence of a person's character or character trait is not admissible to prove that on a particular occasion the person acted in accordance with the character or trait.

Exceptions for a Defendant or Victim in a Criminal Case. The following exceptions apply in a criminal case:

a defendant may offer evidence of the defendant's pertinent trait, and if the evidence is admitted, the prosecutor may offer evidence to rebut it;

subject to the limitations in [Rule 412](#), a defendant may offer evidence of an alleged victim's pertinent trait, and if the evidence is admitted, the prosecutor may:

offer evidence to rebut it; and

offer evidence of the defendant's same trait; and

in a homicide case, the prosecutor may offer

evidence of the alleged victim's trait of peacefulness to rebut evidence that the victim was the first aggressor.

Exceptions for a Witness. Evidence of a witness's character may be admitted under [Rules 607](#), [608](#), and [609](#).

(b) Crimes, Wrongs, or Other Acts.

Prohibited Uses. Evidence of a crime, wrong, or other act is not admissible to prove a person's character in order to show that on a particular occasion the person acted in accordance with the character.

Permitted Uses; Notice in a Criminal Case. This evidence may be admissible for another purpose, such as proving motive, opportunity, intent, preparation, plan, knowledge, identity, absence of mistake, or lack of accident. On request by a defendant in a criminal case, the prosecutor must:

provide reasonable notice of the general nature of any such evidence that the prosecutor intends to offer at trial; and

do so before trial—or during trial if the court, for good cause, excuses lack of pretrial notice.

5. Federal Rules of Evidence Rule 405;

- (a) By Reputation or Opinion.** When evidence of a person's character or character trait is admissible, it may be proved by testimony about the person's reputation or by testimony in the form of an opinion. On cross-examination of the character witness, the court may allow an inquiry into relevant specific instances of the person's conduct.

By Specific Instances of Conduct. When a person's character or character trait is an essential element of a charge, claim, or defense, the character or trait may also be proved by relevant specific instances of the person's conduct.

6. Federal Rules of Evidence Rule 406;

Evidence of a person's habit or an organization's routine practice may be admitted to prove that on a particular occasion the person or organization acted in accordance with the habit or routine practice. The court may admit this evidence regardless of whether it is corroborated or whether there was an eyewitness.

7. Federal Rules of Evidence Rule 407;

When measures are taken that would have made an earlier injury or harm less likely to occur, evidence of

the subsequent measures is not admissible to prove:

- negligence;
- culpable conduct;
- a defect in a product or its design; or
- a need for a warning or instruction.

But the court may admit this evidence for another purpose, such as impeachment or—~~if disputed—~~proving ownership, control, or the feasibility of precautionary measures.

8. Federal Rules of Evidence Rule 408,

- (a) **Prohibited Uses.** Evidence of the following is not admissible on behalf of any party either to prove or disprove the validity or amount of a disputed claim or to impeach by a prior

inconsistent statement or a contradiction:

furnishing, promising, or offering—or accepting, promising to accept, or offering to accept a valuable consideration in compromising or attempting to compromise the claim; and

conduct or a statement made during compromise negotiations about the claim except when offered in a criminal case and when the negotiations related to a claim by a public office in the exercise of its regulatory, investigative, or enforcement authority.

Exceptions. The court may admit this evidence for another purpose, such as proving a witness's bias or prejudice, negating a contention of undue delay, or proving an effort to obstruct a criminal investigation or prosecution.

Stipulated Settlements: Under What Circumstances Can the Insured Bind the Insurer for Bad Faith?

Speakers:

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Under What Circumstances May an Insured Enter Into a Consent Agreement?

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I. What is a Consent Agreement?

In most instances, the Agreement will contain:

1. a stipulated judgment against the insured establishing liability and identifying a specific amount of damages;
2. a covenant for the claimant not to execute the stipulated judgment against the insured (meaning the insured has no obligation for the judgment amount and the claimant may only enforce it against the insurance company);
and
3. an assignment of the insured's rights under the policy to the claimant.

II. What are Consent Judgments Called?

These types of agreements largely spawned from the Nebraska Supreme Court's decision in *Metcalf v. Hartford Acc. & Indem. Co.*, 176 Neb. 468, 476, 126 N.W.2d 471, 476 (Neb. 1964) (citing *Fullerton v. U.S. Cas. Co.*, 184 Iowa 219, 167 N.W. 700, 705 (Iowa 1918); *Griggs v. Bertram*, 88 N.J. 347, 364, 443 A.2d 163, 171-72 (1982).

1. Consent Judgments go by many different names:
 - a. Florida: *Coblentz* Agreements
 - o *Coblentz v. Am. Sur. Co. of New York*, 416 F.2d 1059 (5th Cir. 1969) (applying Florida law).
 - b. Arizona: *Damron* Agreement or *Morris* Agreement
 - o *Damron v. Sledge*, 460 P.2d 997 (Ariz. 1969); *USAA v. Morris*, 741 P.2d 246 (Ariz. 1987).
 - c. Missouri: "065 Agreements"
 - o § 537.065, Mo. Stat.
 - d. Minnesota & North Dakota: *Miller-Shugart* Agreements

- *Miller v. Shugart*, 316 N.W.2d 729 (Minn. 1982).
- e. Colorado: *Basher* Agreements
 - *Northland Ins. Co. v. Bashor*, 177 Colo. 463, 494 P.2d 1292 (Colo. 1972).
- f. Other states, like Washington and Texas, simply refer to these as “Covenant Judgments” or “Consent Judgments.”
 - e.g. *Bird v. Best Plumbing Grp., LLC*, 766, 287 P.3d 551, 556 (Wash. 2012); *Transportation Ins. Co. v. Heiman*, 1999 WL 239917, at *4 (Tex. App.—Dallas Apr. 26, 1999, no pet.).

III. Under What Circumstances Can an Insured Enter Into a Consent Agreement?

Majority:

1. Consent Agreement is permitted when:
 - a. The claim or insured is covered under the policy
- and ...
- b. The insurer wrongfully refuses to defend.

Or...

- c. the policy is an indemnity only policy

IV. Insured Can Enter Into a Consent Agreement when a defense is being afforded under a Reservation of Rights

1. **Arizona:** *USAA v. Morris*, 154 Ariz. 113, 741 P.2d 246, 249 (Ariz. 1987).

An insurer with a coverage defense must defend its insured under a properly communicated reservation of rights or it will lose its right to later litigate coverage. . . . [I]f the company was defending Waltz unconditionally, the cooperation clause of the policy would have prohibited Waltz from settling the claim without the insurer's consent. This is so because the purpose of a cooperation clause is to prevent insureds from compromising a claim for which the insurer unconditionally has assumed liability under the policy, thus obviating, at least to the extent of the policy limit bargained for, the insured's exposure to personal liability.

249-50

The question in this case is whether an insurer may assert the policy's cooperation clause to prevent insureds being defended under a reservation of rights from protecting themselves by settling.

251

A majority of courts resolve this type of conflict by permitting an insured to reject a defense offered under a reservation of rights. The insured thus forces the insurer to elect either to defend unconditionally or to refuse to defend at its peril.

251

An insurer that performs the duty to defend but reserves the right to deny the duty to pay should not be allowed to control the conditions of payment. The insurer's insertion of a policy defense by way of reservation or nonwaiver agreement narrows the reach of the cooperation clause and permits the insured to take reasonable measures to protect himself against the danger of personal liability. Accordingly, we hold that the cooperation clause prohibition against settling without the insurer's consent forbids an insured from settling only claims for which the insurer unconditionally assumes liability under the policy. Thus, an insured being defended under a reservation of rights may enter into a *Damron* agreement without breaching the cooperation clause. Such agreements must be made fairly, with notice to the insurer, and without fraud or collusion on the insurer. The insurer's reservation of the privilege to deny the duty to pay relinquishes to the insured control of the litigation, almost as if the insured had objected to being defended under a reservation.

252

2. **Maine:** *Patrons Oxford Insurance Co. v. Harris*, 905 A.2d 819 (Me. 2006).

[A]n insurer does not breach the insurance agreement by electing to defend its insured under a reservation of rights. Furthermore, we agree with those **courts that have held that “an insurer who reserves the right to deny coverage cannot control the defense of a lawsuit brought against its insured by an injured party.”** This position strikes a fair balance between the insurer and the insured. If the insurer could continue to control the insured's defense despite reserving its rights to later deny coverage, it could assert a liability defense and insist on fully litigating the insured's case, thus exposing the insured to personal liability if there is a verdict favorable to the claimant. If the verdict is favorable to the claimant, the insurer still has another opportunity to avoid liability by doing exactly as Patrons did here, litigating coverage in a declaratory judgment action. Thus, we agree with the Arizona Supreme Court **that the insured “risks financial catastrophe if he is held liable, while the insurer may save itself by litigating both issues-the insured's liability and the coverage defense-and winning either.”**

825-26

By allowing the insured to control his own case when the insurer issues a **reservation of rights, the insured can protect himself “from the sharp thrust of personal liability,”** *id.* (quotation marks omitted), and the insurer still has a meaningful opportunity to protect its own interests in a declaratory judgment action where it may assert, among other things, a coverage defense. Because Patrons chose to defend Harris under a reservation of rights, it gave up the ability to control Harris's defense. Therefore, Patrons cannot now assert that it was denied the opportunity in the personal injury action to litigate Harris's liability to Luce because it was an opportunity Patrons possessed and relinquished when it proceeded under the reservation of rights
826

In conclusion, an insured being defended under a reservation of rights is entitled to enter into a reasonable, noncollusive, nonfraudulent settlement with a claimant, after notice to, but without the consent of, the insurer.
828

3. **Washington:** *Martin v. Johnson*, 141 Wash. App. 611, 170 P.3d 1198 (Wash. 2007).

If an insurance company refuses in bad faith to settle a claim, the insured may independently negotiate a settlement; the insurance company is then liable for the settlement to the extent that it is reasonable and paid in good faith. . . . [A]t a time when insurance coverage is in doubt, it is in an insured's best interest to accept a settlement offer that effectively relieves him or her of personal liability. An insurer that is disputing coverage cannot compel an insured to forego a settlement that is in his or her best interests.
1202

Here, Metropolitan had informed the Estate that it was denying coverage for the Martins' claims and was providing a defense under a reservation of rights. Facing potential liability for the clean-up costs and general damages, it was in the Estate's best interest to accept a settlement offer that relieved it of liability; Metropolitan cannot compel the Estate to forego this opportunity.
1202

4. **Wyoming:** *Insurance Co. of North America v. Spangler*, 881 F. Supp. 539 (D. Wyo. 1995).

[T]his court concludes that were it faced with this question, the Wyoming Supreme Court would adopt the rationale of those cases holding that an insurer who reserves the right to deny coverage loses the right to control the litigation.
544

[T]his court concludes that where the insurer was defending under a reservation of rights and had filed a declaratory judgment action contesting coverage, the insured's assignee is not barred from recovery from the insurer for a stipulated liability to which the insurer did not consent and the insured is not personally liable.

544

The Supreme Court of Arizona was faced with this issue in *Morris, supra*. That court surveyed the case law holding generally that an insurer disputing coverage could not invoke “its duty to cooperate clause to prevent the insured from taking reasonable measures to protect himself from the hazards of his position.” . . . This court believes that were the issue before the Wyoming Supreme Court, it would follow the *Morris* and *Miller* line of cases.

545

5. *BUT SEE Gainsco Ins. v. Amoco Product*, 53 P.3d 1051 (Wyo. 2002)

May require more than just serving a reservation of rights letter before an insured may enter into a Consent Agreement. (More to Come Later in Outline).

6. *But see Texas: Motiva Enterprises, LLC v. St. Paul Fire and Marine Ins. Co.*, 445 F.3d 381 (5th Cir. 2006) (applying Texas law).

Motiva argues that when National Union’s tender of a defense was subject to its reservation of rights to later deny coverage, Motiva was entitled to settle the [underlying] claim without consulting National Union.

384

We conclude . . . an insurer which tenders a defense with a reservation of rights is entitled to enforce a consent-to settle clause The district court therefore did not err in holding that Motiva breached its insurance policy by **settling without National Union’s consent, even though National Union** reserved its right to contest coverage and therefore did not tender to Motiva an unqualified defense.

385

Compare with:

- a. *Evanston Ins. Co. v. Atofina Petrochemicals, Inc.* 256 S.W.3d 660, 671-73 (Tex. 2008)

In this case, the plaintiffs sued Atofina, Atofina requested coverage from Evanston, and Evanston wrongfully denied coverage Atofina then settled with the underlying plaintiffs and litigated the remaining coverage issues against Evanston. Evanston argued that Atofina failed to meet its burden of showing that the settlement amount was reasonable.

The Court discussed *Employers Casualty Co. v. Block*, which held that if an insurer wrongfully denies coverage and its insured then enters into an agreed judgment, the insurer is barred from challenging the reasonableness of the settlement amount. 744 S.W.2d 940, 943 (Tex. 1988). Noting that although the facts in *Atofina* differed from those in *Block*, the Court held that none of those differences justified departing from the central holding of *Block*. **Evanston's wrongful denial of coverage barred it from challenging the reasonableness of Atofina's settlement.**

b. Lennar Corp. v. Markel American Ins. Co., 413 S.W.3d 750, 754-57 (Tex. 2013)

Though Markel did not consent to Lennar's settlements with homeowners, it concedes . . . that [the consent-to-settle] provision does not excuse its liability under the policy unless it was prejudiced by the settlements.

754

An insurer establishes prejudice from a settlement to which it did not agree by **showing that the insured's unilateral settlement was a material breach of the policy—that is, that it significantly impaired the insurer's position. . . . Markel failed to prove that it was prejudiced in any way by Lennar's settlements.**

756

V. When Can an Insurer Retain Right to Determine if Insured Can Enter Into a Consent Agreement after a ROR?

1. When an insurer tenders a defense subject to a reservation of rights, the **insurer** retains its full authority under a consent to settlement provision.
 - a. *Motiva Enterprises, LLC v. St. Paul Fire & Marine Ins. Co.*, 445 F.3d 381 (5th Cir. 2006) (applying Texas law).
 - b. *Danrik Const. Inc. v. Am. Cas. Co. of Reading Pennsylvania*, 314 F. App'x 720 (5th Cir. 2009) (applying Louisiana law) (unpublished).
 - c. *First Bank of Turley v. Fid. & Deposit Ins. Co. of Maryland*, 1996 OK 105, 928 P.2d 298 (Okla. 1996).
 - d. *Vincent Soybean & Grain Co. v. Lloyd's Underwriters of London*, 246 F.3d 1129 (8th Cir. 2001) (applying Arkansas law).
 - e. *L & S Roofing Supply Co. v. St. Paul Fire & Marine Ins. Co.*, 521 So. 2d 1298, 1304 (Ala. 1987) ("The mere fact that the insurer chooses to defend

its insured under a reservation of rights does not *ipso facto* constitute such a conflict of interest that the insured is entitled at the outset to engage defense counsel of its choice at the expense of the insurer.”).

VI. Can an Insured Enter Into a Consent Agreement after a ROR AND the Filing of a Dec Action?

1. YES!

a. Minnesota: *Miller v. Shugart*, 316 N.W.2d 729 (Minn. 1982).

While Milbank Mutual Insurance Company was litigating whether it had coverage for both the insured car owner and the driver, the insured owner and the driver settled with the injured plaintiff and confessed judgment for a stipulated sum.

731

Milbank argues the indemnity agreement of its policy has been voided because the insureds breached their duty under the policy to cooperate. We disagree.

Under the auto liability policy, Milbank has a duty to defend and indemnify its insureds, and the insureds have a reciprocal duty to cooperate with their insurer in the management of the claim. Plaintiff contends that defendants were relieved from their duty to cooperate because Milbank breached its duty to defend. We would put the issue differently. Milbank has never abandoned its insureds nor, by seeking a determination of its coverage, has it repudiated its policy obligations.² Milbank had a right to determine if its policy afforded coverage for the accident claim, and here Milbank did exactly as we suggested.

733

On the other hand, while Milbank did not abandon its insureds neither did it accept responsibility for the insureds' liability exposure. What we have, then, is a question of how should the respective rights and duties of the parties to an insurance contract be enforced during the time period that application of the insurance contract itself is being questioned. . . . Did the insureds breach their duty to cooperate by not waiting to settle until after the policy coverage had been decided? In our view, the insureds did not have to wait and, therefore, did not breach their duty to cooperate.

While the defendant insureds have a duty to cooperate with the insurer, they also have a right to protect themselves against plaintiff's claim. . . . If, as here, the insureds are offered a settlement that effectively relieves them of any personal liability, at a time when their insurance coverage is in doubt, surely it cannot be said that it is not in their best interest to accept the offer. Nor, do we think, can

the insurer who is disputing coverage compel the insureds to forego a settlement which is in their best interests.

On the facts of this case we hold, therefore, that the insureds did not breach their duty to cooperate with the insurer, which was then contesting coverage, by settling directly with the plaintiff.

733-34

- b. **Texas:** *Motiva Enterprises, LLC v. St. Paul Fire and Marine Ins. Co.*, 445 F.3d 381 (5th Cir. 2006) (applying Texas law).

Motiva notified its insurer, National Union, of two lawsuits that had been filed against it. National Union initially disclaimed coverage, and Motiva filed suit seeking a declaratory judgment regarding its coverage. National Union later tendered its offer to defend the lawsuits subject to a reservation of rights.

Motiva settled one of the underlying lawsuits without National Union's consent, arguing that because National Union tendered its defense subject to a reservation of rights, Motiva was entitled to settle the lawsuit without consulting National Union.

383-84

As discussed in Section IV above, the Court in *Motiva* held that the lower court did not err in holding that Motiva breached its insurance policy by **settling without National Union's consent, even though National Union** reserved its right to contest coverage and therefore did not tender to Motiva an unqualified defense. Neither the parties nor the Court addressed the impact, if any, of the pending declaratory judgment action between Motiva and National Union on Motiva's ability settle the underlying lawsuits.

VII. Can an Insured Enter Into a Consent Agreement After a ROR and a Demand Within Policy Limits?

1. YES!

- a. **Iowa:** *Kelly v. Iowa Mutual*, 620 N.W. 2d 637 (Iowa 2000).

The estate appears to argue that Iowa Mutual's defense of McCarthy pursuant to a reservation of rights violated the contract. An insurer does not breach the policy simply because the defense it provides is under a reservation of rights. Nevertheless, some courts have held that an insured may settle without the insurer's consent where the insurer provides a defense to the insured but reserves its right to deny liability for any ultimate judgment. We think the reasoning of these cases is flawed because they permit an insured to breach his duties under the policy without losing coverage, even though there has not been a breach of the contract by the insurance company. Therefore, we decline to follow them.

We have not had an occasion to consider the insurer's duty to settle under circumstances such as those before us, where the insurer has reserved its right to deny coverage for any judgment entered against the insured. Certainly under these circumstances, where the insured may ultimately be responsible for a judgment if coverage is found not to exist, it is extremely important that the insurance company, who is controlling the defense, fulfill its contractual obligation to settle where appropriate. One commentator has observed that an insurer may breach the contract by failing to settle an appropriate case, even though its failure to settle is attributable solely to the company's negligence. This **commentator suggests that, "recognizing that the company has, despite the absence of bad faith, breached the insurance contract, the company should be precluded from enforcing the provisions in the policy inuring to its benefit, such as the one prohibiting unauthorized settlements by the insured."**

We agree. An insurance company cannot use its erroneous belief that it has no coverage to justify a refusal to settle. At the point in time that the insurer is faced with a fair and reasonable settlement demand that a reasonable and prudent insurer would pay, the insurer must either abandon its coverage defense and pay the demand or lose its right to control the conditions of settlement.⁶ If the insurer prefers to debate coverage and, accordingly, refuses to pay the settlement demand, the insured is free to either pay the settlement demand or stipulate to the entry of judgment in the amount of the demand. The insurer, if found to have coverage, will be liable for the insured's settlement if the settlement is found to be fair and reasonable.

644-45

b. Texas: *Rhodes v. Chicago Ins. Co.*, 719 F.2d 116 (5th Cir. 1983)

If the insurer properly reserved its rights and the insured elected to pursue his own defense, the insurer is bound to pay damages which resulted from covered conduct and which were reasonable and prudent, up to the policy limits.

121

Rhodes has been called into doubt by *Motiva*, discussed in Sections IV and VI. The Court in *Motiva*, **however, seemed to take issue with the insured's argument that *Rhodes* broadly stands for the proposition that an insurer who defends an insured subject to reservation of rights is bound by the insured's settlement.**

c. Wyoming: *Gainsco Ins. v. Amoco Product*, 53 P.3d 1051 (Wyo. 2002).

Amoco refers us first to *Insurance Co. of North America v. Spangler*, 881 F.Supp. 539 (D.Wyo.1995). In *Spangler*, the insurer defended a wrongful death action under a reservation of rights as to coverage, and also brought a separate declaratory judgment action to test coverage. The claimant and the insured then

settled the wrongful death action for an amount within policy limits, and the claimant covenanted not to execute against the insured. The insurer then amended its complaint in the declaratory judgment action to raise the issue of the enforceability against it of the stipulated judgment. *Id.* at 541–42. The specific issue addressed in *Spangler* is similar to the issue now before this Court:

Is the assignee of the insured barred from recovery from the insurer for a stipulated liability to which the insurer did not consent and the insured is not personally liable?

Id. at 543. Because this question had not previously been answered by this Court, **the federal court made its “best estimate” as to how this Court would rule on the question.** *Id.* at 544. In answering the question in the negative, the federal court emphasized two facts: (1) an insurer defending under a reservation of rights **“loses the right to control the litigation;”** and (2) **a covenant not to execute is not a complete release of all liability.** *Id.*

1060

We agree with the rationale of *Spangler* and those cases that find that the inclusion of a covenant not to execute in the settlement agreement between an insured and a claimant, under the circumstances of the case now before us, does not act to negate the fact that a judgment has been entered against the insured and, therefore, does not bar the claimant, as assignee of the insured, from pursuing a claim against the insurer for third-party bad faith. The existence of the judgment, with or without a covenant not to execute, is a detriment to the insured sufficient to support an assignable tort claim. Public policy favors this result in that it allows an insured to reach a reasonable settlement of a case being defended under a reservation of rights and it discourages an insurer from rejecting a reasonable settlement offer. The insurer is adequately protected by the requirement that such settlements be reasonable and by its ability to raise the issues of fraud and collusion.

1061

Because Gainsco defended Andrews under a reservation of rights, Andrews obtained separate counsel. After considerable negotiation, Amoco and Andrews reached a settlement. . . . Gainsco declined to participate in the settlement.

1067

Gainsco concedes that an insured does not violate the cooperation clause of an insurance policy by settling a claim being defended under a reservation of rights, so long as such settlement is preceded by adequate notice to the insurer. 1067

VIII. Can an Insured Enter Into a Consent Agreement After a ROR and the Rejection of the Defense by the Insured?

1. YES if the Insured actually rejects the defense—silence is acquiescence to the qualified defense.

- a. **Florida:** *Taylor v. Safeco Insurance Co.*, 361 So. 2d 743 (Fla. 1st DCA 1978).

We conceive that the insurer's potential obligation to pay also subsists when, as a result of the parties' failure to agree upon a conditional defense, the putative insured chooses to control the litigation and to effect a reasonable settlement.

746

Aguero v. First American, 927 So. 2d 894 (Fla. 3d DCA 2005).

“[W]hen an insurer offers to defend under a reservation of rights, Florida law provides that the insured may, at its own election, reject the defense and retain its own attorneys without jeopardizing his right to seek indemnification from the insurer for liability.” However, the insured must actually reject that defense.

In the instant case, Ryder's May 20, 1999 letter could be construed as a rejection of First American's defense under a reservation of rights. If it is determined that Ryder's letter constituted a rejection of First American's defense under a reservation of rights, Ryder would have been entitled to retain its own attorney to defend against Iglesias' claim without jeopardizing its right to seek indemnification from First American.

898

However: an insured cannot reject a defense that has been previously accepted and then enter into a consent judgment, unless there is a material change in the conditional defense. *Mid-Continent v. Am. Pride Bldg. Co.*, 601 F.3d 1143 (11th Cir. 2010); *Western Heritage Ins. Co. v. Montana*, 30 F. Supp. 3d 1366 (M.D. Fla. 2014).

- b. **Pennsylvania:** *Babcock & Wilcox Co. v. Am. Nuclear Insurers*, 2013 PA Super 174, 76 A.3d 1, 18 (2013) *appeal granted in part*, 84 A.3d 699 (Pa. 2014).

We find that the *Taylor* approach, in providing an insured the option to decline a defense tendered subject to a reservation of rights, but protecting an insurer's right to control the defense when it is accepted by the insured, best balances the interests of insurer and insured, and better honors the binding nature of the insurance contract.

20

We reject the *Morris* approach not only because it contravenes fundamental precepts of contract law, but also because we believe that it is founded on an unrealistic diminution of the risks facing an insurer defending subject to a reservation. . . . We also note that application of the *Morris* standard would appear to reduce an insurer's incentive to undertake the defense at all, if it

anticipates that a viable coverage defense will be available after trial on the underlying suit. If the insurer is to lose control of the terms of settlement simply for reserving its rights until continuing discovery and fact-finding illuminate whether a viable coverage defense exists, subject only to a jury's **determination as to what sort of settlement is "fair and reasonable,"** the insurer reasonably might choose to decline to defend entirely. If it does so, and coverage is found, it is exposed at most for the reimbursement of the insured's costs of defense¹³ and either the verdict or that portion of the amount of settlement that is deemed fair and reasonable. While the insurer may expose itself to an excess verdict by declining to defend, the same is true in the event that it defends subject to a reservation and exercises its right to control settlement in a manner indicating bad faith.

21-22

For the reasons set forth above, we hold that, when an insurer tenders a defense subject to a reservation, the insured may choose either of two options. It may accept the defense, in which event it remains unqualifiedly bound to the terms of the consent to settlement provision of the underlying policy. Should the insured choose this option, the insurer retains full control of the litigation, consistently with the policy's terms. In that event, the insured's sole protection against any injuries arising from the insurer's conduct of the defense lies in the bad faith standard articulated in *Cowden*.

Alternatively, the insured may decline the insurer's tender of a qualified defense and furnish its own defense, either *pro se* or through independent counsel retained at the insured's expense. In this event, the insured retains full control of its defense, including the option of settling the underlying claim under terms it believes best. Should the insured select this path, and should coverage be found, the insured may recover from the insurer the insured's defense costs and the costs of settlement, to the extent that these costs are deemed fair, reasonable, and non-collusive.

22

[W]e believe *Taylor* provides the standard most consistent with Pennsylvania law

22

(NOTE: On January 24, 2014, the Supreme Court of Pennsylvania accepted **appeal as to one issue: "Does a policy holder forfeit its right to insurance coverage by settling an underlying and covered claim without its insurer's consent, where the insurer is defending subject to a reservation of rights to disclaim coverage, the settlement is at arm's length, is fair and is reasonable, and the insurer has failed to offer any amounts in settlement?" No opinion** has been issued).

- c. **Missouri:** *Central Bank v. St. Paul Fire & Marine Ins.*, 929 F.2d 431 (8th Cir. 1991) (applying Missouri law).

Under Missouri law, an insurer may undertake the defense of its insured and reserve its right to later disclaim coverage, provided it gives the insured notice of a reservation of rights. . . . **“Upon such notification the insured may either accept the reservation of rights and allow the company to defend or it may reject the reservation of rights and take over the defense itself.”** This is what happened in the instant case.

Although it was under no obligation to do so, Central Bank agreed to St. Paul's assumption of the defense of the Boyd suit under a reservation of rights, and Central Bank never attempted to disclaim the reservation of those rights.

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Butters v. City of Independence, 513 S.W.2d 418 (Mo. 1974).

[G]arnishee did not offer a full, non-reservation of rights defense to the City, so that the City, following garnishee's denials of coverage, had no further obligation to cooperate with Royal Indemnity Company which had breached the policy and the City was, therefore, free to defend itself as it saw fit, including entering into the statutory covenant with plaintiffs. Further refusal of the City to agree to the tendered reservation defense was not a failure to cooperate.

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d. **Massachusetts:** *Three Sons, Inc. v. Phoenix Ins. Co.*, 357 Mass. 271, 257 N.E.2d 774 (Mass. 1970).

The question, therefore, is whether under the insured's duty to cooperate it may refuse to allow the insurer to defend and control a suit under a reservation of rights. The defendant argues that the insured has no such right. We disagree.

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A reservation of rights in such circumstances notifies the insured that the insurer's defense is subject to the later right to disclaim liability. The insured thus can take the necessary steps to protect his rights, and has no basis for claiming an estoppel. A reservation of rights and insistence on retaining **control of the defence is another matter. As we stated in the Salonen case, ‘We** are not to be understood as holding that an insurer may reserve its rights to disclaim liability in a case and at the same time insist on retaining control of its defense.’

The judge, therefore, rightly ruled that the defendant had a duty to defend the plaintiff in the actions at law without a reservation of rights or claim of nonwaiver, so long as it insisted on retaining control of the defense.

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- e. **Kentucky:** *Medical Protective Co. of Fort Wayne, Indiana v. Davis*, 581 S.W.2d 25 (Ky. Ct. App. 1979) (applying Kentucky law).

[W]hen the insurer reserves a right to assert its nonliability for payment there is little or no reason to require the insured to surrender defense of the claim to a company which asserts that it has no obligation to satisfy the claim. Under such conditions the insured has the right to refuse the proffered defense and conduct his own defense.

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That an insured may seek to defend himself without counsel after refusing to accept a defense offered under a reservation of rights is one of the risks an insurer must take when it elects to offer a defense under a reservation of rights. If it is correct in its position that the policy does not afford coverage or has been breached in some way, then it prevails regardless of whether the insured accepts the defense but it offers such a defense at its peril, because if the insured refuses to accept it and elects to defend himself, the company is found by the result, in the absence of fraud or collusion, unless it can establish that the policy did not afford coverage or was breached by the insured.

In this case the insured refused to accept the qualified defense, he elected to defend himself, and the insurer did not establish noncoverage or that the insured had breached some duty it owed to the company. The company therefore became obligated to the extent of the policy limits of its liability and appellees were entitled to a directed verdict.

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- f. **Idaho:** *Boise Motor Car Co. v. St. Paul Mercury Indem. Co.*, 62 Idaho 438, 112 P.2d 1011 (Idaho 1941)

Respondent elected to go forward with defense of the Heard suit after having notice appellant would not consent to reservation of respondent's right to withdraw, and its continued assertion of such right of withdrawal thereafter was a breach of its insurance contract and created a hazard, to protect itself from which appellant was justified in employing attorneys. 1016

- g. **Alaska:** *Cont'l Ins. Co. v. Bayless & Roberts, Inc.*, 608 P.2d 281 (Alaska 1980)

This appeal presents issues arising from an insurance company's refusal to unconditionally defend its insured and the insured's subsequent decision to settle the case. . . . Continental informed B & R that it would continue to defend only if B & R would agree to a reservation of Continental's right to later deny liability on the ground of the alleged breach. B & R refused to accept such a conditioned defense and, therefore, Continental withdrew from the case.

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While Continental was willing to proceed with B & R's defense, it insisted on reserving its right to later challenge B & R's right to claim the protection of the policy, by asserting the insured's alleged breach as a defense in a later action to enforce the policy.

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In reaching our decision, therefore, we consider only the policy defense situation. We leave open the question whether the insurer has the same obligations and liabilities in the coverage defense situation.

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The Boise approach requires the insurer to make a clear choice between defending and withdrawing, and, in the policy defense situation, we believe that approach is necessary to protect the interests of the insured. Thus, we decline to adopt in full the position of either party. It may be that, where the insurance company wishes to contest coverage, the insured is obligated to accept a defense under a reservation of rights. We hold, however, that where, as here, the insurance company challenges the insured's right to enforce the policy on the ground the insured has breached a condition thereof, the insured has a right to demand an unconditional defense. Thus, the insurance company must either affirm the policy and defend unconditionally or repudiate the policy and withdraw from the defense. The insurer may not reserve its right to repudiate the policy, unless the insured consents to a reservation of that right.

In the case at bar, therefore, B & R was fully within its rights and did not breach the policy when it insisted that Continental either defend unconditionally or withdraw from the defense.

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h. **Texas:** *Rhodes v. Chicago Ins. Co.*, 719 F.2d 116 (5th Cir. 1983)

When a reservation of rights is made . . . the insured may properly refuse the tender of defense and pursue his own defense. The insurer remains liable for **attorneys' fees incurred by the insured and may not** insist on conducting the defense. Refusal of the tender of defense is particularly appropriate where . . . **the insurer's interests** conflict with those of the insured.

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If the insurer properly reserved its rights and the insured elected to pursue his own defense, the insurer is bound to pay damages which resulted from covered conduct and which were reasonable and prudent, up to the policy limits.

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IX. Can an Insured Enter Into a Consent Agreement After a ROR and After Giving the Ins. Co. the Opportunity to Agree to the Consent Judgment?

1. Yes: Insured is prohibited from entering into a Consent Agreement when the insurer is providing the insured with a defense (which may even be conditional) UNLESS the insurer given chance to agree to the judgment.

a. *Wright v. Fireman's Fund Ins. Companies*, 11 Cal. App. 4th 998, 14 Cal. Rptr. 2d 588 (Cal. App. 1992).

b. *Romstadt v. Allstate Ins. Co.*, 844 F. Supp. 361 (N.D. Ohio 1994) *aff'd*, 59 F.3d 608 (6th Cir. 1995) (applying Ohio law).

c. *Motiva Enterprises, LLC v. St. Paul Fire and Marine Ins. Co.*, 445 F.3d 381 (5th Cir. 2006)

An insurer's right to participate in the settlement process is an essential prerequisite to its obligation to pay a settlement.

X. Can an Insured Enter Into a Consent Agreement Obligating the Excess Coverage While Being Defended by an Underlying Policy?

1. NO: Where an insured is covered by both a primary policy and a true excess or umbrella policy, an excess carrier's duty to defend is generally secondary to the primary insurer's duty to defend.

a. Arizona: *Regal Homes, Inc. v. CNA Ins.*, 217 Ariz. 159, 167-68, 171 P.3d 610, 618-19 (Arizona Ct. App. 2007) ("Until a primary insurer offers its policy limit, the excess insurer does not have a duty to evaluate a settlement offer, to participate in the defense, or to act at all.")

b. Florida: *U.S. Fire Ins. Co. v. Mikes*, 576 F. Supp. 2d 1303, 1325 (M.D. Fla. 2007) *aff'd sub nom. U.S. Fire Ins. Co. v. Freedom Vill. of Sun City Ctr., Ltd.*, 279 Fed. Appx. 879 (11th Cir. 2008) ("Once an insurer assumes the defense of the insured pursuant to its duty to defend, other insurers, including an excess insurer, that provide coverage and have a duty to defend are ordinarily no longer obligated to provide a defense to the insured.").

c. Washington: *Rees v. Viking Ins. Co.*, 77 Wash. App. 716, 719, 892 P.2d 1128, 1130 (Wash App. Ct. 1995) ("An excess carrier's obligation to pay and defend begins when, and only when, the limits of the primary insurance policy are exhausted.").

- d. California: *Travelers Cas. & Sur. Co. v. Am. Int'l Surplus Lines Ins. Co.*, 465 F. Supp. 2d 1005, 1028 (S.D. Cal. 2006) (“Unless the excess policy provides otherwise (and Travelers' does not), the primary insurer owes the **exclusive** duty to defend the insured against third party claims until the primary coverage is exhausted or otherwise not on the risk.”).
- e. Kansas: *Associated Wholesale Grocers, Inc. v. Americold Corp.*, 261 Kan. 806, 829, 934 P.2d 65, 81 (Kan. 1997) (“Simply stated, the primary policy provides ‘first dollar’ liability coverage up to the limits of the policy...Before [primary insurer] tendered its policy limits, [excess carrier] was not obligated to defend [the insured] or take charge of settlement efforts on behalf of [the insured]. [Primary insurer] had assumed [the insured]’s defense.”)
- f. Louisiana: *XL Specialty Ins. Co. v. Bollinger Shipyards, Inc.*, 954 F. Supp. 2d 440, 445 (E.D. La. 2013) (“The terms of the policies indicate that as an excess provider, Continental is not liable to pay claims until the primary insurance has been exhausted and does not owe a duty to defend.”).
- g. Texas: *Keck v. National Union Fire Ins. Co.*, 20 S.W.3d 692, 700 (Tex. 2000) (“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.” **National Union (the excess carrier)** had no duty to evaluate a settlement demand until after the primary carrier’s tender of its policy limits.)

XI. However, if The Primary Coverage is ONLY an Indemnity Policy (No Duty To Defend), Then:

1. Yes: *Perera v. U.S. Fid. & Guar. Co.*, 35 So. 3d 893 (Fla. 2010). Rationale: excess carrier has no duty to defend under an indemnity only policy.

XII. What Happens After the Consent Agreement is Entered and the Bad Faith Case is Filed? What Defenses Does a Carrier Have?

1. Consent Judgment may generally be challenged for unreasonableness or bad faith.
2. Purpose: while an Insured may take certain steps to protect itself by entering the Judgment if its insurer wrongfully denies coverage and a defense, the insured does not have carte blanche over the insurer’s checkbook.

- a. In some jurisdictions, such as Texas and Montana, the court is statutorily (no statutory requirement under Texas law) required to hold a “reasonableness hearing” for a Consent Judgment. Better practice in all jurisdictions (e.g. California)
 1. *State Farm Fire & Cas. Co. v. Gandy*, 925 S.W.2d 696 (Tex. 1996)
 2. *Tidyman's Mgmt. Servs. Inc. v. Davis*, 2014 MT 205, 376 Mont. 80, 330 P.3d 1139 (Mont. 2014).
 - a.
3. Consent Judgment must be reasonable and not entered into in bad faith/not collusive.
4. What Defenses Does a Carrier Have?
 - a. Reasonableness
 - b. Bad faith,
 - c. Fraud, or
 - d. Collusion - absence of an arms-length transaction
 1. *Associated Wholesale Grocers, Inc. v. Americold Corp.*, 261 Kan. 806, 934 P.2d 65 (Kan. 1997)
 2. *Detroit Edison Co. v. Michigan Mut. Ins. Co.*, 102 Mich. App. 136, 301 N.W.2d 832 (Mich. App. 1981)
 3. *Transportation Ins. Co. v. Heiman*, 1999 WL 239917, at *7-8 (Tex. App.—Dallas Apr. 26, 1999, no pet.)
- e. No bad faith - Without bad faith, a consent judgment can only be enforced up to the policy limit.
 1. **Florida**: consent judgment can only be enforced up to the policy limit, unless there is an additional showing of bad faith. *Perera v. USF&G*, 35 So. 3d 893 (Fla. 2010); *Mobley v. Capitol Specialty Ins.*, 2013 U.S. Dist. LEXIS 101329 (S.D. Fla. 2013).
 2. **Minnesota**: *Miller v. Shugart*, 316 N.W.2d 729 (Minn. 1982)
 3. **Texas**: *Wilcox v. American Home Assur. Co.*, 900 F. Supp. 850 (S.D. Tex. 1995); *Rhodes v. Chicago Ins. Co.*, 719 F.2d 116 (5th Cir. 1983).

XIII. How Can an Insurer Ultimately Prove That the Consent Agreement was Unreasonable or Collusive/Made in Bad Faith

1. Both *objective* and *subjective* factors are considered

2. Prudent Person standard - prudent person in the position of the insured would **have settled for on the merits of the claimant's claim.**
3. Has insured made an effort to "minimize his/**her liability**".
 - a. *Fireman's Fund Ins. Co. v. Sec. Ins. Co. of Hartford*, 72 N.J. 63, 71, 367 A.2d 864 (N.J. 1976)
 - b. *Taylor v. Safeco Ins. Co.*, 361 So. 2d 743 (Fla. 1st DCA 1978)
 - c. *Yorkshire Ins. Co., Ltd. v. Seger*, 407 S.W.3d 435, 441 (Tex. App.—Amarillo 2013, pet. denied).
4. Can comparative negligence of injured party be considered?
 - a. *Alton M. Johnson Co. v. M.A.I.Co.*, 463 N.W.2d 277 (Minn. 1990)
 - b. *Mid-Continent Cas. Co. v. Am. Pride Bldg. Co., LLC*, 534 F. App'x 926, 927-28 (11th Cir. 2013)
5. If cannot retry underlying case, why can jury consider comparative negligence?
 - a. Factors courts consider when determining whether a Consent Judgment is reasonable, which envelopes bad faith, fraud, and collusion:
 1. The releasing person's damages;
 2. The merits of the releasing person's liability theory;
 3. The merits of the released person's defense theory;
 4. The released person's relative fault;
 5. The risks and expenses of continued litigation;
 6. The released person's ability to pay;
 7. Any evidence of bad faith, collusion, or fraud;
 8. The extent of the releasing person's investigation and preparation of the case; and,
 9. The interests of the parties not being released.

Besel v. Viking Ins. Co. of Wisconsin, 49 P.3d 887, 891 (Wash. 2002).
 - b. Reasonableness of settlement agreement determined by ***degree of probability of the insured's success*** and the size of the possible recovery. Including:
 1. The extent of the defendant's liability,
 2. The reasonableness of the damages in comparison with compensatory awards in other cases, (expert testimony)

[P]roof of reasonableness is ordinarily established through use of expert witnesses to testify about such matters as the extent of the defendant's liability, the reasonableness of the damages amount in comparison with compensatory awards in other cases, and the expense which would have been required for the settling defendants to defend the lawsuit.

Chomat v. Northern Insurance Co. of New York, 919 So. 2d 535, 538 (Fla. 3d DCA 2006)

3. The expense which has been required for the settling defendants to settle the suit.

Bond Safeguard Ins. Co. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa., No. 6:13-CV-561-ORL, 2014 WL 5325728 (M.D. Fla. Oct. 20, 2014).

Willcox v. American Home Assurance Co., 900 F. Supp. 850, 855-56 (S.D. Tex. 1995)

6. CANNOT assert defenses which could have been asserted in the underlying tort action.

- a. *Fireman's Fund Ins. Co. v. Imbesi*, 361 N.J. Super. 539, 826 A.2d 735 (N.J. App. Div. 2003).
- b. *Wright v. Hartford Underwriters Ins. Co.*, 823 So. 2d 241 (Fla. 4th DCA 2002).

7. However, facts from underlying case can be presented to the jury as evidence that the Consent Agreement was for an unreasonable amount or was tainted by bad faith, fraud, collusion, or an absence of any effort to minimize liability.

- a. *Bond Safeguard Ins. Co. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa.*, No. 6:13-CV-561-ORL, 2014 WL 5325728 (M.D. Fla. Oct. 20, 2014).

What Coblenz does not do is authorize the insured to indiscriminately load the carrier's wagon with bricks of damage that no reasonable person would expect as consequences of the underlying claim.

- b. *Coastal Refining & Marketing, Inc. v. U.S. Fidelity and Guaranty Co.*, 218 S.W.3d 279, 295-96 (Tex. App.—Houston [14th Dist.] 2007, pet. denied); *Enserch Corp. v. Shand Morahan & Co., Inc.*, 952 F.2d 1485 (5th Cir. 1992).

8. What happens if the consent judgment is deemed unreasonable in amount?

Arizona: If the claimant cannot show that the entire amount of the consent judgment is reasonable, he can recover only the portion proven to be reasonable. If the claimant is unable to prove the reasonableness of any portion of the judgment, the consent judgment is unenforceable. *United Servs. Auto Ass'n v. Morris*, 154 Ariz. 113, 741 P.2d 246 (Ariz. 1987)

Florida: If the consent judgment is determined to be unreasonable in amount, it is unenforceable. The court/jury cannot pick a reasonable number. *Florida Mid-Continent v. American Pride*, 534 Fed. Appx. 926 (11th Cir. 2013)

Minnesota: If the consent judgment is deemed unreasonable, it is unenforceable and the parties are returned to the status quo (i.e., the liability trial is reinstated). *Alton M. Johnson Co. v. M.A.I. Co.*, 463 N.W.2d 277 (Minn. 1990); *Corn Plus Cooperative v. Continental Casualty*, 516 F. 3d 674 (8th Cir. 2009).

Texas: If the court concludes the consent judgment is excessive, the court may enter a remittitur to reduce the damages to an appropriate amount. *United States Aviation Underwriters, Inc. v. Olympia Wings, Inc.*, 896 F.2d 949, 955 (5th Cir. 1990).

Damages in the Age of Regulation: The Murky Void Between Compensation and Punishment

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I. INTRODUCTION

The modern era's capacity to share information through social media and other web-based applications has had incalculable repercussions throughout post-industrial societies. Among them is the opportunity to defame, annoy, and invade one another's privacy with unprecedented abandon. At the same time, local, state, and federal laws have increasingly provided statutory recourse to persons aggrieved – or, as the case may be, not really aggrieved – by such misconduct, often creating remedies that are not wholly compensatory, yet not necessarily punitive, in nature. A critical issue for liability insurers and their insureds, as a result, will be to understand the new exposures created by these risks, regulated by these laws, and addressed (whether successfully or not) by specific policy language. Below, the author addresses the extent to which these statutory remedies constitute covered damages or loss under general and professional liability policies, as well as the industry's attempt to curb its exposure through new endorsements and other limiting language.¹ The intent is not to canvas the existing rulings, but instead to highlight the basic points of contention and identify significant precedent to facilitate further debate and analysis.

II. BACKGROUND: AN ALPHABET SOUP OF REGULATION

A generation ago, the Eagles famously observed that residents of the Hotel California can check out any time they like, but they can never leave. The same notion of residence in perpetuity can be said of most statutes, which similarly arrive with great flourish yet remain long after they have overstayed their welcome. Legislators live to pass laws, not to repeal them. As a result, regulation tends to increase over time, redundancy and irrelevance aside, like the stacked newspapers and empty pizza boxes in a hoarder's dining room.

There is nothing novel about regulation, of course. But the explosion in the dissemination of personal information made possible by modern technology, from fax machines to cellular phones and of course to the internet, has made it easier than ever to create havoc, real or perceived, with very little (and sometimes with no) effort. Much of that havoc involves the disclosure of personal information. As a result, the federal and state governments have reacted with a slew of new statutes and regulations creating new remedies for persons aggrieved by such transgressions or, at a minimum, for lawyers who are certain their clients would feel aggrieved if properly informed.

Many of these new, and even some not-so-new, statutes create financial remedies of uncertain character. In particular, statutory remedies often impose financial burdens on transgressors that have no direct relationship to a victim's injury. Indeed, some require no injury at all as a condition of liability. While it would be impossible to catalogue all these laws, a sampling of them provides a foundation for analyzing insurance coverage questions for the obligatory suits brought under them.

Most prominently, largely because of the ease of recovering money under it, the Telephone Consumer Protection Act prohibits unsolicited phone calls and fax transmissions, and allows the prevailing plaintiff to recover actual monetary loss or \$500, whichever is greater. 47 U.S.C. § 227(b)(3)(B).

¹ The author appreciates the editorial assistance of Angela Elbert, a partner at Neal, Gerber & Eisenberg, LLP in Chicago, Illinois, and co-presenter on this topic at the May 2016 ACCEC annual meeting, as well as the valuable assistance of Cynthia Liu, an associate in Dentons' San Francisco office, in researching the authorities cited in this article.

Under an older, more ubiquitous statute, UCC section 9-625 mandates notice of loan defaults and allows, in the event of a violation, recovery of an amount not less than the credit service charge plus 10 percent of the principal amount of the obligation or the time-price differential plus 10 percent of the cash price. U.C.C. § 9-625(c)(2).

Also at the federal level, the Fair and Accurate Credit Transactions Act (FACTA), which is part of the Fair Credit and Reporting Act (FCRA), regulates the truncation of credit card information, and violations will support recovery of actual damages or damages of not less than \$100 and not more than \$1,000. 15 U.S.C. § 1681n(a)(1).

The Controlling the Assault of Non-Solicited Pornography and Marketing Act of 2003 (“CAN-SPAM”) regulates unsolicited commercial email, and allows for statutory damages of \$250 per unlawful message, not to exceed \$2,000,000. 15 U.S.C. § 7706(f)(3).

The HIPAA statute (Health Insurance Portability and Accountability Act of 1996) requires health care providers to develop procedures that ensure the confidentiality of medical information, and permits statutory damages of \$100 per violation, not to exceed \$25,000 annually or for violations of an identical prohibition. 42 U.S.C. § 1320d-5(d)(2)(B).

Similarly, the Federal Wiretap Act permits statutory damages of the greater of \$100 a day for each day of violation or \$10,000. 18 U.S.C. § 2520(c)(2)(B).

Under the Federal Stored Communications Act, the court may assess as damages the sum of the actual damages suffered by the plaintiff and any profits made by the violator, but in no case less than \$1,000. 18 U.S.C. § 2707(c).

Under California’s Unruh Civil Rights Act, “[w]hoever denies, aids or incites a denial, or makes any discrimination or distinction contrary to [the Act]” is liable for actual damages and any amount that may be determined by a trier of facts up to three times the actual damages, but in no case less than \$4,000. Cal. Civ. Code § 52(a).

Louisiana’s PPO Act requires a Preferred Provider Organization to give notice to a medical provider of discounts, and the failure to comply with the act subjects a group purchaser to damages payable to the provider of double the fair market value of the medical services provided, but in no event less than the greater of fifty dollars per day of noncompliance or two thousand dollars, together with attorney fees. La. R.S. § 40:2203.1(G).

A pair of California statutes regulating private information is also notable. The Lanterman Petris Short Act prohibits the unauthorized disclosure of confidential information, and a willful and knowing release of confidential information will entitle the aggrieved party to \$10,000 or three times the actual damages, whichever is greater. Cal. Welf. & Inst. Code § 5330(a). The negligent release of confidential information entitles a plaintiff to recover both \$1,000 and actual damages. Cal. Welf. & Inst. Code § 5330(b).

Not to be outdone, Alaska’s Genetic Privacy Act prohibits disclosure of a person’s DNA analysis without written and informed consent, and renders a person violating the act liable for damages of \$5,000 or, if the violation resulted in profit, \$100,000. Alaska Stat. § 18.13.020.

Similarly, under California’s Confidentiality of Medical Information Act, a plaintiff can recover “nominal” damages of \$1,000 (whether or not injured), actual damages, and an administrative fine or civil penalty ranging from \$2,500 to \$25,000 per violation. Cal. Civ. Code § 56.36(b)(1).

And under California's Song-Beverly Credit Card Act, any person who seeks a consumer's personal information in connection with a credit card transaction is subject to a civil penalty not to exceed \$250 for the first violation and \$1,000 for each subsequent violation. Cal. Civ. Code § 1747.08(e).

It is also noteworthy that most, if not all, of these statutes allow a prevailing plaintiff to recover his, her, or its attorneys' fees, raising an additional layer of complexity for the defendants' insurance coverage inquiry as well as an incentive to bring suits.

Although addressing a wide range of behaviors, what these laws have in common is that their monetary remedies do not necessarily correspond to the victims' injury, but are instead set by statute without regard to the extent – or, in some cases, without any requirement – of actual injury. To make matters worse, the pre-set monetary relief, being tied to the statutory violation rather than the victim's injury, fits perfectly with the commonality and typicality requirements for certifying a class action, because the class members have no unique injuries to quantify. As a consequence, actions under these statutes are a plaintiffs' attorney's dream and a defendant's worst nightmare. Whether they should also interrupt the sleep habits of the defendants' insurer is the subject to which we now turn.

III. THE COVERAGE GRANT: ARE STATUTORY DAMAGES AWARDED BECAUSE OF A COVERED INJURY?

The first foundational question is whether statutory monetary remedies constitute "damages" within the meaning of a standard general liability policy. A related question is whether such damages are "loss" as defined in a professional liability policy. Dispensing with the spoiler alert, the answer is "probably," but the issue is not without controversy.

The insuring agreement of a typical CGL policy reads something like this:

We will pay those sums that the insured becomes legally obligated to pay as damages because of "bodily injury" or "property damage" to which this insurance applies. We will have the right and duty to defend the insured against any "suit" seeking those damages. However, we will have no duty to defend the insured against any "suit" seeking damages for "bodily injury" or "property" to which this insurance does not apply. We may, at our discretion, investigate any "occurrence" and settle any claim or "suit" that may result.

As a result, the policy does not cover all monetary relief, but only covers relief awarded "as damages." As if those two words had not been the subject of enough controversy, there is yet another layer of nuance contained within that sentence: to be covered, damages must be awarded "because of 'bodily injury' or 'property damage.'"² It would be an understatement to say there is something less than unanimity in the understanding of what damages are awarded "because of" a covered injury.³

For insurers, the template for arguing against coverage for statutory damages is *Whole Enchilada, Inc. v. Travelers Prop. Cas. Co. of America*, 581 F. Supp. 2d 677 (W.D. Pa. 2008). There, the District Court

² Or, of course, "because of 'personal and advertising injury'" in the case of Coverage B.

³ Constraints of space prevent this article from addressing two other foundational issues that would merit separate discussions on their own. The first is the extent to which the violation of a statute *that was motivated by* privacy concerns is, *a fortiori*, an "invasion of privacy" or other covered offense. The other is the extent to which a legislature's characterization of a remedy as "damages," a "penalty," "restitution," or a "fine" impacts whether it is viewed as "damages" for purposes of insurance coverage.

addressed coverage for a class action brought under FACTA, which prohibits a person accepting credit cards from printing a receipt displaying more than five digits of the credit card number. Violations of that prohibition, as noted above, permit an award of actual damages “or” an amount between \$100 and \$1,000. The court held the statutory damages awarded under FACTA fell outside the insuring agreement, because they did not represent *compensation for an injury*. Proof of an injury is not an element of a FACTA violation: the violation itself is actionable. Noting that the term “damages” “generally has been interpreted to refer to awards of compensation,” or “compensation for a legal injury sustained,” the court held that relief under FACTA was not covered because it did not represent payment for an injury:

“Statutory” damages are distinguished from the legal meaning of “damages,” generally. * * * In this case, the damages sought in the allegations of the Complaint are not damages for actual sustained injury, but rather, are sought pursuant to the provisions of FACTA, which prescribe statutory damages where no actual damage is alleged. [Cite.] However, the plain meaning of the term “damages” is “compensation for a loss or injury sustained by the plaintiff.”

Because the damages sought in the FACTA class action would have been awarded because the statute was violated, not because anyone was injured, they were not damages within the meaning of the insuring clause.

Travelers prevailed in similar fashion in *Ulta Salon, Cosmetics & Fragrance, Inc. v. Travelers Prop. Cas. Co. of America*, 197 Cal. App. 4th 424 (2011). There, the underlying plaintiff sued Ulta Salon, on behalf of the general public, for civil penalties and injunctive relief, claiming Ulta’s products contained inadequate health warnings required by California’s Proposition 65.⁴ The Court of Appeal held there was no duty to defend because the suit was not brought to recover damages for “bodily injury.” Indeed, there was not even an allegation that Ulta’s products had injured anyone. As the court put it:

[B]ecause the *Deubler* complaint neither alleged any facts giving rise to a claim for damages because of bodily injury nor did it allege any bodily injury (or property damage), Ulta did not become legally obligated to pay damages for bodily injury, and the policy was not triggered.

Likewise, a California trial court judge held, in *Arch Ins. Co. v. Michaels Stores, Inc.*, No. 37-2011-00097053-CU-IC-CTL, 2013 WL 8752285 (Cal. Super. Ct. Dec. 20, 2013), that a statutory award under the Song-Beverly Credit Card Act for requesting credit card customers’ personal information was not “damages” within the meaning of the act. The court began by noting that “[t]he common understanding of ‘damages’ means compensation recovered by a party for a loss or detriment it has suffered through the acts of another.” Citing previous trial decisions characterizing the goal of the act as deterrence, not compensation, and observing that the act only permitted civil penalties and not damages, the court concluded that the relief sought was a penalty, not damages. The court acknowledged that the amount of penalty was based in part on the degree of harm to the consumer, but reasoned that “the mere fact that an award of damages takes into account the harm suffered does not, by itself, make the award compensatory.” Finally, the court rejected the argument that the plaintiffs could have sued for common law invasion of privacy, and therefore the suit potentially sought covered damages. Because no common

⁴ Under Proposition 65, a person who discharges certain toxic substances “is liable for a civil penalty not to exceed two thousand five hundred dollars (\$2,500) per day for each violation in addition to any other penalty established by law.” (Cal. Health & Safety Code §25249.7(b)(1).)

law invasion of privacy claims were then being asserted, the insured could not secure a defense by speculating over unpleaded claims.

Finally, a very recent ruling, *ACE American Ins. Co. v. DISH Network LLC*, No. 1:13-cv-00560-REB-MEH, 2016 WL 1182743 (D. Colo., Mar. 28, 2016), found no coverage for an underlying TCPA and Telemarketing Act suit by the federal and state governments. Starting with the observation that “damages” are sums paid to a person as compensation for an injury, the court characterized the \$500 statutory award, “[d]espite the use of the word ‘damages’ in the TCPA,” to be a financial penalty designed to incentivize enforcement of the act, similar to punitive damages. The \$500 sum recoverable under the TCPA is expressly not a form of “actual damages,” but is assessed each time the statute is violated. Because punitive damages are uninsurable in Colorado, ACE had no obligation to cover the underlying action.

Insurers making similar arguments in other cases, however, were less successful. In *Hartford Cas. Ins. Co. v. Corcino & Associates*, No. CV 13–3728 GAF (JCx), 2013 WL 5687527 (C.D. Cal., Oct. 7, 2013), the court addressed coverage for a class action by patients of Stanford Hospital whose medical records had been posted online by a vendor, leading to a suit under California’s Confidentiality of Medical Information Act and Lanterman Petris Short Act. Hartford argued the suits sought no damages “because of” personal injury, because the statutory remedies were imposed for disclosing confidential medical information and not for harm to the patients. The court disagreed, reasoning that “the LPS and CMIA were enacted to create effective remedies for breaches of an individual’s right to medical privacy,” and as such “fall squarely within the Policy’s coverage.”

Similarly, in *Western Rim Investment Advisors, Inc. v. Gulf Ins. Co.*, 269 F. Supp. 2d 836 (N.D. Tex. 2003), the insurer argued that the statutory damage award under the TCPA (\$500 per unsolicited fax) was not “actual damages,” because the fixed sum was an alternative to “actual damages.” The court agreed with the insured that the underlying claimants sought damages because their privacy had been invaded, and merely chose “to seek . . . damages in the amount of \$500 for each advertising injury instead of actual damages because this is an option provided to them under the TCPA.”

The Missouri Supreme Court reached the same conclusion in *Columbia Cas. Co. v. HIAR Holding, L.L.C.*, 411 S.W. 3d 258 (Mo. 2013). In *HIAR*, another TCPA case, the court rejected the reasoning of an earlier Missouri decision, *Olsen v. Siddiqi*, 371 S.W. 3d 93 (Mo. App. 2012), which had concluded the fixed \$500 award under the TCPA could not be damages “because of” a personal injury, because it was awarded as an *alternative* to “actual damages” and therefore was not, by definition, compensation. In *HIAR*, the Missouri Supreme Court followed *Universal Underwriters Ins. Co. v. Lou Fusz Auto. Network, Inc.*, 401 F.3d 876 (8th Cir. 2005) to hold the \$500 liquidated awards must be covered damages because they “are not damages in the nature of fines or penalties.”

Finally, in *Standard Mut. Ins. Co. v. Lay*, 989 N.E. 2d 591 (Ill. 2013), the court held the \$500-per-violation TCPA award, if not trebled, is a liquidated sum representing harm, or at least an incentive for aggrieved parties to bring suit, and not a penalty.

In short, where the term “damages” is undefined in a policy,⁵ courts are divided on whether a statutory award that does not compensate someone for covered damages is imposed “because of” the covered injury or because the insured violated the statute. Those courts finding coverage tend to classify remedies in a binary sense: that is, remedies are either compensatory or punitive, and everything that is

⁵ Which is the case with the vast majority of general liability policies, including ISO forms.

not a penalty is covered. Other courts have recognized that remedies come in three flavors: compensatory, punitive, and statutory, and statutory damages are not automatically “compensatory” simply because they are not penalties.⁶ This latter group of decisions recognizes that an award does not automatically represent compensation by default merely because it not entirely deterrent or punitive.

With so much disagreement in the case law, one would think the insurance industry would amend its policies to clarify their intent regarding coverage for statutory damages. And, indeed, it has, and we will turn to that subject below in discussing the courts’ treatment of policy exclusions.

IV. EXCLUSIONS

If an underlying liability falls within the insuring clause, the next question is whether an exclusion applies. Below, we address decisions involving two types of exclusions. The first is the common CGL exclusion for – or, conversely, the omission from the definition of “loss” in professional liability policies of -- fines and penalties. The second consists of more recent efforts to create specific exclusions for statutory remedies that too-frequently manifest themselves in the form of consumer class actions in which thousands of class members seek precisely the same award. As we shall see, the insurance industry has had some success with the latter group of exclusions, but they are far from airtight. And finally, we will consider the role of public policy in limiting coverage for statutory remedies.

A. Fines and Penalties

Many CGL policies exclude liability arising from the “willful violation of a penal statute or ordinance.” By most measures, courts applying such exclusions to statutory damages have been few and far between. In the same vein, courts interpreting professional liability policies have generally been loath to conclude that statutory damages fall outside the definition of “loss” because they are “fines or penalties.”

In *Western Rim Inv. Advisors, Inc. v. Gulf Ins. Co.*, 269 F. Supp. 2d 836 (N.D. Tex. 2003), discussed above, the court considered whether damages awarded under the TCPA “arise out of the willful violation of a penal statute or ordinance,” and concluded they did not. The TCPA is a civil statute that awards a private litigant money for the violation a law, whereas a “penal” law is one that involves a criminal offense. Therefore, although the policy would not cover violations of the Texas Fax Law, which makes it a misdemeanor to transmit a junk fax, the TCPA is not “penal” because its violation is not a crime. *See also Acuity v. Superior Marketing Systems, Inc.*, No. 02 CH 8643, 2003 WL 24004567 (Ill. Cir. Ct. May 30, 2003) (exclusion does not apply because the insured is liable under the TCPA even if it did not “willfully or knowingly” violate the Act.)

Courts addressing coverage under professional liability policies tend to arrive at the same conclusion. In *Flagship Credit Corp. v. Indian Harbor Ins. Co.*, 481 Fed. Appx. 907 (5th Cir. 2012), the Fifth Circuit questioned Indian Harbor’s obligations to cover a class action brought by auto loan consumers, who claimed Flagship gave inadequate notice of default and sought UCC remedies tied to the amount of the service charge or the amount financed. Because the requested relief bore no relationship to any injury, Indian Harbor argued the relief was not “loss,” because that term excepted “fines, penalties or taxes.” Applying the canon of construction *noscitur a sociis* (similar to “*ejusdem generis*”), the court interpreted “penalties” to contemplate amounts paid to the government, because it appeared sandwiched between “fines” and “taxes,” two other remedies that are paid only to a government.

⁶ Professional liability policies generally do not cover “damages” *per se* but cover “loss,” meaning monetary awards *other than* “fines or penalties.” Because that coverage limitation turns on the meaning of a “fine” or “penalty,” it is discussed in the following section addressing the exclusion of such awards.

To the same effect is *Evanston Ins. Co. v. Gene by Gene, Ltd.*, --- F.Supp.3d ---, 2016 WL 102294, *4 (S.D. Tex. Jan. 6, 2016), which involved an underlying class action under the Alaska Genetic Privacy Act. Citing *Flagship*, the court concluded an award of “actual and statutory damages of \$5,000” per violation did not involve “taxes, criminal or civil fines, or attorney’s fees or penalties imposed by law” under primary and excess professional liability policies. Because “[f]ines, penalties, and taxes are ‘limited to payments made to the government’ and do not include statutory damages that make up the monetary portion of a judgment,” the suit sought “loss” under the professional liability policies in question.

In *Williams v. SIF Consultants of Louisiana, Inc.*, 133 So. 3d 707 (La. Ct. App. 2014), the court found coverage for a class action brought against a medical services company for failing to disclose discounts under PPO plans. Because the statute authorized an award equal to twice the fair market value of the medical service provided, or alternatively between \$50 per day and \$2,000, the insurers argued the relief constituted “fines, penalties, taxes, [or] punitive, exemplary or multiplied damages,” and hence was not covered under their errors and omissions policies. The court noted that the policy did not exclude “statutory damages” and, since the statute did not label the award a “penalty,” the exclusionary provisions “do not include a monetary amount that is a statutory damage or a damage punitive in nature.”

Likewise, in *Columbia Cas. Co. v. HIAR Holding, L.L.C.*, 411 S.W. 3d 258 (Mo. 2013), the Missouri Supreme Court held the \$500 award for nonwillful TCPA violations is a form of “damages,” not a form of deterrence. Following the Eighth Circuit’s decision in *Lou Fusz*, the court reasoned that the treble damages option of \$1,500 for willful violations indicated a standard \$500 award was not a penalty for purposes of HIAR’s CGL policy. Instead, \$500 represented liquidated damages and was remedial, not punitive.

Similarly, in *Navigators Ins. Co. v. Sterling Infosystems, Inc.*, 2015 NY Misc. LEXIS 2764 (Sup. Ct., July 28, 2015), the court found that statutory damages awarded under FCRA for providing inaccurate credit information were covered by Sterling’s errors and omissions policy, and did not represent excluded “fines, penalties, forfeitures or sanctions.” The court observed that statutory damages under FCRA are a substitute for hard-to-prove compensatory damages, and the availability of punitive damages under FCRA undermined the notion that the basic statutory award was a form of punishment.

On the other hand, in *Health Net, Inc. v. RLI Ins. Co.*, 206 Cal. App. 4th 232 (2012), the California Court of Appeal found that awards sought under ERISA for mishandling health plans were “penalties” outside the coverage of a professional liability policy. In that case, the policy defined “damages” not to include “civil or criminal fines or penalties imposed by law.” The underlying suits sought \$100 per day from the plan administrators for failing to furnish certain information, which the insured characterized as a liquidated damage award. In addition to the fact that the Department of Labor referred to the amount as a “civil penalty,” the court noted, “it appears that a plan administrator may be required to pay this amount *not* in order to compensate the beneficiary for the loss suffered by not being furnished the required information, but, instead, in order to penalize the plan administrator for failing to comply with the duty to disclose.”⁷ See also *Wellcome v. Home Ins. Co.*, 849 P.2d 190, 193 (Mont. 1993) (holding that litigation sanctions imposed on insured attorney for trial misconduct were “fines,” although not “statutory penalties,” and therefore excluded from errors and omissions policy).

⁷ The *Health Net* court also agreed an award of the plaintiffs’ attorneys’ fees was not covered as “damages,” because it “d[id] not compensate a plaintiff for the injury that brought the plaintiff into court.”

B. Specific Exclusions

Faced with decisions like *HIAR* that construed liquidated statutory sums to be “damages,” or at least finding them not to be “fines or penalties,” the insurance industry has responded with specific endorsements, whether standardized in ISO forms or unique language, to limit coverage for statutory awards under laws regulating internet communications, privacy, and related concerns. Those efforts have met with mixed results, but overall the rulings have been more favorable to insurers.

For instance, ISO has adopted, within the newer CGL forms, an exclusion for “Recording And Distribution Of Material Or Information In Violation Of Law.” Applicable to both Coverage A and Coverage B, that exclusion applies to suits arising from conduct that violates the TCPA, the CAN-SPAM Act, FCRA, FACTA, or any other law that “addresses, prohibits, or limits the printing, dissemination, disposal, collection, recording, sending, transmitting, communicating or distribution of material or information.”

In *MDC Acquisition Co. v. North River Ins. Co.*, 898 F. Supp. 2d 942 (N.D. Ohio 2012), the court addressed an “Unsolicited Communications” exclusion in a Travelers policy, which applied to injury “arising out of unsolicited communications by or on behalf of the [sic] any insured,” including violations of “the Telephone Consumer Protection Act and any amendments” to it. In an underlying class action, the insured had been sued under the Junk Fax Prevention Act of 2005, an amendment to the TCPA. The court found it would be “absurd” to think a suit under the Junk Fax act, an amendment to the TCPA, did not involve unsolicited communications. As a result, Travelers had no duty to defend or indemnify the insured.

Similarly, in *Interline Brands, Inc. v. Chartis Specialty Ins. Co.*, 749 F.3d 962 (11th Cir. 2014), the Eleventh Circuit applied Florida law to find no coverage for a TCPA case under a CGL policy. In that case, the Chartis policy excluded injury resulting from “any act that violates any statute, ordinance or regulation of any federal, state or local government . . . [that] applies to the sending, transmitting or communicating of any material or information, by any means whatsoever.” Despite the insured’s argument that the exclusion was so broad as to be ambiguous, in that it failed to identify which statutes it contemplated, the court held a policy is not ambiguous simply because it is broad or nonspecific. Indeed, the court noted, the insured likely would have been *more* confused, not better informed, if the policy listed every law, ordinance and code that was excluded, especially since statutes are constantly being enacted, amended, and renamed.

The insurer fared less well in *Evanston Ins. Co. v. Gene by Gene, Ltd.*, --- F.Supp.3d ---, 2016 WL 102294 (S.D. Tex., Jan. 6, 2016). There, an insured that maintained a genetic genealogy website had been sued under the Alaska Genetic Privacy Act for publishing the class members’ DNA on its website without consent. The insured’s professional liability insurers disputed coverage, citing an exclusion for “Electronic Data and Distribution of Material in Violation of Statutes,” but the court ruled for the insured. The exclusion in question applied to violations of the TCPA, the CAN-SPAM Act, and “any other statute, law, rule, ordinance, or regulation that prohibits or limits the sending, transmitting, communication or distribution of information or other material.” The court concluded that the focus of the exclusion was on laws similar to the TCPA and CAN-SPAM Act, since “any other statute” followed the reference to those laws. Because the underlying action involved the disclosure of individuals’ DNA, not the transmission of annoying communications, the exclusion was inapplicable.

Finally, a pair of decisions from California underscores the importance of the specific wording of such exclusions and the nature of the statute that was allegedly violated. In *Big 5 Sporting Goods Corp. v. Zurich American Ins. Co.*, No. 13–56249, 2015 WL 8057228 (9th Cir., Dec. 7, 2015), the Ninth Circuit affirmed a ruling that two exclusions barred coverage for a class action accusing Big 5 of violating the

state's Song-Beverly Act, which prohibits merchants from requesting personal information – such as ZIP code information – in credit card transactions. Zurich's policies contained a "Statutory Violation Exclusion," which applied to violations of "any statute, ordinance or regulation that prohibits or limits the sending, transmitting, communicating, or distribution of material or information." Hartford's policy included a "Right Of Privacy Created By Statute" exclusion, and the court found both exclusions applicable. In rejecting Big 5's argument that it faced potential liability under the common law for violation of privacy, the court observed there was no common law right to maintain the privacy of one's ZIP code, and therefore the right to ZIP code privacy was, indeed, "created by statute." The court also rejected the argument that the complaint could have been amended to assert a common law privacy claim, and therefore potentially sought covered damages. Because no such right existed at common law, the court found no reason to think the plaintiffs might amend their complaint as Big 5 suggested.

By contrast, in *Hartford Cas. Ins. Co. v. Corcino & Assocs.*, No. CV 13-3728 GAF (JCx), 2013 WL 5687527 (C.D. Cal., Oct. 7, 2013), the court found the same Hartford exclusion inapplicable to a class action arising from the online posting of patients' medical information in violation of two state statutes. The Hartford exclusion applied to the violation of privacy rights created by statute – obviously aimed in part at TCPA claims, but not limited to them – but excepted "liability for damages that the insured would have in absence of" the statute. Although no common law privacy claims were asserted, and thus the insured faced no liability it would have had in the absence of the statute, the court held the statute was not implicated in the first place, because the right to medical privacy existed prior to, and independently of, the statutory remedies. Because the exclusion applied to privacy "rights" created by statute, not to privacy "remedies" created by statute, it did not apply to the statutory privacy claims at issue.

C. Public Policy

Finally, a number of cases have addressed whether public policy precludes coverage for statutory TCPA awards, for the same reason punitive damages are uninsurable. Those cases have generally agreed that the \$500 TCPA award is a fixed or liquidated sum in lieu of actual damages, but is not punitive *per se*. See, e.g., *Motorists Mut. Ins. Co. v. Dandy-Jim, Inc.*, 182 Ohio App. 3d 311 (2009) (reasoning malice is not an element of a TCPA claim); *Penzer v. Transportation Ins. Co.*, 545 F.3d 1303 (11th Cir. 2008) (TCPA requires no intent, except for treble damages); *Standard Mut. Ins. Co. v. Lay*, 989 N.E. 2d 591 (Ill. 2013) (\$500 award, if not trebled, is a liquidated sum for actual harm, or an incentive for aggrieved parties to bring suit, and thus serves more than purely punitive or deterrent goals); *Terra Nova Ins. Co. v. Fray-Witzer*, 869 N.E. 2d 565 (Mass. 2007) (declining to find "punitive damages" exclusion applicable absent evidence that Congress intended TCPA remedies to be punitive); but see *Kaplan v. Democrat & Chronicle*, 698 N.Y.S.2d 799 (App. Div. 1999) (outside the insurance context, court held TCPA plaintiff need not show actual damages, as statute is punitive).

On the other hand, as noted above, United States District Judge Robert Blackburn of Colorado has recently held that Colorado's prohibition of coverage for punitive damages relieved DISH Network's insurers from having to defend an underlying TCPA suit brought by the federal government and four states. See *ACE Amer. v. DISH Network*, *supra*.

V. LESSONS

Those of a certain age will remember the Slinky, a toy made from a compressed spring whose leading end could be stretched a great distance from the device's trailing end. At some point, however, the tension became unsustainable, and the trailing end would snap back, sometimes with a vengeance.

Liability insurance innovations tend to follow a similar course. As new and different liability exposures come into focus, policyholders tend to have early success, with court rulings frequently placing coverage well out in front of what the insurers assumed they were covering. In due course, however, insurers respond with new policy language that closes the gap, sometimes abruptly.

Where statutory damages are concerned, insurers may have been caught flatfooted in not anticipating the exposures created by the perfect storm of cyber ubiquity, government regulation, class action litigation, and imprecise policy language. Courts that view remedies in a binary fashion have generally agreed that statutory awards are covered, if only because they are not punitive. Courts with a more nuanced appreciation of insurance principles, however, have been more willing to recognize a nether world of relief that is not quite punitive, yet not quite compensatory, either.

Insurers creating specific (and often nonstandard) exclusions in response to these challenges have largely succeeded, but insureds have had notable successes there, too. The key for both sides is to focus intensively on the wording of the exclusionary language and the nature of the statutory scheme, including its legislative history and intended goals, as there can be no “one-size-fits-all” analysis where an unsettled array of policy revisions is superimposed over a kaleidoscope of legislative schemes.

The good news for practitioners, of course, is that there will *always* be new governmental regulations, which will beget new lawsuits, which will beget new insurance claims, which will beget new policy language, and the circle will continue unbroken.

ALI Restatement

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THE EMPIRE STRIKES BACK

A Critique of The American Law Institute's Restatement of the Law of Liability Insurance

By
Michael F. Aylward

I. INTRODUCTION

Nearly six years after work on it began, the American Law Institute's *Restatement of the Law of Liability Insurance* is more than half way to completion. Surprisingly, despite its significance for the future of insurance jurisprudence, the *Restatement* has only recently received attention from representatives of the insurance industry and their advocates. Although insurers are now fully engaged in analyzing and responding to proposed provisions, much remains to be done with respect to the Chapters due to be voted on next year, as well as the still to be drafted Chapters 3 and 4. In this article, we will trace the history and evolution of this project and what its future may hold for insurance and practitioners of insurance coverage law.

The *Restatement of the Law of Liability Insurance* represents the first significant national effort to codify insurance law. Indeed, one might wonder why the ALI took on this project, given the state-specific nature of insurance law. While much of this *Restatement* sets forth familiar legal principles, some sections challenge conventional wisdom and propose new rules that are surprising and, in some cases, disturbing.

--The American Law Institute

The American Law Institute is a Philadelphia-based organization of lawyers, legal scholars and judges who are devoted to maintaining and advancing the law. Founded in 1923 by eminent judges and scholars such as Benjamin Cardozo and Learned Hand, the ALI takes as its mission the goal of promoting "the clarification a simplification of the law and its better adaptation to social needs, to secure the better administrative of justice and to encourage and carrying out scholarly insights of legal work." Over the past century, the ALI has had a profound impact on American law through model statutes such as the Uniform Commercial and Penal Codes as well as its various Restatements of the Law in areas as diverse as torts, conflicts of law and the law of lawyering.

--A Short History of the Restatement of Liability Insurance

In 2010, the American Law Institute embarked on an analysis of legal issues presented by liability insurance disputes. The idea for this project appears to have begun with a suggestion by Professor Kenneth Abraham of the University of Virginia, one of the foremost academic specialists on insurance law in America. The ALI named Professors Thomas Baker of the University of Pennsylvania Law School and Kyle Logue of the University of Michigan Law School to serve as the project's Reporters. A team of 44 judges, industry executives and outside counsel with specific expertise in this area of the law were appointed by the ALI to serve as Advisers to the Reporters. There is also a large Members Consultative Group, consisting of ALI

members who are interested in insurance and who have volunteered to review drafts and provide input to the Reporters.

ALI Restatements proceed through a slow iterative process. First, Reporters circulate Memoranda and Preliminary Drafts. These initial drafts are reviewed by the Advisors and the Members Consultative Group, who provide feedback to the Reporters. With this input, the Reporters produce so-called Tentative Drafts. When these drafts are approved, a so-called Council Draft is submitted to the ALI Council, a small group of senior members that vet all proposed text before they go to the full membership for final approval at the ALI's annual May meetings in Washington, D.C.

This project was originally envisioned as a "Principles of the Law." Unlike the ALI's more familiar "Restatements," Principles projects are geared more towards regulators and legislatures and set forth "best practices" that the Reporters feel should be adopted, whether they currently reflect the way that most courts address such issues or not. In short, *Principles* set forth the law as it should be, whereas *Restatements*, for the most part, codify the law as it is.

Four years into the project, however, the new executive director of the ALI decided that it should be a Restatement. As a result, and despite the fact that Chapters One and Two had already by then been voted on and approved by the full ALI membership, the Reporters were obliged to pull back Chapters One and Two at the end of 2014 and reassess their provisions to eliminate aspirational provisions that were not rooted in the common law or that were otherwise inappropriate for inclusion in a Restatement.

Around the same time, the ALI released a revised Style Manual in January 2015. The new Style Manual provides insight with respect to the circumstances in which Reporters may vary from the majority rule in writing a Restatement. The ALI is clear that Restatements are meant to be much more than a codification of existing law. In particular, if the "majority" approach is outmoded, impractical and the "minority" view reflects the emerging trend and better rule, the Reporters have discretion to abandon the majority rule, so long as they clearly state what they are doing. As the Style Manual states:

The Restatement process contains four principal elements. The first is to ascertain the nature of the majority rule. If most courts faced with an issue have resolved it in a particular way, that is obviously important to the inquiry. The second step is to ascertain trends in the law. If 30 jurisdictions have gone one way, but the 20 jurisdictions to look at the issue most recently went the other way, or refined their prior adherence to the majority rule, that is obviously important as well. Perhaps the majority rule is now widely regarded as outmoded or undesirable. If Restatements were not to pay attention to trends, the ALI would be a roadblock to change, rather than a "law reform" organization. A third step is to determine what specific rule fits best with the broader body of law and therefore leads to more coherence in the law. And the fourth step is to ascertain the relative desirability of competing rules. Here social-science evidence and empirical analysis can be helpful.

In the Spring of 2015, the Reporters released a new Discussion Draft of Chapters One and Two that eliminated many of the provisions that insurers had vehemently objected to, notably sections dealing with misrepresentation, waiver and estoppel and the duty to defend. While the revised Discussion Draft of Chapters One and Two was initially fast-tracked for approval at the May 2015 ALI Annual Meeting, the Reporters ultimately agreed to only present it for discussion.

In late September, the Reporters submitted a Council Draft No. 1 of Chapters One and Two for consideration by the ALI Council. The Reporters took the unusual step of submitted Chapters 1 and 2 to the Council while holding back two sections that they reserved for further discussion with the project Advisors at their October 28, 2015 meeting. Sections 13(3) and 19 of Chapter Two were the subject of intense discussion at the Reporters' meetings with the Restatement Advisors and MCG at the close of October, along with the newly-released text of Chapter 3. On December 28, 2015, the Reporters published Council Draft No. 2, which incorporated their final decisions with respect to Sections 13(3) and 19 as well as a refined presentation of Chapter 3 based on the input that they had received at their October meetings.

This latest draft will be reviewed by the ALI Council at its next meeting in January 2016. If all proceeds accordingly to schedule, Chapters 1, 2 and 3 will be submitted for a vote by the ALI at its Annual Meeting in Washington, D.C. in May 2016, with Chapter 4 to follow in 2017.

II. THE RESTATEMENT IN BRIEF

When it is finally completed, the Restatement of the Law of Liability Insurance will contain four chapters. Chapter One addresses basic principles of insurance contract interpretation, the doctrines of waiver and estoppel and the effect of misrepresentations made by policyholders during the application process. Chapter Two focuses on the obligation of a liability insurer to defend (or pay defense costs), as well as the duty to settle and cooperation issues. Chapter Three will address the scope of insured risks and topics such as trigger, allocation, and issues related to high profile exclusions and conditions, while Chapter Four will focus on advanced insurance contract issues like choice of law, remedies, bad faith, and enforceability.

A. Chapter One (Basic Liability Insurance Contract Principles)

Following an opening definitional section, Chapter One consists of three topics: (1) Interpretation (in Sections 2-4); (2) Waiver and Estoppel (in Sections 5-6) and (3) Misrepresentations (in Section 7-11).

Topic 1: Interpretation (Sections 2-4)

§ 2: Insurance Policy Interpretation

Section 2 sets forth familiar and established principles of contract construction (*e.g.*, insurance policies shall be interpreted in the same manner as other contracts).

§ 3: The Presumption In Favor of Plain Meaning

Section 3 is far more controversial. Instead of adopting "plain meaning" as a fixed rule, it proposes a *presumption* of plain meaning that can be refuted by extrinsic evidence of contractual intent. Furthermore, even if a policy term is unambiguous on its face, that plain meaning can be overcome if a judge "determines that a reasonable person would clearly give the term a different meaning in light of extrinsic evidence."

Comment c. indicates that "plain meaning" is assumed to be the understanding that "an ordinary reasonable person would have, if that person took the time to read all of the relevant parts of the policy in the context of the claims at issue..." The Reporters are at pains not to adopt an exception for "sophisticated insureds" although their modified objective standard clearly reflects the circumstances in which a particular insured or business lies. This "tailored objective" standard "takes into account the level of sophistication and insurance-purchasing experience expected of the party buying the policy, but not that party's subjective understanding." Comment e.

§ 4: Ambiguous Policy Terms

In most states, when standard-form policy language is involved, a finding of ambiguity automatically results in coverage ("tie goes to the insured"). The rules in many states provide that, on boilerplate or standard-form policy language, an insurer's preferred interpretation must be the only reasonable interpretation. Thus, even if an insurer's proposed interpretation is demonstrably reasonable, ambiguity (and coverage) will be found so long as the insured's proposed interpretation is also reasonable. As set forth in Comment j., however, Section 4 does not adopt the standard "tie breaker" rule followed in many jurisdictions but instead declares that coverage should be found only if a court is otherwise unable to determine the meaning of an insurance policy term "using all other permissible sources of meaning, including extrinsic evidence."

In comment (b) to Section 4, the Reporters explore the relationship between *contra proferentem* and the doctrine of "reasonable expectations." They comment that the reasonable expectation doctrine is not actually a rule of interpretation but rather "is a rule regarding the enforceability of terms that are inconsistent with the reasonable expectations of the insured." Their position is that while policies should be interpreted in accordance with the reasonable expectations of coverage, coverage may not be found based on this doctrine where to do so would confound the actual language of the policy.

Topic 2: Waiver and Estoppel (Sections 5-6)

Sections 5 and 6 set forth the general rules governing the application of the doctrines of waiver and estoppel to insurance coverage disputes. For the most part, the principles enunciated follow the common law in most jurisdictions both as regards the distinction between waiver and estoppel and the general principle that an insurer cannot "waive into coverage." Section 6 does state, however, that an insurer's post-loss conduct can estop it to dispute coverage if the insured reasonably relies on it to their detriment.

Topic Three—Misrepresentation (Sections 7-8)

The analysis of misrepresentation issues in Topic Three was one of the most contentious issues during the *Principles* phase of this project. In particular, insurers objected to Section 7's use of a "fraud" standard of proof as well as the requirements in Section 11 that insurers accept coverage, albeit at the cost of additional premium to the insured, in cases of "innocent misrepresentation." Both of these provisions have been eliminated in the 2105 Council Draft, along with any distinction between negligent and intentional misrepresentations. As revised, Sections 7 and 8 generally track the rules in most states with respect to intent, materiality and reliance.

§ 7: Misrepresentation

Section 7 states that an insurer may decline to pay a claim or, after returning all premiums owed, may elect to rescind an insurance policy if its insured made a false or misleading representation in an application for coverage or for the renewal of the policy that the insurer reasonably relied on. Earlier language that further required insurers to prove that the insured had acted intentionally or recklessly was removed in the April 30, 2015 Discussion Draft and is not contained in the 2015 Council Draft.

§ 8: Materiality Requirement

The subject of a misrepresentation is "material" if it either would have caused the insurer either not to have issued the policy at all or to have issued it under substantially different terms.

B. Chapter Two: Management of Potentially Insured Liability Claims (Sections 10-30)

Chapter Two is divided into three topics: (1) defense; (2) settlement, and (3) cooperation. According to the Reporters, these three Topics have "engendered much confusion in the case law" and there is a "real opportunity to clarify and improve the law. . . ." The Reporters go on to assert that Chapter Two is an attempt to "clarify and unify existing law" and that it largely sets forth rules that already apply in most jurisdictions. Indeed, Chapter Two is generally less controversial than Chapter One and thus was changed less in the Council Drafts issued in 2015.

Topic 1 – Defense

Sections 10-23 analyze the right and duty of insurers to defend. Section 13 proposes a "four corners plus" approach to the duty to defend that would require insurers to consider not only the facts alleged but also facts that become known through the insurer's investigation. However, extrinsic facts will only defeat a duty to defend that otherwise exists where the issue concerns whether the claimant is an insured or whether a vehicle is covered under an auto policy.

Text in Section 12 that would have declared insurers vicariously liable for the conduct of defense counsel was shed in the metamorphosis of this project from a *Principles* to a *Restatement*. However, insurers may still be liable for the acts of their employees, an issue that

may arguably create liability for the conduct of staff counsel. Insurers may also be liable for negligence in the selection or supervision of defense counsel.

Section 16 addresses the circumstances in which an insured may insist on its own defense counsel and, for the most part, adopts the California *Cumis* standard. Section 17 states that an insurer's determination of the hourly rate for independent counsel may not be determined solely based on what the insurer pays to its panel counsel. An earlier provision requiring the insurer to front the full amount charged subject to a right to sue defense counsel at the conclusion of the litigation to recoup excessive fees has been eliminated.

Section 18 provides that an insurer may terminate its defense duty by entering into a settlement with the underlying claimant to dismiss the covered claims, but only with the insured's express consent.

Section 20 states that if multiple insurers have a duty to defend, the insured may target a single insurer to handle its defense. Unlike the Illinois "targeted tender" approach, however, that insurer is entitled to contribution from other insurers that shared a similar obligation.

Section 21 states that insurers may not retroactively recoup their costs of defense, absent explicit policy wordings allowing such recovery. The Reporters are at pains to reconcile this finding with Section 35 of the *Restatement (Third) of Restitution and Unjust Enrichment*, which does allow for equitable restitution under analogous circumstances.

§ 10: Scope of the Right to Defend

Comment b. states where an insurance policy gives the insurer the right to defend, that right extends all aspects of the policyholder's defense, including the right to select counsel and the right to receive reports from defense counsel pertaining to the defense or settlement of the suit. Assigning this right to insurers is consistent with the policy language, as well as with the practical reality that, in most cases, insurers are better equipped to handle a legal defense than all but the most sophisticated policyholders.

While an insurer's right to defend is deemed "unlimited" in so-called "full coverage" cases, Comment a. takes note of situations where some portions of a claim may not be covered, either as falling outside the scope of coverage, being subject to policy exclusions or as involving damages exceeding the available policy limits. Whether such circumstances curtail or preclude the insurer from exercising its right to defend is discussed in Section 18.

§ 11: Confidentiality

Section 11 provides that information communicated by a policyholder to its insurer does not waive the confidentiality of such communications. It further provides in Subsection 2 that:

An insurer does not have the right to receive any information of the insured that is protected by attorney-client privilege, work-product immunity, or a defense lawyer's duty of confidentiality under rules of

professional conduct, if that information could be used to benefit the insurer at the expense of the insured.

Comment c. makes clear that the insurer is free to obtain publicly available information, such as deposition transcripts, that may bear on coverage concerns but is not entitled to private information, such as statements made by the policyholder client to defense counsel.

§ 12 Liability of Insurer for Conduct of Defense

Section 12 was originally entitled “Vicarious Liability” and stated that, where an insurer engages counsel to defend its policyholder, it is vicariously liable for any breach of professional obligation by defense counsel and related service providers.

Following intensive debate, the Reporters announced at the March 2015 Advisers meeting that they were withdrawing the original text of Section 14. As restated in Section 12, insurers are now only liable if defense counsel was an employee of the insurer acting within the scope of their employment or if the insurer “negligently selected or supervised defense counsel,” including by failing to ensure that the firm has adequate malpractice coverage.

§ 13: Conditions Under Which Insurers Must Defend

Section 13 sets forth general principles that define the duty to defend. Subsection (1) declares that an insurer’s duty to defend arises if there is a claim against its insured “that is based in whole or in part on any set of alleged facts and an associated legal theory that, if proven, would be covered by the policy, without regard to the merits of those allegations or that theory.” Comment c. states in explanation:

This widely accepted rule reflects a public policy of construing defense coverage broadly. The complaint-allegation rule and the one-way use of information beyond the complaint are two of the most important ways in which the duty to defend is broader than the duty to indemnify.

Likewise, Comment a, confirms that an insurer’s defense obligations continue through final resolution of the underlying claim:

An allegation in a complaint that would subject the insured to a covered liability conclusively establishes that the insurer has a duty to defend. In such case, the insurer must defend the claim until the duty to defend terminates in one of the ways enumerated in § 20. This widely accepted “complaint allegation” rule generally means that the insurer must defend the claim all the way through final adjudication of the claim, unless the claim is settled or the insurer prevails in a declaratory-judgment action establishing that the claim is not covered by the liability insurance policy.

Section 13 appears to adopt a “four corners plus” approach whereby the duty to defend may be activated either by an allegation or legal theory “complained in the complaint or comparable document stating the claim or that is identified in the course of the investigation or

defense of the claim or inferable from the complaint or comparable document, that a reasonable insurer would regard as an actual or potential basis for all or part of the claim.” Briefly stated, Section 13 sets forth the following rules:

1. If there is an allegation that clearly gives rise to a potential for coverage, the insurer must defend until the litigation concludes or the case settles.
2. If the complaint is vague or silent with respect to pertinent facts, an insurer has a duty to defend only if the insurer “knows or reasonably should know of other information that would lead a reasonable insurer to conclude that a claim is based on an allegation that, if included in the complaint, would require the insurer to defend.” Except with regard to the two situations identified in Section 13(3), this rule works in one direction only: facts or circumstances not alleged in the complaint or comparable document may not be used to justify a refund or failure to defend.”

Section 13 has also been amended to substitute “legal action” for “claim” to avoid becoming entangled in the issue of whether and when a claim that is not actually in suit may trigger a duty to defend, an issue which the Restatement does not purport to resolve.

Much of the recent discussion concerning Section 13 focused on the circumstances in which a liability insurer could look to extrinsic facts to defeat a duty to defend. Earlier drafts limited this ability to specific issues, such as whether the claimant was an insured or a vehicle was covered under the policy. During the October 28, 2015 Advisors Meeting, however, there was a spirited debate as to whether Section 13(3) should attempt to identify all specific instances in which extrinsic facts could preclude a duty to defend or whether a more generalized statement of the rule would be more effective. Ultimately, the Reporters adopted the latter approach. In contrast to Council Draft No. 1, Council Draft No. 2 now provides that:

(3) An insurer is not required to defend a legal action brought against an insured if undisputed facts that are not at issue in the legal action for which defense is sought establish as a matter of law that the legal action is not covered. Unless such undisputed facts establish as a matter of law that the legal action is not covered, the insurer must defend until its duty to defend is terminated under § 18.

In short, Section 13 has adopted the California Montrose approach, wherein extrinsic facts may be relied on to eliminate a duty to defend so long as the facts are not in dispute and do not contradict factual allegations in the underlying action.

Section 13 distinguishes between “factual uncertainty” and “legal uncertainty.” “Legal uncertainty” refers to the situation where the courts in that jurisdiction have not clearly ruled on the scope or meaning of certain coverage terms. In that regard, Comment e. suggests that an insurer may either deny the claim and face estoppel with respect to indemnity as set forth in

Section 19 or may be relieved of any duty to defend if it is later held not to have owed coverage. Alternatively, the insurer may defend under a reservation of rights.

§ 14: Duty to Defend: Basic Obligations

Section 14 provides that, where an insurer has a duty to defend it must do so in a professional manner protecting the insured from all risks including risks not covered by the liability insurance policy. Subsection 2 states that an insurer may carry out its obligation to defend by using staff counsel except where independent counsel is required as per Section 16. It further states that, unless the policy provides otherwise, the costs of defense are assumed to exist independent of policy limits.

§ 15: Reserving the Right to Contest Coverage

Section 15 states that an insurer may contest coverage only if it gives notice to its policyholder before agreeing to defend on the grounds on which it intends to contest coverage. The reservation must identify all bases for disputing coverage of which the insurer is or should be aware. To preserve its right to contest coverage, the insurer already defending a claim must update its reservation as soon as it learns of a ground for denial.

The reservation shall consist of a written explanation of the grounds that makes reference to the specific policy terms and facts upon which the defense is based in language that is understandable by reasonable persons in the position of the insured. If an insurer cannot reasonably complete its investigation of a claim before it has to undertake the policyholder's defense, the insurer may preserve its right to contest coverage by providing an initial general notice of reservation of rights so long as it sends a more detailed notice letter as soon as practicable. If an investigation is ongoing, an insurer may preserve its rights by issuing "an initial, general reservation of rights," as long as it provides a detailed reservation as soon as practicable.

The Reporters have since eliminated language in Section 15 that would have required insurer to give the policyholder the opportunity to discuss the insurer's coverage defenses with appointed defense counsel "for the limited purpose of understanding the impact of the reservation of rights on the defense of the claim and evaluating whether to retain other counsel at the insured's own expense."

§ 16: The Obligation to Provide an Independent Defense

Where an insurer has a duty to defend and "there are common facts at issue in the claim and the coverage defense such that the claim could be defended in a manner that would advantage the insurer at the expense of the insured," the insurer must agree to provide independent counsel. Independent counsel is not required merely because the underlying suit seeks damages in excess of the applicable limits. This is more or less the *Cumis* approach that most courts already follow. It is less problematic for insurers than the "reject the defense" approach followed in some states that allows independent counsel in cases where an insurer reserves rights. It is also better for policyholders than the rule followed in some other states that

does not require independent counsel or requires that the insurer consent to the insured's selection.

Comment c. does not take a clear position with respect to whether a claim for punitive damages (assuming punitive damages are uninsurable in that jurisdiction) necessarily gives rise to a right to independent counsel, indicating that, "while troubling," any such conflict must be evaluated on a case-by-case basis to see whether it would result in the defense being conducted in a manner that advantages the insurer at the expense of the insured. The Comment notes that efforts of defense counsel to reduce the policyholder's exposure with respect to compensatory damages will typically also reduce the policyholder's exposure to the uncovered punitive damage counts. Nevertheless, the Comment notes the possibility that a claim for punitive damages could give rise to a serious conflict in the defense if, for example, the compensatory damage claim is small in relation to the potential punitive damages. In such cases, the defense may be handled in a "hard edged manner" that disproportionately risks exacerbating the punitive damages exposure or the manner of presentation at trial could affect the jury's allocation between pain and suffering damages, on the one hand, and punitive damages, on the other.

§ 17: The Conduct of an Independent Defense

If independent counsel is justified pursuant to Section 16, the insurer is obliged to pay the reasonable costs of defense in a "timely manner." The determination of what is a "reasonable" fee is fact-based and, while the fees that an insurer may pay to panel counsel to defend similar types of cases may be relevant, it is not dispositive as it is presumed that panel counsel discount their fees in return for a guaranteed volume of work from insurers.

Comment b. had originally stated that in the event of a dispute over fees, the insurer was obliged to front the full cost of defense subject to a right to bring a claim for recoupment against defense counsel (not the insured) after the litigation was concluded. This proposal proved extremely controversial and was dropped when Council Draft No. 1 was put forward in 2015.

§ 18: Terminating the Duty to Defend a Claim

Section 18 enumerates the situations in which an insurer may withdraw from the defense of a case that it was originally obligated to defend:

- (1) An explicit waiver by the insured of its right to a defense of the action;
- (2) Final adjudication of the action;
- (3) Final adjudication or dismissal of part of the action that eliminates any basis for coverage of any remaining components of the action;
- (4) Settlement of the claim that fully and finally resolves the entire action;
- (5) Partial settlement of the action, entered into with the consent of the insured, that eliminates any basis for coverage of any remaining components of the action;

- (6) If so stated in the insurance policy, exhaustion of the applicable policy limit;
- (7) A correct determination by the insurer based on undisputed facts not at issue in the legal action for which the defense is sought, as permitted under § 13(3); or
- (8) Final adjudication that the insurer does not have a duty to defend the action.

Comment d. states that a partial adjudication may end the duty if the covered causes of action are resolved and rights of appeal are extinguished. Further, if so stated in the policy, exhaustion of the applicable policy limit will eliminate any continuing duty to defend.

§ 19: Consequences of Ordinary Breach of the Duty to Defend

Section 19 provides that “an insurer that breaches the duty to defend a legal action loses the right to assert any control over the defense or settlement of the action.” Further, it originally provided that an insurer that failed to defend lost the right “to contest coverage for the claim.”

This aspect of Section 19 met with vehement opposition by insurers, who variously pointed out that the proposed estoppel rule was very much a minority rule inappropriate for a Restatement; that the proposal was at odds with how the Restatement of Contracts addressed the damages consequent to a breach and that, in fact, many states had adopted contract-based remedies for an insurer’s failure to defend that seemed to have addressed the problem without the draconian solution that the Reporters envisioned.

Shortly before the Advisors’ meeting in October 2015, the Reporters withdrew the original text of Section 19(1) and instead proposed that insurers should only lose the right to raise defenses to indemnity if their failure to defend lacked a reasonable basis. This proposal was the subject of intense discussion prior to and during the Advisors Meeting and was eventually adopted in Council Draft No. 2 that was promulgated on December 28, 2015.

§ 20: When Multiple Insurers Have a Duty to Defend a Claim

Where more than one insurer has a duty to defend, that duty is joint and several notwithstanding any term in any insurance policy that purports to establish a priority of responsibility for the defense among the insurers except as provided in the exceptions detailed in Section 23.

Where multiple insurers have a duty to defend, the policyholder may choose one except as provided in the following section. If that insurer refuses to defend, it is subject to the estoppel consequences provided in Section 19 and the policyholder may select another to defend. In such circumstances, “only the selected insurer has the right to defend the claim” although it may seek contribution from any non-selected insurer for the costs of defense and any judgment rendered. Nevertheless, other insurers whose obligations to defend would otherwise have arisen will have the right to associate in the defense.

Section 20 purports to present a practical approach to ‘other insurance’ disputes. It states an insured may select any of its insurers to defend, without regard to “other insurance” wordings. It is then up to the designated insurer to sort out whether there is another insurer that properly should provide the defense and, if so, to make sure that the proper insurer in fact provides the defense. Section 20 does provide limited deference to “other insurance” clauses if

[T]he policies establish an order of priority of defense obligations among them, or if there is a regular practice in the relevant insurance market that establishes such a priority, that priority will be given effect...

Although Section 20 allows insurers to “tender” their defense to a designated insurer, there is an important distinction between this approach and Illinois’ “targeted tender” rule. As noted in Comment d., Section 20 allows the targeted insurer to obtain contribution from other insurers whereas the Illinois approach requires the targeted insurer to bear full responsibility for the claim and precludes claims for contribution from other carriers.

§ 21: Insurer Recoupment of the Costs of Defense

Section 21 provides that, unless an insurance policy expressly states otherwise, insurers have no right to seek reimbursement for defense costs “even when it is subsequently determined that the insurer did not have a duty to defend or pay defense costs.” This is the default rule. Comment a. also states the history of this rule, observing that, “[f]or many years it was assumed that existing insurance policies did not grant insurers a right of reimbursement. This assumption was challenged in litigation starting in the latter part of the 20th century.” The Comment discusses the traditional “contractual approach” and the more recent “equitable rule” which some courts have adopted, allowing insurers to seek reimbursement for claims found to fall outside of coverage. Comment c. summarizes the underpinning of this Section based on the “more recent trend”:

The early understanding and the more recent trend, however, treat reimbursement as a contractual right that must be explicitly stated in the policy. No courts or commentators adopting or advocating the equitable approach contend that an insurer is prohibited from disclaiming the right to reimbursement. Thus, under both the equitable and contractual approaches, the baseline legal rule is merely a default rule.

Comment c. acknowledges that barring a right to reimbursement may discourage insurers from voluntarily undertaking the defense of claims that are probably not covered. However, it also notes that parties may contract around this default rule by entering into separate agreements to allow reimbursement in return for the insurer’s promise to defend. .

If an insurance policy sets forth such a right, the insurer may seek reimbursement only under the following conditions set forth in Section 21(2):

- (i) the insurer has reserved its right to seek reimbursement in accordance with Section 15;

- (ii) the underlying claim has been resolved; and
- (iii) a determination of no coverage has been made.

The Reporters acknowledge (but not agree) that this “no recoupment” default rule is at odds with Section 35 of the Restatement (Third) of Restitution and Unjust Enrichment, which does allow for equitable restitution under analogous circumstances.

§ 22: Defense Cost Indemnification Policies

This Section provides that defense cost indemnification policies that oblige the insurer to pay defense costs on an ongoing basis should be treated in the same manner as policies containing standard duty to defend language.

§ 23: The Right to Associate in the Defense of a Claim

It is not uncommon for certain types of liability insurance policies, particularly excess policies, to give an insurer the right to “associate” in the policyholder’s defense even when the insurer has no contractual duty to defend. Section 23 provides that, in such cases, the insurer is entitled to receive information from defense counsel that is necessary to assess the policyholder’s liability so long as the information in question does not include confidential information concerning coverage issues. The insurer should also be afforded “a reasonable opportunity to be consulted regarding major decisions in the defense of the claim that is consistent with the insurer’s level of engagement with the defense of the claim.”

Topic 2 – Settlement

§ 24: The Liability Insurer’s Duty to Make Reasonable Settlement Decisions

Section 24 addresses settlement when either a liability insurer has the authority to settle a claim against the policyholder or the policy grants the insurer a right to consent to a settlement negotiated by the policyholder. It provides that the insurer has a duty to the policyholder to make reasonable decisions but stipulates that this duty pertains only to claims that potentially exceed policy limits. The Section defines a “reasonable settlement decision” as “one that would be made by a reasonable person that bears the sole financial responsibility for the full amount of the potential judgment and the costs of defending a claim.” Subsection (3) provides that this duty extends to accepting reasonable settlement demands made by plaintiffs with a proviso that the insurer’s liability is “never greater than policy limits.” The duty also includes the “duty to contribute its policy limits . . . if that settlement exceeds those policy limits.”

Comment a. describes the rationale for these rules as follows:

The objective is to encourage liability insurers to make efficient and equitable settlement decisions. In addition, because insureds are generally more risk adverse than insurers, this rule maximizes the joint well-being of the parties by shifting the risk of excess judgments from insureds to insurers.

The purpose of the duty to make reasonable settlement decisions is to align the interest of insurer and insured in cases that expose the insured to damages in excess of the policy limits. Therefore, the duty is owed only with respect to cases that expose the insured to such damages.

Comment b. refers to this principle as a “long-standing rule of insurance law.” The Comment observes that the Reporters use the term “duty to make reasonable settlement decisions” instead of the more common term “duty to settle,” to emphasize their view that insurers do not have a duty to settle every claim but, rather, “to make reasonable settlement decisions.” It emphasizes that insurers “may reject unreasonable settlement demands,” as defined in Section 24(2) of the black-letter. The reasonableness standard is “flexible,” permitting the finder of fact “to take into account the whole range of reasonable settlement values.” This range includes consideration of whether an insurer made reasonable offers and counteroffers.

Comment f. specifically distinguishes between an insurer’s rejection of a reasonable settlement demand and its failure to make a reasonable offer at all:

A rejection of a reasonable settlement demand automatically subjects the insurer to liability for any excess judgment. By contrast, the insurer’s decision not to make a reasonable offer, or counter-offer, is merely evidence of unreasonableness on the part of the insurer from which a trier of fact may or may not conclude that the insurer is subject to liability for an excess judgment.

Comment f. makes plain that this difference rises from differences in proof of causation. When an insurer rejects a reasonable settlement demand leading to an excess judgment against the policyholder, causation is plain. It is less clear when an insurer fails to make any offer or counter-offer. This rule applies to both duty to defend and defense costs indemnification policies.

Comment g. acknowledges the argument that these rules may “hamper negotiation strategies by liability insurers in settlement discussions, to the detriment of policyholders as a whole.” The Comment uses several examples. For instance, Comment g. points to a possible refusal by a reasonable insurer to make any settlement offers until the claimant has submitted one “because doing so produces a lower all settlement figure (provided the case ultimately settles) or because doing so forces the claimant to reveal through its settlement demand information about the case that might be of use to the insurer in the defense.” The Comment acknowledges that insurers may be reluctant to pursue such strategies because of the risk of an excess judgment. As a result, the Comment notes that “[s]uch bargaining practices may tend to produce lower settlements on average, a fact that can lead to lower overall liability insurance premiums.” These are facts that “would merely be evidence of a lack of reasonableness on the part of the insurer to be considered by the trier of fact along with other evidence”

Section 24 rejects this perspective for several reasons. The Comment states, as a first reason, that “minimization of liability insurance premiums is not the primary objective of the duty to make reasonable settlement decisions. Rather, the primary objective is to protect

insureds from the conflict of interest inherent in the standard less-than-full-coverage case where the insurer has the sole settlement discretion.” The rule also does not prevent liability insurers from rejecting settlement demands or refusing to make settlement offers. “Rather, the rule simply imposes on insurers (and, thus, the insurance pool) the risk of being wrong in making that determination in individual cases.” Section 24 specifically includes both the amount of the potential judgment and the costs of defending a claim in its definition of “reasonable settlement decision.”

Comment h. notes various reasons why defense costs should be considered in the definition of a reasonable settlement decision but ultimately concludes that they should not be and that doing so would impose a duty on insurers to pay “nuisance value” in most cases.

Comment m. observes that the issue of whether an insurer has failed to make a reasonable settlement decision is not the same as whether an insurer has acted in bad faith or breached the implied duty of good faith and fair dealing as liability for failing to make a reasonable settlement decision does not require proof of bad intent. The Reporters observe, therefore, that the issue is one of “reasonableness” and not a question of “good faith” or “bad faith.”

Comment n. states that the insurer’s duty is owed only to its policyholder and that while an excess insurer may have a right of action to “subrogation,” an insurer’s duty here is to the policyholder, not the excess insurer. Nor, as Comment o. states, is the duty owed to tort claimants; they typically have no right to bring direct actions against the insurers based upon a failure to negotiate settlement. This is not, of course, the rule in all jurisdictions. *See, e.g., Rhodes v. AIG Domestic Claims, Inc.*, 461 Mass. 486 (2012) (awarding doubled damages to accident victim based on insurer’s failure to effectuate a settlement in case where insured’s liability was clear. This Section “follows the majority rule.”

§ 25: The Effect of a Reservation of Rights on Settlement Rights and Duties

Apart from cases that insurers do not settle given their evaluation of the insured’s potential liability, insurers are reluctant to pay to settle cases that are not covered in whole or in part. Faced with the conflict between an insurer not having any duty to pay to settle cases that are not covered and the need to protect the insured from potentially catastrophic exposures, some courts have granted insurers the right to recoup that portion of the settlement that is later found not to be covered. However, Section 25 precludes recoupment in such circumstances “unless specifically provided for in the policy or the insured has otherwise agreed.”

Further, Section 25 confirms the insured’s right to settle without waiving its rights to later get coverage for its payment. Section 25(3) states that a policyholder may settle without the insurer’s consent so long as:

- (i) the insurer is made aware of the proposed settlement;
- (ii) the insurer withdraws its reservation of rights;
- (iii) a reasonable person would have accepted the settlement; and

- (iv) if the settlement includes uncovered damages, that portion of the settlement is reasonable.

Comment a. states that an insurer has no duty to settle uncovered claims, but an insurer's reservation of rights does not eliminate its duty to make reasonable settlement decisions. Again, as with Section 17, the insurer bears the risk of liability for an excess judgment when, at trial, its decision is found to be unreasonable or it rejects an offer to settle within limits.

As with the discussion of an insurer's right to recoup defense costs, Comment c. discusses a perceived inconsistency between insurer arguments that policyholders are otherwise unjustly enriched by receiving settlement payments to which they are not contractually entitled and the discussion of unjust enrichment in Section 35 of the *Restatement (Third) of Restitution*.

§ 26: The Effect of Multiple Claimants on the Duty to Make Reasonable Settlement Decisions

A situation in which there are more claimants than policy limits can raise difficult questions of timing and entitlement to its proceeds, particularly when an insurer has not paid defense costs as they are incurred. Courts have struggled to identify appropriate rules to govern such situations. Does the insurer in such cases act in bad faith if it pays its full limit to settle some of the cases but not all? Alternatively, if the insurer is unable to settle all of the claims, does the insurer nonetheless have a duty to settle such claims as it can?

The answer, according to Section 26, is interpleader. Thus, the Reporters state that an insurer has a duty to make "a good-faith effort to settle the claims in a manner that minimizes the insured's overall exposure." The insurer may satisfy this duty by "joining all affected claimants in the underlying action and tendering its policy limits to the court" with a motion to allocate the limits "among the claimants on the basis of the relative value of their claims."

If a claimant in such a situation rejects a portion of the policy limits offered in full satisfaction of its claim, the insurer's duty to defend remains in effect until the claim is settled, the claim is finally adjudicated, or a court finds that the insurer does not have a duty to defend.

§ 27: Damages for Breach of the Duty to Make Reasonable Settlement Decisions

Section 27 provides that an insurer that fails to make a reasonable settlement decision is liable for the entire amount of the judgment, not just the amount within its policy limits. Furthermore, the insurer may be liable for "any other reasonably foreseeable harms." If there is an excess judgment, this liability encompasses possible liability for emotional distress. This rule applies only if there is an excess judgment.

Comment d. discusses the minority rule which limits damages in duty to settle cases "when the insured has insufficient assets to cover the excess judgment." Under this rule, it is assumed that the insured has not been financially harmed because the excess judgment will simply be unpaid. This Section instead adopts a majority rule which measures the policyholder's damages by "the difference between the policy limit and the judgment against the insured." The

Comment cites several reasons for this decision. For instance, although the insured may be judgment-proof, the policyholder will continue to face that debt unless the insured files for bankruptcy or the tort plaintiff waives the debt. The Reporters also note that “the minority rule discourages settlement compared with the majority rule.”

Comment e. states that an insurer that fails to effectuate a reasonable settlement is liable for all damages flowing from that failure even if the resulting excess judgment may include elements, such as punitive damages, that would not otherwise have been covered. This is contrary to the view of cases such as *PPG Industries, Inc. v. Transamerica Ins. Co.*, 975 P.2d 652 (Cal. 1999), and *Lira v. Shelter Insurance Co.*, 913 P.2d 514 (Colo. 1996), cited in the Reporters’ Notes. In those cases, state courts in some of the states that do not allow for coverage of punitive damages have ruled that an insurer may not be held liable for award of punitive damages that resulted from alleged failure to settle within policy limits because such damages are not insurable.

The Comments acknowledge the tension between state-law principles barring coverage for punitive damages and the approach set forth in this Section. However, Section 27 expresses “a strong public policy in favor of encouraging reasonable settlement decisions by liability insurers.” Including punitive damages as an element of damages for breach of this duty to make reasonable settlement decisions compensates insureds for “the full harm caused by an insurer’s unreasonable decision” and, thus, “is integral to the regulatory function of the duty.”

§ 28: Excess Insurers’ Right of Subrogation

Section 28 recognizes that an excess insurer may pursue a right of equitable subrogation against a primary insurer for failing to effectuate a reasonable settlement. This appears to reflect the emerging majority view on this issue, although it is not one that is universally accepted.

Topic 3 – Cooperation

§ 29: The Insured’s Duty to Cooperate

Section 29 provides that policyholders have a duty to cooperate with their insurers in:

- (i) “the investigation and settlement of a claim for which the insured seeks coverage;
- (ii) the insurer’s defense of a claim, “when applicable”; and
- (iii) situations in which the insurer associates in the defense.

As the Comments note, the duty to cooperate “serves to align the incentives of insurer and insured,” helping to ensure that the insured has the incentive to aid the insurer in its defense and management of the claim. The duty requires the insured to render “reasonable assistance,” with reasonableness assessed depending on the complexity of the claim, the insurer’s ability to obtain information from other sources, the extent to which the insurer needs the policyholder’s cooperation, etc. Comment c. explicitly states that the duty to cooperate is not intended to

“become a trap for the insured,” and states that an insurer “may not unilaterally withdraw from the defense of a claim based on non-cooperation.” Instead, an insurer must follow the procedure set forth for reserving rights and pursuing a declaratory judgment action in such situations. Similarly, Comment d. states that the duty to cooperate does not obligate the insured to comply with unreasonable requests.

§ 30: Consequences of the Breach of the Duty to Cooperate

Section 30 states that, where an insured has failed to cooperate with its insurer, the insurer may avoid coverage only if the insured’s action has substantially prejudiced the outcome of the case. Further, if the insurer can show that its policyholder colluded with the claimant, the insurer is excused from coverage unless the insured proves that the collusion “if undetected, would not have caused substantial prejudice to the insurer in the outcome of the claim.”

The Comments note that most jurisdictions require an insurer to prove substantial prejudice before a breach of the duty to cooperate will relieve the insurer of its policy obligations. However, a few jurisdictions continue to follow a “strict condition precedent rule under which an insurer may avoid its policy obligations if the insured has materially breached its duty to cooperate.” Comment b. discusses the differing standards that courts may apply to the substantial prejudice test. Some jurisdictions require the insurer to show “a substantial likelihood that the insured’s cooperation would have allowed the insurer to defeat the plaintiffs’ claim.” Other jurisdictions apply a presumption that the insured’s breach of the duty did prejudice the insurer, giving the insured the opportunity to rebut that presumption. This Section follows the “substantial likelihood test” which “sets a high standard for meeting the substantial prejudice requirement,” focusing “on the impact of the failure to cooperate on the outcome of a claim. It is not enough that the insured’s failure to cooperate increase the cost or difficulty of the defense.” The Comments state that the rule in this Section applies the “disproportionate forfeiture principle” in which “a small and minimally blameworthy breach of a condition by an insured does not excuse the insurer from performance, because the harm to the insurer from the breach is so much less than the value of the coverage to the insured.” According to the Comments, this result is both fair and efficient because it protects insureds or policyholders from the exposures for which they “purchase liability insurance: their own negligence.” It is fair, according to the Comments, “because it is consistent with widely accepted proportionality norms, as well as the public policy in favor of compensation of the underlying claimants.”

C. Chapter Three: General Principles Regarding the Risks Insured (Sections 31-45)

Chapter Three represents a comprehensive effort to analyze and apply the building blocks of all liability insurance policies, including (1) the scope of coverage; (2) conditions to coverage; (3) terms affecting the amount that an insurer must pay.

Topic 1 – Coverage

§ 31: Insuring Clauses

Section 31 sets forth the general rules with respect to insuring agreements and states that terms granting coverage are intended to be interpreted broadly and do not depend on their location in the policy for their status.

§ 32: Exclusions

Unlike terms conferring coverage, exclusions are to be read narrowly. A provision in earlier drafts stating that exclusions should generally be read separately from the standpoint of each insured has been deleted. Exceptions to exclusions may not be read to confer coverage not otherwise granted in the insuring clause.

Exclusions requiring proof of intent will generally be interpreted as requiring proof of subjective intent, although Comment d. confirms that insurers may draft around this requirement, as homeowners form exclusions commonly do. Comment d. also points out that subjective intent must be proved by objective evidence and may sometimes be inferred as a matter of law, as in cases of sexual assault.

§ 33: Timing of Events That Trigger Coverage

Section 33 describes the role that “trigger” clauses play in liability insurance, whether in the context of “occurrence”-based policies or “claims made” policies. Comment f. adopts the “injury in fact” approach as the default solution, for long-tail claims, while acknowledging that “injury in fact” may implicate multiple years of coverage depending on the causal circumstances of loss. Comment g. assigns the burden of proof in such cases to insureds, although the burden appears to be light and an insured may be able to compel coverage based on mere evidence of exposure, subject to each insurer’s ability to show that no harm actually occurred in its policy period.

§ 34: Insurance of Liabilities Involving Aggravated Fault

Section 34 declares that it is not against public policy for insurers to pay to defend cases involving aggravated fault, as where an insured acted with intent to cause injury, nor are insurers precluded from paying judgments or settlements in such cases. Insofar as the law forbids insurers from indemnifying cases of aggravated fault, Section 34(2) proposes that insurers pay such losses in the first instance but be allowed to obtain reimbursement from their policyholders.

Section 34 observes that there is little empirical support for the proposition that the availability of insurance may encourage anti-social behavior or that its unavailability is likely to act as a deterrent in such cases. Further, Comment f. rejects the proposition that punitive damages are uninsurable as a matter of public policy, even in cases based on the insured’s own intentional acts.

Topic 2 – Conditions

§ 35: Conditions in Liability Insurance Policies

Section 35 defines a “condition” as an event that “unless excused, must occur, or must not occur, before performance under the policy becomes due.” Whether a term is a “condition” or not does not depend on where it is placed in a policy. Subsection (3) states that a failure to satisfy a condition will generally only defeat coverage if it results in prejudice to the insurer. Earlier language requiring “substantial prejudice” was removed, although Comment e. confirms the Reporters’ view that the prejudice must be “material.”

Comment d. states that the insured’s breach must have impacted the insurer’s ability to protect its interests in a “significant” way; “an increase in the cost or burden of defense or investigation is not sufficient.” Examples of prejudice are “loss of a defense in the underlying claim, a significant increase in the amount of damages or the settlement value of the claim, the destruction of evidence needed for the insurer to prove that the claim is not covered, and the extinction of the insurer’s subrogation rights in a context in which the insurer would have had a meaningful possibility of recovery pursuant to those rights.”

Prejudice is also required to sustain a breach of the cooperation clause, although Council Draft No. 2 is more equivocal on this point than prior drafts, stating that courts have “sometimes” so ruled. Comment g. states, moreover, that prejudice may often be found as a matter of law in cases where the insured has settled before giving notice or is late in tendering its defense. In such cases, the Reporters observe that denying reimbursement for the settlement or “pre-tender” costs would be “proportional” to the insured’s breach.

§ 36: Consent or Approval of Insurer as a Condition

Section 36 addresses instances where coverage is contingent on the insurer giving advance consent, as is the case with indemnity payments and, in some types of policies, defense costs. It provides that the insurer need not give its assent, so long as consent is sought within the time required and a reasonable insurer would have consented.

§ 37 The Exception for Claims-Reporting Conditions in Claims-Made and Reported Policies

Having articulated a general requirement of prejudice for notice conditions in Section 35, the Reporters proceed to carve out an exception for “claims made” policies in Section 37 in light of the different role that such terms play in “claims made” coverage. Section 37 does insist, however, that policyholders be given a “reasonable” amount of time within which to report claims that are received towards the end of the policy period.

§ 38: Circumstances Under Which Anti-Assignment Conditions Are Enforceable

Section 38 distinguishes between the assignment of a specific claim and rights under a policy generally. As to the former, Section 38 states that insureds are free to assign individual

claims. As to the latter, an insured may only enter into such an assignment as part of a merger or other corporate transaction that also transfer financial responsibility, the policy has already expired and the transfer does not materially increase the risk insured by the carrier.

Comment c. also confirms that these rights only extent to liabilities that were already insured under the policy; successor entities may not obtain coverage for pre-merger liabilities.

Topic 3 – Application of Limits, Retentions and Deductibles

§ 39 Policy Limits

Section 39 explain the role of policy limits and the difference between “per occurrence” and aggregate limits.

§ 40 Retentions and Deductibles

Section 40 explains the role of deductibles and self-insured retentions and the principal difference between the two, namely that an insurer’s policy obligations generally do not arise until a retention is satisfied by the insured, whereas an insurer’s duty to defend and other obligations are not contingent upon the insured reimbursing a stated deductible.

§ 41 Number of Accidents or Occurrences

Analyzing the various tests that courts have used to determine whether multiple claims or injured persons trigger one or separate “occurrence” limits, the Reporters have adopted the majority “cause” approach and have made the further important determination that “cause” is based on the source of the insured’s liability and not the process or processes that are the physical cause of the underlying injuries.

§ 42 Excess Insurance: Exhaustion and Drop Down

Section 42 addresses two issues of consequence to excess insurers: (1) what event triggers an excess insurer’s duties and (2) whether insurers must “drop down” following the insolvency of a primary insurer.

Section 42(1) provides that an excess insurer’s duties are not triggered until the underlying limits are exhausted, although Section 42(2) adopts the so-called *Zeig* rule that allows those limits to be exhausted through a combination of sums paid by the underlying insurers and the policyholder. Comment d. states that this is only a default rule and that an excess insurer can draft around the *Zeig* rule by adopting language stating that “liability under this excess policy shall attach only after the underlying insurers have paid the full amount of the underlying limits,” or (2) “coverage under this policy shall attach only after the full amount of the underlying limits have been paid by the underlying insurers.”

Section 43(3) provides that an excess insurer’s duties may not be accelerated by the insolvency of a primary insurer but that the primary insurer’s insolvency does not relieve the excess insurer of its duty to pay the limit that it contracted to pay.

§ 43 Indemnification from Multiple Policies: The Default Rule

Section 43 states that, in most cases, “when more than one insurance policy provides coverage to an insured for a claim, the insurers are jointly and severally liable to the insured under their policies, subject to the limits of each policy.” Insurers may, however, internally allocate their obligations through the use of “other insurance” clauses or similar terms so long as they do not conflict with each other and do not operate to eliminate coverage altogether. Thus Section 43(2) states that “when an insurance policy contains a term that alters the default rule stated in subsection (1), that term will be given effect, except to the extent that the term cannot be harmonized with an allocation term in another policy and provided that there is no more allocation to the insured than there would have been under the applicable policy that is most favorable to the insured with regard to allocation.”

§ 44 Long-Tail Harms and Successive Policies

Despite the preceding section’s adoption of “joint and several” liability as the default rule where two policies insure the same risk, Section 44 carves out an exception for “continuing or repeated harm” that causes injury in successive policies. For these “long-tail” cases, insurer’s coverage obligations are pro-rated on a “time on the risk” basis by dividing their years of coverage by the overall duration of the underlying injury or damage. While recognizing the division of authority on the issue, the Reporters have concluded that “pro rata by years” is the most consistent, simplest, and fairest solution to this problem.”

§ 45 Contribution

Section 45 permits an insurer that has paid more than its share of a judgment or settlement to recover from another insurer that has not paid its fair share so long as the other insurer has not, in the interim, entered into a settlement and obtained a release from the insured. Note that this right of contribution only applies to indemnity claims and does not apply in the not uncommon situation where a carrier settles out early for a small amount.

III. A CRITIQUE OF THE RESTATEMENT

Although the *Restatement of the Law of Liability Insurance* nears its mid-point, there is still considerable uncertainty with respect to key provisions and, perhaps more importantly, what impact it will have in shaping the future course of the common law.

With the promulgation of counsel draft No. 2, the Restatement of the Law of Liability Insurance is nearing completion. From advantage point of lawyers and claims people who handle coverage disputes on behalf of insurance companies, it must be acknowledged that Counsel Draft No. 2 and those portions of Chapters 1 and 2 that have now been approved by the ALI Council are a vast improvement over the original *Principles* text as well as early Tentative Drafts of Chapters 1, 2 and 3. In particular, the *Restatement* no longer contains earlier proposals that would have:

- Permitted coverage by estoppel and waiver.

- Limited an insurer's right to rescind to cases of intentional fraud.
- Imposed vicarious liability for the misconduct of defense counsel.
- Allowed an insured to consult with defense counsel to determine whether a reservation of rights presented a conflict of interest requiring independent counsel.
- Required insurers to front the full cost of disputed rates subject to a remedy solely against the law firm.

Yet despite these improvements there are still several provisions in the *Restatement* that cause grave concern to insurers. In particular, insurers have focused on the following Sections of the *Restatement*.

A. Provisions for Contract Interpretation (Section 3 and 4)

ALI Restatements are generally meant to embrace majority rules unless they are outmoded or impractical to apply. As a result, it is surprising that the project's Reporters have chosen to abandon the "plain meaning" rule of contract interpretation, which is the acknowledged standard for interpreting insurance policies in nearly every state, for a novel "presumption of plain meaning."

The Reporters claim to be threading an intermediate approach between strict application of the "plain meaning" rule and the broader "contextual approach" that allows consideration of all sorts of extrinsic evidence to show ambiguity. The Reporters state that "the presumption in favor of plain meaning set forth in this Section rejects the plain-meaning rule's absolute preclusion of extrinsic evidence regarding the meaning of policy terms that on their face have a single meaning would apply to the claim in question, but accord the language of those terms a significance that the contextual approach may deny them." The Reporters assert, however, that extrinsic evidence should be considered, not to determine whether there is *another* reasonable meaning but rather whether that other meaning is in fact, more reasonable and therefore more reflective of the actual meaning of the policy term than the one evident from the terms of the policy itself. The Reporters suggest that permitting consideration of extrinsic evidence is, in fact, in line with the approach that most courts follow in assessing summary judgment filings and may, in fact, be more efficient if it eliminates the need for a second round of summary judgment practice in the event that ambiguity is considered or determined.

The Reporters also reject the oft-stated proposition that policy terms should be interpreted so as to avoid internal inconsistencies or surplusage. Rather, the Reporters observe that "it must be recognized, however, that insurance policies may consist of components that evolve over time along different paths, are amended or retained because of understandings that develop in the market and in judicial interpretations, or make explicit rights or obligations that the law would imply in any event. As a result, insurance policies frequently contain what might be considered redundancies or surplusage."

Sections 3 and 4 are also troubling in their one-sided aspect. Although the black letter rules seem to promote an approach that permits an evenhanded search for the true meaning of the

parties, the Comments and Reporters Notes, in fact, make clear that this remedy is heavily weighted towards policyholders. Policyholders are free to present a wide-range of extrinsic evidence in support of their proposed interpretation, including evidence of a policy's drafting history; regulatory filings with state insurance departments; other versions of the policy available on the market and expert testimony regarding custom and practice in the insurance industry, the history, purpose, and functions of policy terms and forms of insurance coverage . By contrast, insurers may only present extrinsic evidence that the insured would or should have had knowledge of at the time of contracting! While this might presumably encompass the direct discussions between the insurer and policyholder in the negotiations for coverage, even such course of dealing evidence may be inadmissible: As Comment f. to Section 3 states:

Because the objective of using the extrinsic evidence is to understand the meaning that a reasonable person in this policyholder's position would ascribe to the term, such evidence may only be used against an insured when the policyholder could reasonably have been expected to have been aware of it.

In short, insurers are giving up the certainty and protection of the "plain meaning" rule for an uncertain new regime of contract interpretation that seems more likely to generate ambiguity and delay than facilitate the resolution of coverage disputes.

B. Liability for Conduct of the Insured's Defense (Section 12)

Although Section 12 no longer automatically makes an insurer vicariously liable for the misconduct of defense counsel, it nonetheless opens the door to claims beyond those that are permitted under the rule in most states. Thus, insurers may now be liable for negligence in the selection and supervision of counsel or for failure to ensure that defense counsel have appropriate malpractice insurance limits. Furthermore, as Section 12 states that insurers are likely for the actions of their employees, it leaves open the possibility that insurers may be vicariously liable for the conduct of staff counsel.

C. Liability for Punitive Damages (Section 27)

Section 27 provides that an insurer's failure to effectuate a reasonable settlement within limits makes it liable for all damages flowing from that failure, including punitive damages even if such damages would not ordinarily be insurable. As yet, there is not a single court in the United States that has so found. Nevertheless, the Reporters purport to rely on significant dissents in rulings from the California and Colorado Supreme Courts in which the majority had refused to impose liability on this basis.

D. Trigger of Coverage (Section 33)

Notably, Section 33 does not contain any discussion of what circumstances may serve as an end-point to a continuous trigger. In the absence of such an end-point, an insured might argue that it can obtain coverage for continuing losses even after the losses ceased to be fortuitous, as where the insured has already been sued or put on notice of its claimed liability.

While a claim of this sort would mainly be of concern to insurers, policyholders also have need of some sort of ending point. Long-tail liabilities that may be excluded in more recent policies may give rise to significant blocks of years for which the insured must be responsible per the allocation discussion in Section 44 if the triggered coverage block is not cut off at some point.

E. Coverage for Cases of Aggravated Fault (Section 34)

Chapter 3 adopts a rule of subjective intent as a default principle in Section 32 despite the fact that courts around the United States are closely divided with respect to whether to use a subjective or objective standard (or a hybrid standard in many states that distinguish between the meaning of "expected" and "intended"). Further, the Restatement fails to address the significant body of case law in which intent has been presumed as a matter of law in cases of inherently injurious conduct such as sexual assaults.

F. Coverage for Punitive Damages (Section 34)

Although the Restatement reflects the majority rule that coverage should not be barred as a matter of public policy where the insured is merely vicariously liable for the intentional misconduct of its agents or representatives, it goes well beyond the rule in most states in precluding public policy entirely. While the Reporters are to be commended for declaring that such issue should be resolved on the terms of the policy and not principles of public policy, it appears that their treatment of this issue in Section 34 is contrary to the emphasis on public policy in their discussion of whether coverage should be required for instances of intentional harm or other types of aggravated conduct in Section 32.

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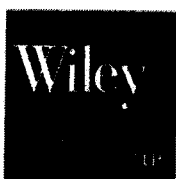
Re: Restatement of the Law, Liability Insurance

Dear ALI Council Members and Emeriti:

I write in my capacity as the American Insurance Association Liaison to the American Law Institute (ALI) Restatement of the Law, Liability Insurance project to urge that, consistent with the ALI process for developing a Restatement, the Council should allow for additional dialogue and consideration of Chapters 1 and 2 of the Liability Insurance project, and defer any final vote approving them until a future Council meeting.

As a Restatement, the project is just one year old. It is addressing a completely new subject for ALI. In its October 2014 meeting, the Council voted to change the project from Principles of the Law of Liability Insurance to the Restatement of the Law of Liability Insurance. This is also new territory. I believe it is the only time in ALI's history that a Principles project has been changed to a Restatement. Members of the Council know that these are very different work products. Principles projects may be based on the Reporters' subjective views of what the law should be. Restatements, in comparison, must be grounded on existing law. In February 2015, just eight months ago, ALI Reporters Professor Tom Baker and Professor Kyle Logue released the first Tentative Draft No. 1 of the Restatement project. The drafts of Chapters 1 and 2 of the Restatement have generated substantial controversy and debate, often focused on whether the positions taken by the Reporters depart too often and too dramatically from the common law and are inconsistent with the mission of an ALI Restatement. Important comments and critiques of some of the Sections of Council Draft No. 1 have been submitted as recently as the past few weeks. Moreover, given the unique nature and circumstances of this project, a special burden falls on the ALI to ensure a careful, deliberative process that sets the right precedent moving forward.

Members of the Liability Insurance project ALI Advisory Committee and the MCG, as well as other commentators, have pointed out that a number of Sections in Chapters 1 and 2 that depart from the common law, sometimes without acknowledging the major changes they would introduce into existing insurance law. Controversial Sections include, but are not limited to, Sections 3 and 4 (policy



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interpretation), Section 12 (insurer liability for conduct of defense), Sections 13, 18 and 19 (duty to defend), Section 21 (recoupment), Sections 24 and 27 (settlement), and Section 30 (duty to cooperate). To demonstrate the serious character of these comments, Attachment 1 to this letter articulates concerns raised about the approach taken in the illustrative listed provisions. These Sections, with the exception of Section 19, have seen little revision, despite the significant scholarship and discussion they have generated. These Sections represent more than a third of the provisions in Chapters 1 and 2, and there are many instances where the Restatement position deviates from the prevailing law and does not set forth a clear and convincing basis for doing so. The draft Restatement also does not discuss extensive contrary law and policy considerations set out in recent submissions made by commentators on the draft. Because the March 2015 meetings of the ALI Advisors and Members Consultative Group took place very soon after the Restatement draft was first released, many -- if not most -- of the highly substantive comments on Chapters 1 and 2 were submitted after those meetings. In light of those comments and materials, I respectfully submit that Chapters 1 and 2 merit additional discussion and review with the ALI Advisors and MCG.

The general public policy path taken to date in the Restatement draft also has been strongly criticized by Yale Law School Professor George L. Priest, who is a nationally recognized expert on the operation of private and public insurance, and the role of the legal system in promoting economic growth and sound public policy. Professor Priest has authored an article analyzing the current approach of Chapters 1 and 2 of the project. The article concludes that, while provisions may seek to put policyholders in a "better position" than they are today, the rules would ultimately make all policyholders worse off by unfairly increasing insurance costs and reducing the availability of insurance. Professor Priest urges that the policy objective of the RLI project should be to develop provisions which maximize the availability of insurance, which would in turn reduce risk levels and benefit society as a whole. Professor Priest's article, titled "A Principled Approach to Insurance Law: The Economics of Insurance and the Current Restatement Project," is available at www.ssrn.com. In an effort to assist those interested in Professor Priest's critique of the RLI project, ALI Member Victor Schwartz of the Shook Hardy & Bacon firm prepared a summary of Professor Priest's article, which is Attachment 2 to this letter.

Consistent with the ALI's publicly-stated process for development of Restatements, the Restatement's aim of providing a clear statement of the common

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law, and the ALI's stated commitment to transparency with respect to the positions adopted in a Restatement, I respectfully submit that Chapters 1 and 2 should be the subject of ongoing discussion and review to incorporate more of the recently submitted comments and scholarship. Allowing for continued dialogue in the Advisors and MCG meetings to be held later this month, in light of the new materials submitted, is most consistent with the ALI mission in creating a Restatement through a process of "engag[ing] the best minds in the profession over an extended period of time, with access to extensive research, testing rules against disparate fact patterns in many jurisdictions." ALI Style Manual, p. 6. Ensuring that there is a full opportunity for debate on the content of the project is consistent with the spirit of the ALI process and can help improve the final Restatement produced as a result of those efforts. Moreover, there remains time for a refined draft to be advanced through the ALI process, fully consistent with the timetable aspired to for this project.

As the American Insurance Association's liaison to the project, I look forward to continuing to work with the ALI in this effort as the Restatement of the Law of Liability Insurance project progresses.

Very truly yours,



Laura A. Foggan

ALI Restatement of the Law, Liability Insurance Examples of Draft Sections Generating Concern

In the Restatement of the Law, Liability Insurance, Council Draft No. 1, examples of sections that depart from the common law, sometimes without even acknowledging that they would dramatically alter existing insurance law, include at least the following:

Section 2: Insurance Policy Interpretation and Section 3: Presumption in Favor of Plain Meaning

There is serious concern that these sections depart from black letter law that an insurance policy term is given its plain meaning. They proscribe rules where the plain meaning of a policy term can be overcome by extrinsic evidence, essentially eliminating certainty and guidance for everyone and inviting unnecessary and expensive collateral litigation. Section 2 is the introductory section proscribing the rules for interpreting insurance contracts. It starts down a slippery slope with respect to ordinary rules of contract interpretation by stating that they apply to the interpretation of liability insurance policies "[e]xcept as this Restatement or applicable law otherwise provides." In other words, Section 2 foreshadows and allows for departures from ordinary rules of contract interpretation throughout the Restatement. Section 3(2) states that "An insurance policy term is interpreted according to its plain meaning, if any, unless the court determines that a reasonable person would clearly give the term a different meaning in light of extrinsic evidence. That different meaning must be one to which the language of the term is reasonably susceptible after consideration of the extrinsic evidence." Section 3(2) has been heavily criticized for deviating from the plain meaning rule and it has been the focus of concerns about undermining the development of uniform, predictable meanings for insurance terms.

Section 12: Insurer Liability for the Conduct of the Defense

Section 12 addresses the insurer's liability for the conduct of defense counsel when the insurer defends an insured. Section 12(2) would impose liability on insurers for defense counsel's breach of a professional obligation when the insurer negligently selects or supervises defense counsel. However, courts generally treat defense counsel as independent contractors with respect to insurers, even if insurers are paying the defense. Further, a majority of the jurisdictions that have addressed this issue have held that insurers are not vicariously liable for the acts of defense counsel that are independent contractors. The current draft adopts a minority position that is at odds with recent rulings, as well as the prevailing view.

Section 13: Conditions Under Which the Insurer Must Defend

Black letter law throughout the country allows an insurer to rely on extrinsic facts on ancillary matters such as insurance contract formation, conditions precedent and the like, in denying a duty to defend. Any suggestion that an insurer could not deny a defense based on grounds such as late notice, misrepresentation or failure to cooperate because those defenses require reference to extrinsic facts would be wildly inconsistent with the black letter law. Section 13 must make clear that it adheres to this settled principle, and that its discussion of the limits of extrinsic evidence and the consideration of all facts and circumstances does not alter this well-established law. To do so, it would be necessary for Section 13(3) to state that it limits

only the insurer's ability to deny coverage based on extrinsic evidence contradicting the complaint, and does nothing to interfere with the basic proposition that an insurer may deny coverage based on extrinsic facts on ancillary matters not addressed in the complaint at all, such as policy compliance and conditions precedent to coverage. Any other approach would wildly swing away from settled law on insurers' ability to rely on contract terms in denying a duty to defend, such as those requiring prompt notice and cooperation.

Section 18: Terminating the Duty to Defend

In contrast to the existing common law rule, Section 18 provides that a duty to defend terminates only when one of eight subsections are met. Unless one of the circumstances in Section 18(1)-(7) is present, Section 18(8) encourages, if not requires, insurers to seek an explicit judicial determination "that the insurer does not have a duty to defend the claim." This rule fundamentally alters the terms of insurance contracts and contradicts black letter law. It would amount to a windfall for insureds—who would continue to receive a defense potentially far beyond what they bargained and paid for while insurers await a court determination on the duty to defend. Going forward, it would result in more expensive premiums, as the rule would encompass a duty to defend that exceeds the terms of the contract. More than 60 years ago Learned Hand wrote, "[i]t follows that, if the plaintiff's complaint against the insured alleged facts which would have supported a recovery covered by the policy, it was the duty of the [insurer] to undertake the defence [sic], until it could confine the claim to a recovery that the policy did not cover. *Lee v. Aetna Cas. & Sur. Co.*, 178 F.2d 750, 753 (2d Cir. 1949) (emphasis added). At some point, in every defense, the duty to defend must cease. It has long been recognized that, once an insurer has "confine[d] the claim to a recovery the policy did not cover," the duty has ceased. *Lee*, 178 F.2d at 753. Section 18 seeks to prolong the duty, until a court determines that it has ceased; this contradicts existing law and goes beyond the obligation the insurer assumed and beyond the protection for which an insured bargained.

Section 19: Consequences of Breach of Duty to Defend

For Section 19, the Restatement black letter rule should be that the breach of a duty to defend results in contract damages, consistent with the weight of authority. A deviation from the contract damages rule is not supported by a trend in the law, a modern view, or any empirical evidence demonstrating a need for change in the law. Moreover, as written, Section 19 would impose punitive liability on an insurer without regard to the actual contract damages incurred by the policyholder. It creates a problem of disproportionate outcomes, by lacking any nexus between the "remedy" of losing the right to contest coverage and the actual harm demonstrated, if any. And, it would create incentives for a policyholder to "set up" an insurer in the hopes of producing some type of breach and thereby obtaining indemnity for an uninsured loss. Section 19 does not tie its application to an insurer that materially breaches the duty to defend, and the Restatement makes clear that a variety of actions may constitute a breach of the duty to defend, creating serious concerns about an immaterial breach — easily cured or curable — leading to draconian results. Insurers have significant incentives to undertake the defense of a potentially covered claim, in defense costs savings, the reduction in settlement or judgment amounts attributable to an insurer-controlled defense, and the avoidance of the costs of an action for breach of the duty to defend. But Section 19 seems to be based on the erroneous premise that an insurer may intentionally seek to escape its defense obligations rather than fulfill them. That

premise of a bad actor is without foundation, and cannot justify a forfeiture rule. Any incidence of purposefully wrongful conduct will be covered in later sections of the Restatement.

Section 21: Insurer Recoupment of Defense Costs

In adopting the minority view in a sweeping rule that would prohibit recoupment in all circumstances where there is no explicit contractual agreement permitting it, Section 21 of the draft turns too far away from articulating black letter law as it stands. To the extent this section is seeking to “ascertain the relative desirability of competing rules” (ALI Revised Style Manual, January 2015), a Restatement provision reversing the majority common law approach to recoupment is unsound because it is not a subtle change in the law, but a major one -- and this change is not supported by reliable empirical analysis or a clear trend in direction of the law. Further, adherence to the majority view allowing recoupment is justified based on coherence with other precedents -- such as the ALI’s own Restatement Third, Restitution and Unjust Enrichment (R3RUE) -- and the law as a whole. The Restatement should adopt the majority view, providing a default rule allowing recoupment of the costs of defense when a court later determines that an insurer advanced costs under a reservation of rights for an uncovered claim. As it stands, the Restatement does not even give courts the flexibility to apply equitable considerations and reach just results with respect to recoupment claims taking into account the individual circumstances of each claim.

Further, it is unsound to suggest that a right to recoupment should only be recognized if explicitly provided for in an insurance policy. By definition, recoupment claims arise in a situation in which the insurer never had a duty to defend under the terms of its insurance policy. Because the insurance policy imposed no defense obligations, and the costs of defense were not incurred pursuant to the insurance policy’s dictates, that policy’s terms are irrelevant for determining the insurer’s right to recoupment. In Section 21, a right to recoupment should be recognized consistent with the prevailing view in the existing case law. Unfortunately, the approach in the draft Restatement is not to recognize a right to recoupment in all cases, thus rejecting the majority view. It turns the majority view on its head and rejects recoupment across the board.

Section 24: The Insurer’s Duty to Make Reasonable Settlement Decisions, and Section 27: Damages for Breach of the Duty to Make Reasonable Settlement Decisions

Sections 24 and 27 of the Restatement of the Law of Liability Insurance, taken together, would rewrite existing law and transform the negotiation of settlements, to the major advantage of claimants. Section 24 appears to impose automatic liability on an insurer who rejects a settlement demand later found to be anywhere within a range of “reasonable” values if there is an excess judgment. In addition to the insurer’s decision whether or not to accept a given settlement offer that is the focus of Section 24, courts considering the reasonableness of settlement demands and offers generally consider a number of factors including but not limited to the potential damages award, the plaintiff’s likelihood of success in proving liability, whether the insurer conducted a good faith investigation, whether the insurer considered advice of counsel and whether the insurer informed the policyholder of the settlement offers. For excess liability to attach, courts also generally require proof that the insurer’s conduct caused the resulting excess judgment, both proximately and in fact.

Under these sections, moreover, the policyholder may recover the full amount of damages assessed against it in the underlying suit, without regard to policy limits. Further, the insured may also recover for “any other foreseeable loss,” which under the Restatement draft would include loss of business reputation, emotional distress and punitive damages awarded against the insured. There are many aspects of these sections that are at odds with prevailing law. For instance, an insurer weighing a settlement offer is not obliged by the policy to consider possible harm to the insured’s business reputation from an adverse judgment. *Parking Concepts, Inc. v. Tenney*, 83 P.3d 19, 26 (Ariz. 2004). It would be inconsistent to include this loss as an element of damages because the insurer’s decision not to accept a settlement offer is not the cause of any harm to business reputation. Rather, that loss resulted from the conduct of the policyholder that gave rise to the lawsuit as well as to the adverse judgment. Section 27 also is at odds with the common law and the public interest in providing that payment for the insured’s punitive damages may be passed on to the insurer. Allowing the recovery of punitive damages would permit the insured to “shift to its insurance company, and ultimately to the public, the payment of punitive damages awarded in the third party lawsuit against the insured as a result of the insured’s intentional, morally blameworthy behavior against the third party.” *PPG Indus., Inc.*, 975 P.2d at 658. As the California Supreme Court explained in the *PPG Industries* case, “No allow such recovery would (1) violate the public policy against permitting liability for intentional wrongdoing to be offset or reduced by the negligence of another; (2) defeat the purposes of punitive damages, which are to punish and deter the wrongdoer; and (3) violate the public policy against indemnification for punitive damages.”

Section 30: Consequences of the Breach of the Duty to Cooperate

Under Section 30, a policyholder’s breach of the duty to cooperate relieves the insurer of its obligations under the policy “only if the insurer demonstrates that the failure caused substantial prejudice to the insurer in the outcome of the claim.” This rule formulation is not supported by existing case law and represents unsound public policy. Section 30 eviscerates the contractual obligation of the insured to cooperate with insurer because, even if the insured breaches that duty, under the draft Restatement the insurer has no recourse unless the insurer can show “substantial prejudice to the insurer in the outcome of the claim.” Most courts allow an insurer to be relieved of its policy obligations if the insurer is able to show “actual prejudice” from the insured’s failure to cooperate. See *Darcy v. Hartford Ins. Co.*, 554 N.E.2d 28, 33 (Mass. 1990) (surveying cases). Further, courts have long appreciated that purposeful misconduct by a policyholder at any point in the handling of a claim can cause substantial harm to an insurer that is deserving of relief. They have not limited the consequences of a policyholder’s breach of the duty to cooperate only to impacts on the claim’s “outcome.” In addition, the requirement that an insurer await the “outcome” of the claim before being able to allege a breach of a policyholder’s duty to cooperate would be impractical. Once the final “outcome” is known, a subsequent claim for breach of the policyholder’s duty to cooperate would needlessly extend litigation that could have been resolved much earlier and in a manner that minimized instead of exacerbated the harm caused to the insurer.

Summary of Professor George L. Priest's Forthcoming Law Review Article on the *Restatement of the Law of Liability Insurance*

By Victor E. Schwartz*

I. Introduction

For decades, Yale Law School Professor George L. Priest has researched and written about important issues in insurance law and policy. This scholarship has made him an internationally recognized expert on the operation of private and public insurance, and the role of the legal system in promoting economic growth and sound public policy. He has also instructed some of the nation's brightest legal scholars on the subject of insurance law and policy. Thus, when Professor Priest "takes on" a topic of insurance law, the legal and academic community pays attention.

Recently, Professor Priest has focused his attention on the American Law Institute (ALI) Restatement of the Law of Liability Insurance (RLI) project. This first-of-its-kind ALI project was commissioned to "restate" the most sound legal rules from existing case law on a wide range of insurance law topics. Professor Priest has monitored the development of this project and found that a number of the project's proposed legal rules would adversely impact insurance operations, causing harm to insurers, policyholders, and society as a whole.

Professor Priest has prepared a law review article analyzing the first two chapters of the four chapter RLI project and its public policy implications on the cost and availability of insurance. The forthcoming article – a draft of which is available at www.ssrn.com – is titled, "A Principled Approach to Insurance Law: The Economics of Insurance and the Current Restatement Project." The article incorporates highly complex economic analyses, assumptions, and terminology. In an effort to assist those interested in Professor Priest's critique of the RLI project, I have prepared the following summary.

II. The Importance of Maximizing the Availability of Insurance

Professor Priest's fundamental criticism of the current RLI project is its failure to recognize just how vital, from an economic and public policy perspective, it is to develop insurance law rules with an eye towards promoting greater availability of insurance. According to Professor Priest, "the most important objective of the law governing liability insurance is to maximize the availability of insurance." He states that this objective "helps all of society," and, in particular, low-income individuals whose entry into the insurance market allows more people to obtain the benefits of coverage and reduces costs for existing policyholders.

As Professor Priest explains, the RLI project gives short shrift to this objective, and, instead, puts forth unsound rules that would reduce a person's ability to acquire insurance. He states that the RLI project's two authors (called "Reporters") have developed what they believe to be "pro-policyholder" rules; rules that, by and large, would require insurers to pay more claims and pay greater amounts per claim.

Professor Priest explains that the fallacy in the Reporters' basic approach to the RLI project is that these unwarranted "pro-policyholder" rules would benefit only a small number of policyholders in the short-term. In the long-term, all policyholders would be disadvantaged because such rules would effectively require insurers to increase their premiums to cover the costs of paying more claims. These needless cost increases would price some policyholders (e.g. low-income policyholders) out of the insurance market; a result that would further increase insurance costs on the remaining smaller pool of policyholders.

In Professor Priest's view, the failure of the RLI project Reporters to develop rules that account for these economic realities stems, in part, from an incorrect view of insurance as purely a means to redistribute risks from one party (a policyholder) to another (an insurer). Professor Priest shows that the operation of insurance really achieves much more than so-called "risk-spreading"; it can be risk-reducing.

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Professor Priest identifies three specific ways in which maximizing the availability of liability insurance – the goal he believes should be the guiding principle of the RLI project's development – effectively reduces risk levels and benefits society. They include:

1. Aggregation of Risks – An increase in the number of policyholders enables insurers to better predict the likelihood that a loss will occur. As this predictive ability improves, it can reduce the level of risk associated with an injury (and allow for more accurate pricing of insurance policies).
2. Segregation of Risks – An increase in the number of policyholders allows insurers to better distinguish high-risk from low-risk policyholders. By grouping together individuals of similar risks, insurers can reduce the overall level of risk (and better tailor policies).
3. Controlling Moral Hazard – A moral hazard occurs where a policyholder takes more risk knowing he or she has insurance coverage. An increase in the number of policyholders enables insurers to better identify and curb moral hazard through deductibles, coinsurance, or coverage exclusions. Insurers can reduce risk levels by reducing policyholder incentives to engage in risky behavior.

Professor Priest's main critique of the current RLI project, therefore, is that it overlooks these important functions of insurance to reduce risk levels, and instead favors rules that would reduce insurance availability without any demonstrated need to do so. Such a path, he asserts, is unsound public policy.

III. Specific Problem Areas in the New Restatement

Rather than examine every provision in the RLI project, Professor Priest highlights a few to illustrate his concerns. While the Reporters designed these provisions to put policyholders in a "better position" than they are today, the rules would ultimately make all policyholders worse off by unfairly increasing insurance costs and reducing the availability of insurance.

1. Misrepresentation – Professor Priest discusses the RLI project's early treatment of misrepresentation doctrine as a cautionary tale. The RLI project had proposed to change the traditional common law rule allowing an insurer to rescind a policy based on a policyholder's misrepresentation. Although this rule is supported by "good economic reasons," the Reporters wanted to add a requirement that a policyholder must intentionally or recklessly misrepresent facts.

The proposed rule would have significantly impaired insurers' ability to rescind a policy, increasing insurance costs which would be passed on to all policyholders. Fortunately, controversy generated by this topic – most notably that the proposed approach was not supported by existing case law – prompted the Reporters to adopt the traditional common law rule.

2. Duty to Defend – Professor Priest criticizes the RLI project's "extremely punitive" rules governing an insurer's breach of the duty to defend a claim. These proposed rules would have an insurer forfeit all of its coverage defenses (as provided in the policy), and lose the right to assert any control over the defense or settlement of a claim. Professor Priest explains that this "radical" minority approach would, absent any clear public policy need, require insurers to pay claims not covered under a policy, which would increase costs and reduce the availability of insurance.
3. Duty to Settle – Professor Priest believes the RLI project adopts an improper, overly "formalistic" approach to whether an insurer has acted "reasonably" in attempting to settle a claim. He cautions that this rigid rule could trap insurers and subject them to liability for a broad array of unfair penalties, including punitive damages that have been awarded against a policyholder in an underlying action. He explains that this unwarranted, enhanced liability exposure would increase insurance costs and reduce the availability of insurance.

IV. Conclusion

The core "takeaway" of Professor Priest's forthcoming law review article is that the current RLI project has its priorities misplaced. The Reporters' chief priority is to craft rules benefitting policyholders, but they set out to achieve this goal by unfairly making insurers pay more money, more often. Professor Priest demonstrates that this approach may benefit some policyholders in the short-term, but would hurt all policyholders in the long-term. Professor Priest further states that to correct this problem, the primary objective of the RLI project should be to develop provisions which maximize the availability of insurance. This approach will truly benefit all policyholders.

**The “A-C-Ps” of Liability Insurance:
Allocation, Contribution, and Proration in the *Restatement of the Law of Liability Insurance***

By Lorelie S. Masters¹

In 2010, the American Law Institute (“ALI”) embarked on a project of utmost importance to the insurance industry, to policyholders and consumers, and to insurance coverage practitioners representing policyholders and insurance companies alike. Initially called the *Principles of the Law of Liability Insurance*, the Council of the ALI in late 2014 voted to make this project a full *Restatement*. In this work, now entitled the *Restatement of the Law of Liability Insurance*,² the ALI, as with all of its *Restatements*, seeks to produce a “work of highly competent group scholarship, thus reflecting the searching review and criticism of learned and experienced members of the bench and bar.”³ *Restatements* are written by Reporters who revise their drafts based on input from experts and other parties interested in the subject matter, seeking to capture the consensus of views from various constituencies who represent different perspectives on the subject matter. The *Restatement of the Law of Liability Insurance* thus

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² As a result of the deliberative process discussed in the text of this article, the ALI traditionally has issued *Restatements* on important areas of the law, including the *Restatements of Contracts, Torts, and Conflict of Laws*. According to the ALI’s handbook published in 2005, *Restatements* are “‘clear formulations of common law and its statutory elements or variations,’ reflecting the law as it presently stands or as it might plausibly be stated by a court.” American Law Institute, *Capturing the Voice of the American Law Institute, A Handbook for ALI Reporters and Those Who Review Their Work*, at 312 (2005) (available at www.ali.org/doc/stylemanual.pdf; see also <http://www.ali.org/index.cfm?fuseaction=projects.main>). In contrast, a *Principles* project seeks to declare what the ALI thinks the law ought to be.

³ Quoted from <http://www.ali.org/index.cfm?fuseaction=about.instituteworks> (accessed Jan. 14, 2015). The ALI website also states: “Many Institute publications have been accorded an authority greater than that imparted to any legal treatise, an authority more nearly comparable to that accorded to judicial decisions.” *Id.*

reflects the views on the comprehensive drafts written by this *Restatement's* Reporters⁴ from judges and lawyers on both sides of the issues, academics, policyholders, insurers, and other interested groups.

Even though the *Restatement* may affect businesses broadly, discussions at the Advisors' and Members' meetings, the ALI Council meetings, and ALI General Membership meetings often have focused on the effect that these provisions will have on ordinary consumers. In addition, a key objective of the project, as stated by the Reporters, is to try to reduce the amount of litigation between policyholders and insurers.

This article focuses on a key issue currently under discussion by the Advisors and Members' groups: the **allocation** of liability between policyholders and insurers, and among insurers. The need to apply an allocation rule arises when a continuing course of injury or damage triggers multiple years of occurrence-based insurance coverage. In those situations, insurers often argue that a portion of the policyholder's liability should be assigned, or "allocated," to the policyholder. Allocation between insurers and policyholders is related – but should not be confused with – allocation among insurers and the **contribution** claims among insurers that arise when one insurer has overpaid its share of liability. Courts choose between two general allocation rules: (1) the "all sums," joint and several, or pick and choose rule; or (2) **proration**. Because insurance presents issues of state law, there is no one law on insurance issues. Thus, allocation has been a hard-fought issue in countless insurance coverage disputes in

⁴ The Reporters of the *Restatement* are Tom Baker of the University of Pennsylvania Law School; and Kyle D. Logue of the University of Michigan Law School.

courtrooms, state and federal, across the United States.⁵ It was a topic of keen interest in the discussions held in 2014 about the then-pending drafts of the ALI *Restatement* provisions.

As discussed in this article, the insurance industry for decades has struggled to draft standard liability insurance policy language that will be widely marketable and as profitable as possible, both satisfying policyholders' desire for broad protection while limiting insurers' liability. During the second half of the 20th century, drafting committees set up by the insurance industry, on numerous occasions, declined to include a proration provision in their forms. Such a provision would have served to limit an insurer's responsibility to a portion of the policyholder's liability. This has been true both for comprehensive or commercial general liability ("CGL") insurance sold to businesses and other commercial entities, and for personal lines liability insurance sold to individual consumers. Because primary CGL and personal lines⁶ insurance policy forms must be approved by state insurance commissions before they can be sold to the public, the understanding of the insurance industry in drafting standard-form policy provisions is relevant and should be considered in drafting and approving the *Restatement* provisions governing allocation.

ALI discussions have focused on which allocation rule should be adopted:

- Joint and several or pick and choose allocation – a rule that requires the companies that sold insurance to the policyholder in each year of coverage triggered by an ongoing course of injury or damage to pay in full for the

⁵ Federal courts in the United States resolve insurance coverage disputes under diversity of citizenship jurisdiction.

⁶ Some states require hearings on proposed standardized policy language before approval is granted. Other states employ a "file and use" system which allows the insurers to use provisions upon filing assuming no objection is made or hearing required. Carrie Cope, *New Appleman on Insurance Law*, "Regulation of Policy Forms," ch. 10 (Library ed.) (available at <http://www.lexisnexis.com/legalnewsroom/insurance/b/applemaninsurance/archive/2010/04/19/regulation-of-policy-forms.aspx>). See also, e.g., <http://thismatter.com/money/insurance/insurance-regulation.htm>.

policyholder's liability. The classic joint and several or "all sums" rule of allocation allows for the policyholder to pick from among the triggered years of one policy period to respond to the policyholder's liability; or

- Proration – a rule that allows insurers to assign to the policyholder a portion of the policyholder's liability for a course of injury or damage continuing over a period of years.

Proration permits insurance companies to minimize their liability for a continuing course of injury or damage – and directly contradicts the intent of the standard language drafted by the insurance industry and approved for use by state insurance departments and commissions. It is the thesis of this article, and the strong position of certain policyholder lawyers involved in the ALI drafting process, that the insurance industry should not be allowed to obtain through the ALI *Restatement* process, a result that it has been unable to achieve on its own either through its insurance-industry drafting process or the approval process required by state insurance commissions. Further, adopting a proration rule would, in effect, allow the insurance industry to market liability insurance as broadly protective of liability for injury or damage that takes place over a long period of time; but, when a claim comes in, then allow insurance companies to limit their liability in a way inconsistent with their advertising and marketing to consumers at the time the insurance was purchased.

This article begins with an overview of the ALI process, followed by a discussion of the scope of the *Restatement of the Law of Liability Insurance*. Thereafter, it gives background on the allocation issue and addresses the insurance industry's efforts – ultimately futile – to try to draft a proration clause to be included in primary CGL insurance policy forms that harmonizes both marketing of such standard-form policy language and reduction of risk to insurers. An

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analysis of relevant insurance industry drafting documents shows that, in drafting standard-form CGL policy language, the insurance industry specifically rejected proration under occurrence-based and other insurance policies that are activated by injury or damage that takes place during the policy period. The insurance industry has drafted proration clauses and included them in certain types of liability insurance policies, but has rejected suggestions made by insurer representatives during policy drafting processes that such a clause be incorporated into the CGL Form. The article also surveys the law on "other insurance clauses" which generally has concluded that such clauses do not apply to require proration to the policyholder.

The insurance industry should be held to its word about the intended meaning of its policy language and should not be allowed, through the *Restatement* process, to obtain a result that it could not achieve either through its own policy drafting processes or the state insurance regulatory processes.

The ALI Process

The ALI creates its *Restatement* and *Principles* projects through a dialectic, involving input from a wide variety of sources. Reporters, usually law school professors, are appointed to write the drafts and oversee the dialectical process of reviewing and revising the text, which is comprised of black-letter statements of law, followed by Comments and Reporters' Notes. The groups commenting on the Reporters' drafts typically include:

- Advisors, appointed by the ALI's Council. The Advisors include practicing lawyers from outside law firms and policyholder businesses and insurance companies, judges, academics, insurance brokers, and others with an interest in the subject area;

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- A Members Consultative Group (“MCG” or “Members”), which consists of ALI Members who volunteer their time to the project. Like the Advisors, the MCG includes practicing lawyers from outside law firms and companies, judges, academics, insurance brokers, and others with an interest in liability insurance.
- The ALI’s Council; and
- The ALI’s General Membership.

Altogether, all interested constituencies are included in this dialectical process. For this *Restatement*, those constituencies include judges, professors, academics, law firm lawyers representing both policyholders and insurance companies, in-house counsel from policyholder companies and insurance companies, lawyers from interested groups, and insurance brokers.

The Reporters’ drafts have been discussed at meetings of the Advisors, the MCG, and the ALI Council. They have also been presented to the ALI General Membership at annual meetings of the ALI which are held once a year. After each of these meetings, the Reporters have taken the comments into account, and revised the drafts based on the input received.⁷ The Reporters may make additional revisions depending on the discussion at the full membership meeting, or the membership may vote to approve the text presented. Once approved by the full ALI, the text may be cited and quoted.⁸

⁷ The ALI drafting and revision process is discussed at <http://www.ali.org/index.cfm?fuseaction=about.instituteworks>. After the ALI Council approves a draft, it is presented for debate and discussion as a Tentative Draft to the full ALI Membership.

⁸ ALI website at <http://www.ali.org/index.cfm?fuseaction=projects.main> (“Once it is approved by the membership at an Annual Meeting, a Tentative Draft or a Proposed Final Draft represents the most current statement of the American Law Institute’s position on the subject and may be cited in opinions or briefs (e.g., as *Restatement Third, Trusts*, Tentative Draft No. 6, 2011) until the official text is published.”).

In directing the process, the Reporters of the *Restatement of the Law of Liability Insurance* have sought to encourage efficiency and fairness to both insurers and policyholders, as well as to serve the interest of the public, including individual consumers and small businesses.

The ALI drafting and revision process is discussed at <http://www.ali.org/index.cfm?fuseaction=about.instituteworks>. The Membership may approve a Tentative Draft, subject to revisions agreed to at the ALI's annual Membership meeting; or may refer the Draft to the Reporters for further revision. After all sections are approved by the full membership, a Proposed Final Draft may be submitted to the Council and membership. Once approved by both the Council and the Membership, the ALI publishes the *Restatement* in final.

The Scope of the Restatement

The *Restatement of the Law of Liability Insurance* will ultimately contain four chapters. Chapters 1 and 2 have been written and approved but may require revision given the change in 2014 from a *Principles* project to a *Restatement*. Chapter 1 addresses basic principles of insurance contract interpretation, the doctrines of waiver and estoppel, and the effect of misrepresentations made by policyholders during the application process. Chapter 2 focuses on the obligation of a liability insurer to defend (and pay defense costs), as well as the duty to settle and cooperation issues. Chapter 3, partially written, addresses the scope of insured risks and topics such as trigger, allocation, and important policy exclusions and conditions. Chapter 4 has not yet been written; it will focus on advanced insurance contract issues like choice of law, remedies, bad faith, and enforceability. The public may find the text of the Sections approved to date at http://www.ali.org/index.cfm?fuseaction=publications.ppage&node_id=135.

Chapter 1 was presented as a "Discussion Draft" at the ALI's May 2012 Annual Meeting. Following further drafts and input from the Advisors, MCG, Council, and ALI General

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Membership, the ALI considered "Tentative Draft No. 1" at its Annual Meeting in May 2013. The ALI General Membership then voted to approve Sections 1 through 15 of Tentative Draft No. 1, which included all sections in Chapter 1, "Basic Liability Insurance Contracts Principles"; and the first four sections of Chapter 2, entitled "Management of Potentially Insured Liability Claims." The Sections approved in May 2013 include:

- Interpretation (Chapter 1, Topic 1);
- Waiver and Estoppel (Chapter 1, Topic 2); and
- Misrepresentation (Chapter 1, Topic 3).

In May 2014, the ALI membership voted to approve Sections 16 through 34 of Tentative Draft No. 2. Those topics included the remaining sections of Chapter 2, Sections 12 through 34, which include:

- Defense (Topic 1);
- Settlement (all sections of Topic 2); and
- Cooperation (Topic 3).

The Reporters have now proposed certain changes to the sections already approved are appropriate or required given that the project now is a *Restatement*.⁹

Section 1 of the *Restatement* includes definitions of terms relevant to the *Restatement*.

For example, Section 1 includes a relevant definition, defining "standard form term" as:

A term is a standard form term if it appears in, or is taken from, an insurance policy form (including an endorsement) that an insurer makes available for a non predetermined number of transactions.¹⁰

⁹ Those changes will be the subject of a future Lexis Nexis article addressing the *Restatement*.

¹⁰ Approved when included in the *Principles of the Law of Liability Insurance*, Tentative Draft No. 1 § 1(11), approved by ALI membership in May 2013 (available at

(Cont'd . . .)

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One of the Comments to this definition explains further what constitutes a “standard form term” in an insurance policy:

Unless the circumstances clearly indicate to the contrary, any term that is not specifically negotiated by the parties to the insurance policy is a standard form term. A term contained in an insurance policy form approved for use by an insurance regulatory authority for any insurer is a standard form term, unless the circumstances clearly indicate the contrary. Similarly, a term that is a standard form term in one insurance policy is a standard form term in another policy. An insurance policy term created by an insurance broker or other entity may become a standard form term through such sufficiently regular use in the market that the term is treated by market participants as one of the standard options available for use in the market. A term does not have to be contained in the forms of multiple insurers for it to be a standard form term.¹¹

This Comment gives the term wide applicability. The objective was to give the term a meaning drawn from real-life experience about how standardized insurance policy terms are used in different types of liability insurance and in today’s marketplace where the insurance industry seeks to provide insurance products of wide acceptability and applicability.

Background of the “Allocation” Issue

The two competing approaches to allocation are based on different rationales or analyses:

- The “joint and several” or “all sums” approach typically considers the contract language as a whole; liability insurance’s “dominant purpose of indemnity”¹²; and insurance industry documents and custom and practice – or even “lore” – showing that the insurance industry recognized the applicability of a continuous trigger and rejected proration of any part of that contractual responsibility from the insurer(s)

(. . . cont’d)

http://www.ali.org/00021333/Liab%20Ins%20TD%201_revised%20as%20of%20Jan%202014%20-%20online.pdf
(accessed Feb. 2, 2015).

¹¹ Approved as part of the *Principles of the Law of Liability Insurance* § 1, Comment e (*supra* n.10).

¹² See *Keene Corp. v. Ins. Co. of N. Am.*, 667 F.2d 1034, 1041 (D.C. Cir. 1981) (“*Keene v. INA*”).

to the policyholder. In its purest form, this rule allows the policyholder to pick the year or years triggered by continuing injury or damage that should respond to the policyholder's liability. Other approaches require all triggered insurance policies to share the liability between and among themselves.

- Proration, alternatively, allows the insurance company(ies) to assign a portion of the policyholder's liability to the policyholder. Proration decisions typically ignore or do not consider insurance industry history, custom and practice, and often reject an analysis of the policy language as a whole, applying instead conceptions of "equity" or "fairness" to insurers. Such decisions typically do not focus on the public policy favoring enforcement of contract or the important public policy role served by insurance.¹³

The joint and several/pick and choose rule accords with the intent of the insurance industry in drafting and obtaining regulatory approval for standard-form CGL policy forms¹⁴ and should form the basis of *Restatement* pronouncements addressing "allocation" in insurance policy forms that do not include fully negotiated proration provisions. This intent is evidenced in the historical documentation of the CGL Form, often referred to as the "drafting history." This drafting history has developed over the decades since the 1950s when insurance industry groups

¹³ In part as a result, the Delaware Supreme Court recognized that "[i]nsurance is different" from other forms of contract. *E.I. duPont de Nemours & Co. v. Pressman*, 679 A.2d 436, 447 (Del. 1996).

¹⁴ The insurance industry in 1986 changed the name of these forms from Comprehensive General Liability to Commercial General Liability forms (collectively referred to here as "CGL" policies). This name change did not change the intent of this coverage to cover all risks except those clearly and explicitly excluded. See discussion of drafting documents in the text accompanying footnotes 10-15, 43-48, 76-87, and 90 cited in Lorelie S. Masters & Jordan S. Stanzler, *Insurance Coverage Litigation* § 1.01 (Wolters Kluwer Law & Business, 2000 & Supp. 2015) (hereafter "Masters & Stanzler"). As one drafting document put it in emphasizing the advantages of combining a variety of formerly separate coverages into the CGL Form: "[T]he objective is to cover all hazards not specifically excluded." Albert, *The Comprehensive Liability Policies*, Ins. Couns. J. at 11 (July 1944) (quoted in Masters & Stanzler at 1-35).

periodically revised the industry's standard policy forms, sought regulatory approval for the revised forms and publicized them to insurance buyers. During these revisions, insurance industry representatives collectively discussed how their policies should respond to asbestos and other "long-tail" claims, an issue that grew in importance to the insurance industry during this period. Under the law in the 50 states, the District of Columbia, and the U.S. Territories, insurance companies must file CGL policy provisions with state regulators and obtain regulatory approval before including the provisions in insurance policies.¹⁵

This drafting history should be taken into account in the ALI's deliberations on allocation. While the insurance industry created the documents discussed below in the process of drafting standard policy provisions and obtaining regulatory approval for standard-form CGL policy provisions, the industry uses substantially the same language in most personal lines liability insurance policies, as well as in excess general liability policies and other liability insurance policies. Thus, adopting a proration theory as the preferred or default rule in the *Restatement* would negatively affect consumers who rely on homeowners' and other liability insurance for protection from liability for harm taking place over multiple years, and would equally contradict the insurance industry drafting and regulatory history described below.

As evidenced by insurance company filings with regulators throughout the United States, the standard "occurrence-based" CGL policy agrees to protect the policyholder from liability¹⁶

¹⁵ See citations, n.6 *supra*.

¹⁶ Liability insurance protects a policyholder not just from actual liability, as encompassed in a judgment against the policyholder, but also from alleged liability and the often considerable costs incurred in defending litigation. Liability insurance policies thus protect the policyholders both from settlements and judgments, and from defense costs even if the allegations against the policyholder are "groundless, false or fraudulent." See quotation of duty to defend language in, for example, *Trizec Properties, Inc. v. Biltmore Construction Co., Inc.*, 767 F.2d 810, 812 (11th Cir. 1985); and *Horace Mann Insurance Co. v. Barbara B.*, 4 Cal. 4th 1076, 1086 (1993). The duty to defend applies if there is at least a potential for coverage. See discussion of duty to defend standard and cases in Masters & Stanzler ch. 3.

for injury or damage that takes place during the policy period.¹⁷ In insurance parlance, an insurance policy is “triggered” by such injury or damage if the injury or damage continues over a period of policy years, each insurance policy on the risk while the injury or damage continues is triggered, and each policy is obligated to and intended to provide full coverage up to its limits of liability. Both the policy language and the documents created by insurance industry drafting committees at the times the policy language was drafted confirm this intent, as discussed below.

Support of the Joint and Several Rule in the Standard CGL Policy Form

The insuring agreement of the standard CGL policy provides that the insurance company “will pay on behalf of the Insured “*all sums*” or “*those sums*” that the Insured shall become legally obligated to pay as damages because of bodily injury or property damage to which this insurance applies cause by an occurrence.”¹⁸ The definitions section of standard general liability insurance policies¹⁹ contains the following definition of *occurrence*: “an accident, including continuous or repeated exposure to conditions, which results in . . . property damage . . . neither expected nor intended from the standpoint of the Insured.”²⁰ *Property damage* is defined as

¹⁷ See 7 Steven Platt *et al.*, *Couch on Insurance* 3d § 102.23 (online database updated Nov. 2014) (discussing general rules on trigger of coverage). See also *Montrose Chem. Corp. v. Admiral Ins. Co.*, 897 P.2d 1, *republished* at 913 P.2d 878 (Cal. 1995) (“*Montrose*”) (this general trigger-rule “is followed in every jurisdiction that has considered the issue except Louisiana.”). See also cases cited in Masters & Stanzler § 4.01 nn.2-4.

¹⁸ The insuring agreement from standard-form CGL policies is quoted in various decisions discussed in Masters & Stanzler ch. 4. See, e.g., *Keene v. INA*, 667 F.2d at 1039 (pre 1986 CGL Form (“all sums”)). In most cases, the analysis of the CGL policy as a whole did not change after the 1986 Form was approved for use. It is always important, of course, to check the governing policy language. However, whether insurance policies use “all sums” or “those sums,” the word “sums” remains undefined and “includes no restrictions of the concept of the ‘sums’ which the insurer must pay.” III W. Jeffrey Woodward, Richard J. Scislowski, Maureen C. McLendon, & Jack P. Gibson, *Commercial General Liability Insurance* at XI.C.4 (Int’l Risk Mgt. Institute, 2013).

¹⁹ See Masters & Stanzler, ch. 1, which discusses various parts of the insurance policy.

²⁰ The 1986 and later ISO Forms took the “expected or intended” language out of the occurrence definition and put it into an exclusion. For example, the 1986 Form defines “occurrence” as “an accident, including continuous or repeated exposure to substantially the same general harmful conditions.” For a discussion of the “expected or intended” see Masters & Stanzler, ch. 7.

“physical injury to or destruction of tangible property which occurs during the policy period.”²¹

The CGL policy contains no proration clause.

As shown by these provisions, the “all sums”/“those sums” language is not limited or qualified in any way. The phrase, “during the policy period,” used by insurance companies and by some courts to support proration does not appear in the insuring agreement that defines the grant of coverage. Instead, it appears in the definition of “property damage”; thus, that phrase, critical to insurer arguments, appears in a completely different section of policy form, the “Definitions” section, where it does not modify, and structurally cannot modify, the “all sums” or “those sums” language in the insuring agreement. Unless the insurance policy contains an explicit clause requiring proration to the policyholder, allocation of liability to the policyholder in reliance on the “during the policy period” phrase is an improper reading of both the policy language and the structure or organization of the policy.

Courts have held that, in purchasing CGL insurance policies, policyholders reasonably could have expected them to apply to cover liability from a cause of harm continuing over the years.²² Moreover, as one court explained, where the public purchases standard-form insurance, the policy language should not be subject to “hidden pitfalls”:

Where members of the public purchase policies of insurance, they are entitled to the broad measure of protection necessary to fulfill their reasonable expectations. They are not to be subjected to technical encumbrances or to hidden pitfalls, and their policies are to be construed liberally to the end that coverage is afforded to the full extent that any fair interpretation will allow.²³

²¹ For discussion of relevant policy provisions, see Masters & Stanzler §§ 4.01-4.05.

²² *E.g., Joy Techs., Inc. v. Liberty Mut. Ins. Co.*, 421 S.E.2d 493 (W. Va. 1992) (“*Joy Technologies*”).

²³ *Kievit v. Loyal Protective Life Ins. Co.*, 34 N.J. 475, 482 (1961).

At a minimum, when read as a whole, the insurance policy language has been found to be ambiguous on the issue of allocation. The ALI process should not endorse a rule that construes this ambiguity not in favor of coverage, but against it – and against the insurance industry’s own intent in drafting the standard-form language.

The Insurance Industry Drafting Process

Primary CGL insurance policies, like certain other coverages, are, and historically have been, drafted by committees of insurance industry executives working under the auspices of insurance industry groups. These insurance industry committees since 1971 have been organized in a single entity, the Insurance Services Office, Inc. (“ISO”), an insurance rating bureau that creates insurance rates²⁴ and drafts standard policy forms; in addition, on behalf of member insurance companies, ISO presents those standard forms to state insurance regulators in the 50 states, the District of Columbia, and U.S. Territories for required regulatory approval.²⁵ Standardized policy forms permit insurers to analyze and price the insurance they sell more accurately. Without standardization of insurance policy provisions, insurance companies could not market and sell insurance policies on a mass basis, and insurance would not be as widely

²⁴ ISO also formulates and provides to its member and subscriber insurance companies insurance “rates,” derived from analysis of claims data collected by ISO. Liability (and other) insurance companies buy these ratings and policy drafting and filing services from ISO. Insurance companies use the rates provided by ISO to calculate insurance premiums for the various lines, or types, of insurance sold in the United States. See discussion about ISO at www.verisk.com/iso.html (“Since 1971, ISO has been a leading source of information about property/casualty insurance risk.”) (accessed Jan. 3, 2015).

²⁵ Before 1971, these insurance industry groups were committees of various insurance “rating bureaus,” including the Insurance Rating Board (“IRB”), the Mutual Insurance Rating Bureau (“MIRB”), and the National Bureau of Casualty Underwriters (“NBCU”). These and other rating bureaus merged to create the Insurance Services Office, Inc. (“ISO”), the insurance industry organization that, since 1971, has drafted standard CGL policy forms. See, for example, the discussion of the development of the insurance policy drafting process in Masters & Stanzler §§ 1.02-1.04, 4.02 and in the citations therein.

available to provide the protection against loss that helps facilitate commerce and protect commercial and personal assets on a widespread basis in our modern economy.²⁶

Since its inception, the insurance industry has revised the standard CGL Form periodically to respond to court decisions interpreting certain policy terms, and to make CGL insurance a more attractive, and thus a more marketable, product.²⁷ These forms have been revised, and approved for use by state insurance departments and commissions at various intervals.²⁸ For the purposes of the allocation issue, the 1955, 1966, and 1986 versions of the CGL Form are particularly relevant and discussed here.

These efforts are recorded in many documents produced by insurance industry drafting committees. A sampling of those documents is discussed below.²⁹ Policyholders were not represented on any of the insurance industry drafting committees. In addition, most policyholders, even large commercial policyholders, have little leverage to negotiate different terms, in part because of the importance that the insurance industry attaches to maintaining the uniformity of its policy language and the regulatory process applicable to those policy provisions.

²⁶ See discussion and citations in Masters & Stanzler, § 1.02, 1.04. See also, e.g., the discussion of the insurance industry drafting process in the following court decisions: *In re Insurance Antitrust Litig.*, 938 F.2d 919 (9th Cir. 1991), *aff'd in part, rev'd in part, modified*, 5 F.3d 1556 (9th Cir. 1993), *cert. denied sub nom. Reinsurance Corp. of America v. Calif.*, 509 U.S. 921 (1993) (*Insurance Antitrust*); *American Home Products Corp. v. Liberty Mutual Insurance Co.*, 565 F. Supp. 1485, 1500-03 (S.D.N.Y. 1983) ("*American Home Products I*"), *aff'd as modified*, 748 F.2d 760 (2d Cir. 1984); *Aerojet-General Corp. v. Transport Indemnity Co.*, 948 P.2d 909, 932 (Cal. 1997); *Morton International, Inc. v. General Accident Insurance Co. of America*, 266 N.J. Super. 300 (App. Div. 1991), *aff'd*, 629 A.2d 831 (N.J. 1993).

²⁷ See discussion and citations in Masters & Stanzler §§ 1.02-1.04.

²⁸ See discussion and citations in Masters & Stanzler § 1.02.

²⁹ This discussion is taken from a longer discussion of the drafting history of the CGL policy form relevant to the issues of allocation and proration included in Masters & Stanzler §§ 4.07[A][2] (on trigger of coverage) & [D][1] (on allocation). The drafting history documents quoted in this article have been entered into evidence in public trials, and otherwise over the years have entered the public domain.

The Insurance Industry's Rejection of Proration, Non-Cumulation, and Other Approaches in the 1950s and 1960s

Rejection of Proration in the 1955 CGL Policy Form: Before 1966, the standard CGL policy was written on an “accident” basis, typically without even defining the term “accident.”³⁰ Insurance industry drafters in the late 1950s and early 1960s sought to revise the CGL policy form to provide “occurrence”-based coverage, in order to respond to court decisions that had interpreted the term “accident” to provide coverage for injury or damage that took place over more than one policy period. Many insurance companies during this period were adding “occurrence” wording to their policies by endorsement in any event, given court decisions rejecting their preferred interpretation of “accident” as a “boom event,” limited to one point in time. In addition, policyholders wanted insurance products that would protect them from their increasing exposure to liabilities for injuries and damage that continues over a period of years.³¹

In working to revise the 1955 CGL Form, the insurance industry drafters struggled to secure the marketing benefit of an “occurrence” form for such continuing damage, while at the same time mitigating insurers’ exposure to liability spanning multiple policy years. As part of this effort, the drafting committee members repeatedly considered a variety of different triggers, including a manifestation trigger and a “last exposure” trigger, other concepts like “non-cumulation”³² and “deemer” clauses³³ in addition to allocation clauses.

As summarized in a 1959 drafting document, the insurance industry drafters rejected all of those options:

³⁰ See, e.g., 1955 CGL Form, available at www.lexisnexis.com.

³¹ See discussion of the evolution, and expansion, of tort concepts of liability from *MacPherson v. Buick Motor Co.*, 111 N.E. 1050 (N.Y. 1916) (Kellogg, J.), forward through the 20th century. Masters & Stanzler § 14.03.

³² See discussion of non-cumulation clauses in text accompanying nn.54-56, 83, 88-90 *infra*.

³³ See discussion of deemer clauses in text accompanying nn.82, 84-87 *infra*.

The objections were:

1. When the Claim is Brought
 - a) Injury may be in one policy period and claim in another policy period (This is foreign to the insurance concept.)
 - b) Possibility of collusion.
2. Date Injury Manifestes [sic] Itself
 - a) Inconsistent with what we mean by "caused by accident[.]" This approach may not be adaptable to the "sudden" accident e.g. a stairway accident resulting in a back injury which does not manifest itself for six months.
3. Last Day of Last Exposure
 - a) Principal exposures would often be in other policy period.
 - b) Not possible to determine when the policy coverage terminates.
 - c) Possibility of collusion.
4. Pro Rate
 - a) Generally objectionable, even with language of the following type to prevent pyramiding [sic] of claims and limits: "but in no event shall the coverage be in excess of the highest limits under any policy individual [sic] covering the accident."

The meeting concluded that none of the four proposals would accomplish the desired result.³⁴

³⁴ Minutes of the Joint Meeting on Mutual Bureau and National Bureau Scope of Coverage Subcommittee, at 1-2 (Mar. 3-4, 1959) (quoted in Masters & Stanzler, § 4.07, at 4-153-4-154).

The CGL drafters thus rejected proration in 1959 and did not consider it again until 1964. At that time, one of the three principal drafters of what became the 1966 CGL Form, George Katz of Aetna, distinguished between the two kinds of proration – proration to reduce coverage for the policyholder,³⁵ and proration among insurers after one of them has paid the policyholder.³⁶ In doing so, he made clear that proration to the policyholder, or “claimant,” was not practical:

Mr. Katz . . . went on to explain that prorating cannot be effectuated between the insurer and the claimant. Between two insurers, of course, they would prorate. We cannot ask our Claims Departments to adjust parts of claims; also, we cannot defend our pro rata share of claims, but must defend the entire claim.³⁷

Rejection of Proration in the 1966 CGL Policy Form: After completing the 1966 edition of the CGL Form, the insurance industry drafters³⁸ and other commentators on the new form publicly acknowledged that their revision of the 1955 Form did not provide for proration of policy limits for injuries that spanned multiple policy years.

For example, in 1966, E.R. Woodworth of the Insurance Company of North America confirmed that, with introduction of the “occurrence” based wording, the 1966 CGL Form was designed to protect policyholders against liability for injuries or damage that extends over

³⁵ In this use of the term “proration,” the policyholder cannot collect the entire liability from one triggered insurance policy but receives only a pro rata share from each of a series of policies during the “trigger” period of injury or damage, with no recovery for portions of that period when the policyholder was uninsured or self-insured.

³⁶ That is, the policyholder may collect the entire liability from one policy or insurer (within the policy’s limits) and, thereafter, the paying insurer may spread the loss over the triggered years, either on its own books (if it sold insurance to the policyholder for the other triggered years) or by seeking equitable contribution from the other insurance companies on the risk during the period of continuous injury or damage. The term “proration,” in this sense, is also sometimes called “proration among insurers” or “proration among indemnitors.” In litigation, it typically arises through **contribution claims** by insurers who claim they paid the policyholder more than their share of the liability, and sue other insurers on the risk for contribution or indemnity.

³⁷ Joseph Marrone, Minutes, Joint Forms Committee Meeting, at 11 (Sept. 21-23, 1964) (quoted in Masters & Stanzler, § 4.07, at 4-158.2).

³⁸ See Ch. 2 of Masters & Stanzler for a discussion and citations regarding the drafting process for standard-form CGL insurance policies.

multiple policy periods. The drafters referred to that situation as one that would result in “pyramiding” of limits, meaning that each policy year triggered by a course of continuing injury or damage would be required to respond in full, without proration or apportionment.

The new policy will apply only to bodily injury or property damage which occurs during the policy period and within the policy territory. Coverage will no longer attach [as it did in the 1955 CGL Form] when the accident occurs, but rather when the injury or damage takes place, and will apply, regardless of when the accident took place. This is particularly true, for example, if the injury or damage is from waste disposal, or similar operations, [and] should continue after the waste disposal ceased or operations [are] completed, as can happen. *It could produce losses on each side of a renewal date and, in fact, over a period of years with a separate policy period applying in each year.* Policy limits are renewed every year, and the underwriter may find a rather substantial pyramiding of his liability limits under the new contract for delayed action injuries.³⁹

Richard Schmalz, another primary drafter of the 1966 Form, confirmed that more than one policy period would be triggered to pay when the injury actually takes place over two or more policy periods.⁴⁰ As Mr. Schmalz recognized, the CGL policy contains no clause requiring pro rata allocation because the insurance industry drafters were unable to draft provisions that could apply fairly to all situations, as is necessary in a standard-form policy like the CGL. When the 1966 Form was prepared for release, Mr. Schmalz gave a speech confirming that the revised policy contained “no proration formula”:

The policy applies under the new program to bodily injury or property damage which occurs during the policy period. Inasmuch as the new policies afford blanket occurrence coverage it is possible that where the injury actually occurs over two or more

³⁹ E.R. Woodworth, *New Comprehensive General Liability Policy: The Effect on Contracting Risks* 9 (Apr. 14, 1966) (comments at Cleveland seminar) (quoted in Masters & Stanzler, § 4.07, at 4-128 (emphasis added in quotation in Masters & Stanzler)).

⁴⁰ Richard A. Schmalz, *New Comprehensive General Liability and Automobile Program*, Mutual Insurance Technical Conference (Nov. 15-18, 1965) (quoted in Masters & Stanzler at § 4.07, at 4-128–4.129).

policy periods, the Claims Department will have to make some sort of reasonable allocation to each. *There is no pro-ration formula in the policy, as it seemed impossible to develop [sic] a formula which would handle every possible situation with complete equity.*⁴¹

The policy provisions governing trigger and allocation remained the same when the insurance industry revised the 1966 Form to create the 1973 Form. In the late 1970s, however, the insurance industry again turned to the question of allocation – and, as discussed below, again rejected proration.

Rejection of Proration in the 1970s and 1980s: In the late 1970s, the insurance industry drafting committees revived the effort to draft a proration formula for the standard CGL policy form when a number of insurance companies renewed concerns that the policy language in the 1973 CGL Form was “not desirable because it pyramids the limits available to the insured for losses resulting from continuous or repeated exposures over multiple policy periods.”⁴² These renewed concerns arose in light of the insurance industry’s recognition of its exposure to potential asbestos liabilities. The insurance industry in 1977⁴³ created a “discussion group,” called the Enterprise Liability Study Group, to discuss the industry’s response to the *Borel* decision,⁴⁴ which adopted the theory of “enterprise liability” in the context of asbestos personal injury.

⁴¹ *Id.* (quoted in Masters & Stanzler § 4.07, at 4-158.2 (emphasis added in quotation from Masters & Stanzler)).

⁴² Graham V. Boyd, Jr., “Memorandum to Members of the General Liability Rules and Forms Committee,” at production #610004324 (Apr. 18, 1978) (enclosing minutes of the committee’s Mar. 28, 1978 meeting) (quoted in Masters & Stanzler § 4.07, at 4-130–4-131).

⁴³ See Masters & Stanzler § 4.01[B].

⁴⁴ *Borel v. Fibreboard Paper Prods. Corp.*, 493 F.2d 1076 (5th Cir. 1973).

As shown in meeting minutes, on April 21, 1977, the Enterprise Liability Study Group concluded that each insurance policy triggered by continuing injury or damage was liable in full to pay for the policyholder's liability, with no proration to the policyholder:

The majority view was that coverage existed for each carrier throughout the period of time the asbestosis condition developed – i.e., from the first exposure through the discovery and diagnosis. The majority also contended that *each carrier on [the] risk during any part of that period could be fully responsible for the cost of defense and loss.*⁴⁵

Thus, the insurance industry's Enterprise Liability Study Group recognized that, in the context of long-tail, continuing injury from asbestos, each CGL insurer's policy on the risk during any part of the extended period of asbestos-related injury "could be fully responsible for the cost of defense and loss" for that claim.⁴⁶ In March 1978, the members of the insurance industry's General Liability Rules and Forms Committee again recognized that the standard CGL policy language was "not desirable because it pyramids the limits available to the insured for losses resulting from continuous or repeated exposures over multiple policy periods."⁴⁷ As the minutes of this ISO drafting committee reflect, however, the committee again declined to add proration language to the standard CGL policy form or otherwise to prevent the "pyramiding" of limits problem in the context of asbestos and other claims for "long-tail" or continuing injury.⁴⁸

The insurance industry rejected proration in its standard "occurrence" language in the 1970s and 1980s. Instead, as part of the revisions creating the 1986 CGL Form, the industry

⁴⁵ Charles Berryman & Richard Ingegneri, Memorandum of Meeting of Discussion Group – Asbestosis 1 (Apr. 21, 1977) (quoted in Masters & Stanzler at § 4.07, at 4-130 (emphasis added in quotation from Masters & Stanzler)).

⁴⁶ *Id.*

⁴⁷ See "Memorandum to Members of the General Liability Rules and Forms Committee," at production #610004324 (Apr. 18, 1978) (enclosing minutes of Mar. 28, 1978 meeting) (quoted in Masters & Stanzler § 4.07, at 4-130–4-131).

⁴⁸ See *id.* at production #610004324-29 (at Masters & Stanzler § 4.07, at 4-130–4-131).

adopted a new approach: it introduced a claims-made form, as an option to be used with large commercial risks. Under the claims-made form, coverage is triggered by a claim made against the policyholder during the policy period. Under that trigger, only a single policy year is normally triggered, a result the industry sought to limit its exposure to multi-year injuries triggering multiple policy years under traditional CGL form policies. After massive objections from policyholders and regulators, the insurance industry retrenched, offering two CGL forms, one with the traditional occurrence concept, triggered by injury or damage during the policy period; and one with a claims-made trigger.⁴⁹ However, the insurance industry drafters again did not introduce any proration formula into the “occurrence” form.

That remains true today – the standard CGL “occurrence” form has no proration provision and remains on the market for businesses and to ordinary consumers in their automobile and homeowners insurance policies.

Proration Clauses Used by Insurance Industry in Other Types of Insurance

As shown by this history, the insurance industry’s decisions not to include a proration requirement in the standard CGL “occurrence” policy forms was not inadvertent. It was a considered decision, discussed across the industry; disclosed to the public through the regulatory process, and watched (and in public hearings rejected) by state insurance regulators across the country.

This is not to say that it would have been impossible to craft such a provision. Insurance industry drafters have proven repeatedly that they are capable of writing proration or

⁴⁹ Masters & Stanzler §§ 1.11, 4.03. Indeed, the proposal to change the CGL trigger to a claims-made trigger for all policyholders met stiff resistance from state insurance commissions, policyholders, and businesses; and, for those reasons, it did not advance. See discussion in *Insurance Antitrust*, 938 F.2d at 928-30; see also Masters & Stanzler § 4.01[B][5].

apportionment clauses when consistent with the coverage and trigger, and when they thus choose to prevent the policyholder from recovering from more than one policy period or insurer. For example, a 1928 Manufacturers' Public Liability Policy contained the following apportionment clause:

Concurrent Insurance. If the Assured carries a policy of another insurer, against any loss and/or expense covered by this Policy, the Assured shall not recover from the Company a larger proportion of the entire loss and/or expense than the amount hereby insured bears to the total amount of valid and collectible insurance applicable thereto.⁵⁰

The first version of the New York Standard Fire Insurance Policy, admittedly a first-party coverage, also contained a proration provision. The insurance industry first promulgated that policy form and mandated its use for all fire risks more than 100 years ago, in 1886. It included the following proration clause explicitly assigning part of the policyholder's loss to the insured:

The company shall not be liable under this policy for a greater proportion of any loss on the described property . . . than the amount hereby insured shall bear to the whole insurance . . . covering such property . . .⁵¹

Similarly, today, some directors and officers ("D&O") policy forms include proration or apportionment provisions. While not an industry-wide standardized coverage like fire or general liability insurance, and not sold to individuals, D&O insurance is a common coverage, and use of

⁵⁰ Clyde Crobaugh & Amos Redding, *Casualty Insurance*, at 439 (1928) (quoted in Masters & Stanzler at § 4.07[D][1][d], at 4-159). This general language was carried forward into the accident-based standard CGL forms of the 1940s and 1950s as the "other insurance clause." While helpful as long as the trigger was an "accident" and that term connoted a "boom" or other event fixed at a discrete moment in time, this clause did not help with "cumulation," or pyramiding of policy limits outside the policy period once the policy was triggered by injury that took place over a period of years, as was true for occurrence-based policy forms. It is important also to note that, unlike "other insurance clauses" included today in CGL insurance policies, this clause explicitly assigned liability to the "assured." Thus, unlike today's other insurance clauses, this clause intended to be assigned to the policyholder. See discussions *infra* of "other insurance clauses."

⁵¹ Guilford Deitch & Joseph Wood, "The Old New York Standard," chapter 2 of *The New York Standard Fire Policy*, at 10, lines 96-98 (The Rough Notes Co., 1905 and 1930) (quoted in Masters & Stanzler at § 4.07[D][1][d], at 4-159).

such provisions in D&O policies shows that the insurance industry knows how to draft, and use, such proration provisions when it believes that such provisions can be included in the coverage without appreciably diminishing its marketability.⁵² For D&O and like coverages, the insurance industry drafters have thought it important to include a proration clause in their policy forms, and have developed proration clauses that limit the insurance company's exposure. Conversely, in the general liability insurance context, the insurance industry has not reached consensus on adding such proration provisions to the standard CGL Form other coverage relied on by individual consumers for protection. Courts correctly have refused to read such a clause into liability insurance policies that do not include them.⁵³ The ALI should follow their lead.

Rejection of "Non-Cumulation": The insurance industry also considered in the 1950s and early 1960s "non cumulation," an approach intended to let progressive injury trigger a series of consecutive annual policy years and, at the same time, limit financial exposure, by "rolling up" all of the triggered limits into one year. In this approach, insurers proposed using a version of a "non-cumulation clause" providing that, if injury continued over several policy periods, the amounts paid or payable under the earlier triggered policies would reduce the limits of the later policies.

⁵² For a discussion of D&O allocation, see, e.g., Dan A. Bailey, "Allocation," available at www.baileycavalieri.com/38-D&O_Allocation.pdf. Mr. Bailey's law firm typically represents insurers only. See also Darren S. Teshima, "Can D&O Insurers Contract Around Duty to Advance Costs?," available at <http://www.law360.com/articles/587028/can-d-o-insurers-contract-around-duty-to-advance-costs> (accessed Jan. 30, 2015). D&O insurance also typically uses a claims-made trigger.

⁵³ E.g., *Monsanto Co. v. C.E. Heath Comp. & Liab. Ins. Co.*, 652 A.2d 30 (Del. 1994) (applying Missouri law); *Plastics Eng'g Co. v. Liberty Mut. Ins. Co.*, 759 N.W.2d 613 (Wis. 2009).

The drafters specifically rejected this concept in March 1959 in the minutes of the Joint Scope of Coverage Subcommittee,⁵⁴ discussed above. In the spring of 1961, the CGL drafters returned to this concept, proposing the following non-cumulation clause:

Our proposal then is as follows:

* * *

introduce a new provision, along the lines suggested by the final paragraph of Insuring Agreement IV in Dick Schmalz's memo, to avoid accumulation of limits in the exposure type of case that results when exposure continues over successive policy years.⁵⁵

That proposal died a quick death. In May 1961, the drafters rejected that approach, concluding that it could not be enforced, particularly when, as is common, different insurers issued policies over a period of time. They also believed that it might create marketing difficulties by encouraging policyholders to change insurers:

Considerable doubt was expressed by members of the Joint Forms Committee during discussion of this problem that such a provision would be enforceable as a practical matter, particularly if the successive policies were issued by different companies. On the other hand, if the application of the provision were limited to successive policies issued by the same company, it would highlight the advantage of switching coverage from one company to another.⁵⁶

Drafting History Showing That Multiple Policies May Respond to a Continuing Loss

Insurance companies argue that allowing a policyholder to pick the triggered policy year to respond to continuing injury or damage is "unfair." That position flies in the face of the conclusion reached by a key policy drafter Gilbert Bean. Mr. Bean specifically affirmed that a

⁵⁴ Minutes of Joint Scope of Coverage Subcommittee at 1-2 (Mar. 3-4, 1959) (quoted *supra* in text accompanying n.34).

⁵⁵ Report of Joint Drafting Committee to Joint Forms Committee, at 4-5, attached to April 17, 1961 letter from George Katz to Edward Earle of NBCU (quoted in Masters & Stanzler § 4.07[D] at 4-156).

⁵⁶ Explanatory Memorandum from the Joint Forms Committee to the Rating Committees of the National and Mutual Bureau Regarding May 4, 1961 Draft, at 8 (June 7, 1961) (quoted in Masters & Stanzler § 4.07[D] at 4-157).

“separate policy” could “appl[y] each year” when damage – for example, in a long-tail waste disposal case – continued over a period of years:

[T]he policy in force when a particular injury or damage takes place is the one which applies, regardless of when the causing accident took place. *So if the injury or damage from waste disposal should continue after the waste disposal ceased, as it usually does, it could produce losses on each side of a renewal date, and in fact over a period of years, with a separate policy applying each year.*⁵⁷

In a 1968 publication, another key drafter from the 1960s, Richard H. Elliott, then secretary of the National Bureau Casualty Underwriters, a key insurance rating organization involved in the drafting process, observed that “the definition of occurrence serves to identify the time of loss for the purpose of applying coverage – the injury must take place during the policy period,” and that, in cases involving progressive injury, “more than one policy period afford[s] coverage.”⁵⁸

After an extensive review of the drafting history and with a focus on insurance’s “dominant purpose of indemnity,”⁵⁹ the court in *Keene v. INA* concluded that the policyholder should “be able to collect from any insurer whose coverage is triggered, the full amount of indemnity that it is due,” subject to the insurers’ rights of contribution among themselves under “other insurance clauses.”⁶⁰

⁵⁷ Gilbert L. Bean, “New Comprehensive General and Automobile Program: The Effect on Manufacturing Risks,” address delivered at the Mutual Insurance Technical Conference 6 (Nov. 15-16, 1965) (emphasis added) (quoted in Masters & Stanzler § 4.09 at 4-199).

⁵⁸ Richard H. Elliott, “The New Comprehensive General Liability Policy,” in *Liability Insurance Disputes* 12-5 (S. Schreiber ed., 1968) (quoted in *American Home Products I*, 565 F. Supp. at 1502).

⁵⁹ 667 F.2d at 1041.

⁶⁰ 667 F.2d at 1050. See discussion of “other insurance clauses” *infra* at text accompanying nn.72-81.

Decisions on Allocation by State Appellate Courts

Well-reasoned decisions by state supreme and appellate courts in at least 12 states have adopted the joint and several rule on allocation, and rejected proration, in complex long-tail claims, like environmental claims, triggering coverage in multiple policy years. These courts appropriately recognize the overall economic advantages of this approach. They also focus on its superiority to the proration approach advocated by insurers. The joint and several rule ensures the timely availability of insurance funds to facilitate environmental cleanups, and discourages the unnecessary litigation between policyholders and insurers necessitated under proration schemes. It also enforces the bargains made between policyholders and insurers and effectuates the insurance industry intent shown in industry drafting history and lore. Some state supreme courts have also applied the joint and several rule to the related “dollars and cents” issue of whether deductibles, self-insured retentions, or fronting policies in the primary layer should be prorated.⁶¹

The joint and several liability/pick and choose rule accomplishes loss recovery more effectively than the alternative **allocation and contribution (proration)** theories that insurers consistently advocate.⁶² Moreover, it more accurately reflects the quality of protection that the insurance industry markets to customers and presents to regulators. The joint and several/pick and choose rule avoids time-wasting finger-pointing and is administratively simpler to apply.

⁶¹ In such cases, insurers have argued that deductibles, SIRs, or fronting policies should be considered “insurance,” requiring the policyholder to pay a pro-rata share. *E.g.*, *Aerojet*, 948 P.2d 909; *Am. Nat’l Fire Ins. Co. v. B&L Trucking & Constr. Co.*, 951 P.2d 250 (Wash. 1998); *Weyerhaeuser Co. v. Commercial Union Ins. Co.*, 15 P.3d 115 (Wash. 2000). For a full discussion of this issue, see Masters & Stanzler § 4.08[B] & [C].

⁶² Contribution applies only among insurance companies and arises only if only insurer has overpaid, a process that Keene called a “reallocat[ion].” *Id.* at 1051; *see also id.* at 1050 n.37. Contribution is an equitable doctrine requiring “clean hands”; arguably, contribution/proration should not apply when the insurance industry has in its industry processes rejected proration as between policyholders and their insurers.

Unlike proration, it does not raise complicated issues of proof or analysis. Indeed, that was part of the rationale for joint and several allocation.⁶³

As the U.S. Court of Appeals for the District of Columbia Circuit concluded in its landmark decision in *Keene Corp. v. Insurance Co. of North America*,⁶⁴

The only logical resolution of this [allocation] issue is for Keene to be able to collect from any insurer whose coverage is triggered, the full amount of indemnity that it is due, subject only to the provisions in the policies that govern the allocation of liability when more than one policy covers an injury. That is the only way that Keene can be assured the security that it purchased with each policy.⁶⁵

State Supreme Courts That Have Adopted the "All Sums" or Joint and Several Liability Rule on Allocation:

California Law:

State of Calif. v. Continental Ins. Co., 281 P.3d 1000 (Cal. 2012);
Aerojet-General Corp. v. Transport Indem. Co., 948 P.2d 909 (Cal. 1997).

Delaware Law:

Hercules, Inc. v. AIU Ins. Co., 784 A.2d 481 (Del. 2001). *See also Monsanto Co. v. C.E. Heath Comp. & Liab. Ins. Co.*, 652 A.2d 30 (Del. 1994) (applying Missouri law).

Illinois Law:

Zurich Ins. Co. v. Raymark Indus., Inc., 514 N.E.2d 150 (Ill. 1987). *See also John Crane, Inc. v. Admiral Ins. Co.*, 2013 IL App (1st) 109340-B (June 4, 2013) (following *Raymark* and refusing to follow *Outboard Marine Corp. v. Liberty Mut. Ins. Co.*, 670 N.E.2d 740 (Ill. Ct. App. 1996); *Missouri Pac. R.R. v. Int'l Ins. Co.*, 679 N.E.2d 801 (Ill. Ct. App. 1997); *see also Benoy Motor Sales, Inc. v. Universal Underwriters Ins. Co.*, 679 N.E.2d 414 (Ill. Ct. App. 1997).

Indiana Law:

Allstate Ins. Co. v. Dana Corp., 759 N.E.2d 1049 (Ind. 2001).

Missouri Law:

⁶³ 667 F.2d at 1051 n.38.

⁶⁴ 667 F.2d at 1050-51.

⁶⁵ 667 F.2d at 1050.

Monsanto Co. v. C.E. Heath Comp. & Liab. Ins. Co., 652 A.2d 30 (Del. 1994) (applying Missouri law). *See also Doe Run Resources Corp. v. Certain Underwriters at Lloyd's London*, 400 S.W.3d 463 (Mo. Ct. App. 2013).

New York Law:

Continental Cas. Co. v. Rapid-Am. Corp., 609 N.E.2d 506 (N.Y. 1993) (rejecting proration of defense costs under a CGL policy) ("*Rapid-American*"); *but see Consolidated Edison Co. of New York, Inc. v. Allstate Ins. Co.*, 774 N.E.2d 687 (N.Y. 2002) (adopting proration under non-standard CGL policy language, concluding "this is not the last word on allocation" in New York) ("*ConEd*").

Ohio Law:

Pa. Gen. Ins. Co. v. Park-Ohio Indus., 930 N.E.2d 800 (Ohio 2010); *Goodyear Tire & Rubber Co. v. Aetna Cas. & Sur. Co.*, 769 N.E.2d 835 (Ohio 2002).

Pennsylvania Law:

J.H. France Refractories Co. v. Allstate Ins. Co., 626 A.2d 502 (Pa. 1993).

Rhode Island Law:

Emhart Indus., Inc. v. Century Indem. Co., 559 F.3d 57 (1st Cir. 2009) (following *Ins. Co. of N. Am. v. Kayser-Roth Corp.*, 770 A.2d 403 (R.I. 2001) (imposing most costs on one insurer despite the existence of other insurance).

Texas Law:

Lennar Corp. v. Markel Am. Ins. Co., 413 S.W.3d 750 (Tex. 2013); *American Physicians Ins. Exch. v. Garcia*, 876 S.W.2d 842 (Tex. 1994).

Washington Law:

Am. Nat'l Fire Ins. Co. v. B&L Trucking & Constr. Co., Inc., 951 P.2d 250 (Wash. 1998); *Weyerhaeuser Co. v. Commercial Union Ins. Co.*, 15 P.3d 115 (Wash. 2000).

Wisconsin Law:

Plastics Eng'g Co. v. Liberty Mut. Ins. Co., 759 N.W.2d 613 (Wis. 2009).

State Intermediate Appellate Courts That Have Adopted the "All Sums" or "Joint and Several Liability" Rule on Allocation:

Missouri Law:

Doe Run Res. Corp. v. Certain Underwriters at Lloyd's London, 400 S.W.3d 463 (Mo. Ct. App. 2013).

Oregon Law:

Cascade Corp. v. Am. Home Assur. Co., 135 P.3d 450 (Or. Ct. App. 2006) (interpreting Or. Rev. Stat. § 465.480 (3)-(5) Env. Ins.).

See also:

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Connecticut Law:

O'Brien v. United States Fidelity & Guar. Co., 669 A.2d 1221 (Conn. 1996) (court refused to apply "other insurance" clause to require automobile policyholder to obtain a portion of his recovery from another insurance company). See *Reichhold Chems., Inc. v. Hartford Accident & Indem. Co.*, 750 A.2d 1051 (Conn. 2000) (applying "all sums" allocation under Washington law); but see *Reichhold Chems. v. Hartford Accident & Indem. Co.*, 750 A.2d 1051 (Conn. 2000) (applying proration under New York law). See decisions in insurer vs. insurer disputes: *Metropolitan Life Ins. Co. v. Aetna Casualty & Surety Co.*, 765 A.2d 891 (Conn. 2001); *Security Ins. Co. v. Lumbermen's Mut. Cas. Co.*, 826 A.2d 107 (Conn. 2003) (holding that a policyholder, who is self-insured or has no proof of insurance, is responsible for its defense costs for those times in which it was self-insured or had no applicable coverage).

District of Columbia Law:

Keene Corp. v. Ins. Co. of No. Am., 667 F.2d 1034 (D.C. Cir. 1981), *cert. denied*, 455 U.S. 1007 (1982) (no decision made on choice of law), the landmark decision on continuous trigger and the joint and several or pick and choose rule on allocation.

Hawaii Law:

Sentinel Ins. Ltd. v. First Ins. Co. of Haw., Ltd., 875 P.2d 894 (Haw. 1994) (squarely adopting proration *between insurers*, but indicating it might not apply between a policyholder and its insurers).

Minnesota Law. Applying joint and several liability rule in certain circumstances:

In re Silicone Implant Ins. Coverage Litig., 667 N.W.2d 405 (Minn. 2003); *SCSC Corp. v. Allied Mut. Ins. Co.*, 536 N.W.2d 305 (Minn. 1995) (*overruled on other grounds*, *Bahr v. Boise Cascade Corp.*, 766 N.W.2d 910 (Minn. 2009)).

Court decisions adopting proration typically ignore the regulatory and drafting history of the CGL Form, ignore the contractual language, or both.⁶⁶ Some decisions adopting proration

⁶⁶ For examples, see:

Colorado: *Public Serv. Co. of Colo. v. Wallis & Cos.*, 986 P.2d 924, 935 (Colo. 1999).

Connecticut: *Sec. Ins. Co. v. Lumbermen's Mut. Cas. Co.*, 826 A.2d 107 (Conn. 2003) (requiring proration of defense costs for those periods where policyholder had no insurance or had self-insured retentions); *Metro. Life Ins. Co. v. Aetna Cas. & Sur. Co.*, 765 A.2d 891 (Conn. 2001).

Kansas: *Atchison, Topeka & Santa Fe Ry. Co. v. Stonewall Ins. Co.*, 71 P.3d 1097 (Kan. 2003).

Kentucky: *Aetna Cas. & Sur. Co. v. Commonwealth*, 179 S.W.3d 830 (Ky. 2005); *Ohio Cas. Ins. Co. v. State Farm Mut. Auto. Ins. Co.*, 511 S.W.2d 671 (Ky. Ct. App. 1974).

Louisiana: *Arceneaux v. Amstar Corp.*, 66 So. 3d 438 (La. 2011) (allowing proration on indemnity only) ("*Arceneaux II*"); *Arceneaux v. Amstar Corp.*, No. 2014-CA-0271, 2015 WL 798980, at *7 (La. Ct. App., 4th Cir., (Cont'd . . .)

have construed non-standard policy language that the court found required proration but left open the possibility that other cases, involving other policy language, could lead to adoption of a different allocation rule.⁶⁷ Courts adopting proration also typically refer to “equity” and “fairness” (to insurers) in reaching their result. Those courts ignore the inequity and the unfairness of disregarding insurance industry drafted standard form language, thus nullifying the bargain (to the extent standardized policy language can be said to be negotiated) that the parties struck.⁶⁸ Two states with proration decisions on the books limit proration to indemnity and have not extended proration to the duty to defend.⁶⁹

At best, states are more or less evenly divided on this issue, with several recent cases giving the “joint and several” approach an edge. In addition, as courts have concluded, disagreement among courts about the meaning of form policy terms evidences ambiguity.⁷⁰

(... cont'd)

Feb. 25, 2015) (“Continental’s duty to defend American Sugar going forward in this litigation is not subject to proration”) (*Arceneaux IV*”).

Maryland: *Riley v. United Servs. Auto. Ass’n*, 871 A.2d 599 (Md. Ct. Spec. App. 2005) (allocation by time on the risk), *aff’d*, 899 A.2d 819 (Md. 2006); *Baltimore v. Utica Mutual Ins. Co.*, 802 A.2d 1070, 1101 (Md. Spec. App. 2002), *cert. granted*, 810 A.2d 961 (Md. 2002), *cert. dismissed*, 821 A.2d 369 (Md. 2003).

New Hampshire: *EnergyNorth Natural Gas, Inc., v. Certain Underwriters at Lloyd’s*, 934 A.2d 517, 526-27 (N.H. 2007).

New Jersey: *Carter-Wallace, Inc. v. Admiral Ins. Co.*, 712 A.2d 1116 (N.J. 1998) (“*Carter-Wallace*”); *Owens-Illinois, Inc. v. United Ins. Co.*, 650 A.2d 974, 993-94 (N.J. 1994).

⁶⁷ See, e.g., *Boston Gas Co. v. Century Indem. Co.*, 910 N.E.2d 290, 312 (Mass. 2009); *Consolidated Edison Co. v. Allstate Ins. Co.*, 746 N.Y.S.2d 622 (N.Y. 2002); see also *Crossmann Communities of N.C., Inc. v. Harleysville Mut. Ins. Co.*, 717 S.E.2d 589 (S.C. 2011); *Ohio Cas. Ins. Co. v. Unigard Ins. Co.*, 268 P.3d 180 (Utah 2012); *Sharon Steel Corp. v. Aetna Cas. & Sur. Co.*, 931 P.2d 127, 141 (Utah 1997).

⁶⁸ For a discussion of allocation, additional insurance industry drafting and regulatory history relevant to this issue, and relevant case law, see Masters & Stanzler §§ 4.02 and 4.07 and state-law survey charts in Tables 4-1 (trigger of coverage) and 4-2 (allocation).

⁶⁹ Louisiana: *Compare Arceneaux III*, 66 So. 3d at 438 (La.; proration of duty to indemnify only), *with Arceneaux IV*, 2015 WL 798980 at *5-7 (La. Ct. App.; no proration of defense costs).

New York: *Compare Rapid-American*, 609 N.E.2d at 514 (refusing allocation of duty to defend/defense costs to policyholder); *with Con Ed*, 774 N.E.2d at 693-95.

⁷⁰ E.g., *Hartford Acc. & Indem. Co. v. Dana Corp.*, 690 N.E.2d 285, 295, 297 (Ind. Ct. App. 1997) (“We conclude that the division of authority on this issue is instructive and is evidence that more than one reasonable interpretation (Cont’d . . .)

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Such ambiguity on standard-form policy provisions like those should be interpreted in favor of coverage.⁷¹

Inapplicability of "Other Insurance Clauses"

The *Keene* court emphasized that the insurance company or companies that have paid the policyholder under the joint and several/pick and choose rule have the right to seek contribution from other insurance companies on the risk during the period of continuing injury. In discussing this right of contribution by an insurer chosen by the policyholder to respond, the D.C. Circuit explained that this right of contribution is implemented and confirmed in standard CGL policies by the "other insurance clause." The court also rejected the insurers' arguments that "other insurance clauses" required a different result. The court found that, in fact, "other insurance clauses" do not apply at all in a dispute between a policyholder and its liability insurers.

It is a well-established principle of both insurance law and insurance industry custom and practice that "other insurance" clauses apply only in battles between insurance companies. They do not apply to disadvantage policyholders or require allocation to the policyholder.⁷² Payment of the policyholder's claim always takes priority over claims by insurers which seek contribution or indemnity from other insurers. "Other insurance clauses" apply only to determine "reallocat[ion]" of the loss between, or among, concurrent insurers.⁷³ "[O]ther insurance" clauses thus apply to apportion coverage only if there is other "concurrent" insurance coverage.⁷⁴

(. . . cont'd)
of the term . . . is possible"); *accord Travelers Indem. Co. v. Summit Corp. of Am.*, 715 N.E.2d 926, 938 (Ind. Ct. App. 1999).

⁷¹ *E.g., Eli Lilly & Co. v. Home Ins. Co.*, 482 N.E.2d 467, 470 (Ind. 1985).

⁷² *See, e.g.*, 667 F.2d at 1050.

⁷³ Douglas R. Richmond, *Bad Faith Litigation – "Other Insurance" Provisions: Cutting Through the Virtually Impenetrable Thicket "of" Other Insurance*, New Appleman on Insurance: Current Issues in Insurance Law 69 (Dec. 2007) ("Richmond II"); Douglas R. Richmond, *Issues and Problems in "Other Insurance," Multiple*

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Concurrent insurance coverage is insurance that is concurrent as to both (1) time insured and (2) the risk insured.⁷⁵ For example, in *St. Paul Fire & Marine Insurance Co. v. Vigilant Insurance Co.*, insurance company versus insurance company case, the court refused to apply an "other insurance clause," even in a case between insurance companies, because the insurance policies there applied to different time periods. Thus, they were not concurrent in time, and, under the rules applicable to "other insurance" clauses, the clauses did not apply.⁷⁶

Courts have drawn clear distinctions between the rights of contribution among insurance companies and an insurer's obligation to indemnify its policyholder.⁷⁷ As a California court explained:

As a general rule, "courts will give heed to 'primary' and 'excess' insurance provisions of insurance policies. This rule is particularly applicable where the dispute is between two or more insurance carriers and . . . the rights of policyholders or their accident victims will be unaffected by its application."⁷⁸

Because "other insurance clauses" provide a scheme by which an insurance company's liability is to be apportioned with other insurers, the clauses should not be used to impose liability on the policyholder:

(. . . cont'd)
Insurance and Self-Insurance, 22 Pepp. L. Rev. 1373, 1380-81 (1995) ("Richmond I"); see, e.g., *Reliance Ins. Co. v. St. Paul Surplus Lines Ins. Co.*, 753 F.2d 1288 (4th Cir. 1985) (applying D.C. law); *Zurich Ins. Co. v. Northbrook Excess & Surplus Ins. Co.*, 494 N.E.2d 634, 650 (Ill. App. Ct. 1986), *aff'd sub nom. Zurich Ins. Co. v. Raymark Indus., Inc.*, 514 N.E.2d 150 (Ill. 1987) ("Raymark"); *Plastics Engineering*, 759 N.W.2d at 624..

⁷⁴ *St. Paul Fire & Marine Ins. Co. v. Vigilant Ins. Co.*, 919 F.2d 235, 241 (4th Cir. 1990) (applying North Carolina law); see also *Carter-Wallace*, 712 A.2d at 1123-24.

⁷⁵ *Twin City Fire Ins. Co. v. Home Indem. Co.*, 650 F. Supp. 785, 791 (E.D. Pa. 1986).

⁷⁶ 919 F.2d at 241.

⁷⁷ *Raymark*, 494 N.E.2d at 650 ("other insurance" clause does not affect the individual insurance company's obligations to the insured.).

⁷⁸ *Interinsurance Exch. of Auto. Clubs v. Spectrum Inv. Corp.*, 258 Cal. Rptr. 43, 50 (Ct. App. 1989) (citing *National Am. Ins. Co. v. Insurance Co. of N. Am.*, 74 Cal. App. 3d 565, 574 (1977)). *Accord Mission Ins. Co. v. Hartford Ins. Co.*, 155 Cal. App. 3d 1199, 1208 (1984).

“Other insurance” clauses only affect insurers’ rights among themselves; they do not affect the insured’s right to recovery under each concurrent policy. Inter-insurer loss allocation by way of “other insurance” clauses never permits allocation of a loss to the insured. Payment of the insured’s claim always takes priority over the allocation of the loss between concurrent insurers.⁷⁹

Thus, to the extent an insurer attempts to use an “other insurance clause” to diminish recovery by the policyholder, the insurance company has the burden to show that the clause applies.⁸⁰ Under generally accepted principles of policy interpretation adopted by the *Restatement*, insurers cannot meet that burden unless the plain meaning of the clauses show that they apply to policyholders. The clauses, called an “impenetrable thicket” by courts and commentators,⁸¹ have no such plain meaning. Using “other insurance clauses” to support proration of the policyholder both improperly places the burden of proof on the policyholder to defeat an argument that functions as an exclusion of coverage, and improperly allows insurers to use the clause to disadvantage the policyholder.

Inapplicability of “Deemer” and Non-Cumulation Clauses

Some insurance policies, particularly those sold in certain periods by Liberty Mutual Insurance Company, contained a “deemer” clause that provides:

With respect to injury to or destruction of property, including the loss of use thereof, caused by exposure to injurious conditions over a period of time involving two or more liability policies issued by [Liberty Mutual] and affording insurance for such injury to or

⁷⁹ *Richmond I*, 22 Pepp. L. Rev. at 1380-81. See, e.g., *Emp’rs Empires Reinsurance Corp. v. Phoenix Ins. Co.*, 230 Cal. Rptr. 792, 798 (Ct. App. 1986); *Raymark*, 494 N.E.2d at 650; *Bazinet v. Concord Gen. Mut. Ins. Co.*, 513 A.2d 279, 281 (Me. 1986).

⁸⁰ The original reason for “other insurance” clauses was to prevent overinsurance and double recovery by the policyholder under property and fire insurance policies. In the context of third-party liability insurance, the fear of overinsurance is greatly diminished because recovery would not inure to the benefit of the policyholder. E.g., *Jones v. Medox, Inc.*, 413 A.2d 1288, 1290 (D.C. 1980); see also Susan Randall, *Coordinating Liability Insurance*, 1995 Wis. L. Rev. 1339, 1353 n. 48 (1995). Thus, the rationales and need for the clause are less salient in the context of liability insurance, where insurers can (and do) resort to arguments for equitable contribution.

⁸¹ See generally, e.g., *Richmond II*, *supra* n.73.

destruction of property . . . caused by the same general injurious conditions shall be deemed to occur only on the last day of the last exposure and the applicable limit of liability contained in the policy in effect on the last day of such exposure shall be the applicable limit of liability.⁸²

Some also contain a “Non-Cumulation of Liability – Same Occurrence” clause as follows:

If the same *occurrence* gives rise to *personal injury or property damage* which occurs partly before and partly within any annual period of this policy, each occurrence limit and the applicable aggregate limit or limits of this policy shall be reduced by the amount of each payment made by the company with respect to such *occurrence*, either under a previous policy or policies of which this policy is a replacement, or under this policy with respect to previous annual periods thereof.⁸³

These “anti-stacking” provisions have not convinced courts to reject the language in the insuring agreement triggering multiple policy periods.⁸⁴ In *Joy Technologies*, for example, the West Virginia Supreme Court recognized “that, where a definite meaning has been ascribed to language used in an insurance policy, that meaning should be given to the language by the courts.”⁸⁵ Insurance companies have confirmed that, under the “all sums” or “those sums” language, general liability insurance is “triggered” when bodily injury or property damage takes place during the policy period.

⁸² See, e.g., *Endicott Johnson Corp. v. Liberty Mut. Ins. Co.*, 928 F. Supp. 176 (N.D.N.Y. 1996).

⁸³ A.S. Klein, Annotation, *Insurer's Liability or Punitive Damages or Refusal to Make Under-Contracts for Consequential for Wrongful Delay Payments Due*, 47 A.L.R.3d 314 (1998) (emphasis in original); see also *Liberty Mut. Ins. Co. v. Treesdale, Inc.*, 418 F.3d 330 (3d Cir. 2005) (finding that non-cumulation clause precludes stacking of coverage under Pennsylvania law) (quoted in *Masters & Stanzler* § 4.09 at 4-198–4-199).

⁸⁴ *Joy Technologies*, 421 S.E.2d at 494; *Viking Pump, Inc. v. Century Indem. Co.*, 2009 Del. Ch. LEXIS 180, *aff'd*, withdrawn from publication, 2010 Del. LEXIS 678 (Del. 2010) (Table) (unpublished decision); see also *Spaulding Composites Co. v. Aetna Cas. & Sur. Co.*, 176 N.J. 25 (2003) (finding that non-cumulation clauses are unenforceable under New Jersey law); *Ernie Haire Ford, Inc. v. Universal Underwriters Ins. Co.*, 331 Fed. App'x 640 (11th Cir. 2009) (applying Florida law).

⁸⁵ *Joy Technologies*, 421 S.E.2d at 499 (citing *Christopher v. United States Life Ins. Co.*, 116 S.E.2d 864 (W. Va. 1960)).

Relying on the insurance company's own internal documents, the West Virginia Supreme Court in *Joy Technologies* affirmed the insurance company's conclusion that general liability insurance covers environmental damage taking place over a period of years:

The record shows at the time Liberty Mutual adopted this standard form for the commercial general liability policy, a memorandum entitled "Summary of Broadened Coverage Under New GL Policies With Necessary Limitations to Make This Broadening Possible," was circulated internally with the company. *That memorandum indicated that the policies covered liabilities including:*

Coverage for gradual BI [bodily injury] or gradual PD [property damage] resulting over a period of time from exposure to the insured's waste disposal. Examples would be gradual adverse effect of smoke, fumes, air or stream pollution, contamination of water supply or vegetation. We are all aware of cases such as contamination of oyster beds, lint in the water intake of down stream industrial sites, the Donora Pa. atmospheric contamination, and the like.⁸⁶

The *Joy Technologies* court concluded that "[t]he 1966 commercial general liability insurance policies, as originally issued, covered gradual bodily injury and property damage resulting over a period of time from exposure to the insured's waste disposal, as was suggested by Mr. Bean in the memorandum issued in conjunction with the drafting of the policies.⁸⁷

Although not widely addressed, courts also have refused insurers' reliance on non-cumulation clauses to escape liability.⁸⁸ The language in non-cumulation clauses can vary substantially, and it is important, for that reason, to compare the language in a policyholder's

⁸⁶ 421 S.E.2d at 497 (emphasis added) (quoted in Masters & Stanzler § 4.09 at 4-200),

⁸⁷ 421 S.E.2d at 497. The Bean memorandum to which the court refers is that quoted in the text accompanying n.54 *supra*.

⁸⁸ See, e.g., *Air Prods. & Chems., Inc. v. Hartford Accident & Indem. Co.*, No. 86-7501, 1989 U.S. Dist. LEXIS 7435, at *3 n.2 (E.D. Pa. June 30, 1989), *aff'd in part, vacated in part on other grounds*, 25 F.3d 177 (3d Cir. 1994) (rejecting application of a general non-cumulation clause) ("*Air Products*"); *Viking Pump*, 2014 Del. Super. LEXIS 707 (withdrawn). *Contra Air Products*, 1984 U.S. Dist. LEXIS 7435, at *7-8 (rejecting non-cumulation clause that sought to eliminate all liability by the insurer). See also the discussion of non-cumulation clauses in Masters & Stanzler § 19.03[B].

insurance policy to the language at issue in a particular decision. These clauses can be grouped roughly into the following categories. "General non-cumulation clauses" refer to "loss covered." Other non-cumulation clauses refer to "payments" by the insurance company and have been called "specific" non-cumulation clauses. Courts refuse to implement the clauses finding them ambiguous and, in effect, acting as invalid escape clauses.⁸⁹ The New Jersey Superior Court equated the non-cumulation clause to an (or another) other insurance clause, refusing to use either the non-cumulation clause or other insurance clause to disadvantage the policyholder.⁹⁰

CONCLUSION

The ALI's *Restatement of the Law of Liability Insurance* should not adopt a rule on allocation that ignores the drafting and regulatory history and the insurance industry's own intent in rejecting proration for standard CGL insurance policies. Such a rule contradicts policyholders' contractual expectations and reasonable expectations of protection under not only commercial liability insurance policies, but also under the personal lines insurance policies bought every year by millions of ordinary consumers. A provision specifying proration of liability to the policyholder should be adopted (if at all) only by the regulatory process that the insurance industry must follow in seeking significant changes to standardized coverages like the CGL coverage, or as a result of a true meeting of the minds in contract. With regard to standardized liability coverages, if the insurance industry has obtained the requisite regulatory approval, and, after public review and comment, includes a proration clause, it is appropriate to give it effect if its terms are clear and unambiguous. For coverages or insurance policies not

⁸⁹ *Air Products*, 1989 U.S. Dist. LEXIS at *3, n.2.

⁹⁰ *Carter-Wallace*, 712 A.2d at 1123-25.

requiring regulatory approval, the same approach is appropriate if parties with equal bargaining power freely agree to include such a provision.

Outside of those situations, the ALI should reject the inequity and anti-consumer (and anti-regulatory) intent of proration and instead should follow the contractual and marketing intent of the insurance industry, as confirmed, clearly, by its own drafting history and marketing documents. The ALI should not be a party to a process that ignores the insurance drafting documents and the insurance regulatory process which was adopted in this country to protect both consumers and the public. Doing so would not advance the ALI's mission and intent of promoting "the clarification and simplification of the law and its better adaptation to social needs, secur[ing] the better administration of justice, and encourag[ing] and carry[ing] on scholarly and scientific legal work."⁹¹ Consistent with the ALI's mission:

- It is *simpler* to follow the rule confirmed by the insurance industry's drafting history.
- It *better serves social needs* to avoid conclusions that have not been adopted through the regulatory process used by state insurance commissions across the country to protect the consumers and the public.
- It *secures the administration of justice* to defer on this issue to state regulatory processes designed to protect consumers; and to follow the court decisions which follow – and enforce – the contract language (and thus promote the public policy of enforcing contract).

⁹¹ ALI Charter, as quoted on ALI available on ALI website, Governance (Certification of Incorporation) tab, ALI Overview (Creation) tab (<http://www.ali.org/index.cfm?fuseaction=about.chartercite> accessed Jan. 16, 2015).

- Finally, it *encourages the scholarly work* in the field of insurance law to rely on the insurance industry's own pronouncements on allocation.

The *Restatement* should make clear that, where – as here – it is possible to ascertain industry intent on standard-form policy language, that intent should govern, unless and until a policy form includes a proration clause that has received regulatory approval or the parties to the insurance policy at issue have “specifically negotiated” the terms of the insurance policy. This is consistent with the definition of “standard form” policy terms adopted by the full ALI membership⁹²; advances the public policies promoting freedom, and enforcement, of contract; and accords with equity⁹³ and good process.

⁹² See *supra* text accompanying nn.7, 8.

⁹³ As noted above (text accompanying notes 66-68 *supra*), courts adopting proration often point to principles of “equity” and “fairness” as support for proration. What is equitable and fair about ignoring boilerplate contract language that the insurance industry itself has repeatedly recognized is not intended to support proration?